STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

(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 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview the facility failed to develop and maintain a comprehensive emergency preparedness (EP) program which contained required information to meet the health, safety and security needs of the resident population and staff. This failure had the potential to affect all residents and staff.	E 001	The Plan of Correction is not to be construed as an admission of any wrongdoing of liability. The facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings.	2/25/20

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

Electronically Signed | 02/28/2020

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E 001	Continued From page 1 Findings included: 1. The facility's EP plan was reviewed on 02/05/20 and 02/06/20. This review revealed the EP plan did not contain the following required information: a. The EP plan did not include the patient/client population, including, but not limited to: persons at risk, the type of services the long-term care (LTC) facility has the ability to provide in an emergency and continuity of operations, including delegations of authority and succession plans. b. The EP plan did not include policies and procedures regarding safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities, transportation; identification of evacuation locations; and primary an alternate means of communication with external sources of assistance. c. The EP plan did not include policies and procedures for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integrations of State and Federally designated health care professionals to address surge needs during an emergency. d. The EP plan did not include the development of arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. e. The EP plan did not include the role of the LTC	E 001	This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves the rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of corrections should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceedings. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. E001 Establishment of the Emergency Program 1. On 2/7/2020, Chief Operating Officer educated Administrator and Maintenance Director on the importance of maintaining the Facility Emergency Plan. 2. Emergency Plan completed on 2/25/2020 by Administrator and Maintenance Director, to include missing elements required by regulation. 3. Maintenance Director is responsible for facilitating Facility□'s Emergency	

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E 001	Continued From page 2 facility under the waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate site identified by emergency management officials. f. The EP plan did not include the development and maintenance of an EP communication plan that complies with Federal, Stated and local laws that was reviewed and updated at least annually. g. The EP plan did not include the names and contact information for staff, residents' physicians, other long-term care facilities and volunteers. h. The EP plan did not include the emergency officials contact information including federal, state, tribal, regional or local emergency preparedness staff, the state licensing and certification agency, the office of the stated long-term care ombudsman and other sources of assistance. i. The EP plan did not include emergency preparedness training and testing based on the emergency plan set forth in the risk assessment, policies and procedures, and the communication plan. j. The EP plan did not include emergency preparedness training which included all of the following: initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement and volunteers, consistent with their expected roles. EP training must be provided annually, and documentation of the training maintained and demonstrated staff	E 001	Preparedness Training, that will be added to the Education Calendar, to be held annually in March. Maintenance Director is responsible for facilitating Facility□'s full scale annual exercise. 4. Effective February 25, 2020, The Quality Assurance and Performance Improvement Committee will review Emergency Preparedness Training to ensure 100% staff completion annually. The Quality Assurance and performance Improvement Committee will review Emergency Plan Quarterly and modify as needed. Nursing Home Administrator and Maintenance Director are responsible for implementation of the plan. Correction date: February 25, 2020	

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E 001	Continued From page 3	E 001		

knowledge of emergency procedures.

k. The EP plan did not include emergency preparedness testing requirements including unannounced staff drills using emergency procedures, participate in a full scale exercise that is community based or if not accessible, an individual facility based exercise, conduct an additional exercise that may include, but is not limited to: a second full scale exercise that is community based or individual facility based, a tabletop exercise that includes group discussion led by a facilitator, and analyze the facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the EP plan as needed.

l. The EP plan did not include the emergency and standby power systems, emergency generator location, emergency generator inspection and testing or the emergency generator fuel and how to keep emergency power systems operational during the emergency unless evacuated.

An interview on 02/06/20 at 1:00 PM with the Administrator revealed he was responsible for the EP plan. He explained he had only been in his role for 2 weeks and had not had an opportunity to even read the EP plan until it was requested. He stated the staff were trained on disaster preparation on hire and annually. The Administrator confirmed the EP plan was missing several components as outlined above and stated he and the Maintenance Director would be meeting to establish the missing components of the plan. According to the Administrator, the current plan was established by the former Administrator and stated he would be reviewing and revising the plan to meet the standards. He

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E 001	Continued From page 4 also stated he would ensure the staff had the appropriate training and once trained would be performing testing the system.	E 001		
F 000	INITIAL COMMENTS The survey team entered the facility on 02/03/20 to conduct a recertification and complaint investigation survey and exited on 02/06/20. Additional information was obtained on 02/07/20. Therefore, the exit date was changed to 02/07/20. There were 9 allegations investigated and 4 were substantiated and cited.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		2/25/20

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F 580	Continued From page 5 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and interview with the resident's Guardian/legal representative the facility failed to notify a resident's legal representative that the resident missed two scheduled radiation treatments for 1 of 2 residents reviewed for notification of changes (Resident #45). The findings included: Resident #45 was admitted to the facility on 01/16/20 with diagnoses which included	F 580	F580 Notification of Changes 1. On 2/5/2020, Administrator, Director of Nursing and Social Services Director met with Resident #45□s Guardian/legal representative. Resident was taken to a later radiation session on the same day, 2/5/2020. Resident has since attended appointments as scheduled. 2. On 2/21/2020, Director of Nursing	

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F 580	Continued From page 6	F 580		

malignant neoplasm of oropharynx, diabetes and psychotic disorder.

Review of the resident's medical record revealed the resident had an appointed Guardian of the Person (GOP)/legal representative, which was the County Department of Health and Human Services. Further review of the admission record dated 01/16/20 revealed the Guardian was listed as the responsible party and emergency contact.

Resident #45's admission Minimum Data Set assessment dated 01/23/20 revealed he was cognitively intact for daily decision making.

An interview with the resident's Guardian/legal representative on 02/05/20 at 2:14 PM revealed she was not notified by the facility that Resident #45 missed his radiation treatment appointments on 02/04/20 and 02/05/20. She stated she received a call from the resident's oncology office on 02/05/20 notifying her the resident had missed 2 appointments in a row. The Guardian/legal representative further stated the radiation treatments were life sustaining for the resident and if he missed any more, they could potentially stop his treatments, or his condition could worsen. She stated the radiation treatments were keeping the tumor from growing and spreading according to the oncologist.

An interview was completed with the Social Services Director (SSD) and the Director of Nursing (DON) on 02/05/20 at 2:23 PM. The SSD stated he was busy with other responsibilities and he forgot to take the resident for his appointment on 2/04/20. The SSD stated he had not called the resident's legal representative on 02/04/20 to let her know the

audited facility□s resident appointment book from January 1st to present, to ensure appropriate notifications were complete if a resident missed a scheduled appointment. Those found to have a deficit, notification was made to appropriate party no later than 2/25/2020. Administrator educated Social Services Director (SSD) on 2/6/2020 regarding the notification of missed appointments to appropriate parties.

3. Beginning 2/21/2020, Director of Nursing educated Licensed Nursing Staff on when and who to notify. Education completed by 2/25/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/24/2020, Director of Nursing and/or Designee to audit previous day□s nursing 24-hour report and SBARs to ensure appropriate notification completed, during Daily Clinical Meeting (held Monday through Friday). Unnotified events will be immediately corrected by Director of Nursing and/or Designee. Effective 2/24/2020, Social Service Director and/or Designee will discuss the days□ scheduled appointments during Daily Morning Meeting (held Monday through Friday) to ensure transportation is arranged by in-house or contracted agency.

4. Effective February 25, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality

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F 580	Continued From page 7 resident had missed his radiation treatment and had not called her on 02/05/20 about his missed treatment appointment. He did not have a reason for not contacting the resident's legal guardian about Resident #45 missing his scheduled radiation treatments for 2 days. An interview on 02/05/20 at 2:45 PM was completed with the Administrator. The Administrator stated he expected the SSD to provide notification of any change to the guardian, legal representative or responsible party. The Administrator also stated the resident's legal representative should have been notified by the SSD of Resident #45's missed radiation treatment appointments.	F 580	Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 25, 2020	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		2/25/20

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F 583	Continued From page 8 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to protect the private health information by leaving confidential medical information unattended and exposed on a medication cart computer in an area accessible to the public for 1 of 3 sampled residents reviewed for medication administration (Resident #17). The findings included: A continuous observation was made on 2/4/20 from 8:10 AM to 8:15 AM of an unattended medication cart (100 hall medication cart) parked across the hallway approximately 5 feet in front of Resident #17's room. Nurse #1 left the MAR (Medication Administration Record) visible on the medication cart computer when she went into Resident #17's room. During the observation, the MAR for Resident #17 showed a picture of the resident, her room number, list of her medications and diagnoses on the computer screen which were exposed for others to read and not covered up.	F 583	F583 Personal Privacy/Confidentiality of Records 1. 2/4/2020, Administrator educated Nurse #1 regarding how to lock and unlock computer screen to provide resident privacy. 2. 2/4/2020, Administrator rounded facility to ensure no other computer screen displayed resident personal information while unattended, no further deficiencies found. 3. Beginning 2/4/2020, Administrator educated Licensed Nursing Staff on how to lock and unlock computer screen to maintain resident privacy. Beginning 2/4/2020, Director of Nursing educated all Licensed and Non-Licensed Nursing Staff regarding Facility□s HIPPA policy and procedures. All education completed by 2/25/2020, no Licensed and	

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F 583	Continued From page 9 Nurse #1 was observed to leave the 100 hall medication cart unattended on 2/4/20 from 8:27 AM to 8:31 AM when she went into Resident #17's room to administer her medications. Nurse #1 left the MAR visible with Resident #17's medical information on the computer screen without covering it up. During this time, a nurse aide was observed passing by in the hallway. Nurse #1 left the 100 hall medication cart unattended on 2/4/20 from 8:32 AM to 8:35 AM and walked approximately 25 feet away from the medication cart towards the medication room. During the observation, the MAR for Resident #17's medical information on the computer screen was visible for others to read and was not covered up. On 2/4/20 at 8:40 AM, an interview conducted with Nurse #1 revealed she had not been covering up the MAR while administering the medications because she didn't know how to. Nurse #1 stated she realized that she had to maintain privacy and confidentiality of Resident #17's medical information and to not leave it exposed for other people to read. On 2/4/20 at 4:27 PM, a follow-up interview with Nurse #1 revealed she had not been taught how to lock the screen when they switched over to the electronic MAR and had not been doing this. Nurse #1 stated that the Administrator had just showed her how to lock the screen to hide private resident medical information whenever she stepped away from the medication cart. On 2/6/20 at 8:11 AM, an interview with the Director of Nursing (DON) revealed Nurse #1	F 583	Non-Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/20/2020, HIPPA policy and procedures added to Facility□s New Hire Orientation. Effective 2/24/2020, Director of Nursing and/or Designee will audit 5 computers a week for 12 weeks to ensure resident privacy maintained. 4. Effective February 25, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 25, 2020	

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F 583	Continued From page 10 should not have left Resident #17's medical information visible without covering it up when she walked away from the medication cart. She further stated Nurse #1 could have closed the laptop monitor if she did not know how to lock the screen in order to prevent Resident #17's medical information from being exposed. On 2/6/20 at 10:51 AM, an interview with the Administrator revealed the facility was still in their training window for the electronic medical record and would need to conduct an in-service for all nursing staff regarding how to maintain privacy and confidentiality of electronic medical records.	F 583		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide incontinence care to keep residents clean and dry (Resident #20 and Resident #12) and failed to provide nail care (Resident #26) for 3 of 3 dependent residents reviewed for activities of daily living (ADL). Findings included: 1. Resident #20 was admitted to the facility on 09/17/18 with diagnoses which included chronic atrial fibrillation, chronic pain and dementia. Review of Resident #20's most recent quarterly	F 677	F677 ADL Care Provided for Dependent Residents 1a. Resident #20 was provided incontinence care by NA #4 on 2/4/2020 1b. Resident #12 was provided incontinence care by NA #1 and NA #4 on 2/4/2020 1c. Resident #26 was provided nail care by Nurse #1 on 2/4/2020 2ab. On 2/22/2020, Central Supply CNA audited all incontinent residents, Incontinence care provided as needed. 2c. On 2/22/2020, Central Supply CNA	2/25/20

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F 677	Continued From page 11 Minimum Data Set (MDS) dated 12/06/19 revealed the resident was severely cognitively impaired for daily decision making. The MDS also revealed the resident required extensive assistance of 2 staff for toileting and was always incontinent of bowel and bladder. Review of Resident #20's care plan dated 12/11/19 revealed a care plan for Activities of Daily Living (ADL) self-care performance deficit related to limited mobility, osteoarthritis and dementia. The goal was for the resident to maintain her current level of function in ADL with no significant changes through the review date. The interventions included in part: "personal hygiene: the resident requires extensive assistance by one staff with personal hygiene" and "toilet use: the resident requires one to two assist with toileting." An observation on 02/04/20 at 11:45 AM of Resident #20 revealed the resident in bed with foul smelling brown material smeared on both hands, her bedside table and a milk carton that was on her bedside table. There was foul smelling brown material on the pad underneath the resident and on the bed sheets and bed spread. The resident was pleasant and smiling and stated she needed to be cleaned up to get the stink off of her. The resident stated she had not been changed this shift. Nurse Aide (NA) #4 came in to the room and saw the resident and stated she would be back with washcloths and towels to clean the resident. NA #4 returned, and Nurse #1 came in to the room and proceeded to take the breakfast tray out of the room and clean the overbed table with Clorox wipes. NA #4 cleaned the resident's face and hands, cleaned dried stool on the front of her vaginal area and	F 677	audited all Resident Nails, Nail care provided as needed. 3. On 2/22/2020, Director of Nursing educated Non-Licensed Nursing Staff regarding purposeful rounding to include timely incontinence care and nail care. All education completed by 2/25/2020, no Non-Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/24/2020, Director of Nursing and/or Designee will audit 5 incontinent residents a week for 12 weeks. Effective 2/24/2020, Director of Nursing and/or Designee will audit 5 residents a week for 12 weeks to ensure nail care provided. 4. Effective February 25, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 25, 2020	

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from the resident's buttocks and cleaned the rest of the resident's body thoroughly, applied barrier cream and a clean brief. The resident's brief was saturated with urine all the way up the back of the resident and the pad underneath her was saturated with urine as well. NA #4 changed the bedding, dressed the resident and got her up in her wheelchair with the assistance of NA #1.

An interview on 02/04/20 at 12:05 PM with NA #4 revealed she was not assigned to care for the resident, but was covering for NA #1 who was assigned to the resident and had gone to lunch.

An interview on 02/04/20 at 2:46 PM with NA #1 revealed she was assigned to care for Resident #20. NA #1 stated she was so busy helping the other NAs she had not had time to concentrate on her duties with her residents. She stated she had not been able to provide incontinence care to Resident #20 since she began her shift at 7:00 AM. She stated the resident was not unclean when she had taken her breakfast tray into her around 8:00 AM but said she had not been able to get back to check on Resident #20 prior to her being cleaned and changed by NA #4. NA #1 stated she knew Resident #20 needed to be checked at least every 2 hours and changed as needed.

An interview on 02/04/20 at 3:01 PM with Nurse #1 revealed she was the nurse assigned to Resident #20. She stated the resident was not unclean when she had passed her medications earlier in the morning at around 8:30 AM. According to Nurse #1, NA #1 is usually attentive to her residents but stated she was not usually assigned to the hall she was on today and had been asked numerous times to assist the other

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nursing assistants with their residents. Nurse #1 stated NA #1 usually completed her rounds on her assigned residents and stated she was not aware she was behind on providing care to her assigned residents.

An interview on 02/06/20 at 12:41 PM with the Director of Nursing (DON) revealed their usual procedure was to check and change dependent residents 2 times before lunch and 2 times after lunch and as needed. She stated Resident #20 was dependent on staff to anticipate her needs and should have been checked and changed during the 7:00 AM to 3:00 PM shift prior to 11:45 AM on 02/04/20.

2. Resident #12 was admitted to the facility on 08/27/17 and readmitted on 02/27/19 with diagnoses which included chronic obstructive pulmonary disease, diabetes, anxiety disorder and depression.

A review of Resident #12's most recent quarterly Minimum Data Set (MDS) dated 01/28/20 revealed she was cognitively intact for daily decision making. The MDS also revealed the resident was totally dependent on 2 staff members for toileting and was always incontinent of bowel and bladder.

A review of Resident #12's care plan dated 01/28/20 revealed she had a care plan for ADL self-care performance deficit related to her diagnoses of congestive heart failure and osteoarthritis. The goals were for the resident to have care needs met as evidenced by her neat appearance with as much assistance from the resident as possible through the next review date and the resident will maintain current level of

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function in participating with her ADL through the next review date. The interventions read in part: "toilet use: the resident requires extensive to total physical assistance by staff for incontinence care and wears briefs."

An observation and interview with Resident #12 on 02/04/20 at 12:44 PM revealed her lying in bed with the head of her bed elevated finishing up her lunch. Resident #12 stated she had not been changed since 7:00 AM and needed to be changed. She stated the girls had been busy and had just not gotten back to her since early in the morning. According to Resident #12 she was ready to be changed and dressed so she could get up in her wheelchair and out of her room. Resident #12 went on to say she had been left before in urine and stool but stated not typically for long periods of time.

An observation on 02/04/20 at 1:14 PM of Resident #12 being provided incontinence care revealed she had wet her brief with urine all the way up the back of the brief and had wet the pad underneath her on the bed as well as the back of her gown. The resident was thoroughly cleaned by NA #1 with the assistance of NA #4 and clean brief and her clothing were placed on her. The bed sheets and pad were changed, and the resident was dressed and assisted via lift up into her wheelchair. Resident #12 stated she felt much better after being changed, dressed, and gotten up out of bed.

An interview on 02/04/20 at 2:46 PM with NA #1 revealed she was assigned to care for Resident #12. NA #1 stated she was so busy helping the other NAs she had not had time to concentrate on her duties with her residents. She stated she had

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not been able to provide incontinence care to Resident #12 since this morning at 7:00 AM. She stated she had done her first this morning because 3rd shift had not been able to get to her on their last round. According to NA #1, she had not been able to get back in Resident #12's room prior to her being changed after 1:00 PM. NA #1 went on to say she had not been able to do rounds every 2 hours like normal because of helping other NA's with their residents.

An interview on 02/04/20 at 3:01 PM with Nurse #1 revealed she was the nurse assigned to Resident #12. According to Nurse #1, NA #1 is usually attentive to her residents but stated she was not usually assigned to the hall she was on today and had been asked numerous times to assist the other nursing assistants. Nurse #1 stated NA #1 usually completed her rounds on her assigned residents and stated she was not aware she was behind on providing care to her assigned residents.

An interview on 02/06/20 at 12:41 PM with the Director of Nursing (DON) revealed their usual procedure was to check and change dependent residents 2 times before lunch and 2 times after lunch and as needed. She stated Resident #12 was dependent on staff to provide incontinence care and should have been checked and changed for a second time during the 7:00 AM to 3:00 PM shift prior to 1:14 PM on 02/04/20.

3. Resident #26 was admitted to the facility on 12/27/19 with diagnoses that included paraplegia, chronic kidney disease and type 2 diabetes. The most recent Minimum Data Set (MDS) dated 12/31/19 specified the resident's cognition was intact, he did not reject care and required

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one-person assistance with personal hygiene.

A care area assessment (CAA) dated 12/31/19 specified that due to paraplegia, Resident #26 was dependent on staff to meet all his daily needs.

A care plan dated 01/07/20 identified Resident #26 had a self-care deficit from paraplegia and his needs would be anticipated and met daily by staff.

On 02/03/20 at 10:09 AM Resident #26's fingernails were observed and noted that all the nails were greater than 1/8 of inch long and extended past the tip of his fingers. The resident stated he would like to have as nails trimmed.

On 02/04/20 at 10:53 AM Resident #26 was seated in a reclining geri chair in the dining room watching television. The resident was interviewed and reported he had morning care, but his fingernails were not trimmed. Observations of his fingernails revealed they were more than 1/8 inch long. Resident #26 stated he could not recall the last time his fingernails had been trimmed.

On 02/04/20 at 10:56 AM nurse aide (NA) #4 was interviewed and explained she was an agency staff and that this was her second day in the facility. She added that she had provided morning care for Resident #26 that included incontinence care, bed bath and dressing the resident. She stated that she also brushed teeth and attended to nails if needed. She recalled Resident #26's fingernails, stating they were long, and she forgot to trim them on 02/03/20. She also stated that she had not trimmed his nails on

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02/04/20 because she could not find nail clippers.

On 02/04/20 at 11:04 AM NA #4 asked another staff member for nail clippers and was told they were locked in the central supply closet. NA #4 proceeded to ask Nurse #1 for her key to the central supply closet and was told to wait. The nurse aide was unable to provide nail care for Resident #26.

On 02/04/20 at 11:14 AM the Director of Nursing (DON) was interviewed about nail care and explained nails were trimmed by the nurse aides unless the resident was diabetic and then the nurse was expected to trim fingernails and toenails. The DON added that nails were checked daily during morning care and especially during showers. The DON observed Resident #26's fingernails and stated the fingernails were too long and would have them trimmed by the nurse aide.

On 02/04/20 at 11:34 AM the DON was interviewed again and notified that Resident #26 was diabetic and stated she would have a nurse trim Resident #26's fingernails.

On 02/04/20 at 2:59 PM Nurse #1 was interviewed and explained that she was responsible for trimming resident's fingernails if they had diabetes. She stated she tried to visualize fingernails on all residents daily when making rounds and providing medications. Nurse #1 also stated she relied on staff to notify her if a resident's nails needed to be trimmed. Nurse #1 reported that she had not observed Resident #26's fingernails to know if they needed to be trimmed and no one had notified her either.

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F 679	Continued From page 18	F 679		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to provide weekend activities for a resident that desired to have activities for 1 of 1 sampled resident reviewed for activities (Resident #7). The findings included: Resident #7 was admitted to the facility on 02/03/19 with diagnoses that included hemiplegia. The most recent Minimum Data Set (MDS) dated 11/12/19 specified the resident's cognition was intact. A care plan reviewed on 01/29/20 specified Resident #7 would attend 1 to 3 out of room group activities per week. The care plan identified activities of choice as butterbean auction, BINGO, nail spa and porch sitting. On 02/05/20 at 2:15 PM Resident #7 was interviewed and expressed concerns about the lack of weekend activities. Resident #7 stated,	F 679	F679 Activities Meet Interest/Needs each Resident 1. Resident #7 was asked what activities she would like to participate in on the weekends by Social Services Director on 2/21/2020, No suggestions made. 2. Beginning 2/22/2020, Central Supply CNA asked all current Resident/Responsible Party what activities they would like to participate in on the weekends. Audit completed on 2/24/2020. Suggestions provided to Activities Director. 3. On 2/20/2020, Facility hired 2 Weekend Activity Assistants, to work opposite weekends. Effective 2/24/2020, Administrator and/or Designee will audit weekend activities on Mondays for 12 weeks, to ensure activities took place on Saturday and Sunday. Audit tool to consist	2/25/20

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F 679	Continued From page 19 "there is nothing to do on the weekend because no one is here to provide activities." The resident added that she was bored on the weekends and there was nothing to do. On 02/06/20 at 9:52 AM the Activity Director (AD) was interviewed and explained that she was full time Monday through Friday and did not have an assistant. She added that she planned the activity calendar that included some weekend activities. She stated that she posted the planned weekend activities on a bulletin board to notify the nursing staff and residents. The AD explained that weekend activities were to be provided by a nurse. The AD provided her attendance log and review of the log revealed there was no attendance records for the weekends of January. She also reported that a church group came on Sunday afternoon, but she was unaware if any residents attended. The AD stated that weekend activities had not been happening and offered no explanation as to why. On 02/06/20 at 10:09 AM Nurse #2 was interviewed and explained she worked weekends and was not aware she needed to assist residents with weekend activities. She added that she did not have time in her shift to organize group activities. The nurse also stated that group activities were not provided on the weekend but there was a church group that came in the afternoon. On 02/06/20 at 10:47 AM the Administrator was interviewed and explained he had been the Administrator less than 2 weeks and was unaware weekend activities were not provided. He stated he would expect weekend activities be provided to meet the needs of the residents.	F 679	of what activities were held and who conducted activity. 4. Effective February 25, 2020, the Administrator and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Activities Director are responsible for implementation of the plan. Correction date: February 25, 2020	

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F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and resident, Physician and staff interviews, the facility failed to schedule on ophthalmology consult appointment as ordered by the Physician for 1 of 1 resident reviewed for vision (Resident #2). The findings included: Resident #2 was admitted to the facility on 5/22/19 with diagnoses that included left-side hemiparesis (muscle weakness on one side of the body) following cerebrovascular accident (stroke). Further review of Resident #2's medical record revealed a hand-written note by the Physician dated 9/17/19 regarding Resident #2 having left vision impairment and needing an ophthalmology appointment. There was also a written order for an ophthalmology appointment due to cataracts signed by the Physician dated 9/17/19 and noted by Nurse #5.	F 685	F685 Treatment/Devices to Maintain Hearing/Vision 1. On 2/12/2020, Social Services scheduled an ophthalmology for Resident #2 for 2/20/2020. Resident was sent to Hospital on 2/18/2020 and not in Facility on 2/20/2020. Appointment will be rescheduled when Resident #2 returns to the facility. 2. Beginning 2/21/2020, Director of Nursing and/or Designee audited current resident orders from January 1st to present. Appointments not scheduled were immediately scheduled by Social Services Director. Audit completed 2/25/2020. 3. On 2/6/2020, Administrator educated Social Services Director on the importance of scheduling resident	2/25/20

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F 685	Continued From page 21 The quarterly Minimum Data Set (MDS) assessment dated 1/23/20 indicated Resident #2 was cognitively intact and had adequate vision but used corrective lenses. On 2/3/20 at 9:43 AM, an interview with Resident #2 revealed she was having trouble seeing out of her left eye and did not have peripheral vision from her left eye. Resident #2 stated she needed to see an ophthalmologist because of cataracts and had told the Social Services Director (SSD) about this. The SSD told her that she would have to see the optometrist who came to the facility, but she told the SSD that she would need to see an ophthalmologist and not an optometrist. The SSD told her that he would need to clear it with the doctor first. Resident #2 shared the SSD never got back with her regarding the ophthalmology appointment. On 2/4/20 at 12:18 PM, an interview with the Physician revealed Resident #2 had told him that she was having problems with her vision, so he had recommended for the facility to set up an ophthalmology appointment. The Physician was not sure if the order that he had written on 9/17/19 for an ophthalmology appointment had been carried out. On 2/5/20 at 8:34 AM, an interview conducted with the SSD revealed he had talked to Resident #2 needing to be seen by an ophthalmologist. Initially, he had included her in the optometrist's list of residents to be seen at the facility, but the previous Administrator did not let the optometrist see any resident at the facility. The SSD told Resident #2 that he had to clear with the Physician first if she could be seen by an outside	F 685	appointments. Beginning 2/21/2020, Director of Nursing educated Licensed Nursing Staff on how to properly relay appointments ordered by Facility/Hospital Physicians. Education completed by 2/25/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/24/2020, Director of Nursing and/or Designee will audit previous day□s orders during Daily Clinical Meeting (held Monday through Friday) to ensure ordered appointments are scheduled. Director of Nursing and/or Designee will relay appointment ordered to Social Service Director during Daily Morning Meeting (held Monday through Friday). 4. Effective February 25, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 25, 2020	

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F 685	Continued From page 22 provider for an ophthalmology appointment. The SSD admitted that he had forgotten to check with the Physician, and he had not made an ophthalmology appointment for Resident #2. On 2/5/20 at 2:04 PM, a phone interview with Nurse #5 revealed she had noted the order on 9/17/19 for Resident #2 to have an ophthalmology appointment. Nurse #5 could not remember if she had physically handed a copy of this order to the SSD or if she had placed a copy in his mailbox, but she did notify the SSD regarding this order. On 2/6/20 at 12:14 PM, an interview with the Director of Nursing (DON) revealed she had not been aware that Resident #2 had an order for an ophthalmology appointment that had not been set up. The DON stated the SSD should have talked to her and she would have communicated any concern to the Physician so they could have arranged for Resident #2 to see an ophthalmologist. On 2/6/20 at 10:51 AM, an interview with the Administrator revealed he had not been aware that Resident #2 had an order for an ophthalmology appointment that did not get set up. The Administrator stated they will set up the ophthalmology appointment for Resident #2 as ordered by the Physician on 9/17/19.	F 685		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	F 745		2/26/20

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F 745	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on record review, staff, family and legal representative interviews, the facility failed to ensure a resident was transported to appointments (Resident #45) and failed to ensure a resident was scheduled for a follow up specialist appointment (Resident #8) for 2 of 2 residents reviewed for medically related social services. Findings included: 1. Resident #45 was admitted to the facility on 01/16/20 with diagnoses which included malignant neoplasm of oropharynx, and diabetes. The resident's medical record revealed the resident had an appointed Guardian of the Person (GOP)/legal representative which was the County Department of Health and Human Services. Further review of the admission record dated 01/16/20 revealed the Guardian/legal representative was listed as the responsible party and emergency contact. Resident #45's admission Minimum Data Set (MDS) dated 01/23/20 revealed he was cognitively intact for daily decision making and required limited to extensive assistance with most activities of daily living and was occasionally incontinent of bladder and frequently incontinent of bowel. An interview was completed with the resident's Guardian/legal representative on 02/05/20 at 2:14 PM revealed she received a call from the resident's oncology office on 02/05/20 notifying her the resident had missed 2 appointments in a	F 745	F745 Provision of Medically Related Social Service 1a. Resident #45 was transported to a later radiation session on 2/5/2020 by Central Supply CNA. 1b. On 2/5/2020, Social Service Director inquired about scheduling an appointment with Spine Specialist, Specialist stated they will need a new order from Medical Director. New ordered obtained from Facility Medical Director on 2/26/2020 and Spine Specialist appointment scheduled for 3/6/2020. 2a. Beginning 2/22/2020, Central Supply CNA audited appointments set from January 1st to present, Scheduled appointments that were missed were immediately rescheduled. Audit completed 2/25/2020. 2b. Director of Nursing and/or Designee audited current resident orders from January 1st to present. Appointments not scheduled were immediately scheduled by Social Services Director. Audit completed 2/24/2020. 3a. On 2/20/2020, Facility hired a Full-Time Transportation CNA. On 2/24/2020, Facility contracted an outside Transportation Company to assist with transports when needed. On 2/6/2020, Administrator educated Social Services Director and Maintenance Director on the importance of transporting residents to scheduled appointments. On 2/24/2020,	

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F 745	Continued From page 24 row. The Guardian/legal representative went on to say she had been assured by the facility when she placed him there it would not be a problem to get him to his daily radiation treatments. She stated the treatments were life sustaining and if he missed any more they could potentially stop his treatments, or his condition could worsen. An interview was completed with the Social Services Director (SSD) and the Director of Nursing (DON) on 02/05/20 at 2:23 PM. The DON stated she had not been aware until 02/05/20 Resident #45 had daily radiation appointments. The SSD stated on 02/04/20, he was busy with other responsibilities and time had passed and he had forgotten to take the resident for his appointment. He stated he had not called the oncology office to see if he could reschedule the resident's appointment for a later time on 02/04/20. On 02/05/20 the SSD stated he had reminded the Scheduler the resident had an appointment at 12:30 PM and she would need to get with the Maintenance Director to arrange for transport to his appointment. The SSD stated he assumed everything was arranged until he noticed the van was still at the facility, so he reminded the Maintenance Director at around 12:10 PM, he would need to transport the resident to his appointment. According to the SSD, he later saw the Maintenance Director upstairs and he asked the SSD if the resident was ready to go for his appointment and the SSD told him to check with the Scheduler. The DON interjected that she had told the Maintenance Director and Scheduler to go ahead and take the resident to his appointment at the rescheduled time of 2:30 PM. The DON further stated the SSD was responsible for making outside appointments and assisting in providing	F 745	Administrator educated Transportation CNA on the importance of transporting residents to scheduled appointments. Effective 2/24/2020, Social Service Director and/or Designee will discuss the days□ scheduled appointments during Daily Morning Meeting (held Monday through Friday) to ensure transportation is arranged by in-house or contracted agency. 3b. On 2/6/2020, Administrator educated Social Services Director on the importance of scheduling resident appointments. Director of Nursing educated Licensed Nursing Staff on how to properly relay appointments ordered by Facility/Hospital Physicians. Education completed by 2/25/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/24/2020, Director of Nursing and/or Designee will audit previous day□s orders during Daily Clinical Meeting (held Monday through Friday) to ensure ordered appointments are scheduled. Director of Nursing and/or Designee will relay ordered appointments to Social Service Director during Daily Morning Meeting (held Monday through Friday). 4. Effective February 25, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The	

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F 745	Continued From page 25 transportation to those appointments. An interview on 02/05/20 at 2:45 PM was completed with the Administrator. According to the Administrator, the SSD was responsible for ensuring the resident went for his appointments and the SSD and the Maintenance Director were responsible for providing the transportation to the appointments until a Transportation Aide was hired. 2. Resident #8 was admitted to the facility on 04/10/19 with diagnoses which included chronic obstructive pulmonary disease, hypertension and vascular dementia. Resident #24's most recent quarterly Minimum Data Set (MDS) dated 11/14/19 revealed he was cognitively impaired for daily decision making and required limited to extensive assistance with activities of daily living (ADL). Resident #8's medical record revealed an After-Visit Summary dated 04/26/19 which read in part: "Follow up in about 4 weeks around 5/24/19 for repeat thoracic and lumbar x-rays." The following issue was addressed: midline thoracic back pain with unspecified chronicity. Review of the medical record revealed there were no notes regarding a follow up on or around 05/24/19. An interview was completed with the Social Services Director (SSD) and the Director of Nursing (DON) on 02/05/20 at 2:23 PM. The DON stated she was not aware Resident #8 was supposed to follow up in May of 2019 with his spine specialist. The SSD stated that was before	F 745	Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 26, 2020	

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F 745	Continued From page 26 he was hired into his position and was not aware of the follow up appointment to the specialist. The SSD and DON confirmed it was the responsibility of the SSD to arrange all outside appointments and ensure residents had transportation arranged to those appointments. The DON and SSD stated they would follow up with the physician to see if Resident #8 needed to be referred back to the spine specialist. An interview on 02/05/20 at 2:45 PM was completed with the Administrator. According to the Administrator, the SSD was responsible for making outside appointments.	F 745		
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	F 758		2/28/20

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F 758	Continued From page 27 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, Physician, Consultant Pharmacist, Psychiatric Nurse Practitioner (NP) and staff interviews, the facility failed to administer an anti-depressant medication (Zoloft) as ordered and failed to ensure a Physician's order for PRN (as needed) anti-anxiety medication (Ativan) had a stop date for 1 of 5 residents (Resident #25) reviewed for unnecessary medications. The findings included:	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use 1. Resident #25□s anti-depressant Medication was discontinued on 2/27/2020, effective 2/27/2020 by Facility Medical Director. On 2/27/2020, Resident #25□s PRN anti-anxiety Medication was adjusted to reflect a stop date of 8/27/2020 by Facility Medical Director. 2. On 2/24/2020, Director of Nursing	

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F 758	Continued From page 28 Resident #25 was admitted to the facility on 11/21/13 with diagnoses that included schizoaffective disorder, bipolar disorder, anxiety disorder, major depressive disorder and conduct disorder. Resident #25 was re-admitted to the facility on 12/26/19 following surgery for left hip fracture. a. A review of the Hospital Discharge Summary dated 12/26/19 for Resident #25 indicated an order for Zoloft 50 mg (milligrams) by mouth daily. A review of a copy of the Physician's Telephone Order dated 12/26/19 in Resident #25's physical chart noted by Nurse #4 included Zoloft 50 mg once daily. The significant change Minimum Data Set (MDS) assessment dated 12/31/19 indicated Resident #25 was moderately cognitively impaired, had behavioral symptoms not directed towards others on 1-3 days and received antianxiety medications x 7 days and antidepressant x 6 days during the assessment period. The Care Area Assessment (CAA) indicated Resident #25 was forgetful, repeated herself over and over and yelled at staff and residents who annoyed her. Resident #25 did not always do well with redirection and could easily become agitated. Resident #25 received medications to manage her mood and behaviors and was at risk for ineffective medication management and adverse effects. A review of the orders on the Medication Administration Record (MAR) starting on 12/27/19 indicated an order for Zoloft 100 mg 1 tablet by mouth in the morning and an order for Zoloft 50 mg 1 tablet by mouth one time a day.	F 758	audited all current PRN Psychotropic Medications to ensure stop dates were appropriately assigned. Audit completed 2/28/2020, deficiencies found were immediately corrected. 3. Beginning 2/24/2020, Director of Nursing educated Licensed Nursing Staff on State Regulation regarding PRN Psychotropic Medications including stop date requirements. Education completed by 2/27/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/24/2020, Director of Nursing, and/or Designee will audit previous day'□s orders during Daily Clinical Meeting (held Monday through Friday) to ensure psychotropic medications have appropriate stop/review dates. Effective 2/26/2020, Director of Nursing and/or Designee will review Medication Orders entered upon admission, to ensure Medication is initiated/discontinued as ordered by physician. Director of Nursing and/or Designee will meet, in person, with Pharmacy Consultant on a monthly basis to discuss psychotropic recommendations made. 4. Effective February 25, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance	

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F 758	Continued From page 29 A review of Resident #25's MAR starting on 12/27/19 revealed the following: 1. December MAR - Resident #25 received Zoloft 100 mg 1 tablet by mouth in the morning from 12/27/19 to 12/31/19. The MAR indicated Resident #25 refused this medication on 12/28/19 and 12/29/19. Resident #25 also received Zoloft 50 mg 1 tablet by mouth one time a day from 12/27/19 to 12/31/19. The MAR indicated Resident #25 refused this medication on 2 (12/28/19 and 12/29/19) out of 5 days it was offered to her. 2. January MAR - Resident #25 continued to receive both Zoloft 100 mg and Zoloft 50 mg doses. The MAR indicated Resident #25 refused this medication on 2 out of 31 days in January. 3. February MAR - Resident #25 continued to receive both Zoloft 100 mg and Zoloft 50 mg doses until 2/4/20 when the order for Zoloft 50 mg dose was discontinued. A review of the Psychiatric NP's note dated 2/3/20 indicated the following: Resident #25 was seen for routine psychiatry follow-up. Her overall mood had been at baseline per staff with no real concerns. Staff stated she continued to refuse medications at times. She was prescribed Zoloft for her mood, along with (2 other anti-depressants) which looked to be recently started by the PCP (Primary Care Physician). Plan to discontinue Zoloft 50 mg and (one of the other anti-depressants). On 2/4/20 at 12:16 PM, an interview conducted with the Physician revealed Resident #25 refused	F 758	Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 28, 2020	

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all her medications anyway, so it didn't really matter what dosage of Zoloft she was receiving currently. The Physician stated he did not even know what Resident #25's current dosage of Zoloft was and how much she should be on. He further stated Resident #25 had been refusing all her medications except her pain pills.

After clarification was made with the Physician that Resident #25 had not been refusing all her medications all the time, a follow-up interview was conducted with the Physician on 2/4/20 at 12:59 PM who stated that the Psychiatric NP had been managing all of Resident #25's psychotropic medications.

A review of the "Note to Attending Physician/Prescriber" by the Consultant Pharmacist dated 1/29/20 indicated that Resident #25 was currently receiving three anti-depressants: Zoloft and (2 other anti-depressants). The Consultant Pharmacist recommended for an evaluation to be made regarding this multiple anti-depressant therapy due to the risk of increased side effects/toxicity with similar agents being used.

On 2/5/20 at 10:32 AM, a phone interview with the Consultant Pharmacist revealed she reviewed Resident #25's medications once a month and right after she was re-admitted to the facility on 12/26/19. The Consultant Pharmacist stated she had recently made a recommendation for the Physician to review the anti-depressants that Resident #25 had been receiving after being re-admitted because of a duplicate order for the Zoloft, along with (2 other anti-depressants) that had been started. She shared that she e-mailed all her recommendations to the Director of

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Nursing (DON) as well as downloaded them online where all the providers might be able to access them.

On 2/6/20 at 8:54 AM, an interview conducted with the Psychiatric NP revealed she agreed that Resident #25 had way too many medications. She denied having ordered the Zoloft 50 mg on 12/26/19 and stated that she couldn't write any medication changes on Resident #25 because she did not have access to her electronic medical record. The Psychiatric NP shared she visited Resident #25 once a month and that the PCP controlled all her medications. During her last visit on 2/3/20, she requested the facility to print out her MAR and she noted that Resident #25 had been on 3 different anti-depressants at the same time since 12/26/19. She discontinued the Zoloft 50 mg and (another anti-depressant) on 2/3/20. The Psych NP was not aware that Resident #25 continued to receive the Zoloft 100 mg dose once daily and stated she did not notice this when she checked her MAR. She stated she wanted her off the Zoloft completely.

On 2/6/20 at 9:44 AM, an interview conducted with the DON revealed the telephone orders that had been copied off by Nurse #4 on 12/26/19 came from the hospital discharge summary. Nurse #4 failed to discontinue the old Zoloft order of 100 mg and replace it with the new Zoloft order of 50 mg. The DON stated Nurse #4 should have followed all orders from the hospital discharge summary and discontinued all of Resident #25's medications prior to her hospitalization. The DON stated the error did not get caught because no one had checked behind Nurse #4 when she re-admitted Resident #25 on 12/26/19. The DON confirmed that she did review the Consultant

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Pharmacist's recommendations on 1/29/20 about the multiple anti-depressant therapy and this was addressed by the Psych NP on 2/3/20.

On 2/6/20 at 10:51 AM, an interview with the Administrator revealed the nurses should talk to the Physician and his NP about the pharmacy recommendations and the DON should double check to make sure they received them. The Administrator agreed that communication need to be improved between all providers including the Physician, his NP and the Psychiatric NP regarding management of Resident #25's psychotropic medications.

On 2/7/20 at 3:39 PM, a phone interview was conducted with Nurse #4 who stated that she had copied off the orders on 12/26/19 for Resident #25 from the hospital discharge summary. Nurse #4 could not remember that Resident #25 was already on Zoloft 100 mg once daily when she added Zoloft 50 mg on 12/26/19. Nurse #4 stated she did not check the previous MAR before adding on these orders on 12/26/19.

b. A review of the Hospital Discharge Summary dated 12/26/19 for Resident #25 indicated an order for Ativan 0.5 mg by mouth every 6 hours as needed for anxiety.

A review of a copy of the Physician's Telephone Order dated 12/26/19 in Resident #25's physical chart noted by Nurse #4 included Ativan 0.5 mg tablet every 6 hours as needed.

A review of the "Note to Attending Physician/Prescriber" by the Consultant Pharmacist dated 12/27/19 and 1/29/20 indicated that Resident #25 had a PRN (as needed) order

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for a psychotropic drug without a stop date: Lorazepam (Ativan) 0.5 mg - give 1 tablet by mouth every 6 hours as needed for anxiety with a start date of 12/26/19. Both reviews had not been addressed by the Physician.

A review of Resident #25's MAR in her electronic medical record revealed the following:

1. December MAR - An order for Ativan 0.5 mg 1 tablet by mouth every 6 hours as needed for anxiety was started on 12/26/19 and the MAR indicated Resident #25 received this medication on 12/29/19.

2. January MAR - Resident #25 continued to have an order for the Ativan as needed and received it on 1/12/20 and 1/25/20.

3. February MAR - Resident #25 continued to have an order for the Ativan as needed.

An interview was conducted with the Physician on 2/4/20 at 12:59 PM who stated that the Psychiatric NP had been managing all of Resident #25's psychotropic medications. The Physician shared that the PRN Ativan order had been ordered by the Psychiatric NP and that she should have known to write a stop date for it.

On 2/5/20 at 10:32 AM, a phone interview with the Consultant Pharmacist revealed she reviewed Resident #25's medications once a month and right after she was re-admitted to the facility on 12/26/19. She stated that she had made a recommendation in December for the PRN Ativan order that did not have a stop date and had to repeat it in January because it had not been addressed. The Consultant Pharmacist stated it

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THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

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F 758	Continued From page 34	F 758		

was hard to get information which was scattered at the facility and was not sure why her recommendations for the PRN Ativan order had not been addressed. She shared that she e-mailed all her recommendations to the DON as well as downloaded them online where all the providers might be able to access them.

On 2/5/20 at 3:05 PM, an interview with the DON revealed whenever she received the recommendations from the Consultant Pharmacist, she printed them off and split them between the Physician and his Nurse Practitioner (NP) who came on alternate days to the facility. The DON stated she placed them on the chart in front of the Physician's orders so the providers would be able to see them easily. She further stated that sometimes, the Physician assigned some of them to his NP because of his limited time at the facility. The DON said the Physician did not want to write a stop date on the PRN Ativan order because he had thought it had been ordered by the Psychiatric NP.

On 2/6/20 at 8:54 AM, an interview conducted with the Psychiatric NP revealed she agreed that Resident #25 had way too many medications. She denied having ordered the PRN Ativan on 12/26/19 and stated that she couldn't write any medication changes on Resident #25 because she did not have access to her electronic medical record. The Psychiatric NP shared she visited Resident #25 once a month and that the PCP controlled all her medications. The Psych NP agreed that the PRN Ativan order should have had a stop date.

On 2/6/20 at 10:51 AM, an interview with the Administrator revealed the nurses should talk to

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F 758	Continued From page 35 the Physician and his NP about the pharmacy recommendations and the DON should double check to make sure they received them. The Administrator agreed that communication need to be improved between all providers including the Physician, his NP and the Psychiatric NP regarding management of Resident #25's psychotropic medications.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by the omission of 2 medications out of 25 opportunities, resulting in a medication error rate of 8% for 2 of 3 residents (Residents #17 and #11) observed during medication pass. The findings included: 1. Resident #17 was admitted to the facility on 8/27/19 with diagnoses that included muscle weakness. The Physician's Orders in Resident #17's electronic medical record indicated an order for Vitamin D2 tablet - give 2000 units by mouth one time a day. On 2/4/20 at 8:16 AM, Nurse #1 was observed as	F 759	F759 Free of Medication Error Rts 5 Prcnt or More 1a. Resident #20 received Vitamin D2 tablet by Nurse #1 on 2/5/2020 and continued to receive medication as scheduled. 1b. Resident #12 received Ferrous Sulfate tablet by Nurse #2 on 2/5/2020 and continued to receive medication as scheduled. 2. On 2/27/2020, Director of Nursing Reviewed all current Resident□s Medication Administration Record (MAR), from January 1st to present, to ensure all residents received their medications as ordered. 3. Beginning 2/24/2020, Director of	2/28/20

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F 759	Continued From page 36 she prepared and administered Resident #17's medications. Nurse #1 searched for Resident #17's Vitamin D2 in the 100 hall medication cart, but could not find it. Nurse #5 proceeded to administer the rest of Resident #17's medications. On 2/4/20 at 8:40 AM, an interview with Nurse #1 revealed she did not know why Resident #17's Vitamin D2 had not been re-ordered. During the interview, Nurse #1 looked for a stock medication bottle of Vitamin D2 in the medication room, but did not find one. Nurse #1 stated she would call the pharmacy and re-order the Vitamin D2 on the same day. On 2/4/20 at 4:27 PM, a follow-up interview with Nurse #1 revealed she had called the pharmacy and found out that Vitamin D2 was a stock medication and had to be ordered through the facility's supply clerk. Nurse #1 stated she had instructed the supply clerk to place an order for Vitamin D2. On 2/5/20 at 6:51 AM, during an interview with the Director of Nursing (DON), a bottle of Vitamin D2 was observed in the top drawer of the 100 hall medication cart. The DON stated Nurse #1 should have looked harder for the resident's Vitamin D2 when she was preparing to give Resident #17's medications. On 2/6/20 at 10:51 AM, an interview with the Administrator revealed it was his expectation that the residents received their medications as prescribed and as scheduled. 2. Resident #11 was admitted to the facility on 5/4/19 with diagnoses that included anemia.	F 759	Nursing educated Licensed Nursing Staff regarding the 5 Rights of Medication Administration (Right: Resident, Medication, Time, Dosage and Route). Education completed on 2/26/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Education added to New Hire Orientation on 2/27/2020. Beginning 2/26/2020, Director of Nursing educated Licensed Nursing Staff on what to do when medication is not available for resident use. Education completed on 2/28/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Education added to New Hire Orientation on 2/27/2020. Effective 2/24/2020, Director of Nursing and/or Designee will weekly audit nurse medication carts to ensure medications ordered are available for resident use, weekly for 90 days. Effective 2/24/2020, Director of Nursing and/or Designee will audit resident□s Medication Administration Record (MAR) 5x weekly for 30 days, then 3 x weekly 60 days and 1x weekly for 90 days. Effective, 2/28/2020, Director of Nursing and/or Designee will Shadow 2 floor nurses during Medication pass weekly for 12 weeks, to ensure correct number of medications administered. 4. Effective February 28, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any	

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F 759	Continued From page 37 The Physician's Orders in Resident #11's electronic medical record indicated an order for Ferrous Sulfate 325 milligrams - give 1 tablet by mouth one time a day. On 2/5/20 at 7:50 AM, Nurse #2 was observed as she prepared and administered Resident #11's medications. Nurse #2 looked at Resident #11's electronic MAR (Medication Administration Record) and pulled the resident's medications off the medication cart. Nurse #2 did not make a final check to make sure she pulled all of Resident #11's medications that were scheduled to be given at that time. Nurse #2 then proceeded to administer the medications she had pulled to Resident #11. On 2/5/20 at 10:04 AM, an interview with Nurse #2 revealed she thought she had poured the Ferrous Sulfate tablet into the medication cup but after counting the medications that she had given to Resident #11, Nurse #2 agreed that she must have missed it. On 2/6/20 at 8:11 AM, an interview conducted with the Director of Nursing revealed Nurse #2 should have double checked the medications in the cup to make sure they matched what was on the MAR before administering the medications to Resident #11. On 2/6/20 at 10:51 AM, an interview with the Administrator revealed it was his expectation that the residents received their medications as prescribed and as scheduled.	F 759	additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 28, 2020	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		2/28/20

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F 867	Continued From page 38 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 03/07/19, the complaint investigation survey of 05/24/19 and the on site follow up/complaint survey of 07/09/19. This was for two recited deficiencies. One recited deficiency was in the area of Quality of Life for activities of daily living (ADL) provided for dependent residents (F 677). A second recited deficiency was in the area of Pharmacy Services for free from unnecessary psychotropic meds/prn (as needed) use (F 758). The continued failure of the facility during 4 Federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Process Improvement Program. Findings included: This tag is cross referred to: 1. a. 483.24 Quality of Life F 677 - activities of daily living (ADL) for dependent residents: Based on observations, record reviews, resident and staff interviews, the facility failed to provide incontinence care to keep resident clean and dry	F 867	F867 QAPI/QAA Improvement Activities 1a. Resident #20 was provided incontinence care by NA #4 on 2/4/2020. Resident #12 was provided incontinence care by NA #1 and NA #4 on 2/4/2020. Resident #26 was provided nail care by Nurse #1 on 2/4/2020. 1b. Resident #25□s anti-depressant Medication was discontinued on 2/27/2020, effective 2/27/2020 by Facility Medical Director. On 2/27/2020, Resident #25□s PRN anti-anxiety Medication was adjusted to reflect a stop date of 8/27/2020 by Facility Medical Director. 2a. On 2/22/2020, Central Supply CNA audited all incontinent residents, Incontinence care provided as needed. On 2/22/2020, Central Supply CNA audited all Resident Nails, Nail care provided as needed. 2b. On 2/24/2020, Director of Nursing audited all current PRN Psychotropic Medications to ensure stop dates were appropriately assigned. Audit completed 2/28/2020, deficiencies found were immediately corrected. 3a. On 2/22/2020, Director of Nursing	

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F 867	Continued From page 39 (Resident #20 and Resident #12) and failed to provide nail care (Resident #26) for 3 of 3 dependent residents reviewed for activities of daily living (ADL). During the facility's 7/9/19 complaint investigation and follow-up survey the facility was cited at F-677 for failure to provide incontinence care for 1 of 3 residents reviewed for assistance with activities of daily living. During the facility's 5/24/19 complaint investigation survey the facility was cited at F-677 for failure to provide incontinence care for 2 of 4 dependent residents reviewed for assistance with activities of daily living. During the facility's 3/7/19 recertification and complaint investigation survey the facility was cited at F-677 for failure to provide nail care for 1 of 5 dependent residents. b. 483.45 Pharmacy Services F 758 - free from unnecessary psychotropic medications/prn use: Based on record review, Physician, Consultant Pharmacist, Psychiatric Nurse Practitioner (NP) and staff interviews, the facility failed to administer an anti-depressant medication (Zoloft) as ordered and failed to ensure a Physician's order for prn (as needed) anti-anxiety medication (Ativan) had a stop date for 1 of 5 residents (Resident #25) reviewed for unnecessary medications. During the facility's 03/7/19 recertification and complaint investigation survey the facility was cited at F 758 for failure to ensure a specific duration order was obtained for a psychotropic drug for 1 of 5 residents reviewed for	F 867	educated Non-Licensed Nursing Staff regarding purposeful rounding to include timely incontinence care and nail care. All education completed by 2/25/2020, no Non-Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/24/2020, Director of Nursing and/or Designee will audit 5 incontinent residents a week for 12 weeks. Effective 2/24/2020, Director of Nursing and/or Designee will audit 5 residents a week for 12 weeks to ensure nail care provided. 3b. Beginning 2/24/2020, Director of Nursing educated Licensed Nursing Staff on State Regulation regarding PRN Psychotropic Medications including stop date requirements. Education completed by 2/27/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/24/2020, Director of Nursing, and/or Designee will audit previous day'□s orders during Daily Clinical Meeting (held Monday through Friday) to ensure psychotropic medications have appropriate stop/review dates. Effective 2/26/2020, Director of Nursing and/or Designee will review Medication Orders entered upon admission, to ensure Medication is initiated/discontinued as ordered by physician. Director of Nursing and/or Designee will meet, in person, with Pharmacy Consultant on a monthly basis to discuss psychotropic recommendations made. 4. Effective February 25, 2020, the Director of Nursing (DON) and/or	

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F 867	Continued From page 40 unnecessary medication use. During an interview with the Administrator on 02/06/20 at 1:00 PM, he confirmed he was responsible for the Quality Assessment and Process Improvement Committee; however, he was new to his role and had only been at the facility for about 2 weeks. The Administrator stated he had not had a meeting since coming to the facility and plans to concentrate on the findings of the survey once received. According to the Administrator, he and the Director of Nursing had identified some of the areas that had in citations and would begin working on their process improvement.	F 867	Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan. Correction date: February 28, 2020	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		2/28/20

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F 883	Continued From page 41 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to offer the pneumococcal vaccine to 2 of 5 residents (Resident #2 and Resident #17), failed to provide	F 883	F883 Influenza and Pneumococcal Immunizations 1a. Residents #2 was discharged to	

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F 883	Continued From page 42 education regarding the benefits and potential side effects of influenza immunization to 4 of 5 residents (Resident #2, Resident #11, Resident #17 and Resident #25) and pneumococcal immunization (Resident #11) and failed to document refusal for influenza immunization for 1 of 5 residents (Resident #25) reviewed for immunizations. The findings included: 1. Resident # 2 was admitted to the facility on 5/22/19 with diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated 1/23/20 indicated Resident #2 was cognitively intact, received the influenza vaccine on 11/13/19 and pneumococcal vaccine was not assessed/no information. A review of Resident #2's Immunizations in her electronic medical record indicated she received the influenza vaccine on 11/13/19. There was no information regarding the pneumococcal vaccine and no documentation that education was provided to Resident #2 regarding the benefits and potential side effects of the influenza vaccine. On 2/6/20 at 7:35 AM, an interview conducted with the Director of Nursing (DON) revealed they were still working on giving the pneumococcal vaccines to all the residents and had not yet offered this to Resident #2. The DON stated she was not aware that there should be documentation in the medical record that Resident #2 was given education regarding the influenza vaccine and confirmed that this had not been done.	F 883	hospital on 2/18/2020, Pneumococcal vaccine will be offered upon her return to the facility. Initiated by RN Unit Manager, Resident #17 was offered and refused the Pneumococcal vaccine on 2/26/2020. 1b. Residents #2 was discharged to hospital on 2/18/2020, education regarding the benefits and potential side effects of the influenza immunization will be provided upon her return. Residents #11 was discharged to hospital on 2/21/2020, education regarding the benefits and potential side effects of the influenza immunization will be provided upon her return. Resident #25 was provided education regarding the benefits and potential side effects of the influenza immunization on 2/27/2020 by Director of Nursing. Resident #17 was provided education regarding the benefits and potential side effects of the influenza immunization and the Pneumococcal Immunization on 2/26/2020 by RN Unit Manager 1c. Director of Nursing Documented Resident #25□s refusal of the influenza immunization on 2/27/2020. 2. Beginning 2/24/2020, Director of Nursing and RN Unit Manager audited current resident charts to ensure Influenza and Pneumococcal vaccines were provided, education regarding the benefits and potential side effects of the influenza immunization were provided and that any refusals were documented. All deficiencies immediately corrected. Audit completed 2/27/2020.	

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F 883	Continued From page 43 On 2/6/20 at 8:34 AM, an interview with Resident #2 revealed that she had not been offered the pneumococcal vaccine and did not get educated about the adverse effects of the influenza vaccine when she received it in November. Resident #2 stated that the nurse just made her sign a consent form regarding the influenza vaccine. On 2/6/20 at 10:51 AM, an interview conducted with the Administrator revealed that it was his expectation that all immunizations be offered to the residents and given in a timely manner and education regarding the benefits and potential side effects should be given and documented in the medical record. The Administrator stated that he will add all this information in the admission packet so that the facility would be able to address them right away. 2. Resident #17 was admitted to the facility on 8/27/19 with diagnoses that included atrial fibrillation and heart failure. The quarterly MDS assessment dated 12/2/19 indicated Resident #17 was cognitively intact, received the influenza vaccine on 11/11/19 and pneumococcal vaccine was not assessed/no information. A review of Resident #17's Immunizations in her electronic medical record indicated she received the influenza vaccine on 11/11/19. There was no information regarding the pneumococcal vaccine and no documentation that education was provided to Resident #17 regarding the benefits and potential side effects of the influenza vaccine. On 2/6/20 at 10:36 AM, an interview conducted	F 883	3. Beginning 2/21/2020, Director of Nursing educated Licensed Nursing Staff regarding Administering vaccines timely and documenting refusals. Education completed by 2/27/2020, no Licensed Nursing Staff member will be allowed to work until mandatory education is completed. Effective 2/6/2020, education regarding the benefits and potential side effects of the influenza immunization and the Pneumococcal Immunization was added to Facility Admission Contract. Effective 2/24/2020, Director of Nursing and/or Designee will audit previous day□s New Admissions during Daily Clinical Meeting (held Monday through Friday) to ensure Influenza and Pneumococcal Immunizations were offered, refusal documented and that education regarding the benefits and potential side effects of the influenza immunization and the Pneumococcal Immunization was provided. 4. Effective February 25, 2020, the Director of Nursing (DON) and/or Designee will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Nursing Home Administrator and Director of Nursing are responsible for	

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F 883	Continued From page 44	F 883		

with the DON revealed they have not gotten around to giving Resident #17 her pneumococcal vaccine and that she needed to call her family member about it first. The DON stated that she had talked to Resident #17's family member the day before regarding her current condition but she had not discussed or offered the pneumococcal vaccine to be given to Resident #17. The DON also stated that she was not aware that there should be documentation in the medical record that Resident #17 and/or her family member was given education regarding the influenza vaccine and confirmed that this had not been done.

On 2/6/20 at 10:51 AM, an interview conducted with the Administrator revealed that it was his expectation that all immunizations be offered to the residents and given in a timely manner and education regarding the benefits and potential side effects should be given and documented in the medical record. The Administrator stated that he will add all this information in the admission packet so that the facility would be able to address them right away.

3. Resident #11 was admitted to the facility on 5/4/19 with diagnoses that included chronic obstructive pulmonary disease.

The quarterly MDS assessment dated 11/18/19 revealed Resident #11 was cognitively intact, not assessed for the influenza vaccine but was updated on the pneumococcal vaccine.

A review of Resident #11's Immunizations in her electronic medical record indicated she received the influenza vaccine on 11/20/19 and the pneumococcal vaccine on 1/21/20. There was no

implementation of the plan.

Correction date: February 28, 2020

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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 883	Continued From page 45	F 883		

documentation that education was provided to Resident #11 regarding the benefits and potential side effects of both influenza and pneumococcal vaccines.

On 2/6/20 at 7:35 AM, an interview conducted with the DON revealed she was not aware that there should be documentation in the medical record that Resident #11 was given education regarding the influenza and pneumococcal vaccines and confirmed that this had not been done.

On 2/6/20 at 11:49 AM, an interview with Resident #11 revealed she did not get educated regarding the benefits and potential side effects of both the influenza and pneumococcal vaccines prior to receiving them. Resident #11 stated they just made her sign the consent form and checked if she had a fever before they gave her the vaccines.

On 2/6/20 at 10:51 AM, an interview conducted with the Administrator revealed that it was his expectation that education regarding the benefits and potential side effects of both influenza and pneumococcal vaccines should be given to the resident and/or responsible party and documented in the medical record. The Administrator stated that he will add all this information in the admission packet so that the facility would be able to address them right away.

4. Resident #25 was admitted to the facility on 11/21/13 with diagnoses that included peripheral vascular disease.

The significant change MDS assessment dated 12/31/19 revealed Resident #25 was moderately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 02/07/2020

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F 883	Continued From page 46	F 883		

cognitively impaired, had not received the influenza vaccine during this year's influenza vaccination season but was updated on the pneumococcal vaccine.

A review of Resident #25's Immunizations in her electronic medical record indicated she last received the influenza vaccine on 10/26/16 and the pneumococcal vaccine on 11/8/14. There was no documentation that education was provided to Resident #25 regarding the benefits and potential side effects of the influenza vaccine for 2019-2020 flu season. There was also no documentation that Resident #25 had recently refused to receive the influenza vaccine.

On 2/6/20 at 10:38 AM, an interview conducted with the DON revealed that Resident #25 had refused to receive the influenza vaccine, but the facility did not have documentation that Resident #25 had declined it. The DON also stated that she was not aware that there should be documentation in the medical record that Resident #25 and/or her family member was given education regarding the influenza and pneumococcal vaccines and confirmed that this had not been done.

On 2/6/20 at 10:51 AM, an interview conducted with the Administrator revealed that it was his expectation that all immunizations be offered to the residents and given in a timely manner and education regarding the benefits and potential side effects should be given and documented in the medical record. The Administrator stated that Resident #25's refusal to receive the influenza vaccine should have been documented in the medical record. He further stated that he will add all this information in the admission packet so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 47 that the facility would be able to address them right away.	F 883		