STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165217	A. BUILDING _____ B. WING _____	07/02/2019

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F 000	INITIAL COMMENTS Correction date 8/22/19 The following deficiencies relate to the facility's health survey and investigation of complaint #77704-C Complaint #77704-C was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This constitutes my credible allegation of compliance. All deficiencies will be corrected by 08-22-2019 This plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely because the provisions of Federal and/or State law require it.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to complete a self administration of medications assessment for one of one resident reviewed (Resident #31). The facility reported a census of 36 residents. Findings include: According to a quarterly Minimum Data Set (MDS) with a reference date 6/10/19, Resident #31 had a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS indicated Resident #31 required extensive assistance of 1 staff for bed mobility and dependent of 2 staff for transfers. The MDS listed glaucoma as a diagnosis for Resident #31. During an interview with Resident #31 on 6/30/19	F 554	F554 The nursing department failed to ensure that 1 of 36 residents had the right to self-administer eye drops. Resident#31 eye drops were removed from his/her room on 06-30-19. A room audit was done to ensure other residents did not have prescribed medications in his/her room. The interdisciplinary team in conjunction with the Attending Physician will ensure that self-administration of drugs is assessed and documented as appropriate on all residents and report any negative findings to the QA committee for further address.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/14/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	Continued From page 1 at 3:32 PM a bottle of combigan eye drops was noted on her bedside table in her room. When asked if she administers them herself, she stated she could but stated staff do a better job than she does. Review of Resident #31's care plan with a revision date of 6/18/19 revealed no entries that indicated she administered eye drops on her own, had the bottle of eye drops at her bedside, or an assessment of the resident's ability to self-administer medications. Review of Resident #31's physician's orders signed by her physician on 5/6/19, revealed the following order: combigan eye drops - instill one drop in both eyes twice a day with a start date of 5/13/13. During an interview on 07/01/19 at 3:00 PM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) reported they did not have a self-administration assessment for Resident #31. They stated the eye drops in her room may have been from her recent hospital stay and her husband may have brought them back with her.	F 554		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 637	F637 The DON/MDS coordinator failed to ensure a "Significant change" assessment was accomplished when resident #20 was discontinued from Hospice services. Education was provided to the DON on 07-02-19 in regards to accurate assessment determinations by the Admin. Staff. All resident MDS assessments reviewed.	

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F 637	Continued From page 2 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a significant change assessment after Resident #20's hospice services had been discontinued. The facility reported a census of 36 residents. Findings include: Review of a discharge with re-entry anticipated Minimum Data Set (MDS) with a reference date of 2/26/19 and had received hospice services while a resident in the facility. Review of Resident #20's hospice discharge-transfer summary report revealed his hospice services stared on 2/6/19 and ended on 2/26/19. Review of an entry MDS with a reference date of 3/13/19 revealed Resident #20 was readmitted to the facility from an acute hospital. The MDS indicate Resident #20 had a Brief Interview of Mental Status (BIMS) score of 7, indicating moderately impaired cognition. The MDS indicated Resident #20 had not received hospice services. During a staff interview on 07/02/19 at 8:45 AM the Director of Nursing (DON) and facility owner stated he was hospice in February and was discontinued from hospice after he returned from the hospital at his family's request.	F 637	The corporate nurse will randomly audit readmissions/discharges to/from the facility and ensure a timely assessment is accomplished. Any negative findings shall be reported to the QA committee for further address.	

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F 637	Continued From page 3 During a staff interview on 07/02/19 at 10:47 AM the DON stated it never crossed her mind to do a significant change MDS after he returned to the facility and not longer received hospice services.	F 637		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640	F640 The Director of Nursing/MDS coordinator failed to ensure timely submission of resident #2 discharge assessment. Training was provided to the DON/MDS coordinator on 07-17-19 on timely submission of all MDS assessments. The corp. nurse and/or Admin. shall run an Assessment warning report monthly to ensure compliance and report any negative findings to the QA committee for further address.	

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F 640	Continued From page 4 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to submit the Minimum Data Set (MDS) within the required 14 days following completion for 1 of 2 residents reviewed (Resident #2). The facility reported a census of 36 residents. Findings include: The MDS with an Assessment Reference Date (ARD) of 1/30/19 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses cellulitis of right and left lower limbs. The resident's census showed a discharge date of 1/31/19. The resident's record showed an MDS with an ARD of 1/31/19 with a discharge return not anticipated. The exported date for this MDS was	F 640		

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F 640	Continued From page 5 documented as 6/30/19. During an interview on 7/1/19 at 1:05 p.m. the Director of Nursing reported that she would expect an MDS to be submitted generally within 7 days of completion. She stated the resident discharged while she was off for the day. She would check the current resident's MDS's to ensure completion daily, but if a resident discharged, she did not see that their MDS was due.	F 640		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to care plan specialized services documented in PASARR	F 644	F644 The DON failed to ensure that resident #24 PASSAR recommendations were included on the residents individualized care plan. Resident #24 care plan has been updated with those recommendations. All other residents with PASARR recommendations has his/her care plan updated with recommendations. The Corporate Nurse attended PASARR web training on 08-21-19. The Interdisciplinary team shall ensure ongoing compliance thru the MDS and care plan review process and report any negative findings to the QA committee for further address.	

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F 644	Continued From page 6 (Pre Admission Screening and Resident Review) Level 2 approval for one of four residents reviewed (Resident #24). The facility reported a census of 36 residents. Findings include: 1. According to a quarterly Minimum Data Set (MDS) assessment with a reference date of 6/24/19, Resident #24 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment. The assessment documented a diagnosis that included depression. The PASSAR assessment dated 11/11/17 identified the need for specialized services including initial psychiatric evaluation to determine diagnosis and develop plan of care and ongoing psychiatric services by a psychiatrist to evaluate the response and effectiveness of psychotropic medications on target symptoms, to modify the resident's medication orders and to evaluate the ongoing need for additional behavioral health services. Review of the resident's care plan showed it lacked the recommended specialized services recommended by the PASARR assessment. During a staff interview on 07/02/19 at 10:45 AM the Director of Nursing (DON) stated she was not familiar with the resident's PASARR and was not the DON when Resident #24 admitted to the facility. She reported she would update Resident #24's care plan.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		

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F 645	Continued From page 7 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645	F645 The DON resubmitted a status change for Resident #9 thru PASARR with long term care approval for placement. The DON will ensure that all residents PASARR approvals are done timely with admission and follow approval recommendations as necessary. The Corporate Nurse attended PASARR web training on 08-21-19. The Administrative team shall ensure compliance by random audits of PASARR approvals and report any negative findings to the QA team for further address.	

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F 645	Continued From page 8 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to submit a Status Change Level 1 to ascend after Resident #9's approved 60 days had expired. The facility reported a census of 36 residents. Findings include: According to a quarterly MDS with a reference date of 4/15/19, Resident #9 had a Brief Interview	F 645		

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F 645	Continued From page 9 of Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS indicated he was independent for bed mobility, transfers, and locomotion, and listed the resident had the following pertinent diagnoses: depression and anxiety Review of Resident #9's care plan with a revision date of 6/12/19 revealed he had depression and directed staff to administer medications as ordered, monitor/document/report any risk for harm to self and signs and symptoms of depression, and complete pharmacy review monthly or per protocol. Record review revealed a Notice of PASRR (Preadmission Screening and Resident Review) Convalescent Approval with a date of determination of 1/3/19 and approved for 60 days. The document stated, Resident #9 may be admitted to a nursing home for up to 60 calendar days. If the stay goes beyond 60 calendar days, a representative must submit a Status Change Level 1 to Ascend. During a staff interview on 07/02/19 at 10:55 AM the Director of Nursing (DON) stated his paperwork was completed before she took the DON position, but added she would resubmit this today.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656	F656 The Interdisciplinary team failed to develop comprehensive care plans for 4 residents. Resident #9 care plan has been updated to show his/her smoking status. Resdient#25 has been discharged. Resident #31 care plan has	

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F 656	Continued From page 10 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and facility policy review, the facility	F 656	been updated to include the use of two upper side rails. Resident #33 care plan has been updated to include side rails and fall interventions. The interdisciplinary team shall review all care plans thru the MDS assessment process to ensure compliance. Any new intervention shall be placed on the care plan and communicated with the care team. Random audits shall occur by the Admin. staff to ensure ongoing compliance and negative findings reported to the QA team for further address.	

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F 656	Continued From page 11	F 656		

failed to develop comprehensive care plans for Residents #9, 25, 31, and 33. Resident #9's care plan lacked documentation related to cigarette smoking. Resident #25's care plan lacked documentation related to cigarette smoking and transfer assistance. Resident #31's care plan lacked documentation related to the use of two upper side rails. Resident #33's care plan lacked documentation related to his falls, fall interventions, and and the interventions put in place after his falls, and the use of side rails. The facility identified a census of 36 residents.

Findings include:

1. According to a quarterly MDS with a reference date of 4/15/19, Resident #9 had a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS indicated he was independent for bed mobility, transfers, and locomotion.

Observation on 07/3/19 at 7:00 AM revealed Resident #9 sat outside, smoking with his peers.

Review of Resident #9's assessment for supervision of smoking revealed the most recent assessment completed on 6/1/19

Review of Resident #9's care plan with a revision date of 6/12/19 revealed no documentation related to the resident smoking cigarettes.

During a staff interview on 07/02/19 at 10:53 AM the Director of Nursing (DON) acknowledged his care plan lacked information and stated she may have put the information on the wrong care plan. . According to a quarterly MDS with a reference date of 5/10/19 revealed Resident #31 had a

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F 656	Continued From page 12 BIMS score of 15, indicating no cognitive impairment. The MDS indicated Resident #31 required extensive assistance of one staff for bed mobility and was dependent of 2 staff for transfers. Review of Resident #31's care plan with a revision date of 10/5/17 revealed she was at risk for falls due to sustaining a left sided stroke. Observation on 06/30/19 at 1:21 PM revealed Resident #31 lay in her bed with bilateral upper side rails in an upward position. Record review revealed a bed rail restraint usage assessment with an assessment completed on 6/28/19. The assessment documented the resident requested side rails to assist her to reposition herself in bed. Review of Resident #31's care plan revealed it lacked documentation related to the resident's use of bilateral upper side rails. 3. According to a quarterly MDS with a reference date of 5/20/19, Resident #33 had a BIMS score of 4, indicating severe cognitive impairment. The MDS documented Resident #33 required extensive assistance of 2 staff for bed mobility and transfers. The MDS listed Resident #33 had the following diagnoses : depression, respiratory failure, and encephalopathy. General observations revealed the following: a. 06/30/19 at 10:07 AM Resident #33 lay in bed with the bed in the lowest position and a fall mat across the room against the wall (where a roommate would be, but no bed), and an alarm	F 656		

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F 656	Continued From page 13 on right side rail, and bilateral upper side rails in an upward position. b. 06/30/19 at 2:56 PM Resident #33 lay in bed with a fall mat across the room against the wall. c. 07/01/19 at 7:24 AM Resident #33 lay in bed with a fall mat across the room against the wall, not next to his bed. d. 07/01/19 at 10:56 AM Resident #33 lay in bed with a fall mat across the room against the wall not next to his bed. e. 07/01/19 at 2:00 PM Resident #33 lay in bed with fall mat to the right of his bed on the floor f. 07/02/19 at 7:27 AM Resident #33 lay in bed with fall mat to the right of his bed on the floor Review of Resident #33's care plan with a revision date of 6/20/19 revealed the following focus: the resident (specify high, moderate, low) risk for falls related to confusion and deconditioning; with an initiated date of 7/1/19 . The care plan did not list any goals or interventions. The care plan lacked documentation related to his falls and the interventions put in place following each falls. The care plan also lacked documentation related to the use of bilateral upper side rails. Record review revealed an incident report dated 5/6/19 that documented staff found the resident on the floor next to his bed. He stated he just slid out of bed, no obvious injuries. On the incident report, facility staff wrote floor mat placed next to his bed as the new fall intervention. Record review revealed a facsimile (fax) sent to Resident #33's physician on 5/6/19 with the following information: resident was found on the floor next to his bed. The resident reported he just slid out of bed, no obvious injuries. The fax	F 656		

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F 656	Continued From page 14 documented staff placed a floor mat next to the resident's bed. Record review revealed a bed rail restraint usage assessment with an assessment completed on 4/24/19. The assessment documented the resident requested to use the side rails to assist Resident #33 with repositioning. During an interview on 07/02/19 at 10:49 AM, the DON stated these care plan may have been missed when staff updated others with pertinent information. 4. The MDS for Resident #25 dated 6/4/19 revealed a BIMS score of 15, which revealed the resident experienced intact cognition. The resident had diagnoses of complete lesion at the C7 level of the cervical spinal cord, subsequent encounter, and quadriplegia. The MDS documented the resident admitted to the facility on 5/22/19. Record review revealed the resident's care plan was incomplete. The care plan documented problems or concerns,, but did not contain goals or interventions. The resident's care plan lacked documentation that directed staff how to transfer the resident and also failed to document the resident's smoking status. During an interview on 7/1/19 at 1:05 p.m. the Director of Nursing reported she would expect the care plan to be completed in the first three weeks to a month maximum. She stated that care plans have been struggling for a long time and they are just starting to use the point click care, care plan	F 656		

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F 656	Continued From page 15 review section as a trial. The policy labeled Care Plan, Interdisciplinary (Nur-1004) with a revision date of 4/03/18 directed staff that an individualized plan of care for each resident would be developed no later than seven days after the completion of the resident assessment instrument (RAI). The plan of care would reflect the resident assessment, include measurable goals and objectives and time frames for meeting the goals and objectives. The interventions or steps to be taken to reach goals and the disciplines involved shall also be identified. The plan of care would focus on maintaining the highest practicable level for the resident's condition.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to— (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657	F657 The MDS coordinator failed to ensure that interventions were updated to the care plan for resident #6, #8, #11 and #24. Resident #6 care plan has been updated to reflect the residents needs. Resident #8 has been discharged. Resident #11 care plan has been updated. Resident#24 care plan has been updated to reflect the use of antidepressant medications and to monitor for side effects. The interdisciplinary team have been re-educated on the need to revise the residents care plan per the RAI guidelines. The Admin. Team shall randomly audit care plan updates through morning QA meeting reporting of resident change of conditions to ensure compliance. Any negative findings shall be reported back to the QA committee for further address.	

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F 657	Continued From page 16 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to update care plans to reflect each resident's status for 4 of 13 residents reviewed (Residents #6, 8, #11 and #24). The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) dated 4/16/19 documented Resident #6 had a Brief Interview for Mental Status score of 13, which meant the resident experienced intact cognition. The resident had diagnoses of mild intellectual disabilities and type 2 diabetes mellitus. A fax to the physician dated 1/17/19 documented staff found the resident sitting on the floor, and she reported she "just fell." The incident report dated 1/17/19 documented staff educated the resident and applied a scoop mattress to the bed as fall interventions. The care plan intervention dated 4/2/18 directed staff the resident had a scoop mattress. A fax to the physician dated 1/20/19 revealed staff found the resident on the floor cuddled in a	F 657		

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F 657	Continued From page 17	F 657		

blanket with a pillow under her head.

The incident report dated 1/20/19 documented a scoop mattress and grip strips in front of the resident's bed.

The care plan dated 1/17/18 documented the new fall intervention as grip strips by the bed.

An incident report dated 1/23/19 revealed staff found the resident on the floor. The writer documented the resident stated she was trying to get out of bed to get the bell as she was unable to reach it. The new intervention documented the resident was to have a personal alarm as she would allow.

The care plan intervention with a revision date of 4/1/18 directed staff to place a personal alarm as resident allows.

A fax to the physician dated 1/26/19 documented staff found Resident #6 on the bathroom floor sitting upright. The writer reported the resident said she lost her balance and lowered herself to the floor.

The incident report dated 1/26/19 listed the new intervention as staff not to leave the resident alone when she used the restroom.

Review of the care plan revealed it lacked that directed staff not to leave the resident alone in the bathroom.

A fax to the physician dated 3/9/19 documented staff found the resident on the floor on her stomach. The fax revealed the resident refused pressure alarms, threw them at the nurse, then

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F 657	Continued From page 18 attempted to throw herself on the floor. The incident report dated 3/9/19 an intervention of education provided to the resident as the writer attempted to put alarms on the chair and bed. The resident ripped off alarms, threw them at the nurse stating she would not use them. The resident attempted to put herself on the floor again stating she would just stay on the floor if alarms were placed back on the bed and chair. The care plan lacked any documentation related to the resident's refusal of alarms and the risk of the resident purposely putting or throwing herself on the floor if the alarm was used. A fax to the physician dated 4/14/19 revealed staff found the resident on the floor in the Wing 2 bathroom. The resident reported she transferred by herself and hit her head. The incident report dated 4/14/19 documented education for resident as she becomes very upset with alarms if placed. The care plan lacked any documentation of interventions related to the 4/14/19 fall. 2. The MDS dated 4/8/19 documented Resident #8 had a BIMS score of 11 indicating moderate cognitive impairment. The resident had diagnoses of anxiety disorder and depression. During an observation on 6/30/19 at 3:27 p.m., observed the resident used oxygen. The resident's treatment administration order for the month of June showed an order for Oxygen 1 to 4 liters as needed to keep oxygen saturations	F 657		

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F 657	Continued From page 19 above 88%. The resident's census showed the resident on hospice. The care plan failed to contain information related to the use of oxygen or hospice care. 3. According to the MDS dated 4/15/19, Resident #11 had diagnoses of atrial fibrillation and coronary artery disease. The MDS documented a (BIMS) score of 15, which indicated the resident experienced intact cognition. A 5/3/19 fax directed staff to start the resident on Eliquis. On 6/5/19, staff sent communication to the Physician that revealed the resident was passing blood clots in her urine. Was on Eliquis 5 mg BID was held due to bleeding. Bleeding improved and stopped. Eliquis recently restarted and staff asked to hold it due to the bleeding. The physician directed staff to hold and set up with Urology. A fax to the physician dated 6/9/19 showed the bleeding improved with Eliquis being held. The nurse stated the resident reported a history of taking Coumadin with a request to restart Coumadin. On 6/10/19 order received to discontinue Eliquis and to start Coumadin 5 milligrams (mg) daily then recheck an international normalized ratio (INR) in two days. The care plan dated 10/12/17 lacked documentation regarding the use of	F 657		

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F 657	Continued From page 20 anticoagulants or the side effects related to the use of the anticoagulants. 4. The MDS completed for Resident #24 with an ARD date of 4/1/19 showed a BIMS score of 15, indicating intact cognition. The resident had diagnoses of depression and hypertension. The resident was coded for the use of antidepressants for 7 of 7 days in the look-back period. The resident's care plan lacked documentation related to the use of antidepressants of the side effects to monitor related to the use of antidepressants. During an interview on 7/1/19 at 1:05 p.m., the Director of Nursing stated she would expect Oxygen and antidepressants to be on the care plan. She stated the care plans have been a struggle for a long time. They are starting to use the care plan review process in Point Click Care to help review the care plans. The policy labeled Care Plan, Interdisciplinary (NUR-1004) with a revision date of 4/3/18 stated the plan of care would reflect the resident assessment, include measurable goals, objectives and time frames for meeting the goals and objectives. The interventions or steps to be taken to reach goals and the disciplines involved shall also be identified. The plan of care would be reviewed quarterly or upon a significant change in the resident's condition. The plan of care should be revised at any time a significant change in condition was indicated per the guidelines in the RAI manual.	F 657		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689 SS=D	Continued From page 21 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review revealed the facility failed to implement interventions that were put in place after Resident #33 fell. Resident #33's fall mat was not next to his bed as documented on an incident report as an intervention after he was found on the floor. The facility also failed to implement new interventions following a fall to prevent future falls for 2 of 5 residents reviewed (Residents #6 and #24). The facility reported a census of 36 residents. Findings include: 1. According to quarterly Minimum Data Set (MDS) with a reference date of 5/20/19, Resident #33 had a Brief Interview for Mental Status (MDS) score of 4, indicating severe cognitive impairment. The MDS indicated Resident #33 required extensive assistance of 2 staff for bed mobility and transfers. The MDS listed the following diagnoses for Resident #33: depression, respiratory failure, and encephalopathy. Review of Resident #33's care plan with a revision date of 6/20/19 revealed the following focus: the resident (specify high, moderate, low)	F 689	F689 The facility failed to ensure that the care plan intervention related to #33 floor mat was placed next to his/her bed. The interdisciplinary team has reviewed resident interventions and updated plan of care to reflect these changes. Nursing education was provided to the nursing department to ensure compliance with following plan of care. Resident #6 care plan has been updated to reflect the current interventions in place. Resident #24 plan of care has been updated to reflect current interventions in regards to self-transfers. Charge nurses have been educated to review resident plan of care and implement new intervention upon an incident. All falls shall be brought to the morning QA committee for review to ensure new intervention implemented on resident plan of care. The QA nurse shall randomly audit compliance and report any negative findings to the QA committee for further address.	

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F 689	Continued From page 22 risk for falls related to confusion and deconditioning; with an initiated date of 7/1/19 . The care plan did not list any goals or interventions. General observations revealed the following: a. 06/30/19 at 10:07 AM Resident #33 lying in bed, his bed in the lowest position, fall mat across the room against the wall (where a roommate would be, but no bed), and an alarm on right side rail. b. 06/30/19 at 2:56 PM Resident #33 lying in bed with a fall mat across the room against the wall. c. 07/01/19 at 7:24 AM Resident #33 lying in bed with a fall mat across the room against the wall, not next to his bed. d. 07/01/19 at 10:56 AM Resident #33 lying in bed with a fall mat across the room against the wall not next to his bed. e. 07/01/19 at 2:00 PM Resident #33 lying in bed with fall mat to the right of his bed on the floor f. 07/02/19 at 7:27 AM Resident #33 lying in bed with fall mat to the right of his bed on the floor Record review revealed an incident report dated 5/6/19. It stated, resident was found on floor next to his bed. He stated he just slid out of bed, no obvious injuries. On the incident report it lists a new intervention: floor mat placed next to the resident's bed. Record review revealed a facsimile (fax) sent to Resident #33's physician on 5/6/19 with the following information: resident was found on the floor next to his bed. The resident reported he just slid out of bed, no obvious injuries. The fax indicated they would place a floor mat next to his bed.	F 689		

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F 689	Continued From page 23 During a staff interview on 07/02/19 at 10:49 AM, the Director of Nursing stated Resident #33's floor mat should be on the floor next to his bed and she would find out why it was across the room. 2. The MDS completed for Resident #6 with an Assessment Reference Date (ARD) of 4/16/19 showed a BIMS score of 13, indicating intact cognition. The resident had diagnoses of mild intellectual disabilities and type 2 Diabetes Mellitus. A fax to the physician dated 1/17/19 stated the resident was observed sitting on the floor. Per the written fax the resident stated she just fell. The incident report dated 1/17/19 indicated the intervention was to educate resident and add a scoop mattress. The care plan intervention dated 4/2/18 indicated the resident was to have a scoop mattress. A fax to the physician dated 1/20/19 stated staff found the resident was on the floor with a pillow under her head cuddled up in a blanket. The incident report dated 1/20/19 stated a scoop mattress and grip strips in front of the resident's bed. The care plan dated 1/17/18 showed an intervention of grip strips by the bed. An incident report dated 1/23/19 stated the resident was on the floor. The writer reported the resident stated she was trying to get out of bed to get the bell as she was unable to reach it. The	F 689		

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F 689	Continued From page 24	F 689		

intervention indicated the resident to have a personal alarm as the resident would allow.

The care plan intervention with a revision date of 4/1/18 stated personal alarm as resident allows.

A fax to the physician dated 1/26/19 stated the resident was found on the bathroom floor sitting upright. The writer reported the resident said she lost her balance and lowered herself to the floor.

The incident report dated 1/26/19 indicated an intervention to not leave the resident alone when using the restroom.

The care plan lacked interventions to not leave the resident alone in the bathroom.

A fax to the physician dated 3/9/19 stated the resident was found laying on stomach on her floor. The fax stated the resident refused pressure alarms and had thrown them at the nurse. The writer indicated the resident attempted to throw herself on the floor after throwing the alarm at the nurse.

The incident report dated 3/9/19 indicated an intervention of education provided to the resident as the writer attempted to put alarms on the chair and bed. The resident ripped off alarms, threw them at the nurse stating she would not use them. The resident attempted to put herself on the floor again stating she would just stay on the floor if alarms were placed back on the bed and chair.

The care plan lacked any documentation related to the resident's refusal of alarms and the risk of the resident purposely putting self on the floor the

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F 689	Continued From page 25 alarm was used. A fax to the physician dated 4/14/19 resident found on the floor in the wing 2 bathroom. The resident reported she self transferred and hit her head. The incident report dated 4/14/19 showed the new intervention to be educated as the resident becomes very upset with alarms if placed. The care plan lacked any documentation of interventions related to 4/14/19 fall. 3. The MDS completed for Resident #24 with an ARD date of 4/1/19 showed a BIMS score of 15, indicating intact cognition. The resident had diagnoses of depression and hypertension. During an interview on 6/30/19 at 1:03 p.m., the resident reported he had two falls and he was educated by staff not to get up by himself. The incident report dated 2/22/19 showed the resident tried to transfer himself from the wheelchair to the bed when staff found him sitting on the floor leaning his head against the dresser. The interventions listed included keep call light in reach and educate the resident on risks of transferring himself. The care plan problem dated 7/19/17 listed an intervention dated the same day that directed staff to ensure call light in reach and review information on past falls, attempt to determine the cause of the falls, record possible root cause, and then alter or remove any potential causes if possible. The care plan also directed the facility to educate the	F 689		

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F 689	Continued From page 26 resident/family/Caregivers/Interdisciplinary Team (IDT) as to the causes. The policy labeled Falls Prevention and Management (NUR-206) with a revision date of 10/29/10 directed staff to follow the steps as outlined in the Pathway to Falls Prevention and Management. The undated form labeled Pathway to Falls Prevention and Management directed staff to initiate care plan to prevent falls with appropriate interventions. If the resident had 1) Fallen, 2) found on the floor, or 3) lowered to the floor, then implement additional interventions to prevent falls. Then update the care plan to include new interventions.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700	F700 The DON failed to ensure the siderail assessments and consents were obtained for residents #6, #24, #31, and #33. All 4 identified residents have signed consents in place for side rail usage and his/her plan of care has been updated to reflect this use. The facility electric beds upper siderails contain the electronic controls for adjusting the head and foot of the bed, the interdisciplinary team shall ensure that residents who use the controls for bed mobility have signed consents in place. The Admin. team shall randomly audit side rail usage to ensure consents are signed. All negative findings shall be reported to the QA team for further address.	

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F 700	Continued From page 27 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview an facility policy the facility failed to obtain consent for the use of side rails for 4 of 4 residents (Resident #6, #24, #31, and #33) reviewed for the use of bed rails. The facility reported a census of 36 residents. Findings include: 1. According to a quarterly Minimum Data Set (MDS) with a reference date of 5/20/19, Resident #33 had a Brief Interview for Mental Status (MDS) score of 4, indicating severe cognitive impairment. The MDS indicated Resident #33 required extensive assistance of 2 staff for bed mobility and transfers. The MDS listed the following diagnoses for Resident #33: depression, respiratory failure, and encephalopathy. Review of Resident #33's care plan with a revision date of 6/20/19 revealed the following focus: the resident (specify high, moderate, low) risk for falls related to confusion and deconditioning; with an initiated date of 7/1/19 . The care plan did not list any goals or interventions. Observation on 06/30/19 at 10:07 AM revealed Resident #33 lying in bed with bilateral upper side rails in an upward position. Record review revealed a bed rail restraint usage assessment with an assessment completed on	F 700		

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F 700	Continued From page 28 4/24/19. The assessment indicated the resident requested to use side rails to assist with repositioning. 2. According to an MDS dated 5/10/19, Resident #31 had a BIMS score of 15, indicating no cognitive impairment. The MDS documented the resident required extensive assistance of one staff for bed mobility and was dependent on 2 staff for transfers. Review of Resident #31's care plan with a revision date of 10/5/17 revealed she was at risk for falls due to sustaining a left sided stroke. Observation on 06/30/19 at 1:21 PM revealed Resident #31 lay in her bed with bilateral upper side rails in an upward position. Record review revealed a bed rail restraint usage assessment with an assessment completed on 6/28/19. The assessment indicated the resident requested to use side rails to assist with repositioning. During a staff interview on 07/02/19 at 10:49 AM the Director of Nursing (DON) stated they are in the process of getting consents for the use of side rails. She also stated they have forms printed and were ready to implement them. 3. According to an MDS dated 4/16/19 Resident #6 had diagnoses of mild intellectual disabilities and type 2 diabetes mellitus. The MDS documented a Brief Interview for Mental Status score of 13, indicating intact cognition. An observation on 6/30/19 at 10:40 a.m. revealed	F 700		

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F 700	Continued From page 29 the resident's bed contained side rails. Record review revealed no side rail assessment or consent forms located in the resident's chart, and the care plan lacked documentation regarding the use of side rails. 4. The MDS completed for Resident #24 with an ARD date of 4/1/19 showed a BIMS score of 15, indicating intact cognition. The resident had diagnoses of depression and hypertension. During an observation on 6/30/19 at 10:57 a.m., observed side rails the resident's bed contained side rails. Record review revealed no side rail assessment or consent forms located in the resident's chart, and the care plan lacked documentation regarding the use of side rails. During an interview on 6/30/19 at 1:11 p.m., the Director of Nursing (DON) stated the residents triggered restraints on the MDS due to the use of the bed rail. She reported she had consents ready to do but hadn't the time to do them yet. The policy labeled Facility Bed Rail (NUR-403) with a revision date of 10/18/12 indicated it was the facility's policy not use bed side rails, except in special circumstances. The procedure state that prior to placing a bed rail on a bed the following must be initiated: 1. Bed Rail Usage Assessment completed, which includes all alternatives tried prior to initiating the bed rail. The assessment must be completed upon initiating the bed rail, quarterly and with any	F 700		

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F 700	Continued From page 30 significant change in condition. 2. Consent for bed rail signed by the resident or Responsible Party which explains all the risks associated with the use of the bed rail. 3. A care plan completed that includes the risks and benefits of the use of the bed rail. The care plan should focus on meeting the resident's individual needs.	F 700		
F 757 SS=J	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to adequately monitor medication-related laboratory values in order to	F 757	F757 The facility failed to ensure that medication related lab values were obtained with Coumadin anti-coagulation therapy in resident #11 and #135. Resident #11 and #135 medication has been discontinued. All other residents were assessed for use of Coumadin on 07-02-19 with no others noted to be taking the medication. Anti-coagulation policy was updated on 07-01-19 and all charge nurses were educated on lab procedures. The facility has implemented a lab book that contains a log of all labs per individualized resident's, a daily calendar to document lab draws, and labs placed on the daily QA form to discuss. The Admin. team shall randomly audit compliance and report results to the QA committee for further address as needed.	

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ensure residents were free from unnecessary medications for 2 of 2 residents reviewed (Residents #11 and #135). On 6/10/19, Resident #11's physician ordered staff to initiate Coumadin (an anticoagulant or "blood thinner") 5 mg daily and then recheck an international normalized ratio (INR, blood test) in two days. An INR is used to monitor how well the blood-thinning medication (anticoagulant) warfarin (Coumadin) is working to prevent blood clots. The higher the number, the longer it takes the blood to clot, which increases the risk of bleeding. Staff administered the first dose of Coumadin on 6/11/19. On 6/13/19, the resident reported she had a loose stool that contained blood. On 6/20/19, the resident reported she continued to have small blood clots at times when she urinated. On 6/25/19, staff noted the resident had two bruises: one on the right clavicle (collar bone) and one on the left foot arch. The facility failed to successfully obtain an INR laboratory (lab) test until 6/27/19. At that time, the results revealed a critical INR of 12.24 (lab reference range of 0.88-1.16). A subsequent lab result dated 6/28/19 showed an INR result of 3.06. Due to the facility's inability to obtain an INR as ordered in a timely manner, the resident's risk/signs of increased bleeding, and a significantly elevated INR value of 12.24, the facility's actions caused the resident's health and safety to be in Immediate Jeopardy. The facility reported a census of 36 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool, Resident #11 had diagnoses of atrial fibrillation and coronary artery disease. The MDS documented a Brief Interview for Mental Status (BIMS) score of 15, which meant the

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F 757	Continued From page 32 resident demonstrated intact cognition. A fax received on 5/3/19 contained a physician order to initiate Eliquis 5 mg daily by mouth. A nurses' noted dated 5/6/19 revealed facility staff sent a fax to the resident's physician to report the resident complained of seeing blood in her urine. The nurses' noted dated 5/10/19 documented the resident complained of blood from the perineal area (the area between the anus and the posterior part of the external genitalia) along with cramping at times. A fax dated 5/10/19 directed staff to hold the Eliquis for 2 days and schedule a pelvic ultrasound due to complaints of bleeding from the perineal area with cramping. The May 2016 Medication Administration Record showed Eliquis initialed daily from 5/3/19 until 5/31/19 (except for 5/11/19 at bed time, which had been left blank). Staff initials from 5/10/19 on day shift until 5/31/19 were circled to indicate the medication was held or not given. The June 2016 MAR showed Eliquis initialed every day on the day shift from 6/1/19 to 6/10/19, with initials from 6/8/19 to 6/10/19 circled. The MAR also showed Eliquis initialed every day at bed time from 6/1/19 to 6/10/19 (except for 6/5/19 to 6/7/19, which had been left blank). Staff initials from 6/5/19 on day shift until 6/7/19 were circled. A nurse's note dated 6/5/19 documented the resident reported blood clots in her urine. A fax dated 6/5/19 documented an order to hold	F 757		

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Eliquis for the second time and have the resident see Urology.

A nurse's note dated 6/5/19 showed staff scheduled the resident an appointment with the Urologist.

A fax to the physician dated 6/9/19 reported the bleeding had improved when staff held Eliquis. The nurse also documented the resident reported a history of Coumadin use and asked if the provider wanted to start Coumadin.
On 6/10/19, staff received an order to discontinue Eliquis and to start Coumadin 5 milligrams (mg) daily, then recheck an international normalized ratio (INR) in two days.

The MAR showed on 6/11/19, staff initiated Coumadin 5 mg by mouth daily.

A nurse's note dated 6/11/19 documented no complaints of polyuria or urgency with no skin rashes, bruises, or irritation noted.

A nurses' note dated 6/13/19 documented the resident reported she had a loose stool that contained blood and mucus.

A nurse's note dated 6/13/19 revealed staff sent a fax to notify the provider regarding the resident's loose stools that contained blood and mucus. The note showed the physician returned the fax with an order for a stool culture and an increase of Culturelle to twice daily. The chart failed to contain any documentation related to the completion of an INR.

A lab result dated 6/19/19 informed staff the normalized curve delta too low, maintenance

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overdue, or failed measured result with regard to the INR and no lab result provided. Record review revealed the resident's medical chart lacked documentation regarding a follow-up with the lab or the physician.

The nurse's note dated 6/20/19 showed the resident reported she continued to have small blood clots at times when she urinated.

A fax dated 6/25/19 documented the resident on Coumadin with the last INR drawn on 6/19/19. The fax also notified the provider the resident had two bruises: one on the right clavicle and one on the left foot arch, with no known injuries that would cause the bruises. The return fax from the provider and noted on 6/25/19 directed staff to redraw the INR.

The lab result dated 6/25/19 indicated the lab canceled the test because the staff person that drew the blood overfilled the blue tube. The chart lacked documentation regarding follow-up of the lab result.

The lab result dated 6/27/19 at 8:38 a.m. showed a critical INR of 12.24. At 9:45 a.m., the result revealed a critical INR of 12.23.

The lab dated 6/28/19 showed an INR of 3.06.

The physician sent a fab result to the facility that staff noted on 6/29/19. The physician directed staff to check the INR on Monday (6/30/19). The physician also requested the resident's Coumadin dose. The chart lacked documentation of follow-up to the physician.

The June 2019 MAR showed staff signed the

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F 757	Continued From page 35 Coumadin as given every day from 6/11/19 through 6/30/19. An observation on 6/30/19 at 10:50 a.m. showed a large bruise to the resident's chest and left antecubital area (inner elbow). During an interview on 6/30/19 at 10:50 a.m., the resident stated she wasn't aware of how (the bruises) got there. In an interview on 7/1/19 at 1:25 p.m., the Director of Nursing (DON) reported staff had previously scheduled a cystoscopy procedure (a hollow tube equipped with a lens-cystoscope-inserted into the urethra and advanced into the bladder) for the resident on 6/27/19 as ordered by one of her specialist physicians. Because the resident's INR had been critical that day at 12.24, the resident had not been able to have the cystoscopy as scheduled. After the critical INR result of 12.24, the hospital gave the resident one pill of Vitamin K and rechecked an INR the next day. The INR dated 6/28/19 was 3.06. The DON reported she did not believe any staff had drawn an IDR on 6/13/19 as a nurse had quit between those two days, so she thought the lab draw had been missed. During a follow-up interview on 7/1/19 at 3:08 p.m. the DON reported that since the Resident #11's elevated INR incident occurred, she set up a lab book to record lab orders to make sure they were completed and drawn as scheduled. 2. The MDS for Resident #135 showed diagnoses of left femur fracture and obesity.	F 757		

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The resident's MAR contained an order for Coumadin 3 mg tablet daily for 30 days.

The resident's admission orders dated 6/20/19 directed staff to draw an INR on 6/24/19.

The first lab result collected on 6/28/19 documented in the resident's chart was 1.59. The physician noted the resident had been on Coumadin 3 mg daily (as prophylaxis for deep vein thrombus (DVT)) following surgery. The physician instructed staff to increase the resident's Coumadin dose to 6 mg once on 6/28/19. Then, start Coumadin 4 mg every Saturday, Monday, Wednesday and 3 mg on Sundays, Tuesdays, Thursday, and Fridays and draw an INR on 7/3/19.

The resident's baseline care plan dated 6/20/19 lacked documentation related to the use of anticoagulant.

During an interview on 7/1/19 at 4:30 p.m., the Administrator and the facility owner reported the facility's registered nurses were capable of drawing blood and taking the blood to the hospital or clinic if the lab person was unable to come to the facility and obtain the blood sample. The Administrator commented the facility had recently had difficulties getting lab results back from the lab.

The facility abated the Immediate Jeopardy on 7/1/19 when they updated the Anti-Coagulation Therapy policy and educated pertinent staff regarding the policy updates and changes.

The policy labeled Anti-Coagulation Therapy (Nur-1305) with a revision date of 7/1/19 revealed

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the policy's purpose was to ensure anticoagulation therapy was safely and effectively administered. The policy directed the physician must be notified of the results of the INR before staff administer the next dose of Coumadin. Also:

a. If the INR results were within the physician's ordered parameters and there is an order for the next INR, then a fax to the physician is sufficient.

b. If the INR results were outside of the physician's ordered parameters or INR parameters have not been identified or there is no order for the next INR, then the physician needed to be notified via a verbal communication (not fax) so the physician can decide to decrease, increase or hold the Coumadin for the next doses. An order must be obtained for the next INR to be drawn.

c. If the lab has not been received by the time the next dose of Coumadin was due to the facility must make every effort to obtain the information. If it was still unavailable by the next dose administration the physician must be notified to inform him or her that the lab results are not available so further instructions could be obtained.

d. If the facility was unable to verbally communicate results to the physician and an alternate physician was not available prior to the next dosing of Coumadin the DON needs to be notified and good sound clinical judgment should be made to determine to administer or hold the next dose of Coumadin.

The policy continued to direct staff to observe for signs of any bruising or bleeding (nasal, skin, and

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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 757	Continued From page 38 blood in feces, urine or vomit) and notify the physician.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order 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	F 758	F758 The facility failed to ensure that resident #9 prn psychotropic medication was d/c after 14 days. Resident #9 prn medication was d/c on 07-05-19. The facility reviewed all resident's prn usage of psychotropics. The facility has implemented a new policy in regards to prn usage of prn psychotrophic medications. The Admin. Team will randomly audit MAR's to ensure compliance and report any negative findings to the QA committee for further review.	

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	165217	A. BUILDING _____ B. WING _____	07/02/2019

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F 758	Continued From page 39 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have an as needed (PRN) psychotropic medication discontinued after Resident #9 had not been used for 5 months. The facility reported a census of 36 residents. Findings include: According to a quarterly MDS with a reference date of 4/15/19, Resident #9 had a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS indicated he was independent for bed mobility, transfers, and locomotion. The MDS listed the following diagnoses for Resident #9: depression and anxiety Review of Resident #9's care plan with a revision date of 6/12/19 revealed he has depression and staff are to administer medications as order, monitor/document/report any risk for harm to self and signs and symptoms of depression, and complete pharmacy review monthly or per protocol.	F 758		

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F 758	Continued From page 40 Review of Resident #9's physician's orders with a signed date of 5/6/19, revealed the following order: Xanax (anti-anxiety) 1 milligram (mg), 1 tablet three times a day (TID), PRN with a start date of 1/4/19. Review of the Resident #9's Medication Administration Records (MAR) revealed the following: -January 2019-medication was used 3 times -February 2019-medication was used 2 times -March 2019 to July 2019-medication was not used Record Review revealed a continuation of order request dated 4/26/19. The physician stated the resident is stable and discontinuing would be harmful to the resident. The physician would like to continue the medication for 6 months. This form was signed and dated by the physician on 5/7/19. During a staff interview on 07/02/19 at 10:56 AM the Director of Nursing (DON) stated the pharmacy consultant comes to the facility every month and looks at what reductions are needed. She stated Resident #9 is a long time patient of his physician, so he may know more than the facility knows about him and that may be why he continued this medication. She stated while the physician is in the facility doing rounds, they do talk about the usage of PRN medications. She stated they will review the PRN medication the 12th when the physician is here.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 41 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and facility interviews, staff failed to store drugs in accordance with currently accepted professional standards. The facility reported a census of 36 residents. Findings include: During an observation on 7/01/19 at 3:55 p.m. noted the medication cart in hallway unlocked, with no staff nearby. During an observation on 7/01/19 at 4:00 p.m.,	F 761	F761 The Charge nurse failed to ensure his/her medication cart was locked when not in the immediate area of the cart. The charge nurse has been reeducated with disciplinary measures implemented. All Charge nurses were educated on maintaining safety of his/her medication cart. Admin. staff shall randomly audit the medication cart to ensure safety and report any negative findings to the QA team for further address.	

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F 761	Continued From page 42 the Maintenance Man walked by the medication cart. He noticed it was unlocked and locked the cart. The facility reported a total of 9 residents who had cognitive impairments. During an interview on 7/1/19 at 1:05 p.m. the Director of Nursing reported that she would expect staff to lock the cart when unattended.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	F880 The facility failed to ensure the laundry cart was covered as he/she transported clean linens to the resident room. A hanging cover has been purchased and placed on the hanging linen cart. All laundry staff were educated on covering linens as they are transported down the halls. The QA committee shall monitor ongoing compliance and report any negative findings for further address.	

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F 880	Continued From page 43 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and facility interviews, the facility failed to ensure appropriate infection control procedures due to the transportation of uncovered linens. The facility reported a census of 36. Findings include: An observation on 7/01/19 at 8:13 a.m., shown the Staff A, Laundry Aide, walking in the hallway with clean laundry uncovered three pants and four button-down shirts on the cart. During an interview on 7/02/19 at 8:13, Staff A reported she didn't usually cover clothes as she had never been told to cover the clothes in the 16 years she had been here. She stated that one resident had their clothes washed outside the facility. During an interview on 7/02/19 at 9:18, the facility owner and the Administrator reported that the laundry aide never covered clothes on the coat hangers as there was no contamination risk. The policy labeled Laundry (HSK-112) with no date provided indicated clean linen carts should be kept covered at all times.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		

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F 883	Continued From page 45 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is 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	F 883	F883 The facility failed to offer a pneumonia vaccination to 1 resident #13. Resident #13 pneumonia vaccination and consent is up to date. An audit of all residents has occurred with the formation of a penumo log documenting current immunization status. Immunizations shall be placed on the care plan for ongoing review. The DON shall ensure that all residents are assessed for pneumonia vaccine status upon entrance to the facility. The MDS coordinator shall ensure that immunizations are placed on the residents indiv. Plan of care. The Admin. staff shall randomly audit residents for immunizations to ensure compliance and report any negative findings to the QA committee for further address.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 883	Continued From page 46 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to offer or provide a pneumonia vaccination to 1 of 5 residents reviewed (Resident #13). The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) with a completed Assessment Reference Date (ARD) of 4/15/19 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnosed hypertension and peripheral vascular disease. The resident ' s chart lacked documentation regarding completion or an offer to administer a pneumonia vaccine. During an interview on 7/02/19 at 9:20 a.m., the Director of Nursing (DON) reported that she had placed a call to the clinic and they were checking for the resident's record. During a follow-up interview on 7/2/19 at 1:05 p.m., the DON reported that the resident did not have his pneumonia vaccination. She stated she would review Iowa ' s Immunization Registry	F 883		

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F 883	Continued From page 47 Information System (IRIS) to determine if the resident had the immunization. She would then follow-up with hospital charts. She recently got the facility into IRIS, and they would be able to enter vaccines as completed into the system. The policy labeled Immunizations and Tuberculosis Testing with no date provided indicated a recommended second dose for people aged 65 and older who got their first dose when they were under 65 if 5 or more years had passed. If vaccination status was unknown, patients should receive the Pneumococcal vaccine.	F 883		