STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Complaint investigation survey was conducted on 12/2/19 through 12/5/19. The facility was found in compliance with the requirement CFR483.73, Emergency Preparedness. See event ID #2Z6J11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint investigation survey was conducted on 12/2/19 through 12/5/19. Seven of twenty four complaint allegations were substantiated resulting in deficiencies (F695, F684, F690 and F550). Exit date was changed to 12/11/19 - MD, Urologist and Pharmacy Manager interviews were conducted to obtain additional information. Per CMS and management review of the 2567, the Statement of Deficiencies was amended on 02/07/20 at Tag F 695 to reflect a change in the scope and severity level from a "D" to a "G". 2/12/2020. The facility revealed the resident in tag F695 was not in a certified bed. Therefore, Tag F695 was removed from the 2567.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		12/28/19

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

Electronically Signed | 12/31/2019

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F 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide dignity by allowing the resident to wait for more than 45 minutes to be fed (Resident # 103), not answering call lights (Resident # 125) and by not covering the urinary catheter bag (Resident #105) for 3 of 3 sampled residents reviewed for dignity.	F 550	Bethany Woods Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and	

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F 550	Continued From page 2 Findings included: 1. Resident #103 was originally admitted to the facility on 2/25/16 with multiple diagnoses including psychosis. The quarterly Minimum Data Set (MDS) assessment dated 10/24/19 indicated that Resident #103 had severe cognitive impairment and she required extensive assistance with eating. A continuous observation of a lunch meal was conducted on 100 hall on 12/2/19 from 12:00 noon through 1:05 PM. The lunch cart arrived on the hall at 12:15 PM and was parked on the hallway near the room where Resident #103 resided. There were 2 Nurse Aides (NAs) observed passing the trays to residents in their rooms who were able to feed themselves. There were 4 trays left in the cart. The 2 NAs started feeding residents who needed to be fed in their rooms at 12:40 PM. At 1 PM, another NA came on the 100 hall and started collecting trays from the resident's rooms. There were still 2 trays left in the cart including the tray of Resident #103. At 1:05 PM, NA #2 was observed to feed Resident #103 in her room. Resident #103 had waited 50 minutes to be fed while other residents had already finished eating. On 12/3/19 at 2:15 PM, NA #2 was interviewed. She stated that she had been working at the facility for 5 years and had been assigned on the 100 hall consistently. She indicated that there 4-5 residents on the hall that needed to be fed and there were always 2 NAs assigned on the hall. She added that the residents had to wait to be fed and some residents were slow to eat.	F 550	provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Bethany Woods Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Bethany Woods Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Identified Residents 1. Facility will correct this deficiency by giving resident #105 a privacy bag for his catheter bag on 12/5/2019 by unit manager 2. Facility will correct this deficiency by assessment of the resident # 125 call light timing by administration on 12/6/2019. 3. Facility will correct this deficiency by assessing resident #103 on for untimely assistance with meals. After this assessment this resident was placed on assignment sheet by director of nursing (DON) on 12/6/2019. Potential 1. A Catheter bag audit was completed by nursing administration on 12/13/19 to	

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F 550	Continued From page 3 On 12/4/19 at 8:25 AM, Resident #103 was observed in bed with her breakfast tray on top of the over the bed table covered and untouched. There were 2 NAs observed collecting the trays from the resident's rooms. At 8:30 AM, Geriatric Care Assistant (GCA) #2 was observed to enter the resident's room and started feeding the resident. Resident #103 had waited an hour to be fed while other residents had already finished eating. On 12/4/19 at 8:45 AM, Geriatric Care Assistant (GCA) #2 was interviewed. She stated that she had been trained on how to feed a resident. She stated that she helped the NAs to pass trays, to feed the residents, to pass ice and to make beds. The GCA reported that she just finished feeding another resident and then she came to feed Resident #103. On 12/4/19 at 8:45 AM, NA #4 was interviewed. NA #4 stated that she was assigned on 100 hall and the hall had 2 NAs scheduled most of the time. The breakfast cart arrived on the hall at 7:30 AM. She indicated that there were 4 residents who needed to be fed on the hall and residents had to wait until a NA was available. She added that the facility had GCAs who helped with feeding but at times they were on the other halls answering call light or feeding residents. On 12/5/19 at 12:53 PM, the Director of Nursing (DON) was interviewed. She stated that she had not assessed each hall recently as to how many residents needed to be fed. The DON added that it was time for her to reassess and to assign the Geriatric Care Assistant (GCA) to the hall that needed assistance with feeding.	F 550	ensure all privacy bags were in place. No negative findings. 2. Call light audits were completed by nursing administration on 12/14/2019 to ensure call lights were answered in a timely manner (approximately 15 mins) to protect residents in similar situations. No negative findings. 3. Audit of residents who need assistance with meals was completed on 12/12/2019 by unit managers. Assistance was provided in a timely manner (meals provided at same time as tablemates, and at acceptable temperature). Training 1. To ensure this problem will not happen again re-education on using privacy bags, answering call lights in a timely manner, and assisting residents in a timely manner was completed with licensed nurses, GCAs (geriatric care assistants), NA (nursing assistants), non-nursing and agency staff by Staff Development Coordinator on 12/27/2019. After 12/27/2019 any staff not educated will complete education prior to working. Newly hired employees will receive this education during orientation. Monitoring 1. Nursing Administration will complete audits 10 times randomly on 1st, 2nd or 3rd shift to include weekends, weekly for 4 weeks and monthly for 2 months ensure use of privacy bag, call lights are being answered in a timely manner, and assisting residents with meals. This audit will be documented on the F550 audit tool(s). A report will be submitted to the Quality Assurance Committee by the	

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F 550	Continued From page 4 2. Resident #125 was admitted to the facility on 10/17/17 with multiple diagnoses including depression. The quarterly Minimum Data Set (MDS) assessment dated 11/6/19 indicated that Resident #125 had intact cognition (Brief Interview for Mental Status score of 15) and she needed extensive assistance with transfer and toilet use. The assessment further indicated that Resident #125 had not displayed any behaviors and she was always continent of bowel and bladder. On 12/3/19 at 9:34 AM, Resident #125 was interviewed. She stated that the facility was short of staff on all shift. She indicated that when she used her call light, she had to wait for more than an hour for the staff to answer it. Resident #125 claimed that she used the call light when she was wet and needed to be changed or to be pulled up in bed. She also revealed that she had informed the nurses of her call bell concerns but there was no improvement. Resident #125 reported that she had observed nurses sitting at the nurse's desk and would not answer the call lights. When asked how she felt about it, she stated "I am moving to another facility". On 12/3/19 at 2:15 PM, NA #2 was interviewed. She stated that she had been working at the facility for 5 years and had been assigned on the 100 hall consistently. She indicated that there were always 2 NAs assigned on the hall. NA #2 indicated that when the 2 NAs were in the resident's room providing care and the nurse was passing the medications, nobody was answering the call lights. On 12/4/19 at 10:45 AM, Nurse # 2 was	F 550	director of nurses for monitoring. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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interviewed. She stated that she was assigned on the 100 hall consistently. She indicated that the hall had 30 residents when full but currently, had 25 residents. Nurse #2 revealed that she had to pass the medications of 25 residents, and it would take 4 hours to pass the morning medications. She stated that when the 2 NAs were in resident's rooms providing care and she was passing medications, nobody was answering the call lights.

On 12/5/19 at 8:45 AM, NA #4 was interviewed. NA #4 stated that she was assigned on 100 hall and the hall had 2 NAs scheduled most of the time. She added that the facility had GCAs who helped with answering the call lights but at times they were on the other halls answering call light or feeding residents.

On 12/5/19 at 12:53 PM, the Director of Nursing (DON) was interviewed. She stated that it was time for her to reassess each hall and to assign the Geriatric Care Assistant (GCA) to the hall that needed more assistance with feeding and with answering of call lights.

3. Resident #105 was originally admitted to the facility on 5/9/17 with the most recent readmission date of 4/9/19. His diagnoses included urinary retention.

Review of the quarterly Minimum Data Set (MDS) dated 10/25/19 indicated Resident #105 was cognitively intact. He was dependent on staff for all his Activities of Daily Living (ADL's) to include eating and had an indwelling urinary catheter.

During an interview and observation with Resident #105 on 12/2/19 at 10:45am, he was noted to have an indwelling urinary catheter with

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the drainage bag attached to the side of the bed. The drainage bag did not have a privacy cover and could be seen from the hall. Resident #105 stated he knew the bag was visible from the hallway and to others and had asked for it to be covered. The privacy cover was noted to be in a chair by the sink unopened. The resident went onto say that when he had visitors they could see the bag and asked questions which made him feel uncomfortable.

On 12/2/19 at 4:05pm an observation was made of Resident #105 with the urinary drainage bag attached to the side of the bed. The drainage bag did not have a privacy cover and could be seen from the hall.

During an observation of Resident #105 on 12/3/19 at 8:15am the urinary drainage bag was attached to the side of the bed, with no privacy cover present and could be seen from the hall.

An observation was made of Resident #105 in his electric wheelchair, in the hall, on 12/3/19 at 1:45pm with a privacy cover to his urinary drainage bag.

On 12/4/19 at 8:25am the resident was observed lying in the bed with the urinary drainage bag connected to the side of the bed and a privacy cover present. Resident #105 stated he felt much better with the drainage bag being covered.

An interview occurred with Nurse #7 on 12/4/19 at 8:40 am who indicated she was made aware Resident #105's urinary drainage bag did not have a privacy cover while she passed out the afternoon medications on 12/3/19.

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F 550	Continued From page 7 An interview occurred with Nurse Aide (NA) #14 on 12/4/19 at 2:55 pm. She explained all residents with urinary drainage bags should have a privacy cover for them. She recalled assisting Resident #105 up to his wheelchair on 12/3/19 and stated a privacy cover was attached to his wheelchair but was unable to recall if a privacy cover was attached to his bed. During an interview with the Director of Nursing on 12/5/19 at 12:43 pm, she indicated it was her expectation for nursing staff to use a privacy cover for urinary drainage bags and was unable to state why Resident #105's drainage bag was not covered.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (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. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (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. (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.	F 565		12/28/19

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F 565	Continued From page 8 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §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. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns reported during Resident Council meetings related to call lights not being answered timely for 9 of 9 consecutive months. The findings included: Review of the monthly Resident Council meeting minutes dated 3/7/19 included, in part, the concern of call lights not being answered in a timely manner. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This follow up form was signed by the Administrator on 3/26/19. Review of the monthly Resident Council meeting minutes dated 4/4/19 included, in part, the concern of call lights not being answered in a timely manner. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This	F 565	F565 Identified residents 1. Resident council minutes were reviewed by administrator and social services on 12/9/2019 for trends not addressed. No negatives noted. Potential 1. An audit of resident council minutes was reviewed to find any trends for the past 3 months on 12/10/2019 by social services to protect residents in similar situations. Call lights were found to be an issue and addressed by education that was provided to all staff on answering call lights in a timely manner (approximately 15 minutes) on 12/27/2019. No other negative findings noted. Training 1. Education provided to social services on the use the resident council minutes and follow up of grievance to ensure issues are resolved by administrator on 12/9/2019. This training will be provided to	

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F 565	Continued From page 9 follow up form was signed by the Administrator on 4/12/19. Review of the monthly Resident Council meeting minutes dated 5/2/19 included, in part, the concern of call lights not being answered in a timely manner. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This follow up form was signed by the Administrator with no date provided. Review of the monthly Resident Council meeting minutes dated 6/4/19 included, in part, the concern of call lights not being answered in a timely manner. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This follow up form was signed by the Administrator on 6/12/19. Review of the monthly Resident Council meeting minutes dated 7/26/19 included, in part, the concern of call lights not being answered in a timely manner. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This follow up form was signed by the Administrator on 8/8/19. Review of the monthly Resident Council meeting minutes dated 8/16/19 included, in part, the concern of call lights not being answered in a timely manner. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This follow up form was signed by the Administrator on 8/26/19.	F 565	any new social workers. Monitoring 1. The administrator will complete an audit monitoring performance to make sure solutions are sustained by reviewing resident council minutes monthly for 3 months to ensure concerns are resolved. This audit will be documented on the resident council meeting concern form. A report will be submitted to the Quality Assurance Committee by the administrator. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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Review of the monthly Resident Council meeting minutes dated 9/5/19 included, in part, the concern of call lights being turned off without assistance being provided. The Resident Council grievance follow up form indicated the staff were inserviced on providing assistance to residents in a timely manner. This follow up form was signed by the Administrator on 9/13/19.

Review of the monthly Resident Council meeting minutes dated 10/23/19 included, in part, the concern of call lights not being answered in a timely manner and call lights being turned off without assistance being provided. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This follow up form was signed by the Administrator on 10/23/19.

Review of the monthly Resident Council meeting minutes dated 11/7/19 included, in part, the concern of call lights not being answered in a timely manner. The Resident Council grievance follow up form indicated the staff were inserviced on answering call lights in a timely manner. This follow up form was signed by the Administrator on 11/20/19.

A Resident Council meeting was conducted on 12/3/19 at 1:30 PM with 14 alert and oriented residents who were active participants in the facility's Resident Council. The residents reported that they had a repeat concern over the past several months related to call bells not being answered timely. The meeting attendees all stated that this concern had not been resolved. When asked what the facility' s response was to them regarding this repeat concern the group indicated they were informed the facility staff had

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F 565	Continued From page 11 been re-educated. An interview with the Administrator on 12/4/19 at 9:45 AM revealed she had attended the Resident Council meetings with the permission of the members since she began working at the facility in mid-July 2019. She acknowledged that call lights not being answered timely were discussed in every meeting she attended by at least one resident. She stated that staff had been re-educated through inservices multiple times on answering call lights timely. She explained that some inservices were directed toward specific staff members based on the residents' report in the meetings and other inservices were provided to all nursing staff. Inservice sign in sheets from June 2019 through November 2019 were provided by the Administrator that confirmed inservices were held for nursing staff as indicated in the Resident Council grievance follow up forms. The Administrator stated that she had also initiated random call bell audits. She indicated that a number of residents had reported an improvement in call bell response time, but the issue had not been completely resolved as noted in the Resident Council minutes.	F 565		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		12/31/19

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representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is

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

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide

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F 623	Continued From page 14 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff and Ombudsman interview, the facility failed to inform or to send a copy of the discharge notice to the Ombudsman when a resident was discharged to the hospital for 5 of 5 sampled residents reviewed for hospitalization (Residents #103, 78, 58, 85 & 87). Findings included: 1. Resident # 58 was originally admitted to the facility on 6/29/19 with multiple diagnoses including malignant neoplasm of the bladder. Review of the nurse's note dated 8/12/19 at 1:53 PM revealed that Resident #58 had an appointment with the oncology clinic and the clinic had sent the resident to the hospital for evaluation and he was admitted. Review of Resident #58's admission record dated 8/13/19 revealed that he was readmitted back to the facility on 8/13/19. On 12/4/19 at 12:05 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that the Social Worker was responsible for informing or sending a copy of the discharge notice to the Ombudsman.	F 623	F623 Identified residents 1. Resident #103, 78, 58, 85, 87 identified Transfer/discharge notices were sent to the ombudsman on 12/30/19 by social services. Potential 1. Audit of resident transfers to a hospital was completed by social services on 12/26/2019 and a copy was of the transfer information was provided to the ombudsman on 12/26/2019 as an additional notification. No negative finding noted. Training 1. Social services and nursing administration were educated on sending transfer/discharge to ombudsman at the least 1 time weekly by administrator on 12/26/2019. This education will be provided to any new social service employee or nursing administration. Audits 1. Administrator, Director of nursing, and/or nursing management will audit all hospital discharges and transfers weekly for 4 weeks and monthly for 2 months ensure transfer discharge notices are sent to ombudsman at the least 1 time weekly. This audit will be documented on the	

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F 623	Continued From page 15 On 12/4/19 at 12:20 PM, Social Worker (SW) #1 was interviewed. She stated that the facility had 2 social workers and they were responsible for informing or sending the ombudsman a copy of the discharge notice for all planned discharges. The SW didn't know who was responsible for informing or sending a copy of the discharge notice to the ombudsman for the unplanned discharges including hospitalization. On 12/4/19 at 12:23 PM, the Ombudsman was interviewed. She stated that the facility had been sending her discharge notices, but she didn't know if they were discharged home or hospital. After reviewing her files, the Ombudsman stated that she didn't receive any discharge notice for Resident #58. On 12/4/19 at 4:24 PM, a follow up interview was conducted with SW #2. The SW stated that she was responsible for notifying or sending discharge notice to the ombudsman for all discharges, however, 4-6 weeks ago she was informed by the corporate office, that nursing would be responsible for informing or sending discharge notice to the ombudsman for all unplanned discharges including hospitalization. SW #2 reported that she had no record that the ombudsman was informed when Resident #58 was discharged to the hospital on 8/13/19. On 12/5/19 at 12:53 PM, the Administrator was interviewed. She stated that the staff had missed to inform the ombudsman when Resident #58 was discharged to the hospital because he was transferred from the clinic and not from the facility. The Administrator further indicated that nursing was now responsible for informing or sending the discharge notice to the ombudsman	F 623	unplanned discharge audit tool. A report will be submitted to the Quality Assurance Committee by the administrator. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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for residents discharged to the hospital.

2. Resident # 103 was originally admitted to the facility on 2/25/16 with multiple diagnoses including psychosis.

The progress note written by the Nurse Practitioner (NP) dated 7/16/19 at 2:55 PM revealed that Resident #103 was referred by nursing due to purple discoloration of upper and lower extremities. The resident was sent to the hospital for emergent attention.

Review of Resident #103's admission record dated 7/19/19 revealed that she was readmitted back to the facility on 7/19/19.

On 12/4/19 at 12:05 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that the Social Worker was responsible for informing or sending a copy of the discharge notice to the Ombudsman.

On 12/4/19 at 12:20 PM, Social Worker (SW) #1 was interviewed. She stated that the facility had 2 social workers and they were responsible for informing or sending the ombudsman a copy of the discharge notice for all planned discharges. The SW didn't know who was responsible for informing or sending a copy of the discharge notice to the ombudsman for the unplanned discharges including hospitalization.

On 12/4/19 at 12:23 PM, the Ombudsman was interviewed. She stated that the facility had been sending her discharge notices, but she didn't know if they were discharged home or hospital. After reviewing her files, the Ombudsman stated

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that she didn't receive any discharge notice for Resident #103.

On 12/4/19 at 4:24 PM, a follow up interview was conducted with SW #2. The SW stated that she was responsible for notifying or sending discharge notice to the ombudsman for all discharges, however, 4-6 weeks ago she was informed by the corporate office, that nursing would be responsible for informing or sending discharge notice to the ombudsman for all unplanned discharges including hospitalization. SW #2 reported that she had no record that the ombudsman was informed when Resident #103 was discharged to the hospital on 7/16/19.

On 12/5/19 at 12:53 PM, the Administrator was interviewed. She stated that the staff had missed to inform the ombudsman when Resident #103 was discharged to the hospital. The Administrator further indicated that nursing was now responsible for informing or sending the discharge notice to the ombudsman for residents discharged to the hospital.

3. Resident #78 was originally admitted to the facility on 7/15/19 with multiple diagnoses including dementia.

A nurse's note dated 10/2/19 at 4:39 PM revealed that Resident #78 was noted to have gastrointestinal (GI) bleeding. She was sent to the gastroenterology clinic for evaluation and the clinic transferred the resident to the hospital for evaluation and the resident was admitted.

Review of Resident #78's admission record dated 10/7/19 revealed that she was readmitted back to

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the facility on 10/7/19.

On 12/4/19 at 12:05 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that the Social Worker was responsible for informing or sending a copy of the discharge notice to the Ombudsman.

On 12/4/19 at 12:20 PM, Social Worker (SW) #1 was interviewed. She stated that the facility had 2 social workers and they were responsible for informing or sending the ombudsman a copy of the discharge notice for all planned discharges. The SW didn't know who was responsible for informing or sending a copy of the discharge notice to the ombudsman for the unplanned discharges including hospitalization.

On 12/4/19 at 12:23 PM, the Ombudsman was interviewed. She stated that the facility had been sending her discharge notices, but she didn't know if they were discharged home or hospital. After reviewing her files, the Ombudsman stated that she didn't receive any discharge notice for Resident #78.

On 12/4/19 at 4:24 PM, a follow up interview was conducted with SW #2. The SW stated that she was responsible for notifying or sending discharge notice to the ombudsman for all discharges however, 4-6 weeks ago she was informed by the corporate office, that nursing would be responsible for informing or sending discharge notice to the ombudsman for all unplanned discharges including hospitalizations. SW #2 reported that she had a copy of the discharge notice when Resident #78 was sent to the hospital on 10/2/19, however, she didn't have a record as to when the notice was sent to the

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ombudsman.

On 12/5/19 at 12:53 PM, the Administrator was interviewed. She stated that the staff had sent the discharge notice to the ombudsman but didn't have a record as to when it was sent. The Administrator further indicated that nursing was now responsible for informing or sending the discharge notice to the ombudsman for residents discharged to the hospital.

4. Resident #87 was originally admitted to the facility on 6/23/17 with multiple diagnoses including Chrohn's disease.

The quarterly Minimum Data Set (MDS) assessment dated 7/29/19 indicated Resident #87's cognition was moderately impaired.

Review of the medical record indicated Resident #87 was admitted to the hospital and discharged from the facility on 9/12/19. On 9/14/19 Resident #87 was readmitted to the facility. Resident #87 was again admitted to the hospital and discharged from the facility on 9/20/19. On 9/22/19 Resident #87 was readmitted to the facility.

On 12/4/19 at 12:05 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that the Social Worker was responsible for informing or sending a copy of the discharge notice to the Ombudsman.

On 12/4/19 at 12:20 PM, Social Worker (SW) #1 was interviewed. She stated that the facility had 2 social workers and they were responsible for informing or sending the ombudsman a copy of the discharge notice for all planned discharges.

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The SW didn't know who was responsible for informing or sending a copy of the discharge notice to the ombudsman for the unplanned discharges including hospitalizations.

On 12/4/19 at 12:23 PM, the Ombudsman was interviewed. She stated that the facility had been sending her discharge notices, but she didn't know if they were discharged home or to the hospital. After reviewing her files, the Ombudsman stated that she didn't receive any discharge notice for Resident #87 related to her hospitalizations on 9/12/19 or 9/20/19.

On 12/4/19 at 4:24 PM, a follow up interview was conducted with SW #2. The SW stated that she was responsible for notifying or sending discharge notices to the ombudsman for all discharges, however, 4-6 weeks ago she was informed by the corporate office, that nursing would be responsible for informing or sending discharge notices to the ombudsman for all unplanned discharges including hospitalizations. SW #2 reported she had a copy of the discharge notice when Resident #87 was sent to the hospital on 9/12/19, however, she didn't have a record as to when it was sent to the ombudsman. SW #2 additionally reported that she had no record that the ombudsman was informed when Resident #87 was discharged to the hospital on 9/20/19.

On 12/5/19 at 12:53 PM, the Administrator was interviewed. She indicated that the staff had sent the discharge notice to the ombudsman for Resident #87's hospitalization on 9/12/19 but didn't have a record as to when it was sent. She additionally indicated that staff had missed the ombudsman notification when Resident #87 was

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discharged to the hospital on 9/20/19. The Administrator stated that nursing was now responsible for informing or sending the discharge notice to the ombudsman for residents discharged to the hospital.

5. Resident # 85 was admitted on 7/10/2014 with diagnosis including, chronic respiratory failure, stage 3 chronic kidney disease, and neuromuscular dysfunction of the bladder.

A progress note written by nursing on 6/27/2019 at 10:49 am noted the resident was shaking, crying and unable to speak a complete sentence. An order was written for resident to be transported to the hospital for evaluation.

Record review indicated the Resident #85 was found to have a multidrug resistant urinary tract infection and she was admitted to the hospital on 6/27/2019 for treatment.

Review of Resident #85's admission record revealed that she was readmitted back to the facility on 7/3/19.

On 12/4/19 at 12:20 PM, Social Worker (SW) #1 was interviewed. She stated that the facility had 2 social workers and they were responsible for informing or sending the ombudsman a copy of the discharge notice for all planned discharges. The SW didn't know who was responsible for informing or sending a copy of the discharge notice to the ombudsman for the unplanned discharges including hospitalization.

On 12/4/19 at 12:23 PM, the Ombudsman was interviewed. She stated she did not receive a discharge notice for Resident #85.

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F 623	Continued From page 22 On 12/4/19 at 4:24 PM, SW #2 stated that she was responsible for notifying or sending discharge notice to the ombudsman for all discharges, however, 4-6 weeks ago she was informed by the corporate office, that nursing would be responsible for informing or sending discharge notice to the ombudsman for all unplanned discharges including hospitalization. SW #2 reported that she had no record that the ombudsman was informed when Resident #85 was discharged to the hospital on 6/27/19. On 12/5/19 at 12:53 PM, the Administrator was interviewed. She stated that the staff had failed to inform the ombudsman that Resident #85 was discharged to the hospital on 6/27/2019. The Administrator further indicated that nursing was now responsible for informing or sending the discharge notice to the ombudsman for residents discharged to the hospital.	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnoses (Resident #127), nutrition (Residents #34, #58, and #98) and skin conditions (Residents #72 and #105) for 6 of 26 sampled residents. The findings included:	F 641	F641 Identified Residents 1. Residents # 34, 58, 98 identified nutritional coding on the minimum data set assessment (MDS) was corrected on 12/30/2019 by Dietary manager. 2. Resident identified #127 MDS was corrected to add diagnosis of fracture 12/3/19 by the MDS nurse.	12/31/19

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F 641	Continued From page 23 1. Resident #127 was admitted to the facility on 7/31/13 with diagnoses that included dementia. Review of a radiology report dated 10/16/19 indicated Resident #127 had a fracture of the distal clavicle. A Nurse Practitioner (NP) note dated 11/4/19 indicated Resident #127 was to continue with clavicle splint for a left clavicle fracture with pain control as needed. The quarterly Minimum Data Set (MDS) assessment dated 11/7/19 indicated Resident #127's cognition was severely impaired. His active diagnoses had not included a clavicle fracture. The active diagnosis section of Resident #127's 11/7/19 MDS was coded by MDS Nurse #3. An interview was conducted with MDS Nurse #3 on 12/3/19 at 4:15 PM and she reported that this was her first job as an MDS Nurse and she began here in February 2019. The 11/7/19 quarterly MDS for Resident #127 that had not included an active diagnosis of a clavicle fracture was reviewed with MDS Nurse #1. She revealed this was an error and she was going to make a modification. During an interview with the Director of Nursing on 12/4/19 at 3:30 PM she indicated that MDS Nurse #3 should have coded the active diagnosis of a clavicle fracture on Resident #127's 11/7/19 MDS. She reported that this was an oversight of MDS Nurse #3 and that a modification was going to be completed and transmitted.	F 641	3. Resident Identified #72 skin condition MDS was corrected on 12/5/2019 by the MDS nurse. Resident #105 skin condition MDS was corrected on 12/2/2019 by the MDS nurse. 4. Corrected MDS assessments for residents # 34, 58, 98, 127, 72, and 105 were transmitted by the MDS nurse by 12/27/2019 by to the National Repository. Potential 1. Audit of residents nutritional coding for all MDS, comprehensive and quarterly assessments was completed on 12/30/2019 by dietary manager. With no negative findings. 2. Audit of residents with active diagnosis of fracture was completed 12/12/19 by minimum data set (MDS) nurse to ensure fracture was coded on all MDS, comprehensive and quarterly assessments appropriately. No negative findings. 3. An audit of resident with wounds was completed on 12/30/2019 by minimum data set (MDS) nurse to ensure wounds were coded correctly on all MDS, comprehensive and quarterly assessments. No negative findings. Training 1. Re-education by corporate MDS consultant on accurate Nutritional coding bases on the resident assessment instrument (RAI) was completed with Dietary manager on 12/20/2019. This education will be provided to any new dietary manager. 2. Re-education by corporate MDS consultant on accurate MDS coding based on the RAI on 12/17/19 for MDS	

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F 641	Continued From page 24 2. Resident #98 was admitted to the facility on 1/24/18 with diagnoses that included dementia. The annual Minimum Data Set (MDS) assessment dated 10/3/19 indicated Resident #98's cognition was severely impaired. She was noted with significant weight loss and a current weight of 139 pounds. The nutrition section of the 10/3/19 MDS for Resident #98 was coded by the Dietary Manager (DM). The Care Area Assessment (CAA) related to nutritional status for the 10/3/19 annual MDS indicated Resident #98 had lost weight in the last 6 months. The significant change MDS assessment dated 10/21/19 indicated Resident #98's cognition was severely impaired. She was noted with significant weight loss and current a weight of 139 pounds. The nutrition section of the 10/21/19 MDS for Resident #98 was coded by the DM. The CAA related to nutritional status for the 10/21/19 significant change MDS indicated Resident #98 had lost weight in the last 60 to 90 days. An interview was conducted with the DM on 12/4/19 at 2:05 PM. The 10/3/19 annual MDS that indicated Resident #98 weighed 139 pounds and had significant weight loss was reviewed with the DM. Resident #98's weight history was reviewed with the DM. Resident #98's weight on 9/4/19 was 139 pounds which showed no weight loss in the last month. Resident #98's weight on 4/11/19 was 150 pounds which showed an	F 641	nurses. This education will be provided to any new MDS nurse. Monitoring 1. Nursing Administration to complete audits weekly of completed comprehensive MDS for 4 weeks and monthly for 2 months to ensure nutrition, diagnosis and wounds are coded accurately on the MDS. This audit will be documented on the MDS audit tool. A report will be submitted to the Quality Assurance Committee by the administrator. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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11-pound weight loss in 6 months equal to a 7% loss. The DM was unable to explain how she had calculated a significant weight loss of 5% or more in the last month or 10% or more in the last 6 months for Resident #98. She reported that Resident #98 had fluctuating weights and that since she had lost weight over the past 6 months that she thought this was significant.

During an interview with the Director of Nursing on 12/4/19 at 3:30 PM she indicated that the DM was expected to follow the Resident Assessment Instrument's (RAIs) instructions and only code significant weight loss if it met the requirements of 5% or more in the last month or 10% or more in the last 6 months.

3. Resident #58 was admitted on 6/29/19 with cumulative diagnoses of Cerebral Vascular Accident and dysphagia (difficult swallowing).

Resident #58's quarterly Minimum Data Set (MDS) dated 10/6/19 indicated severe cognitive impairment and he exhibited no behaviors. Section K was coded for no swallowing disorders.

Review of Resident #58's nutritional care plan dated last revised on 10/7/19 read he was at risk for weight loss due to being on mechanically altered diet of pureed food and nectar thick liquids diet.

Review of Resident #58's December 2019 Physician orders included an order for regular pureed diet with nectar thick liquids.

In an observation on 12/5/19 at 8:50 AM, Nursing Assistant (NA) #4 was assisting Resident #58 with his breakfast. He was eating a pureed diet

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with nectar thick liquids. NA #4 stated the reason he was prescribed his current diet was due to his difficulty swallowing.

In an interview on 12/5/19 at 9:15 AM, Geriatric Care Assistant (GCA) #1 stated Resident #58 had problems swallowing and was prescribed a pureed diet.

In an interview on 12/5/19 at 10:25 AM, MDS Nurse #1 stated the Dietary Manger (DM) completed section K Swallowing/Nutritional Status of the quarterly MDS dated 10/6/19 for Resident #58.

In an interview on 12/5/19 at 11:50 AM, the DM stated section K of Resident #58's quarterly MDS dated 10/6/19 should have been coded for problems with swallowing and stated it must have been an oversight.

In an interview on 12/5/19 at 12:40 PM, the Administrator and Director of Nursing (DON) stated it was their expectation that Resident #58's section K quarterly MDS dated 10/6/19 would have been coded accurately to reflect his difficulty with swallowing.

4) Resident #105 was originally admitted to the facility on 5/9/17 with the most recent readmission date of 4/9/19. His diagnoses included Diabetes Mellitus and pressure ulcer of sacral region.

Review of the Skin/Wound Review progress note dated 9/9/19 indicated a diabetic ulcer was identified to Resident #105's left outer ankle. He was also being treated with a wound VAC (vacuum-assisted closure- a device that suctions fluids and drainage away from an open wound) to

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a Stage 4 pressure ulcer on the right buttock and a hydrocolloid dressing to a Stage 2 pressure ulcer on his gluteal fold (the crease separating the buttocks from the thigh).

Review of the wound ulcer flowsheet dated 10/3/19 revealed Resident #105 had a Stage 4 pressure ulcer to his right hip with a wound VAC in place and a diabetic ulcer to his left ankle with treatments 3 times a week.

A physician's order dated 10/21/19 indicated to:
- Cleanse the gluteal fold with wound cleanser and pat dry. Apply skin prep and a hydrocolloid dressing to the site and cover with dry dressing. Change every Monday and as needed.
- Cleanse left outer ankle with wound cleanser and pat dry. Apply Silver Alginate (a dressing that contains sodium and calcium to absorb wound fluid) and a dry dressing. Change 3 times a week on Monday, Wednesday, Friday and as needed.

Review of the quarterly Minimum Data Set (MDS) dated 10/25/19 indicated Resident #105 was cognitively intact. He was dependent on staff for all his Activities of Daily Living to include eating. He was coded with a diabetic foot ulcer and no pressure ulcers.

On 12/5/19 at 10:23am an interview was completed with the MDS Nurse #1. She stated MDS Nurse #3 was new to the MDS role as of February 2019 and had completed the MDS dated 10/25/19. She stated after reviewing the documentation and wound logs from the Treatment Nurse she identified the pressure ulcers were not captured on the 10/25/19 MDS.

An interview was completed with MDS Nurse #3

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on 12/5/19 at 11:35am where she stated it was an oversight not to have captured the pressure ulcers on the MDS dated 10/25/19. She further explained when coding for skin conditions the nursing progress notes, Wound Ulcer Flowsheets and interviews with the staff and Treatment Nurse were utilized to code the area correctly.

During an interview with the Director of Nursing on 12/5/19 at 12:43pm, she verified Resident #105 had a Stage 2 pressure ulcer to his buttocks, a Stage 4 pressure ulcer to his right hip and a diabetic ulcer to his left ankle. She further indicated it was her expectation for the MDS assessments to be coded accurately.

5) Resident #72 was admitted to the facility on 2/12/15 with diagnoses that included Peripheral Vascular Disease (PVD) with chronic venous ulcers (a wound that develops on the lower leg when the leg veins fail to return blood back towards the heart normally) of the lower extremities, chronic pain and hypertension.

A review of the facility's Wound Ulcer Flowsheet dated 10/8/19 indicated the following venous ulcer measurements in centimeters (cm):
- Left posterior lower leg 19 cm in length, 3 cm in width and 0.1 cm in depth.
- Left heel 2.5 cm in length 2 cm in width and 0.1 cm in depth.
- Top of left foot 1.2 cm in length, 1.9 cm in width and 0.1 cm in depth.
- Right posterior lower leg 15 cm in length, 2.4 cm in width and 0.1 cm in depth.

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A review of the quarterly Minimum Data Set (MDS) dated 10/10/19 indicated Resident #72 was cognitively intact and displayed no behaviors or refusal of care during the look back period. He required extensive to total assistance from staff for bed mobility, dressing, personal hygiene, toileting and bathing and had 2 venous ulcers present.

Review of the active care plan dated 10/17/19 revealed problem areas for venous stasis ulcer of right and left lower extremities related to PVD with interventions to administer treatments as ordered.
On 12/5/19 at 10:23am an interview was completed with the MDS Nurse #1. She stated MDS Nurse #3 was new to the MDS role as of February 2019 and had completed Resident #72's MDS dated 10/10/19.

An interview was completed with MDS Nurse #3 on 12/5/19 at 11:35am and stated she meant to put in 4 instead of 2 venous ulcers. She further explained when coding for skin conditions the nursing progress notes, Wound Ulcer Flowsheets and interviews with the staff and Treatment Nurse were utilized to code the area correctly.

During an interview with the Director of Nursing on 12/5/19 at 12:43pm, she verified Resident #72 had 4 venous ulcers in total to his lower extremities. She further indicated it was her expectation for the MDS assessments to be coded accurately.

6. Resident # 34 was admitted to the facility on 1/6/18 with multiple diagnoses including dementia and cardiovascular disease.

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F 641	Continued From page 30 The annual Minimum Data Set (MDS) assessment dated 9/20/19 indicated that Resident #34 had received tube feeding and was on mechanically altered diet during the assessment period. Resident #34's care plan dated 9/20/19 was reviewed. One of the care plan problems was resident required gastrostomy (G) tube for maintaining nutritional status related to dysphagia and nothing by mouth (NPO). Resident #34's physician's orders for September 2019 listed the resident as NPO. On 12/4/19 at 4:20 PM, the Dietary Manager (DM) was interviewed. She indicated that she was responsible for completing section K of the MDS. The DM stated that Resident #34 was on tube feeding and she was not receiving anything by mouth including food. She added that the annual MDS assessment dated 9/20/19 was not accurate. On 12/5/19 at 12:53 PM, the Director of Nursing (DON) was interviewed. She expected the MDS assessment to be coded accurately. The DON added that she didn't know if the DM was trained on how to complete section K.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		12/31/19

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F 656	Continued From page 31 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. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to develop a comprehensive care plan for the presence of a	F 656	F656 Identified 1. Resident #58 identified care plan was	

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F 656	Continued From page 32 pressure and diabetic ulcer (Resident #105), for the use of oxygen (Resident #119) and for a resident that required total assistance with meals for a resident identified with weight loss (Resident #58). This was for 3 of 26 residents care plans reviewed. The findings included: 1) Resident #105 was originally admitted to the facility on 5/9/17. His diagnoses included Diabetes Mellitus, hypertension and pressure ulcer of sacral region. A physician's order dated 10/21/19 read: - Cleanse the gluteal fold with wound cleanser and pat dry. Apply skin prep and a hydrocolloid treatment to the site and cover with dry dressing. Change every Monday and as needed. - Cleanse right outer ankle with wound cleanser and pat dry. Apply Silver Alginate and dry dressing. Change 3 times a week on Monday, Wednesday, Friday and as needed. Review of the quarterly Minimum Data Set (MDS) dated 10/25/19 indicated Resident #105 was cognitively intact. He was dependent on staff for all his Activities of Daily Living (ADLs). He was coded with a diabetic foot ulcer and no pressure ulcers. The active care plan dated 10/31/19 revealed a plan in place for the potential for skin breakdown or development of further pressure ulcers related to limited mobility, however no interventions present for the treatment of the sacral area pressure ulcer or diabetic foot ulcer. There was no care plan added to address the actual skin impairment and/or the diabetic foot ulcer.	F 656	updated for nutrition on 12/4/2019 by assistant director of nursing (ADON). 2. Residents identified #105 pressure ulcer care plans were updated by wound nurse on 12/30/2019. 3. Resident #119 identified care plan was updated for oxygen usage on 12/27/2019 by nurse manager. Potential 1. An audit of current residents care plans were reviewed for corrected for nutrition on 12/18/2019 by Dietary Manager. No other negative findings noted. 2. An audit was completed for residents with wounds and care plans were corrected by wound nurse on 12/27/2019. No negative findings noted 3. An audit was completed for residents who use oxygen to ensure care plans are correct by nurse managers on 12/27/2019. Finding revealed one resident needed care plan to reflect current oxygen use. Care plan was added on 12/27/2019 by nurse management. No negative findings noted. Training 1. Re-education by corporate minimum data set (MDS) consultant on accurately developing Nutritional care plans was completed with Dietary manager on 12/20/2019. This in-service will be provided to any new dietary manager. 2. Re-education by corporate Wound Nurse consultant to ensure care plans are updated with wound care staff on 12/26/2019. This in-service will be provided to any new wound care staff. 3. Re-education by director of nursing	

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F 656	Continued From page 33 On 12/5/19 at 10:23am an interview was completed with the MDS Nurse #1. She stated MDS Nurse #3 was new to the MDS role as of February 2019 and had completed the care plan review on 10/31/19. MDS Nurse #1 reviewed the care plan and verified a care plan was not developed for the presence of the diabetic foot ulcer or pressure ulcer on the gluteal fold and should have been. An interview was completed with MDS Nurse #3 on 12/5/19 at 11:35am, who stated she was unaware a care plan that addressed the pressure and diabetic ulcers should have been developed in addition to the potential for skin breakdown care plan and acknowledged that interventions for ulcer care should have been present. During an interview with the Director of Nursing on 12/5/19 at 12:43pm, she stated it was her expectation for care plans to be an accurate reflection of the resident. She further revealed she would have expected a care plan and additional interventions to be in place to address Resident #105's pressure and diabetic ulcers. 2) Resident #119 was originally admitted to the facility on 3/14/19. Her diagnoses included asthma, chronic respiratory failure and coronary artery disease. A physician order dated 7/28/19 revealed Oxygen at 2 liters via nasal cannula at bedtime and as needed. The quarterly Minimum Data Set (MDS) dated 11/1/19 revealed the resident to have cognitive	F 656	(DON) to ensure oxygen usage is care plan with nursing managers on 12/27/2019. This in-service will be provided to any new nurse managers. Audits 1. Nursing Administration to complete 10 random (to cover all halls) residents audit weekly for 4 weeks and monthly for 2 months ensure nutrition, pressure ulcer and oxygen care plans are correct. This audit will be documented on the care plan audit tool. A report will be submitted to the Quality Assurance Committee by the administrator. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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impairment and received extensive to total assistance from staff for all Activities of Daily Living (ADLs). She had shortness of breath or trouble breathing with exertion and received oxygen.

A review of Resident #119's active care plan dated 11/11/19 revealed no care plan in place for the use of oxygen.

Review of the nursing progress notes from 7/28/19 to present revealed Resident #119 used oxygen at bedtime as ordered.

On 12/5/19 at 10:23am an interview was completed with the MDS Nurse #1. She stated MDS Nurse #3 was new to the MDS role as of February 2019 and had completed the care plan review on 11/11/19. MDS Nurse #1 reviewed and verified a care plan was not developed for the use of oxygen and should have been.

An interview was completed with MDS Nurse #3 on 12/5/19 at 11:35am and stated it was an oversight to not have developed a care plan for the use of oxygen.

During an interview with the Director of Nursing on 12/5/19 at 12:43pm, she stated it was her expectation for care plans to be an accurate reflection of the resident. She further revealed she would have expected a care plan and interventions to be in place to address Resident #119's use of oxygen at bedtime.

3. Resident #58 was admitted on 6/29/19 with cumulative diagnoses of Cerebral Vascular Accident and dysphagia (difficult swallowing).

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BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

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F 656	Continued From page 35	F 656		

Review of Resident #58's nutrition care plan last revised on 9/24/19 read he was at risk for weight loss due to inadequate intake, decreased appetite and mechanically altered diet. The only intervention on the care plan was to set up his tray and encourage consumption of his meals.

Resident #58's quarterly Minimum Data Set (MDS) dated 10/6/19 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total staff assistance with eating and was coded unprescribed weight loss and a mechanically altered diet.

Review of Resident #58's weights since October 2019 to present were stable.

In an interview on 12/4/19 at 11:00 AM, Nursing Assistant (NA) #2 stated Resident #58 required staff assistance with eating.

In an observation on 12/5/19 at 8:50 AM, NA #4 was assisting Resident #58 with his breakfast. He was eating a pureed diet with nectar thick liquids. There was also a nutritional supplement on his tray. NA #4 stated he consumed all his supplements and breakfast was his best meal for intake.

In an interview on 12/5/19 at 9:15 AM, Geriatric Care Assistant (GCA) #1 stated Resident #58 required staff assistance with all his meals.

In an interview on 12/5/19 at 11:35 AM, MDS Nurse #1 stated it was the facility practice that nursing, Unit Managers, or Dietary Manager were responsible implementing a comprehensive care plan with appropriate interventions if Resident

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F 656	Continued From page 36 #58's weight loss was identified in between MDS assessments. MDS Nurse #1 stated a comprehensive care plan with appropriate interventions should have been completed at the time Resident #58's weight loss was identified. In an interview on 12/5/19 at 12:20 PM, the Assistant Director of Nursing (ADON) stated she completed the nutrition care plan initiated on 9/24/19. She confirmed he required total staff assistance with eating and he was receiving multiple nutritional supplements. The ADON stated the care plan intervention for staff to set up his tray and encourage consumption of his meals was not an appropriate intervention. She stated the Dietary Manger (DM) should have revised the care plan for the quarterly MDS dated 10/6/19 due to weight loss. In an interview on 12/5/19 at 12:27 PM, the DM stated she reviewed Resident #58's nutrition care plan on 10/7/19 but she did not comprehensively care plan him with appropriate interventions. She stated other interventions such as assistance with meals, supplements, monitoring weight, monitoring lab work, notifying the Physician and/or Registered Dietician for continued weight loss. She stated it was an oversight. In an interview on 12/5/19 at 12:40 PM, the Administrator and Director of Nursing (DON) stated it was their expectation that Resident #58's weight loss care plan be comprehensive with appropriate interventions.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		12/28/19

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F 657	Continued From page 37 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to revise the care plan in the areas of medications and falls (Resident #78) and for nutrition (Resident #30) for 2 of 26 sampled residents reviewed. Findings included: 1a. Resident #78 was admitted to the facility on 7/15/19 with multiple diagnoses including dementia and history of gastrointestinal (GI)	F 657	F657 Identified residents 1. Identified Resident #78 care plan was reviewed for discontinued anticoagulant and fall mats by nursing administration on 12/5/2019. 2. Identified resident #30 care plan was reviewed for residents' weight loss by ADON on 12/27/2019. Potential 1. An audit for residents on	

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F 657	Continued From page 38 bleed. The quarterly Minimum Data Set (MDS) assessment dated 10/12/19 indicated that Resident #78 had severe cognitive impairment and she had received an anticoagulant medication for 1 day during the assessment period. On 10/2/19, Resident #78 had a doctor's order to discontinue the Eliquis, anticoagulant medication, due to rectal bleed. Resident #78's care plan dated 10/12/19 was reviewed. One of the care plan problems was potential for bleeding related to anticoagulant therapy. The goal was for the resident to be free from signs/symptoms of bleeding. The approaches included to administer the medication as ordered and to observe for signs/symptoms of bleeding. On 12/5/19 11:35 AM, MDS Nurse #1 was interviewed. She reported that nursing was responsible for revising the care plan. She also stated that MDS Nurse #3 was a new MDS Nurse and she didn't catch it when she reviewed the care plan in October 2019. On 12/5/19 at 12:53 PM, the Director of Nursing (DON) was interviewed. She stated that nursing including the nurses and the unit managers were responsible for revising the care plan, but she would be revamping the system to have the MDS Nurses responsible for revising the care plan when indicated. 1b. Resident #78 was admitted to the facility on 7/15/19 with multiple diagnoses including dementia and history of gastrointestinal (GI)	F 657	anticoagulants was completed on 12/27/19 by nurse management to ensure care plans were in place to reflect current condition and correct by reviewing. No negative findings. 2. An audit for residents with fall mats was completed on 12/27/2019 by nurse management to ensure care plan was accurate to reflect current condition by reviewing. No negative findings. 3. An audit of residents with significant weight loss for the past 90 days was completed on 12/27/2019 by the dietary manager to ensure the care plan was in place and accurate to reflect current condition by reviewing. Care plans were accurate and in place by 12/27/19. No negative findings. Training 1. Re-education was provided to nursing administration and dietary manager on revising care plans by administrator on 12/27/2019. This in-service will be provided to any new nursing administration member or dietary manager during orientation. Audits 1. Nursing management and/or dietary will completed 10 random (to include all halls) resident care plan audits weekly for 4 weeks and monthly for 2 months to ensure anticoagulants, falls and weight loss is care plans are revised. This audit will be documented on the care plan audit tool. A report will be submitted to the Quality Assurance Committee by the director of nurses. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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F 657	Continued From page 39	F 657		

bleed. The quarterly Minimum Data Set (MDS) assessment dated 10/12/19 indicated that Resident #78 had severe cognitive impairment and she had no falls since admission/reentry or prior assessment.

The nurse's note and the incident report revealed that Resident #78 had a fall on 8/11/19 at 3:00 AM.

Resident #78's care plan dated 10/12/19 was reviewed. One of the care plan problems was at risk for falls related to unsteady gait. The goal was to remain free of injury and the approaches included fall mat on the floor when in bed (added on 8/12/19).

Resident #78 was observed in bed on 12/3/19 at 12:25 PM and on 12/4/19 at 12:22 PM. There was no mat on the floor noted on both dates and times.

On 12/4/19 at 10:28 AM, NA #2 was interviewed. NA #2 stated she was assigned on 100 halls where Resident #78 resided. She reported that she had not seen a floor mat on Resident #78's room.

On 12/5/19 at 10:10 AM, Nurse #2 was interviewed. Nurse #2 was assigned to Resident #78. She stated that she had not seen Resident #78 with floor mat beside her bed.

On 12/5/19 at 11:38 AM, MDS Nurse #1 was interviewed. She stated that when Resident #78 was on 300 hall, she had a floor mat beside her bed. Therapy was working with the resident and had discontinued the floor mat due to a trip hazard for her. Resident #78 was moved to 100

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F 657	Continued From page 40	F 657		

hall in August 2019 and the care plan was not revised to remove the floor mat.

On 12/5/19 at 12:53 PM, the Director of Nursing (DON) was interviewed. She stated that nursing including the nurses and the unit managers were responsible for revising the care plan, but she would be revamping the system to have the MDS Nurses responsible for revising the care plan when indicated.

2. Resident #30 was admitted on 4/19/2019 with diagnoses that included chronic obstructive pulmonary disease, diabetes type 2, and stage 4 pressure ulcer of the sacrum.

The quarterly Minimum Data Sheet (MDS) dated 9/17/2019 indicated the resident had moderate cognitive impairment, required physical assistance for activities of daily living, and required only tray set up for eating meals. The resident's weight was documented as 162 pounds and indicated the resident had experienced unplanned weight loss during the assessment period.

Record review of resident's weights indicated the resident was documented as 183 pounds on 9/4/2019 and 168 pounds on 9/18/2019 reflecting a 15 pounds or 8% weight loss in a two weeks period.

The most recent comprehensive care plan, revised on 9/24/2019 by the Dietary Manager, reflects the resident is at risk for caloric intake greater than body requirements, characterized by weight gain, obesity, and excessive appetite. Goals and interventions reflect the resident will eliminate snacking and participate in appropriate

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F 657	Continued From page 41 physical activity. The facility failed to update the focus, goals, and interventions to reflect the resident's weight loss. On 12/05/19 at 11:59 am an interview was conducted with the dietary manager in which she acknowledged the care plan was inaccurate and should reflect the resident's weight loss and not weight gain.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and family interview, the facility failed to accurately transcribe an order for a respiratory medication for 1 of 4 residents reviewed for respiratory (Resident #119). Resident #119 was originally admitted to the facility on 3/14/19 with the most recent readmission date of 7/28/19. Her diagnoses included asthma, chronic respiratory failure and coronary artery disease. The quarterly Minimum Data Set (MDS) dated 11/1/19 revealed the resident had cognitive impairment and received extensive to total assistance from staff for all Activities of Daily Living except supervision and setup assistance with eating. She had shortness of breath (SOB) or trouble breathing with exertion and received	F 658	F658 Identified 1. Resident #119's orders were reviewed for accuracy by nursing administration on 12/5/2019 with corrections made. Potential 1. Audit of residents with as needed (PRN) respiratory medications were reviewed for accuracy by nursing administration on 12/27/2019. No negative findings noted. Training 1. Re-Education was provided to nursing administration, and licensed nurses including agency to ensure orders are transcribed accurately by staff development coordinator (SDC) on 12/27/2019. Any licensed nurse not educated by 12/27/2019 will not be	12/28/19

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F 658	Continued From page 42 oxygen. A review of Resident 119's medical record revealed the following orders: * An order dated 10/28/19 for Albuterol nebulizer (a medication that is used to treat wheezing and SOB via a special machine that turns the medication into a mist that can be inhaled) 1 vial every 6 hours for 7 days. * An order dated 11/22/19 for Albuterol nebulizer 1 vial every 4 hours as needed (prn) for wheezing and/or shortness of breath. A review of the December 2019 Physician Orders did not show an order for Albuterol nebulizer 1 vial every 4 hours as needed for wheezing and/or SOB. A review of the November and December 2019 Medication Administration Records (MAR's) indicated Resident #119 had not used the prn dose of Albuterol nebulizer from 11/22/19 until 12/3/19. An interview occurred with a family member of Resident #119 on 12/3/19 at 4:40pm. She was concerned when she asked for Resident #119 to receive an Albuterol nebulizer treatment today, she was told the order was not present on the December 2019 Medication Administration Record (MAR). She further stated the nurse reviewed the medical record and added the order to the December 2019 MAR. On 12/4/19 at 2:35pm an interview occurred with Nurse #8 who completed the December 2019 MAR review on 11/24/19. She explained she saw Albuterol ProAir prn listed on the MAR and mistook it for the Albuterol nebulizer prn order for	F 658	allowed to work until in-service is complete. This education will be provided to any new nursing administration during orientation. Audits 1. Nursing management to complete 10 resident medication administration records/orders (random halls to include all halls) audits weekly for 4 weeks and monthly for 2 months to ensure PRN respiratory medications are transcribed correctly. A report will be submitted to the Quality Assurance Committee by the director of nurses. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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F 658	Continued From page 43 Resident #119 and was an oversight. On 12/4/19 at 3:10pm a phone call was placed to Nurse #9, who completed the December 2019 MAR review on 11/27/19. No return call was received during the time of the survey. During an interview with the Director of Nursing on 12/5/19 at 12:43pm, she stated the December MAR review came at the time of a holiday with a short window to complete them. The DON further stated it was her expectation for respiratory medications to be transcribed correctly.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff interviews and facility Nurse Practitioner interview, the facility failed to provide dressing change and treatments as ordered by the physician to venous stasis ulcers on the lower extremities (Resident #72) and failed to clarify a consultation note and schedule a follow up appointment with oncology (Resident #105) for 2 of 3 residents sampled for well-being. The findings included:	F 684	F684 Identified 1. Identified resident #72 treatment orders were reviewed by nursing management on 12/05/2019 with no negative findings. On 12/3/2019 resident 72 was provided with treatment as ordered by treatment nurse. 2. Identified resident # 105 consultation notes were reviewed by nursing administration on 12/27/2019 with no	12/28/19

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F 684	Continued From page 44 1. Resident #72 was admitted to the facility on 2/12/15 with diagnoses that included Peripheral Vascular Disease (PVD) with chronic venous ulcers (a wound that develops on the lower leg when the leg veins fail to return blood back towards the heart normally) of the lower extremities, chronic pain and hypertension. A review of the quarterly Minimum Data Set (MDS) dated 10/10/19 indicated Resident #72 was cognitively intact and displayed no behaviors or refusal of care during the look back period. He required extensive to total assistance from staff for bed mobility, dressing, personal hygiene, toileting and bathing. He was coded with 2 venous ulcers present. Review of the active care plan dated 10/17/19 revealed problem areas for venous stasis ulcer of right and left lower extremities related to PVD and resistance to treatments. The care plan further indicated the following interventions were in place for staff to document care being resisted, provide treatments as ordered by the physician, observe ulcers for signs and symptoms of infection and notify the physician for changes. A review of Resident #72's Physician Orders dated 10/29/19 revealed the following: - Cleanse vascular wound to top of left foot with normal saline and pat dry. Apply an antibacterial wound dressing and collagen (a protein based wound dressing), cover with dry dressing and apply a gauze and compression wrap every week. - Cleanse vascular wound to left heel with normal saline and pat dry. Apply an antibacterial wound dressing and collagen (a protein based wound	F 684	negative findings. Resident # 105 has an appointment with oncology on 12/30/2019 with no finding. Potential 1. Audit of wound treatment orders were reviewed by wound nurse on 12/9/2019. No negative findings noted. 2. Audit of all consultations were reviewed for the last 14 days for any action needed taken by nursing administration on 12/27/2019. No negative findings noted. Training 1. Re-education by corporate Wound Nurse consultant to ensure treatments are followed as ordered with wound care staff by 12/26/2019. This education will be provided to any new wound care staff during orientation. 2. Re-education provided to licensed nurses, including agency, on reviewing consultation notes to ensure orders and referrals are made appropriately upon return by the director of nursing (DON) and staff development coordinator by 12/27/2019. Any licensed nurse not completing this education by 12/27/2019 will not be allowed to work until in-service is complete. This in-service will be provided to new licensed nurses during orientation. Audits 1. Nurse Management will complete 10 resident audits (on residents with wounds) weekly for 4 weeks and monthly for 2 months to ensure treatments are followed as ordered and consultation orders are followed. This audit will be documented on the wound audit tool.	

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F 684	Continued From page 45 dressing), cover with dry dressing and apply a gauze and compression wrap twice a week on Tuesday and Thursday. - Cleanse vascular wound to left posterior thigh with normal saline and pat dry. Apply an antibacterial wound dressing and collagen (a protein based wound dressing), cover with dry dressing and apply a gauze and compression wrap every week. - Cleanse vascular wound to right ankle with normal saline and pat dry. Apply an antibacterial wound dressing and collagen (a protein based wound dressing), cover with dry dressing and apply a gauze and compression wrap every week. - Cleanse vascular wound to right posterior thigh with normal saline and pat dry. Apply an antibacterial wound dressing and collagen (a protein based wound dressing), cover with dry dressing and apply a gauze and compression wrap twice a week and prn. A review of the nursing progress notes from 3/11/19 to 12/4/19 revealed Resident #72 had episodes of refusing wound care, assistance with repositioning, personal care and taking medication. The last documented refusal of wound care in the progress notes was 9/21/19. A physician progress note dated 11/6/19 indicated Resident #72 had wounds to his lower extremities with reports of refusals of wound care. Dressings were intact, clean and dry at the time of the physician assessment. The resident was noted as noncompliant however he reported he was allowing treatments more often than not as he would like to see the wounds healed. A review of the facility's Wound Ulcer Flowsheet	F 684	2. Nursing management will complete 10 random resident audits (to include all halls) for 4 weeks and then monthly for 2 months to ensure consultations are reviewed and followed. This audit will be documented on the consultation audit tool. A report will be submitted to the Quality Assurance Committee by the director of nurses. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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dated 11/20/19 revealed the following wound measurements:
- Left posterior lower leg 16.7 cm in length, 2.4 cm in width and 0.1 cm in depth.
- Left heel 6.5 cm in length, 2 cm in width and 0.1 cm in depth.
- Top of left foot 1.7 cm in length, 2 cm in width and 0.1 cm in depth.
- Right posterior lower leg 18 cm in length, 2.6 cm in width and 0.1 cm in depth.

A review of the November 2019 Treatment Administration Record (TAR) revealed the following treatments for Resident #72 were not initialed as done the following dates:
1. Left heel clean with normal saline, pat dry, apply an antibacterial wound dressing and collagen (a protein based wound dressing) and apply a gauze and compression wrap every week on Thursday. (Not initialed as changed anytime for the week of 11/24/19 through 11/30/19).
2. Left posterior thigh clean with normal saline, pat dry, apply an antibacterial wound dressing and collagen (a protein based wound dressing) and apply a gauze and compression wrap every week on Thursday. (Not initialed as changed anytime for the week of 11/24/19 through 11/30/19).
3. Right posterior thigh clean with normal saline, pat dry, apply an antibacterial wound dressing and collagen (a protein based wound dressing) and apply a gauze and compression wrap every week on Thursdays. (Not initialed as changed anytime for the week of 11/24/19 through 11/30/19).
4. Right ankle clean with normal saline pat dry, apply an antibacterial wound dressing and collagen (a protein based wound dressing) and apply a gauze and compression wrap every week

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on Thursday. (Not initialed as changed anytime for the week of 11/24/19 through 11/30/19).

Review of the October and November 2019 TAR's revealed Resident #72 had refused treatments to be completed on 10/1/19 and 10/2/19.

On 12/4/19 at 9:45am an interview occurred with the Treatment Nurse. She confirmed she was working on the scheduled dressing change day of 11/28/19 for Resident #72 and would have been responsible for completing the dressing changes. She reviewed the November 2019 TAR's and stated she had marked the dressings as checked but not changed on 11/27/19, 11/28/19 and 11/29/19. She further explained the dressings were checked to ensure the bandages were intact, not soiled and should have been changed on 11/28/19. She was unable to state why the treatments were not completed as ordered during the week of 11/24/19 through 11/30/19.

An observation of wound care was conducted on 12/4/19 at 11:30am with the Treatment Nurse and the Senior Wound QA Nurse. The observation revealed the following wound measurements:
- Left posterior lower leg 15 cm in length, 3.5 cm in width and 0.2 cm in depth.
- Left heel 5 cm in length, 3.3 cm in width and 0.1 cm in depth.
- Top of left foot 1.3 cm in length, 1 cm in width and 0.1 cm in depth.
- Right posterior lower leg 15 cm in length, 2.4 cm in width and 0.2 cm in depth.

An interview occurred with the Facility Nurse Practitioner (NP) on 12/5/19 at 9:33am who stated she had been familiar with Resident #72

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for 3 to 4 years. She further explained he had various stages of healing vascular ulcers over those 3 to 4 years and was noncompliant with his care. She reviewed the November and December TAR's showing dressing changes were not initialed as completed the week of 11/24/19 through 11/30/19. The NP stated she was unaware the treatments had not been completed as ordered and could not say if the lack of dressing change would have impeded the wound healing.

On 12/5/19 at 10:40am an interview occurred with the Senior Wound Quality Assurance (QA) Nurse. She explained she was hired as the Corporate QA nurse with several other buildings she oversaw. She was first in the building 10/21/19 to start putting new processes in place and identified wounds were misclassified and inconsistent treatment documentation existed with no negative outcomes for the residents. The Senior Wound Care QA Nurse stated she provided in-servicing to the Treatment Nurse, Administrator and Director of Nursing (DON) regarding the new wound care process and wound care documentation; however, the In-Service Training Records were undated and unsigned. Beginning 12/2/19, monitoring of 5 resident wounds weekly for 4 weeks will begin, to ensure proper documentation and treatments are in place. The Senior Wound QA Nurse reviewed the November 2019 TARs for Resident #72 and verified treatments were not initialed as completed as ordered the week of 11/24/19 through 11/30/19. She was unable to state why the treatments were not completed as ordered during that time period.

An interview was conducted with the

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Administrator and Director of Nursing (DON) on 12/5/19 at 1:19pm. The DON explained conversations had occurred with the Treatment Nurse regarding her job performance. The DON was unable to state why the treatments were not completed as ordered during the week of 11/24/19 through 11/30/19 only to say she would have expected them to have been done as ordered. Both parties knew a problem had been identified with wound care documentation and the Senior Wound QA Nurse was working on a Performance Improvement Plan that had not been initiated yet.

2) Resident #105 was originally admitted to the facility on 5/9/17 with the most readmission date of 4/9/19. His diagnoses included neurogenic bladder, diabetes and hypertension.

Review of the quarterly Minimum Data Set (MDS) dated 10/25/19 indicated Resident #105 was cognitively intact with no behaviors or resistance to care during the look back period. He was dependent on staff for all his Activities of Daily Living to include eating. He had an indwelling urinary catheter present and was incontinent of bowel.

Review of a Report of Consultation from an Oncology clinic dated 9/30/19 revealed Resident #105 had a right renal (kidney) mass, wanted management for the lesion and had agreed to proceed with cryoablation (a technique for removing cancerous tissue by killing it with extreme cold) and a biopsy. The report noted "will schedule for next 6 weeks and follow up 2 weeks after procedure".

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Resident #105 was interviewed on 12/2/19 at 10:45am. He explained he had been diagnosed with a mass on his kidney and had agreed to have a biopsy and further treatment when he was last seen at the Oncology Clinic in September 2019. Resident #105 further stated he was concerned an appointment had not yet been made for the biopsy.

On 12/4/19 at 10:00am an interview occurred with the Resident Transporter and Scheduler who stated there was no appointment for Resident #105 for follow up with the Oncology Clinic, as she thought the office would have called with the appointment date and time due to the way it was written on the consultation report. She further stated she had not contacted the Oncology clinic.

Another interview occurred with the Resident Transporter and Scheduler on 12/4/19 at 1:10pm. She explained when a resident went to an appointment, she would get a copy of the consult to schedule any follow-up appointments needed and did not typically follow up with the specialists if they had not called the facility with an appointment. She stated she had not called the Oncology Clinic to clarify who would be making the follow-up appointment for Resident #105.

The Director of Nursing (DON) explained in an interview on 12/4/19 at 2:20pm, when a resident returned from an appointment a copy of the consultation report was provided to the Resident Transporter and Scheduler so future appointments and follow-up with providers could be made as needed. The DON was under the impression the Resident Transporter and Scheduler contacted providers for clarification and to ensure appointments had been made for

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F 684	Continued From page 51 all the residents and could not explain why this appointment had not been made for Resident #105.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide restorative nursing services by not applying the splints and not providing the range of motion (ROM) exercises as care planned for 1 of 1 sampled resident reviewed with limitation in ROM and contracture (Resident # 34). Findings included: Resident #34 was admitted to the facility on 1/6/18 with multiple diagnoses including dementia	F 688	F688 Identified 1. Identified resident #34 restorative program was reviewed by director of nursing (DON) on 12/5/2019 with corrections made and no negative resident effect noted. Resident #34 was provided with splint and range of motion as directed by the plan of care on 12/12/19 by NA nursing assistant. Potential 1. An audit of residents on restorative	12/28/19

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F 688	Continued From page 52 and nontraumatic subdural hemorrhage. The annual Minimum Data Set (MDS) assessment dated 9/20/19 indicated that Resident #34 had memory and decision-making problems and had impairment in ROM on one side of upper and lower extremity. Resident #34's care plan dated 9/20/19 was reviewed. The care plan addressed the resident's limitation in range of motion to right upper and lower extremities and the risk for development of further contractures. The approaches included to provide active ROM exercises to bilateral lower extremities 10 reps (repetitions) 3 sets for 6 days a week, to apply right knee extension splint for 6 hours 6 days a week, provide passive ROM exercises to right upper extremity 15 reps 3 sets 6 times per week, and to apply right elbow splint for 2 hours or more 6 days per week. On 12/3/19 at 12:20 PM and on 12/4/19 at 10:21 AM, Resident # 34 was observed. Her right upper and lower extremities were noted to be contracted. She was not observed wearing any devices on her right upper and lower extremities. On 12/5/19 at 11:40 AM, the Assistant Director of Nursing (ADON) was interviewed. She stated that the facility had 2 Restorative Aides (RA) who were responsible for providing restorative nursing services/program to residents including splinting and ROM exercises. The ADON added that 1 RA was sick and was at the hospital and 1 RA had to come early morning and had left early. When asked for 3 months (September, October and November 2019) of restorative nursing documentation, the ADON reported that she could not find any restorative nursing	F 688	program was completed by DON on 12/27/2019 with no negative resident outcomes noted as audit finding. Training 1. Re-Education provided with restorative staff on ensuring splints are applied and ROM is completed by DON on 12/27/2019. This education will be provided to any new restorative staff during orientation. Audit 1. Nursing management will complete 10 random resident audits weekly for 4 weeks and monthly for 2 months to ensure splints are applied and ROM are completed. A report will be submitted to the Quality Assurance Committee. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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F 688	Continued From page 53 documentation for September and October 2019. She only provided the November 2019 restorative documentation. The November 2019 restorative nursing report revealed that Resident #34 was provided active ROM on 11/7/19, 11/8/19, 11/14/19, 11/15/19, 11/16/19, 11/17/19, 11/21/19 and 11/25/19. The resident was not provided the ROM consistently 6 days a week. The November and December 2019 restorative nursing report also revealed that the splint was applied to Resident #34 on 11/16/19, 11/17/19, 11/20/19, 11/22/19 and 12/2/19. The splint was not applied to the resident consistently 6 days a week. On 12/5/19 at 11:47 AM, RA #1 was called and left a message and did not return the call. On 12/5/19 at 12:45 PM, the Director of Nursing (DON) was interviewed. She stated that she had identified the problem with restorative nursing program not consistently provided. She reported that the 2 RAs had other duties to do, RA #1 had to do restorative program and was responsible for the supplies. RA #2 had to do restorative program and do treatments too and she was sick recently. The DON reported that she had some NAs to be promoted as restorative aides but she was still in the process of revamping the whole restorative program.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		12/28/19

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F 690	Continued From page 54 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to change a urinary catheter as ordered by the physician (Resident #85) for 1 of 4 residents reviewed for indwelling urinary catheters.	F 690	F690 Identified 1. Identified resident #85 was catheter was assessed by nursing 12/5/2019 with no negative resident outcome.	

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F 690	Continued From page 55 Findings included: Resident #85 was admitted on 7/10/2014 with diagnosis including, chronic respiratory failure, stage 3 chronic kidney disease, and neuromuscular dysfunction of the bladder. The annual minimum data sheet (MDS) for Resident #85 updated 10/2/2019 indicated the resident had an indwelling urinary catheter and required one-person -hands -on- assistance for toileting, and supervision for personal hygiene. MDS indicated resident was cognitively intact. The most recent comprehensive care plan for Resident #85 was updated on 10/2/2019 and indicated the resident was at risk for renal failure due to chronic kidney disease. Additionally, the care plan addressed the resident's indwelling suprapubic catheter due to neurogenic bladder. The care plan revealed the urinary drainage bag was to be kept below the level of the bladder and emptied every shift. The care plan also indicated the catheter should be flushed by resident and changed out by the facility per physician's order. A record review completed on 12/4/2019 at 9:30am revealed the resident's physician orders, dated back to May 2019, included urinary catheter was to be changed every two weeks with an 18 French latex free catheter, catheter care every shift that could be completed by the resident if she desired, and catheter collection bag changed every other Friday by staff. The record review also revealed the resident had reoccurring multidrug resistant urinary tract infections on 6/27/2019, 9/18/2019, and 10/7/2019.	F 690	2. Resident #85's indwelling catheter was changed on 12/13/2019 prior to resident discharge. Potential; 1. An audit of residents with indwelling catheters was completed to ensure catheter was changed as ordered by physician (MD) on 12/13/2019 by nursing administration. Results of audit were no negative resident outcomes. Training 1. Re-education provided to licenses nurses, including agency, on changing catheters as ordered by MD on 12/27/2019 by staff development coordinator (SDC). After 12/27/2019 no licensed nurse will be allowed to work until in-service is complete. This education will be provided to new licensed nurses during orientation. Audits 1. Nursing management will complete 10 audits weekly (10 residents on random halls) for 4 weeks and monthly for 2 months to ensure catheter is changed as ordered by MD. This audit will be documented on the Catheter audit tool. A report will be submitted to the Quality Assurance Committee by the director of nurses. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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In an interview with Resident #85, on 12/2/2019 at 11:04am she revealed she had a suprapubic catheter that needed changing every two weeks due to frequent blockage from sediment. She also stated she got frequent urinary tract infections and was concerned because the facility had not changed out her urinary catheter every two weeks as ordered by her urologist.

Resident #85's medication administration record was reviewed and indicated the following: The resident had a suprapubic catheter change on 6/5/2019 and did not have another document catheter change until 6/24/2019 (21 days later). The record also indicated the resident had her catheter changed during her hospitalization for UTI on 7/1/2019. Her next documented urinary catheter change was not until 7/19/2019 (18 days later). During the month of September, the MAR reflected the resident only had one catheter change documented and it was on 9/17/2019 at which time a urinalysis with culture and sensitivity was completed and revealed the resident had a UTI. The next documented urinary catheter change was not until 10/11/2019 (24 days later). Further review of the medication administration record revealed Resident #85's catheter was changed on 10/25/2019 with the next change on documented on 11/15/2019 (21 days later). Close review of the MAR revealed only one refusal of care for catheter change between 6/5/2019 and the current MAR. This was on 11/13/2019 and it was the catheter bag change and not the actual urinary catheter change.

On 12/04/19 at 11:47am an interview was conducted with Nurse #4. She stated she

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F 690	Continued From page 57 frequently cared for Resident #85 and knew her well. She stated the resident's urinary catheter changes are written to be completed every two weeks on Fridays by second shift (3pm-11pm) per physician's order. She further stated she knew resident refused on one occasion (11/13/2019) and she documented it under progress notes. She further stated the resident's catheter care is self-care and completed by resident. She stated she was not aware the urinary catheter was not getting changed every two weeks. An interview with the facility's Nurse Practitioner was conducted on 12/05/19 at 10:06am, she stated the resident is well known to her. The resident liked things done her way and had some psychosocial issues going on. She stated she did know the resident refused treatments at times. She confirmed Resident #85's catheter changes were ordered every two weeks and she believed that was the recommendation of the urologist. She further stated she did not know the urinary catheter was not getting changed as ordered. In an interview on 12/5/2019 at 2:30pm the DON indicated the urinary catheter changes should have been completed by the nurses on the resident's hall every two weeks as ordered by the physician. On 12/11/2019 at 10:30 am, in an interview with the resident's urologist, he stated if the facility is not changing out the suprapubic catheter every two weeks as ordered, it could be a contributory cause of the reoccurring urinary tract infections experienced by the resident.	F 690		
F 757	Drug Regimen is Free from Unnecessary Drugs	F 757		12/28/19

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F 757 SS=D	Continued From page 58 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and Pharmacy Manager, Physician, Nurse Practitioner and staff interview, the facility failed to prevent the resident from receiving a medication that had been discontinued in October 2019 by being placed back on the resident active medication list. This resulted in the resident receiving unnecessary medication Eliquis (an anticoagulant medication) for 4 days without a doctor's order for 1 of 5 sampled residents reviewed for unnecessary medications (Resident # 78). Findings included:	F 757	F757 Identified 1. Identified resident #78 was assessed by physician (MD) on 12/5/2019. Pharmacy was notified of error and medicine was removed from medication administration record (MAR) on 12/5/2019 Potential 1. An audit of residents on anticoagulants was completed by licensed nursing on 12/27/2019 to ensure MD orders are followed and accurate. No negative findings noted.	

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F 757	Continued From page 59 Resident #78 was originally admitted to the facility on 7/15/19 with multiple diagnoses including dementia and Pulmonary Embolism (PE). The quarterly Minimum Data Set (MDS) assessment dated 10/12/19 indicated that Resident #78 had severe cognitive impairment and she had received an anticoagulant medication for 1 day during the assessment period. Resident #78 was admitted to the facility with an order for Eliquis 5 milligrams(mgs) by mouth twice a day for PE. Resident #78's nurse's notes were reviewed. The note dated 9/30/19 revealed that Resident #78 was started on Cipro (an antibiotic medication) for Urinary Tracy Infection (UTI). On 10/1/19 at 1:15 PM, the note indicated that the resident was noted to have large amount of bleeding from the rectum. The Nurse Practitioner (NP) was informed. The progress note dated 10/2/19 written by the NP was reviewed. The note revealed that Resident #78 was referred by nursing due to rectal bleed. Her hemoglobin (a red protein responsible for transporting oxygen in the blood) level on 9/24/19 was 10.8 (normal value 12-15 grams per deciliter) and on 10/2/19 it was 10.7. The plan was to discontinue the Eliquis and to have Gastroenterology consult. On 10/2/19, Resident #78 had a doctor's order to discontinue Eliquis due to rectal bleed. The Gastroenterology consult report dated 10/2/19 indicated that Resident #78 was seen due to gastrointestinal (GI) bleed. The resident	F 757	2. An audit of current orders was completed where current orders were checked against MARs to ensure discontinued medications were removed from MARs on 12/27/19 by licensed nurses. No negative findings noted during audit. Training 1. Re-education provided to license nursing, including agency, to ensure MD orders are followed, checking new MARs, and informing pharmacy when a medication is discontinued by staff development coordinator (SDC) on 12/27/2019. After 12/27/2019 no licensed nurse will be allowed to work until in-service is complete. This education will be provided to new licensed nurses during orientation. Audits 1. Nursing management to complete 10 random audits weekly (10 residents on random halls) for 4 weeks and monthly for 2 months to ensure MD orders are followed (including new MARs at the beginning of a new month, and pharmacy notification of medication being discontinued). This audit will be documented on the MD audit tool. A report will be submitted to the Quality Assurance Committee by the director of nurses. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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was oriented to person but confused and was uncooperative. A consent would be obtained from the family for endoscopy, however, the resident had systolic blood pressure of 90 and on Eliquis with GI bleed, would send the resident to the emergency room for further evaluation and for inpatient endoscopy.

The Emergency Room (ER) history and physical dated 10/2/19 revealed that Resident #78 was sent to the ER due to rectal bleeding. The resident was seen at the GI clinic and was transferred to ER. She was found to be a little drowsy with borderline blood pressure. Her hemoglobin level was 9.9.

The hospital discharge summary dated 10/6/19 indicated that Resident #78 was admitted for GI bleed. Eliquis was discontinued. He hemoglobin was low but stable.
Esophagogastroduodenoscopy (EGD), an endoscopic procedure that allows to examine the esophagus, stomach and duodenum, was normal. Colonoscopy (an examination used to detect abnormalities in the large intestine and rectum) revealed left-sided diverticulosis. No active bleeding noted. The resident was discharged back to the facility on 10/6/19.

The facility was monitoring Resident #78's hemoglobin level (normal value 12-15 grams per deciliter). Her hemoglobin levels were as follows:
7/23/19 - 9.7
8/15/19 - 10.5
9/10/19 - 10.5
9/24/19 - 10.8
10/2/19 - 10.7
10/6/19 - 7.9
10/8/19 - 7.9

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F 757	Continued From page 61 10/11/19 - 8.1 10/15/19, 8.9 10/28/19 - 8.8 11/5/19 - 10.1 11/14/19 - 10.7 11/19/19 - 10.0 The October 2019 Medication Administration Record (MAR) was reviewed and revealed that Eliquis was discontinued on 10/2/19. The November 2019 MAR was reviewed and Resident #78 did not receive Eliquis. December 2019 MAR was reviewed on 12/4/19 and revealed that Resident #78 had received Eliquis 5 milligrams (mgs) by mouth twice a day from 12/1/19 through 12/4/19 (AM dose). On 12/4/19 at 10:45 AM, Nurse #2 was interviewed. She stated that Resident #78 was on Eliquis twice a day and she verified that she had administered the AM dose of Eliquis on 12/2/19, 12/3/19 and 12/4/19. On 12/4/19 at 3:19 PM, a follow up interview with Nurse #2 was conducted. She stated that 2 nurses were responsible for checking the new MARs at the end of each month and she was one of the 2 nurses who checked the December 2019 MARs. She reported that when she checked the December 2019 MARs, she didn't look far enough for the telephone orders and she didn't have the November 2019 MARs in front of her. She further indicated that she had checked the MARs when her shift (morning) was over, and the afternoon shift nurse was using the November 2019 MARs on the hall. These could be the reasons as to why she missed the order to	F 757		

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discontinue the Eliquis.

On 12/5/19 at 9:50 AM, the NP was interviewed. The NP stated that she discontinued the Eliquis in October 2019 when the resident had the rectal bleeding due to diverticulosis. She indicated that Resident #78 was a high risk for bleeding due to her age, from a fall or other factors and so she would not recommend the resident to be back on Eliquis.

On 12/5/19 at 12:53 PM, the Director of Nursing (DON) was interviewed. The DON stated that she was aware of the medication error and she would have to in-service all nurses on how to check the MARs. The DON also indicated that she didn't know why the pharmacy had the Eliquis on the resident's MARs, but she would investigate.

On 12/10/19 at 12:59 PM, the Assistant DON (ADON) was interviewed. She stated that the system when there was a new admission or readmission, the Admitting Nurse had to hand-write the orders and faxed a copy to the pharmacy. Beginning of each month, 2 nurses were responsible for checking the new MARs against the previous month MARs and telephone orders. After the 2 nurses had checked the new MARs, a copy was sent to the pharmacy. After the investigation, she found out it was an oversight on the part of the Admitting Nurse who wrote the readmission orders on 10/6/19. The Admitting Nurse missed to read the hospital discharge summary which indicated to stop the Eliquis and that was how the pharmacy got the Eliquis on their profile. The ADON reported that the Eliquis appeared on the Physician's orders and the MARs for October, November and

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December 2019. The Eliquis on October and November 2019 MARs were crossed out and with a hand-written note "discontinued". The Eliquis on the December 2019 MARs was not crossed out. The Nurse who checked the December 2019 MARs missed to discontinue the Eliquis on the MAR. The ADON further indicated that after the medication error was brought to her attention, the NP was informed and the Eliquis was discontinued. Complete Blood Count (CBC) was sent and the hemoglobin level was 11.4. The resident did not have signs/symptoms of bleeding.

On 12/10/19 at 12:25 PM, the Pharmacy Manager was interviewed via telephone. He stated that the system for obtaining medication orders for new admission or readmission was when the resident was admitted late or close to the end of the day (5 PM), a copy of the hospital discharge summary with the list of medications was sent to the pharmacy for the medications to be dispensed that evening. If the resident was admitted/readmitted early during the day, a copy of the hand-written orders was sent to the pharmacy. The pharmacy had received an order to discontinue the Eliquis on 10/2/19. On 10/6/19, there was hand -written orders which included Eliquis 5 mgs by mouth twice a day. There was no order to discontinue the Eliquis after 10/6/19. The Manager reported that there was a note on their system that the DON had called on 12/4/19 and stated that the resident was not on Eliquis and the Eliquis should not be on the printed MARs.

On 12/10/19 at 2:51 PM, a telephone interview was conducted with the Physician. He stated that the Eliquis did not cause the bleeding for the

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F 757	Continued From page 64 resident. He indicated that Resident #78 was high risk for bleeding due to her age, risk for falls and other factors. He also stated that the use of anticoagulant medication does not cause a person to bleed, but when the person bleeds, it would be more significant than a person not on anticoagulant medication.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		12/28/19

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F 758	Continued From page 65 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with the Pharmacy Consultant, Nurse Practitioner, and staff, the facility failed to have an adequate diagnosis to justify the use of an antipsychotic medication, failed to ensure as needed (PRN) antipsychotic medication was limited to a 14-day duration, and also failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment (used to assess for extrapyramidal symptoms on residents receiving antipsychotic medication) for 1 of 4 residents (Resident #100) reviewed for antipsychotic medications. The findings included: 1a. Resident #100 was admitted to the facility on 6/15/17 and most recently readmitted on 7/8/18 with diagnoses that included dementia, anxiety,	F 758	F758 Identified 1. Identified resident #100 was assessed by physician (MD) on 12/3/2019; A DISCUS (Dyskinesia identification system condensed user scale) assessment was completed for resident on 12/3/2019 and Antipsychotic was discontinued by medical providers on 12/3/19. Potential 1. An audit of residents on antipsychotic was completed to ensure appropriate diagnosis, DISCUS completed and as needed (PRN) antipsychotic is limited to 14 days 12/5/2019 by nursing administration, and/or facility consultant. Audit revealed no negative resident outcomes noted. Training	

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F 758	Continued From page 66 and mood disorder. The annual Minimum Data Set (MDS) assessment dated 7/22/19 indicated Resident #100 had short term memory problems, long term memory problems, and severely impaired decision making. She had no behaviors, no rejection of care, and she was receiving hospice services. Resident #100 received antianxiety medication on 7 of 7 days and no other psychotropic medications. A physician's order signed by the Nurse Practitioner (NP) for Resident #100 dated 9/6/19 indicated Haldol (antipsychotic medication) 0.5 milligrams (mg) sublingual (SL) for mild anxiety/restlessness every 4 hours as needed (PRN) and Haldol 1 mg SL for severe anxiety/restlessness every 4 hours PRN. This physician's order for PRN Haldol had no stop date and there was no adequate diagnosis to justify the use of Haldol for Resident #100. A pharmacy recommendation dated 9/12/19 indicated Resident #100 had an order for PRN Haldol 0.5 mg SL and 1 mg SL every 4 hours. The Pharmacy Consultant reported that the use of PRN antipsychotics were limited to 14 days regardless of hospice status and she recommended a discontinuation of the PRN Haldol on 9/20/19. This recommendation had a handwritten note in the physician/prescriber response section that read "hospice" and the disagree box was checked indicating the recommendation was not going to be followed. This recommendation had not mentioned the lack of an adequate diagnosis for Resident #100's Haldol.	F 758	1. Re-education provided to licenses nurses, including agency, to ensure appropriate diagnosis, DISCUS are completed and PRN antipsychotic is limited to 14 days by staff development coordinator (SDC) on 12/27/2019. After 12/27/2019 any licensed nurse will not be allowed to work until in-service is complete. This education will be provided to new licensed nurses during orientation. Monitoring 1. Nursing management will complete 10 audits weekly (on 10 random residents on random halls) for 4 weeks and monthly for 2 months to ensure appropriate diagnosis, DISCUS are completed and PRN antipsychotic is limited to 14 days. This audit will be documented on the antipsychotic audit tool. A report will be submitted to the Quality Assurance Committee by the director of nurses. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months.	

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A pharmacy recommendation dated 10/10/19 indicated a repeat recommendation related to Resident #100 ' s order for PRN Haldol 0.5 mg SL and 1 mg SL. The Pharmacy Consultant again reported that the use of PRN antipsychotics were limited to 14 days regardless of hospice status and she recommended a discontinuation of the PRN Haldol. This recommendation had a handwritten note in the physician/prescriber section that stated the hospice team was to determine usage. This recommendation had not mentioned the lack of an adequate diagnosis for Resident #100's Haldol.

A pharmacy recommendation dated 11/13/19 indicated another repeat recommendation related to Resident #100's order for PRN Haldol 0.5 mg SL and 1 mg SL. The Pharmacy Consultant once again reported that the use of PRN antipsychotics were limited to 14 days regardless of hospice status and she recommended a discontinuation of the PRN Haldol. The response to this recommendation had not yet been received. This recommendation had not mentioned the lack of an adequate diagnosis for Resident #100's Haldol.

A review of the September 2019 through November 2019's Medication Administration Records (MARs) for Resident #100 indicated she received PRN Haldol 0.5 mg SL 10 times (September: 10, October: 0, November: 0) and PRN Haldol 1 mg SL 6 times (September: 1, October: 0, November: 5).

The December 2019 active physician's orders for Resident #100 was conducted on 12/2/19 and revealed the 9/6/19 orders for PRN Haldol for anxiety/restlessness continued to be active.

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During an interview with Nurse #3 on 12/2/19 at 12:23 PM she reported that Resident #100 had an active order for PRN Haldol and that it was used occasionally for anxiety and/or restlessness.

An interview was conducted with the Director of Nursing (DON) on 12/3/19 at 2:05 PM. Resident #100's 9/6/19 PRN Haldol order for anxiety/restlessness was reviewed with the DON. She acknowledged that Resident #100 had no diagnosis to justify the use of Haldol. She reported that she was unaware that the regulation related to PRN antipsychotic medications applied to residents on hospice. The Pharmacy Recommendations from September 2019 through November 2019 that showed the Pharmacy Consultant specifically stated that PRN antipsychotic usage was limited to a 14-day duration regardless of hospice status were reviewed with the DON. The DON revealed that the facility NP was new to long term care and she suspected that she was probably unaware of the regulations related to PRN psychotropic medications. She indicated that the facility NP, facility staff, and the hospice provider would need to be educated on these PRN psychotropic medication regulations. She reported that the PRN Haldol order for Resident #100 was going to be discontinued today (12/3/19).

During a phone interview with the NP on 12/4/19 at 11:00 AM she revealed she was new to long term and she normally deferred medication management of psychotropic medications to psychiatric providers. The 9/6/19 PRN Haldol order for Resident #100 was reviewed with the NP. She acknowledged that Resident #100 had no diagnosis to justify the use of Haldol and she

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revealed she was unaware of the regulations related to PRN antipsychotic medications. The NP stated that this was an instance that would require education for herself, the facility staff, and the hospice provider to ensure no other PRN antipsychotic medication orders were written without a 14 day stop date and without an adequate diagnosis to justify the medication's use.

1b. Resident #100 was admitted to the facility on 6/15/17 and most recently readmitted on 7/8/18 with diagnoses that included dementia, anxiety, and mood disorder.

The annual Minimum Data Set (MDS) assessment dated 7/22/19 indicated Resident #100 had short term memory problems, long term memory problems, and severely impaired decision making. She had no behaviors, no rejection of care, and she was receiving hospice services. Resident #100 received antianxiety medication on 7 of 7 days and no other psychotropic medications.

A physician's order signed by the Nurse Practitioner (NP) for Resident #100 dated 9/6/19 indicated Haldol (antipsychotic medication) 0.5 milligrams (mg) sublingual (SL) for mild anxiety/restlessness every 4 hours as needed (PRN) and Haldol 1 mg SL for severe anxiety/restlessness every 4 hours PRN. This physician's order for PRN Haldol had no stop date.

A review of the September 2019 through November 2019 ' s Medication Administration Records (MARs) for Resident #100 indicated she

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 70	F 758		

received PRN Haldol 0.5 mg SL 10 times (September: 10, October: 0, November: 0) and PRN Haldol 1 mg SL 6 times (September: 1, October: 0, November: 5).

The December 2019 active physician's orders for Resident #100 were reviewed on 12/2/19 and revealed the 9/6/19 PRN Haldol orders continued to be active.

The hard copy and electronic medical record were reviewed from 9/1/19 through 12/2/19 and revealed an Abnormal Involuntary Movement Scale (AIMS) assessment or any other involuntary movement assessment had not been completed for Resident #100 related to the use of Haldol.

Observations were conducted of Resident #100 on 12/2/19 at 10:30 AM and 12:00 PM. The resident was in bed and was observed with no abnormal involuntary movements.

An interview was conducted with the Director of Nursing (DON) on 12/3/19 at 2:05 PM. She stated that the administrative nurses were responsible for completing AIMS assessment upon initiation of an antipsychotic medication and every 6 months thereafter. Resident #100 ' s PRN Haldol order dated 9/6/19 and the hard copy and electronic medical record that showed no AIMS assessment had been completed within the past year for the resident was reviewed with the DON. The DON confirmed no AIMS assessment had been completed within the past year for Resident #100 and she revealed that the most recent AIMS assessment for the resident was in 2017. She reported that there had been several changes with the administrative nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 12/11/2019

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F 758	Continued From page 71 which she believed contributed to this oversight. During a phone interview with the Pharmacy Consultant on 12/4/19 at 3:01 PM she reported that an AIMS assessment was normally completed upon initiation of an antipsychotic medication and then every 6 months thereafter. She explained that routine AIMS assessments for antipsychotic medication were necessary due to the potential side effects of antipsychotic medications.	F 758		