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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JTGN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00995

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245323**
2. STATE VENDOR OR MEDICAID NO. (L2) **677088600**
3. NAME AND ADDRESS OF FACILITY
   (L3) **WALKER REHABILITATION & HEALTHCARE CENTER**
   (L4) **209 BIRCHWOOD AVENUE WEST PO BOX 700**
   (L5) **WALKER, MN** (L6) **56484**
4. TYPE OF ACTION: **2** (L8)
   1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **02/01/2017**
6. DATE OF SURVEY **11/08/2018** (L34)
7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
   01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA
8. ACCREDITATION STATUS: ___ (L10)
   0 Unaccredited 1 TJC 2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
    From (a) :
    To (b) :
12. Total Facility Beds **40** (L18)
13. Total Certified Beds **40** (L17)

10. THE FACILITY IS CERTIFIED AS:
    A. In Compliance With Program Requirements Compliance Based On:
    ___ 1. Acceptable POC
    X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE: Vienna Andresen, HFE - NE II — Date: 12/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Joanne Simon, Enforcement Specialist — Date: 01/04/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
    _X_ 1. Facility is Eligible to Participate
    ___ 2. Facility is not Eligible
    (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
    2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
    3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

26. TERMINATION ACTION: (L30)
    VOLUNTARY **00**
    01-Merger, Closure
    02-Dissatisfaction W/ Reimbursement
    03-Risk of Involuntary Termination
    04-Other Reason for Withdrawal
    INVOLUNTARY
    05-Fail to Meet Health/Safety
    06-Fail to Meet Agreement
    OTHER
    07-Provider Status Change
    00-Active

27. ALTERNATIVE SANCTIONS
    A. Suspension of Admissions: (L44)
    B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 27, 2018

Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

RE: Project Number S5323029 and H5323021

Dear Administrator:

On November 8, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. In addition, at the time of the November 8, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5323021 that was found to be unsubstantiated.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department has recommended and CMS has authorized us to notify you this Department is imposing the following remedy:

- State Monitoring effective December 2, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy(ies) and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 27, 2019.

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 27, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 27, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions

includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 27, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Walker Rehabilitation & Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 27, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 8, 2019 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING ______ B. WING ______	11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER REHABILITATION & HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on November 5, 6, 7, 8, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On November 5, 6, 7, and 8 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H#5323021 was completed and found not to be substantiated.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or	F 578		

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

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 578	Continued From page 1	F 578		

discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

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F 578 | F 578

Continued From page 2

This REQUIREMENT is not met as evidenced by:

R22's admission Minimium Data Set (MDS) dated 10/25/18, identified R22 was cognitively intact.

R22's current Order Summary Report did not identify a CPR or DNR status. R22's medical chart had a full code sticker on the binder of the chart.

R22's Provider Orders for Life-Sustaining Treatment (POLST) dated 10/22/18, included: Section A for cardiopulmonary resuscitation (CPR) patient has no pulse and is not breathing section, directed staff to "Do Not Attempt" resuscitation/DNR allow for a natural death. Section B indicated selective treatment, to include medical treatment, antibiotics, intravenous fluids, cardiac monitor, no intubation, all patients will receive comfort-focused treatments. Section C was signed by residents although not dated. Section D was signed by physician and dated 10/22/18. Section E indicated no artificial nutrition by tube, use intravenous, intramuscular and oral antibiotics.

On 11/05/18, at 3:20 p.m. during an interview R22 stated she could not remember what she put down but wants to be full code (CPR).
On 11/06/18, at 1:38 p.m. licensed practical nurse (LPN)-B stated she would know the code status by checking the chart or the electronic medical chart. I do most of the admissions so I pretty much know all the resident's code status'.
- At 1:39 p.m. nursing assistant (NA)-C stated there should be stickers on door - green for go & red for no CPR. NA-C could not confirm this by looking at three resident rooms. NA-C then

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F 578	Continued From page 3 stated she would check the sticker on the outside of the medical record. - At 1:41 p.m. registered nurse (RN)-B stated she would check the POLST, electronic record or the sticker on the outside of the chart. - At 1:48 p.m. RN-C stated there should be something in their room that says if they are DNR/DNI - looked in 3 rooms not able to determine. RN-C stated I should find out myself how they flag the rooms. RN-C stated she would not go by the stickers on the chart rather would look at the POLST. - At 2:31 p.m. NA-B stated she would look at the NA care sheet that she carries with her. NA-B confirmed that code status' were not on the NA care sheets. On 10/8/18, at 12:55 p.m. during interview the director of nursing (DON) stated that all staff should be aware that a green star located by the resident's name, outside their room, would indicate that the resident is Full Code. DON indicated that she was not sure why R22's POLST did not match the sticker on the chart and the resident's wishes. DON was unaware that R22's code status was not recorded in the electronic chart. Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to	F 578		

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F 578	Continued From page 4	F 578		

ensure resident wishes would be implemented correctly in an emergent situation for 3 of 3 residents (R9, R, R) reviewed for advanced directives.

Findings include:

R4's admission Minimum Data Set (MDS) dated 7/05/18, identified R4 was cognitively intact.

R4's current Order Summary Report did not identify a CPR or DNR status. R4's electronic medication administration form indicated full code status. R4's medical chart had full code sticker on binder of the chart.

R4's Provider Orders for Life-Sustaining Treatment (POLST) undated, included: -Section A for cardiopulmonary resuscitation (CPR) patient has no pulse and is not breathing" section, directed staff to "Do Not Attempt" resuscitation/ DNR allow for a natural death. Section B indicated selective treatment, to include medical treatment, antibiotics, intravenous fluids, cardiac monitor, no intubation, all patients will receive comfort-focused treatments. Section E indicated trial period of artificial nutrition by tube. The POLST had been signed by R4, however, the POLST lacked a physician signature.

On 10/24/2018, at 2:04 p.m. a nursing note indicated R4's care conference was held. R4 and facility staff were present. The note indicated to continue full code status.

On 11/6/18, at 2:15 p.m., during an interview R4 stated she is not sure if she should be a full code or DNR. R4 stated I would like my family to be involved with that decision.

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F 578	Continued From page 5 On 11/7/18, at 2:30 p.m. R4's record review identified, C4's POLST had been signed by David Chess, medical doctor on 11/7/18. The clinical record lacked documentation indicating the facility had reviewed the POLST choice of DNR with R4 or her family. -At 2:37 p.m. the director of nursing (DON) confirmed R4's clinical record and POLST presented conflicting information related to code status choices. On 11/08/18, at 8:30 a.m. the director of nursing (DON) stated Dr. Chess is the facilities medical director (MD) located in Connecticut. The DON confirmed the POLST had been faxed to the MD for signature and returned to the facility via fax. The DON confirmed R4, her family, and primary medical physician had not been consulted prior to having R4's POLST signed by the MD. The facility Advance Directives policy, reviewed 4/28/18, indicated a POLST would be added to all resident charts upon admission. Nursing contacts the attending physician to obtain appropriate orders for all advance directives. Social Services reviews and updates the Advance Directives as needed but at least quarterly in conjunction with the resident's plan of care.	F 578		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655		

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F 655	Continued From page 6 that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 655		

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F 655	Continued From page 7 Resident #23 Unnecessary Meds, Psychotropic Meds, and Med Regimen Review 11/08/18 07:38 AM Admit:10-19-18 DX: encephalopathy, angina pectoris, pacemaker, parkinson's disease, mood disorder, fx skull and facial bones, adult failure to thrive. MDS: 10/19/18 BIMS 6 CAA: (PSYCH/Pain) nutrition triggered CARE PLAN: ADL self care needs Confusion, Impaired balance Disease Process: Parkinson's disease Date Initiated: 10/25/2018 BATHING/SHOWERING: The resident requires assistance by 1 staff with bathing/showering weekly and as necessary. Date Initiated: 10/25/2018 Revision on: 11/05/2018 CNA LPN RN · BED MOBILITY: The resident is able to: turn and offload independently, at times requiring up to extensive assistance with bed mobility. Date Initiated: 10/25/2018 Revision on: 11/05/2018 CNA LPN RN	F 655		

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F 655	Continued From page 8 · DRESSING: The resident requires assistance by 1 staff to dress Date Initiated: 10/25/2018 Revision on: 11/05/2018 CNA LPN RN · EATING: Assist with eating as he tolerates and allows Date Initiated: 10/25/2018 Revision on: 11/07/2018 CNA LPN RN · ORAL CARE ROUTINE Date Initiated: 10/25/2018 Revision on: 11/05/2018 CNA LPN RN · TOILET USE: requires assist of 1 for toileting Date Initiated: 10/25/2018 Revision on: 11/05/2018 CNA LPN RN · TRANSFER: The resident requires assist of 1 Date Initiated: 10/25/2018 Revision on: 11/05/2018 CNA LPN RN · Encourage the resident to use bell to call for assistance The resident is an elopement risk/wanderer r/t History of attempts to leave facility unattended, Impaired safety	F 655		

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F 655	Continued From page 9 awareness Date Initiated: 11/05/2018 Assess for fall risk. Date Initiated: 11/05/2018 LPN RN · Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: Date Initiated: 11/05/2018 ACTA CNA LPN RN SW · WANDER ALERT: right ankle Date Initiated: 11/05/2018 The resident is high risk for falls r/t Deconditioning, Gait/balance problems, confusion, Parkinson's Disease Anticipate and meet The resident's needs. Date Initiated: 10/28/2018 CNA LPN RN · Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 10/19/2018 CNA LPN RN · Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 10/19/2018	F 655		

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F 655	Continued From page 10 LPN RN · Ensure that The resident is wearing appropriate footwear shoes or gripper socks when ambulating or mobilizing in w/c. Date Initiated: 10/28/2018 Revision on: 10/28/2018 ACTA CNA LPN RN · Follow facility fall protocol. Date Initiated: 10/19/2018 ACTA CNA LPN RN · Pt evaluate and treat as ordered or PRN. Date Initiated: 10/19/2018 LPN RN PT · Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. Assessments: 11/6/18 falls Resident has had 7 falls since admission date of 10/19/18. Resident attempts to ambulate per self, loses balance and falls. Note poor positioning in bed. Will trial low bed and mats. Staff to ensure that he has adequate footwear and performing checks 11/6/18 elopement assessment completed and care plan updated.	F 655		

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F 655	Continued From page 11 MD Orders: just started Hospice 11/7/18, POLST changed to DNR and signed by wife Behavior monitoring:Monitor the resident for safety. The resident is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. ANTIDEPRESSANTS (0 indicates no side effects observed) Monitor for side effects: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes Staff Interventions: Falls: 6 falls since admission, no injury Observations:11/08/18 08:24 AM restless bed low to floor, mat next to bed. Interviews: 11/08/18 12:58 PM Beth RN MDS nurse I could not find a baseline care plan, there should have been one done. It must not have been completed, it should have been done upon admission. Shari DON I was not able to locate it. New admit no pharmacy review completed yet.	F 655		

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F 655	Continued From page 12 Resident #25 FTag Initiation 11/08/18 01:13 PM 11/07/18 08:55 AM Admit: 8/24/18 DX:type 2 DM, MDD, fusion of spine, ESRD, Dependence on renal dialysis, anemia, HTN. MDS: BIMS not assessed CAA: (PSYCH/Pain) CARE PLAN: 11/07/18 11:29 AM Beth MDS nurse, admissions does the 24-48 hour care plans, it should be in his paper chart. I don't see it in here, it should be in the paper chart. I will look in a box that has misc papers, if I find it I will let you know.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive 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	F 656		

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F 656	Continued From page 13 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 observation, interview and document review the facility failed to develop and implement interventions on the person centered care plan for 1 of 1 residents (R16) reviewed for behavior/emotion, dementia care and pain management Findings include: R16's 14 day minimum data set (MDS) dated	F 656		

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10/18/18, indicated R16 was severely cognitively impaired, demonstrated no mood or behavior symptoms and required limited assistance with most activities of daily living (ADL's). Diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD) and recent urinary tract infection. The MDS also indicated that R16 had not pain, was not receiving any scheduled or as needed (PRN) pain medications or any antipsychotic, antianxiety or antidepressant medications.

Care area assessments triggered on 10/18/18, included cognitive loss/dementia, urinary incontinence, falls, nutritional status and pressure ulcer.

Pain Evaluation completed on 10/4/18, indicated R16 had occasional pain in low back and legs. Analgesic pain medication was effective. Summary indicated use of as needed (PRN) analgesics, rest, movement and not staying seated in one place.

Recreation services assessment dated 10/5/18, indicated that R16 interests included crossword games, beading, television game shows, bingo, cards, cribbage, visiting the birds and 1:1's. Assessment indicated R16 preferred 1:1's, small group or in room activities.

R16's care plan dated 10/19/18, indicated R16 had impaired cognitive function/dementia or impaired thought processes related to dementia. Staff were directed to ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding residents capabilities and needs, cue,

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reorient and supervise as needed. Staff were also directed to monitor/document/report as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Additions made to care plan on 11/7/18 includes anti-anxiety med use & pain

Physician orders upon admission 10/4/18, included aspirin 325 milligrams (mg) daily; sulfamethoxazole/trimethoprim (antibiotic) 1 tablet twice daily (BID) for 2 days; guaifensin 600 mg daily PRN for congestion.
Additional medications were added as follows:
- on 10/16/18 acetaminophen 650mg every 4 hours PRN for pain
- on 10/18/18 acetaminophen with codiene #3 (Tylenol #3) give 1 tablet every 6 hours PRN for pain
- on 10/18/18 lorazepam (Ativan) 1mg BID PRN for anxiety
- on 10/23/18 lorazepam 1mg BID for anxiety
- on 10/26/18 Lexapro 5mg daily for depression
- on 10/30/18 lorazepam 1mg every 6 hours PRN agitation (in addition to 1mg BID)
- on 11/6/18 risperidone 0.25 mg BID for mood disorder (antipsychotic medication)

Fax's sent to physician as follows:
- On 10/18/18, at 3:30 p.m. - R16 has been having increased confusion last 2 nights (16th & 17th). Pacing floor, walking out in hallway without oxygen, crying out. Can we get a PRN order for lorazepam or pain. She has been asking for something for pain. Only thing she has is PRN 650mg Tylenol. Wondering if agitation is due to pain?

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F 656	Continued From page 16 - On 10/18/18 at 4 p.m. - orders received for loreazepam 1 mg BID PRN pain & Tylenol #3 1 every 6 hrs PRN - On 10/20/18 response at 4:25 p.m. - change Tylenol to 500mg 2 tablets every 6 hrs PRN - max 3000mg ; lorazepam 1 mg evey 6 hrs PRN agitation - On 10/29/18, no time noted.: restless, agitated, yelling out severe complaints of pain. "feels like knife stabbing" located mid-upper back/spinal region between shoulder blades. Increase yelling with staff intervention, increase incontinence amount 7 frequency soiling bed & leaving puddles of urine on floor wile having brief on. Cold pack, 1:1 reassure, redirect, distraction all ineffective. Phone call to daughter re: dog effective short term (5-10) minutes Scheduled lorazeapam & PRN Tylenol #3 effective in AM. PRN Tylenol #3 again at 3:45 ineffective. Lorazepam scheduled st bedtime. PRN lorazepam discontinued when order received for scheduled. Requesting: OK for PRN lorazepam in addition to scheduled. Urinalysis on 10/23 - increase Tylenol #3 to two tablets every 4 hours. - On 11/5/18, no time noted; - Continues present with anxiety re: placement & dog. Increases in PM, difficulty de-escalating with non-phar interventions. Crying depressed statements. Reassuring dog is with daughter & visits regularly - effective at times during day, decreased effectiveness in PM/night. PRN lorazepam utilized daily in addition to scheduled Lexapro 5mg every AM started 10-29-18. Requesting referral for in-house psych service Review of Medication Administration Records indicated the following: - 5 does of PRN lorazepam was administered in October 2018; 8 doses in Novemeber 2018	F 656		

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F 656	Continued From page 17 - 6 doses of PRN acetaminophen 650 mg given in October 2018 - 13 doses of Tylenol #3 were administered in October 2018; 14 doses in November 2018 No pain monitoring prior to or after administration of pain medications were found. On 11/5/18, at 11:05 a.m. R16 stated she has significant pain in her back between her shoulder blades. - At 11:56 a.m. R16 was observer to be laying self down in bed from a sitting position, grimacing and stating Oh God. - At 2:23 p.m. R16 was asking surveyor to help find her dog - please look in the bathroom and outside. On 11/07/18, at 2:44 p.m. R16 was observed to be assist by staff into her bed. An unidentified staff person stated R16 was found standing at the end of the bed barefoot. - At 2:51p.m. R16 was observed sitting on edge of bed trying to put on socks "oh god, oh god." On 11/8/18, during continuous observation from 7:05 a.m. until 8:06 a.m. R16 was observed lying in bed on left side, facing the wall. - At 8:06 a.m. a covered breakfast tray was placed on overbed table. - At 8:23 a.m. breakfast tray remained covered and R16 was asking where was her puppy. - At 8:46 a.m. licensed practical nurse (LPN)-B entered room with medications. R16 complained of back pain and asked where her dog was. LPN-B administered medications, removed cover from breakfast, and left room. - At 9:07 a.m. R16 was observed crying and stating "Oh God, Oh God I want to die." R16 had	F 656		

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F 656	Continued From page 18 not eaten any breakfast. - At 9:24 a.m. R16 had eaten a piece of bacon. No staff assistance with meal since delivery at 8:06 a.m. - At 11:09 a.m. R16 told surveyor that back pain was an 8 out of 1-10 scale. R16 stated the pain stops me from being able to move about and enjoy things. - At 12:10 p.m. R16 was observed lying in bed, rubbing her head, no TV or music was playing. Progress Notes reviewed as follows: - PN dated 10/5/18, at 12:41 p.m. has been calling out for her dog and has stated her white dog is dead on the road being eaten by a crow, redirection as her dog is with her daughter. Residnt voiced that staff is lying to her and she can see her dog on the road. Attempts to redirect not consistently effective. - PN dated 10/17/18, at 11:29 p.m. resident wandering out in hallway looking for her dog. Staff redirected several times throughout the evening. - PN dated 10/19/18, at 2:14 p.m. resident agitated, came out to the nurse station and asked where my dog was. Writer told resident that her dog was at daughter's. Resident stated I saw my dog run down the hallway. Writer tried to redirect several times. Resident became irritated and went back to room. Left resident's door open for her reassurance that she thinks her dog may come back in. - PN dated 10/20/18, at 3:15 p.m. upset and crying this afternoon regarding dog. Call placed to daughter who will bring dog in this afternoon. - PN dated 10/21/18, at 4:40 a.m. resident agitated and asking where her dog was. States she saw him go to the end of the hallway. Redirected.	F 656		

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F 656	Continued From page 19 - PN dated 10/22/18, at 8:37 p.m. resident is visabily upset, crying that dog is missing. Tried to redirect. Resident verbalized is she had a gun she would "blow her brains out." Lorazepam administered. Resident continued to exhibit signs of distress, 15 minute checks instilled but resident had been on 1:1 since 7:10 p.m. While staff was with resident she verbalized she was going to "slit her wrists" and "bust her head into the wall." Daughter called and wanted sent to emergency room. - PN dated 12:31 a.m. indicated resident was ready to return to facility - no longer suicidal just bored. - PN dated 10/25/18, at 5:11 a.m. resident agitated and looking for dog. Redirected, television turned on. Ineffective. Lorezapam given. - PN dated 10/25/18, at 3:44 p.m. resident anxious this AM looking for dog. Writer voiced dog was with daughter, resident voiced they were lying to her. - PN dated 10/29/18, at 12:19 p.m. anxious in AM regarding dog. Difficulty to reassure or distract. Attempted to call daughter x2 - no answer. - PN dated 11/1/18, at 11:36 p.m. anxious about dog thinks he is missing. Redirected. Resident crying and repeatedly saying "ow." States she feels like someone is stabbing her in the back and pain radiates around the front towards the ribs. Tylenol #3 administered. - PN dated 11/3/18, at 6:59 p.m. resident crying and yelling out at 6:30 p.m. from upper back and anxiety regarding dog. Tylenol #3 administered along with AM lorazepam. Distraction and redirection effective short term. Behaviors escalated early afternoon, in similar fashion as AM. Crying regarding dog and upper back. Repeated interventions with similar effectiveness	F 656		

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F 656	Continued From page 20 noted. On 10/8/18, at 12:37 p.m. activities director (AD) stated that R16 likes adult coloring books but does not have them in her room. AD stated R16 likes socializing in a small group but usually does not get up for morning activities. - At 12:41 p.m. licensed practical nurses (LPN)-A & LPN-B stated R16 cries daily. We make sure she is comfortable but it is usually about her dog. R16's daughter brings the dog in daily but is weaning off the visits because it upset R16 more after she sees her dog. We have not tried a stuffed animal or doll but not sure it would work. When a new medication is ordered it is because we have faxed the physician with symptoms. The local physician comes in every other Friday - due tomorrow. Non pharmacological interventions are tried before we give medications. A psychiatric evaluation has been requested (since the start of the survey) but is 3 weeks out. Some of R16's issues are back pain and other is Alzheimer's disease - we are looking into a possible unit for her to be transferred to. When we give PRN Ativan we document what she is doing. - 12:48 p.m. nursing assistant (NA)-A stated that R16 cries at least once per hour looking for her dog. R16 will yell and call you a liar. - 12:49 p.m. licensed social worker (LSW) stated staff report R16 is constantly looking for her dog, will accuse daughter of taking the dog. The facility would allow the dog to live here but R16's daughter says that is not an option. We tried a stuffed animal and R16 just got angry. LSW is not sware of non-homological interventions to use with R16 and has not had any contact with R16 except to take her back to her room. No LSW progress notes were found in R16's chart since	F 656		

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F 656	Continued From page 21 admission on 10/4/18. - At 12:54 p.m. director of nursing (DON) stated she expected staff to be trying non-pharmaco;ogical approaches before administering medications. DON was unable to determine why risperdone was ordered this morning as there were not progress notes to indicate communication with physician. DON confirmed that person centered interventions were not developed for R16 related to behavioral/emotional, dementia care or pain management.	F 656		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Resident #17 FTag Initiation 11/06/18 07:08 PM Admit: 9-8-14 DX:malignant neoplasm of brain, neuralgia and neuritis, MDD, epilepsy, GERD, degenerative disease of nervous system, MDS: quarterly MDS 8/8/18 BIMS 6	F 678		

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F 678	Continued From page 22	F 678		

CAA: (PSYCH/Pain)

CARE PLAN: alteration in elimination. provide incontinence care with each episode, check on bed pan eveery 10minutes.

CARE Conference Note: 8/14/18

Assessments:

MD Orders: see scanned document

Vitals:

Labs:

Behavior monitoring: expressions of hopelessness or withdrawal from activiites.

Staff Interventions: offer faviorite activities, contact with family. chart mood behavior and antidepressant use

Falls: none

Observations:11/07/18 09:48 AM checked hot water temp 125
11/07/18 01:09 PM no strong urine odor noted.
11/06/18 01:09 PM noted that cna removed urine soaked wet w/c cushion from room. 11/07/18 01:30 PM peri cares done no concerns/ with hand hygiene. No further concerns of urine odor.
Interviews:
11/06/18 07:19 PM I thought we talked about it I decided DNR in August.
11/06/18 07:51 PM shari is this an advance directive? Writer: I want the one from the chart, not the one from today.

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F 678	Continued From page 23 Shari got the chart and the code status directive was in the back to be filed. This was dated 8/9/06. The copy when asked was dated 11/6/18, asked for copy of code status directive that was in the front of the chart, copied was recieved. 11/08/18 07:51 AM How often are the water temps checked? twice a week What should the temp be? 115 Jackie maintence 11/08/18 08:06 AM temp myrna's room 115.9 temp penny's room 118.9 I think I need to get my thermometer calibrated, hers was reading 92 degrees. I will have to go to home depot.	F 678		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		

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by:
Based on observation, interview and document review, the facility failed to provide the use of splints to prevent the development of upper extremity contractures for 1 of 1 residents (R10) observed with contractures. This resulted in actual harm for R10 due to worsening of identified contractures in upper extremities.

Findings include:

R10's quarterly Minimum Data Set (MDS) dated 9/12/18, indicated R10 had severe cognitive impairment and diagnoses which included Parkinson's disease, quadriplegia and depression. The MDS indicated R10 required total assistance of two staff for bed mobility, transfers and all activities of daily living (ADL's) , and had bilateral functional limitation in range of motion of the upper and lower extremities.

R10's Activities of Daily Living Care Area Assessment (CAA) dated 6/29/18, indicated R10 required assistance with all ADL's, required extensive to total cares due to Parkinson's disease and quadriplegia. The CAA indicated R10 was unable to perform tasks on his own and he had contractures. The CAA also indicated R10 was at risk for ADL decline and range of motion (ROM) decline, worked with therapy on braces to arms, and was being monitored by staff for ROM declines.

R10's Therapy and Nursing Communication dated 6/5/18, regarding splints directed all orthotics/splints to be worn at all times with the exception of bathing, dressing and daily passive range of motion (PROM) and stretching. Watch for pressure areas and notify therapy. All nursing

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staff should be in-serviced on ROM and splint application.

In-service training record dated 5/28/18 indicated 10 staff received training on use of braces and PROM for R10.

R10's Occupational Therapy Treatment Encounter note dated 4/25/18, indicated educated nursing staff present on proper application of bilateral elbow splints. Additionally, educated staff on contracture management such as prolonged stretching of bilateral elbows, benefits and importance of applying splints.

R10's Order Summary Report dated 10/8/18, indicated an order stating all orthotics/splints to be worn at all times with the exception of bathing, dressing and daily PROM and stretching. Order was started 6/15/18.

R10's care plan dated 5/9/18 indicated R10 had decline in physical condition due to previous fracture, neurologic decline, Parkinson's as evidenced by poor ROM and inability to reposition. The care plan directed staff to apply hand splints at all times to reverse contractures - off for cares, dressing and bathing. May have off for 20 minutes per shift to allow skin to heal due to potential for impaired skin integrity.

On 11/07/18, at 11:15 a.m. R10 was observed up in wheelchair in room. No elbow splints on.
- At 2:47 p.m. no elbow splints on.
- At 2:48 p.m. director of therapy services indicated she did not know where R10's splints were but knew R10 was suppose to be wearing them at all times.
- At 2:53 p.m. nursing assistant (NA)-E stated she

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has worked here since 9/5/18 and has never known R10 to wear any type of splints

On 11/08/18, at 7:06 a.m. R10 was observed up in wheelchair with no elbow splints on. Right arm contractured. R10 was holding arm upwards across chest.
- At 7:10 a.m. NA-A stated she provides his PROM when R10 lays down after breakfast.
- At 8:10 a.m. administrator wheeled R10 into his room. Observed both arms curled up towards chest.
- At 8:54 a.m. director of therapy services confirmed that R10 was suppose to be wearing splints and she searched throughout room for elbow & hand splints. They were located under items on spare bed in room. (NA)-A stated she began working at facility in April and has never seen R10 with splints in place. After assisting R10 into bed, NA-A did not apply hand/elbow splints to R10.
- At 11:04 a.m. licensed practical nurse (LPN)-B stated that R10 will yell at you when you try to splint him - will yell non-stop.
- At 11:11 a.m. director of therapy services stated she spoke to Physical Therapist by telephone and he was not aware that R10 was not tolerating wearing of splints and by seeing R10 in passing, he would say the R10's contractures had worsened. Physical therapist was not available on-site.

Review of progress notes indicated the following dates R10 was not tolerating splints:
- 9/24, 9/25, 9/27, 9/28
- 10/1, 10/6 - 10/9, 10/11, 10/14, 10/17 - 10/21 & 10/25
- 11/1, 11/2, 11/4, 11/5, 11/7, 11/8
There was no documentation that Physical

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F 688	Continued From page 27 Therapy department was notified of R10 not tolerating splints. On 11/08/18, at 11:28 a.m. director of nursing stated the nurses have signed off that either he is tolerating or not tolerating the use of splints. DON verified that most days were documented "not tolerating" and physical therapy should have been contacted by now that R10 had not been tolerating splints. The Splint policy dated 3/8/18, included procedure to ensure there is an order for the splinting device, ensure the splint is being put on according to care plan and physician order, ensure skin is protected around the splinted area and splint fits properly, all sprints need to be removed for periods of rest to ensure proper circulation and if splint does not fit refer to therapy or physician for new order. The policy indicated documentation may include: any sign of discomfort, changes in skin, refusal of application or changes to ROM.	F 688		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess pain and identify non-pharmacological interventions for 1 of 1 residents (R16) who	F 697		

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voiced complaints of pain.

Findings include:

R16's 14 day minimum data set (MDS) dated 10/18/18, indicated R16 was severely cognitively impaired. Diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD) and recent urinary tract infection. The MDS also indicated that R16 had not pain, was not receiving any scheduled or as needed (PRN) pain medications.

Care area assessments triggered on 10/18/18, included cognitive loss/dementia, urinary incontinence, falls, nutritional status and pressure ulcer.

Pain Evaluation completed on 10/4/18, indicated R16 had occasional pain in low back and legs. Analgesic pain medication was effective. Summary indicated use of as needed (PRN) analgesics, rest, movement and not staying seated in one place.

R16's care plan did not address pain as a problem. (added 11/07/17)

Physician orders upon admission 10/4/18, included aspirin 325 milligrams (mg) daily; sulfamethoxazole/trimethoprim (antibiotic) 1 tablet twice daily (BID) for 2 days; guaifensin 600 mg daily PRN for congestion.
Additional pain medications were added as follows:
- on 10/16/18 acetaminophen 650mg every 4 hours PRN for pain
- on 10/18/18 acetaminophen with codeine #3 (Tylenol #3) give 1 tablet every 6 hours PRN for

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F 697	Continued From page 29 pain Fax's sent to physician as follows: - On 10/18/18, at 3:30 p.m. R16 has been asking for something for pain. Only thing she has is PRN 650mg Tylenol. Wondering if agitation is due to pain? - On 10/18/18 at 4 p.m. -ordered Tylenol #3 - 1 tablet every 6 hrs PRN - On 10/20/18 response at 4:25 p.m. - change Tylenol to 500mg 2 tablets every 6 hrs PRN - max 3000mg - On 10/29/18, no time noted.: restless, agitated, yelling out severe complaints of pain. "feels like knife stabbing" located mid-upper back/spinal region between shoulder blades. Increase yelling with staff intervention, increase incontinence amount 7 frequency soiling bed & leaving puddles of urine on floor wile having brief on. Cold pack, 1:1 reassure, redirect, distraction all ineffective. Phone call to daughter re: dog effective short term (5-10) minutes Scheduled lorazeapam & PRN Tylenol #3 effective in AM. PRN Tylenol #3 again at 3:45 ineffective. Lorazepam scheduled st bedtime. PRN lorazepam discontinued when order received for scheduled. Requesting: OK for PRN lorazepam in addition to scheduled. Urinalysis on 10/23 - increase Tylenol #3 to two tablets every 4 hours. Review of Medication Administration Records indicated the following: - 6 doses of PRN acetaminophen 650 mg given in October 2018 - 13 doses of Tylenol #3 were administered in October 2018; 14 doses in November 2018 No pain monitoring prior to or after administration of pain medications were found.	F 697		

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On 11/5/18, at 11:05 a.m. R16 stated she has significant pain in her back between her shoulder blades.
- At 11:56 a.m. R16 was observed to be laying self down in bed from a sitting position, grimacing and stating Oh God.

On 11/7/18, at 2:51p.m. R16 was observed sitting on edge of bed trying to put on socks "oh god, oh god."

On 11/8/18, at 8:46 a.m. licensed practical nurse (LPN)-B entered room with medications. R16 complained of back pain and asked where her dog was.
- At 9:07 a.m. R16 was observed crying and stating "Oh God, Oh God I want to die." R16 had not eaten any breakfast.
- At 11:09 a.m. R16 told surveyor that back pain was an 8 out of 1-10 scale. R16 stated the pain stops me from being able to move about and enjoy things.

On 10/18/18, at 12:41 p.m. licensed practical nurses (LPN)-A & LPN-B stated R16 cries daily, we assess her pain and give medications as prescribed.
- At 12:54 p.m. director of nursing (DON) confirmed R16 had not been comprehensively assessed for pain and a care plan had not been developed to identify pharmacological and non-pharmacological interventions.

A policy for pain management was requested and was not provided.

F 698 SS=D Dialysis F 698
CFR(s): 483.25(l)

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§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure consistent monitoring of dialysis access sites and develop a comprehensive care plan for 1 of 1 resident (R21) reviewed for dialysis.

Findings include:

The admission record dated 11/8/18 for R21 indicated diagnoses that included, but were not limited to end stage renal disease and was dependent on renal dialysis.

Review of R21's admission Minimum Data Set (MDS) dated 9/12/18, indicated R21 had no memory or cognitive impairment, the resident was independent with transfer and mobility using a wheelchair, had end stage renal disease (ESRD), and received dialysis.

Review of R21's physician orders revealed orders for renal diet, renal dialysis Monday Wednesday, and Friday of each week, a 1200 cc fluid restriction, and to monitor dependent edema, however there was no physician orders to monitor R21's tunneled catheter used for dialysis.

R21 was observed on 11/08/18, at 7:15 a.m. during which it was noted that R21 had a

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F 698	Continued From page 32	F 698		

tunneled catheter on the right upper chest wall that had a double lumen and was covered with a dressing. R21 stated that the facility never checked the catheter following dialysis, and the dialysis unit was responsible for changing the dressing.

R21's medication administration records and treatment administration records were reviewed and there was no indication R21's tunneled catheter was monitored.

R21's dialysis care plan dated 9/25/18, included the following:
-Do not draw blood or take B/P in arm with graft.
-Encourage resident to go for the scheduled dialysis appointments.
-Resident receives dialysis 3 times a week- M-W-F. ·
- Monitor intake and output.
- Monitor labs and report to doctor as needed.
-Monitor/document/report as needed for signs and symptoms of renal insufficiency, changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sound.
-Monitor/document/report as needed for signs and symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock.
-The resident has potential fluid deficit or fluid overload related to diuretic use, hemodialysis, CHF ; The resident will drink/take in a minimum of 1100-1200 cc's each 24-hour period.
-Monitor and document intake and output as per facility policy.

The care plan misidentified that R21 had a graft in the arm, it had not identified R21 had a tunneled catheter(TC), and appropriate interventions related to the TC (like dialysis does

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F 698	Continued From page 33 the dressing changes, the catheter should be checked following dialysis and daily to minimize chances of exsanguination, and interventions to implement should catheter show signs of infection or get dislodged.) The care plan had not identified at which ESRD facility R21 received hemodialysis and how to contact them, appropriate diet restrictions including which foods R21 was restricted from eating in a renal diet, and the care plan had not identified how R21's fluid would be delineated as far as how much R21 was going to receive for each meal, and how much R21 was going to receive with each medication pass. Additionally, The care plan had not identified which drugs would be dialyzed off when given at 8:00 a.m. prior to dialysis on Monday, Wednesday, and Friday. R21's nursing progress notes from 10/18/18-11/4/18, were reviewed and almost daily the notes read that R21 was not following the fluid restriction, although never once did a nursing progress note indicate R21 had been notified of not meeting fluid goals and explained the risks of not meeting the fluid goals. Additionally, care plan interventions had not been developed to address R21's non-compliance with meeting the fluid goals and different interventions for thirst except drinking water (hard candy, ice chips, frozen ice pops etc...) The DON was interviewed on 11/06/18, at 3:35 p.m. during which she confirmed there was no monitoring of R21's TC recorded since admission, the risks and benefits of being fluid over loaded were not documented as explained to R21, and R21's care plan was not completed to show correct dialysis access site with interventions, fluid delineation and fluid goals,	F 698		

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F 698	Continued From page 34 dialysis place and contact information, renal diet choices, and meds that should and should not be given prior to dialysis.	F 698		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide person centered dementia care for 1 of 1 residents (R16) who exhibited behaviors related to dementia. Findings include: R16's 14 day minimum data set (MDS) dated 10/18/18, indicated R16 was severely cognitively impaired, demonstrated no mood or behavior symptoms and required limited assistance with most activities of daily living (ADL's). Diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD) and recent urinary tract infection. Care area assessments triggered on 10/18/18, included cognitive loss/dementia, urinary incontinence, falls, nutritional status and pressure ulcer. Recreation services assessment dated 10/5/18, indicated that R16 interests included crossword games, beading, television game shows, bingo,	F 744		

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cards, cribbage, visiting the birds and 1:1's. Assessment indicated R16 preferred 1:1's, small group or in room activities.

R16's care plan dated 10/19/18, indicated R16 had impaired cognitive function/dementia or impaired thought processes related to dementia. Staff were directed to ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding residents capabilities and needs, cue, reorient and supervise as needed. Staff were also directed to monitor/document/report as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. In the activity of daily living section staff were directed to provide cues and redirection with meals. Additions made to care plan on 11/7/18 includes anti-anxiety med use & pain

On 11/5/18, at 2:23 p.m. R16 was asking surveyor to help find her dog - please look in the bathroom and outside.

On 11/07/18, at 2:44 p.m. R16 was being assisted back to bed by an unidentified staff person who stated she found R16 standing barefoot at the end of her bed. R16 was heard to be short of breath.
- At 2:51 p.m. R16 was observed to be sitting on edge of bed trying to put on socks "oh god, oh god"
- At 3:05 p.m. R16 was observed lying in bed on left side, facing window, with dress pulled up exposing her brief towards the open door to the hallway.

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On 11/08/18 from 7:05 a.m. until 8:22 a.m. R16 was observed lying in bed facing the wall on left side. R16 appeared asleep.
-At 8:06 a.m. nursing assistant (NA)-A placed a covered tray of breakfast on overbed table.
- At 8:23 a.m. R16 was sitting up in bed asking "where's my puppy?"
- At 8:33 a.m. R16 had not began to eat breakfast and no staff have not been in to encourage
-At 8:44 a.m. R16's breakfast remained untouched and no staff have been to room to offer encouragement to eat meal.
- At 8:46 a.m. licensed practical nurse (LPN)-B entered room with medications. R16 was asking for her dog and LPN-B indicated that R16's daughter had her dog. LPN-B removed covers from breakfast and reminded R16 that her breakfast was there. LPN-B then left the room.
-At 9:07 a.m. R16 had not begun to eat meal and was observed to be crying "Oh God, Oh God I want to die"
-At 9:24 a.m. R16 had eaten a piece of bacon.
- At 12:10 p.m. R16 was lying in bed on back, rubbing head - no TV on - no stimulation

Progress Notes reviewed as follows:
- PN dated 10/5/18, at 12:41 p.m. has been calling out for her dog and has stated her white dog is dead on the road being eaten by a crow, redirection as her dog is with her daughter. Resident voiced that staff is lying to her and she can see her dog on the road. Attempts to redirect not consistently effective.
- PN dated 10/17/18, at 11:29 p.m. resident wandering out in hallway looking for her dog. Staff redirected several times throughout the evening.
- PN dated 10/19/18, at 2:14 p.m. resident

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F 744	Continued From page 37 agitated, came out to the nurse station and asked where my dog was. Writer told resident that her dog was at daughter's. Resident stated I saw my dog run down the hallway. Writer tried to redirect several times. Resident became irritated and went back to room. Left resident's door open for her reassurance that she thinks her dog may come back in. - PN dated 10/20/18, at 3:15 p.m. upset and crying this afternoon regarding dog. Call placed to daughter who will bring dog in this afternoon. - PN dated 10/21/18, at 4:40 a.m. resident agitated and asking where her dog was. States she saw him go to the end of the hallway. Redirected. - PN dated 10/22/18, at 8:37 p.m. resident is visabily upset, crying that dog is missing. Tried to redirect. Resident verbalized is she had a gun she would "blow her brains out." Lorazepam administered. Resident continued to exhibit signs of distress, 15 minute checks instilled but resident had been on 1:1 since 7:10 p.m. While staff was with resident she verbalized she was going to "slit her wrists" and "bust her head into the wall." Daughter called and wanted sent to emergency room. - PN dated 12:31 a.m. indicated resident was ready to return to facility - no longer suicidal just bored. - PN dated 10/25/18, at 5:11 a.m. resident agitated and looking for dog. Redirected, television turned on. Ineffective. - PN dated 10/25/18, at 3:44 p.m. resident anxious this AM looking for dog. Writer voiced dog was with daughter, resident voiced they were lying to her. - PN dated 10/29/18, at 12:19 p.m. anxious in AM regarding dog. Difficulty to reassure or distract. Attempted to call daughter x2 - no answer.	F 744		

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- PN dated 11/1/18, at 11:36 p.m. anxious about dog thinks he is missing. Redirected. Resident crying and repeatedly saying "ow." States she feels like someone is stabbing her in the back and pain radiates around the front towards the ribs. Tylenol #3 administered.
- PN dated 11/3/18, at 6:59 p.m. resident crying and yelling out at 6:30 p.m. from upper back and anxiety regarding dog. Distraction and redirection effective short term. Behaviors escalated early afternoon, in similar fashion as AM. Crying regarding dog and upper back. Repeated interventions with similar effectiveness noted.

On 10/8/18, at 12:37 p.m. activities director (AD) stated that R16 likes adult coloring books but does not have them in her room. AD stated R16 likes socializing in a small group but usually does not get up for morning activities.
- At 12:41 p.m. licensed practical nurses (LPN)-A & LPN-B stated R16 cries daily. We make sure she is comfortable but it is usually about her dog. R16's daughter brings the dog in daily but is weaning off the visits because it upset R16 more after she sees her dog. We have not tried a stuffed animal or doll but not sure it would work. When a new medication is ordered it is because we have faxed the physician with symptoms. The local physician comes in every other Friday - due tomorrow. Non pharmacological interventions are tried before we give medications. A psychiatric evaluation has been requested (since the start of the survey) but is 3 weeks out. Some of R16's issues are back pain and other is Alzheimer's disease - we are looking into a possible unit for her to be transferred to.
- 12:48 p.m. nursing assistant (NA)-A stated that R16 cries at least once per hour looking for her

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F 744	Continued From page 39 dog. R16 will yell and call you a liar. - 12:49 p.m. licensed social worker (LSW) stated staff report R16 is constantly looking for her dog, will accuse daughter of taking the dog. The facility would allow the dog to live here but R16's daughter says that is not an option. We tried a stuffed animal and R16 just got angry. LSW is not aware of non-homological interventions to use with R16 and has not had any contact with R16 except to take her back to her room. No LSW progress notes were found in R16's chart since admission on 10/4/18. - At 12:54 p.m. director of nursing (DON) stated she expected staff to be trying non-pharmacological approaches before administering medications. DON confirmed that person centered interventions were not developed for R16 related to behavioral/emotional, dementia care or pain management. A facility policy for provision of dementia care was requested, but not provided.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		

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F 755	Continued From page 40 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure procedures were established and implemented for appropriate disposition and storage of narcotic medication and prescription medications. This had the potential to affect all 25 residents who resided in the facility. Finding include: On 11/8/18, at 2:00 p.m. the medication administration room with toured with registered nurse (RN)-A. A large plastic container approximately 12 inches by 12 inches by 6 inches deep and a paper box approximately 24 x 24 inches by 12 inches deep were observed to be overflowing with medications on the medication room counter. The boxes indicated "to be	F 755		

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destroyed." RN-A explained when resident medications were discontinued or changed, the staff placed the medications in to the boxes to be returned to the pharmacy or to be destroyed in house. RN-A stated she was unaware how the facility documented which medications were to be in the boxes to be destroyed.

At 2:10 p.m. the medications boxes were observed with RN-A. Included in the boxes was 19 tablets of 1 milligram (mg)Lorazepam (narcotic medication/anti-anxiety) for R27, 20 tablets of 0.5 mg ativan for R276, 8 tablets of tramadol (narcotic pain medications) for R277 and 24 tablets of Oxycodne 10 mg (narcotic pain medication) for R277. RN-A stated the narcotic medications were not to be in the boxes on the counter and should have been placed in a lock box until they were able to be destroyed with the pharmacist.

- At 2:13 p.m. the director of nurses observed the medication room. The DON confirmed all of the medications in the overflowing boxes had been discontinued. The medications in included oral prescription medications, prescription eye drops, insulin and topical medications. The DON confirmed the boxes contained greater than 75 prescription medications. The DON stated the narcotic medications were to be locked in a narcotic cupboard until they were destroyed by the consultant pharmacist. The narcotic medications were not to be added to the random box of medications to be destroyed. The non narcotic medications were to be added to a bottle of chemical solution which destroyed the medication. The staff were to document the medications which were destroyed.

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Review of the narcotic log books indicated the following information:

- R275's 24 tablets of Oxycodne had been destroyed on 10/8/18 but two staff members.
- R277's 8 tablets of Tramadol had been removed from the narcotic box on 10/8/18.
- R276's Ativan 0.5 mg had been locked in the narcotic cabinet by a staff members.
- R27's Ativan 1 mg 19 tablets had been discontinued without documentation as to why they were not in the medication cart.

- At 2:20 p.m. the DON confirmed none of the narcotics were missing, however, the staff had incorrectly documented the disposition of the medications. The DON confirmed the facility had not followed their policy regarding medication destruction.

The undated Medication Storage Policy, directed the staff to store controlled medications (narcotics) separately from the non controlled medications.

The Controlled Substances Policy dated 2/15/18, indicated all medications that are expired or no longer in use must be removed from the cart with note stating disposition in the narcotic book and signature of two nurses then given to the director of nursing or designees to put in double locked are until destroyed.

The Pharmacy Service policy for Controlled Medication Disposal dated 4/2014, indicated two witnesses observe the destruction of the

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F 755	Continued From page 43 controlled medications. The witness may included the administrator, DON and the pharmacist. The Pharmacy Services policy dated 4/2014, for Non Controlled Medication Disposal indicated if the prescription medication was able to be returned to the pharmacy, the staff were to return the medications. If the medication could not be returned for credit, the medications were to be disposed of per state regulations.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		

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irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to act upon the consultant pharmacist recommendations of 1 of 5 residents (R19) reviewed for unnecessary medications.

Findings include:

R19's undated Face sheet indicated she was admitted to the facility on 10/12/18, with diagnoses including left hip fracture, Parkinson's disease and major depressive disorder.

R19's After Discharger Orders/ admission orders dated 10/10/18, included multiple orders for medications including Celexa 40 milligrams (mg) by mouth daily for the treatment of depression.

- R19's Consultant Pharmacist's Medication Review dated 10/15/18, indicated the pharmacist had identified R19's Celexa order and indicated the Federal Drug Administration (FDA) had established the maximum does of Celexa for people over 60 years old to be 20 mg per day, due to the potential for cardiovascular

F 756

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complications and lack of documented efficacy at doses greater than 20 mg per day in patients. The pharmacists indicated if the patient is not displaying an adequate response with Celexa 20 mg daily, it was appropriate to switch her to a different antidepressant. The pharmacist indicated the physician was to address the concerns as soon as possible but no later than 30 days.

Review of R19's clinical record lacked indication the pharmacist concern had been addressed with the physician.

Review of R19's Medication Administration Record dated 11/1/18, included an order for Celexa 40 mg daily.

On 11/8/18, at 12:14 p.m. the director of nurses (DON) stated she received the consultant pharmacist recommendations via email. The reports completed on 10/15/18, had been received on 10/16/18, however, she had not had a chance to look at them. The DON confirmed R19's report indicated the physician was to be notified as soon as possible and a physician should have been contacted regarding the dose being double the recommended dose for a person over 60. The DON confirmed she had not opened the email from the pharmacist until the survey staff asked for the most recent recommendations on 11/18/18, and she had was unaware of the identified concern. The DON stated she simply had not had a chance to look at the pharmacy reviews. The DON stated R19's report did not need to be looked at for another 7 days.

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F 756	Continued From page 46 A policy related to pharmacist reviews was requested and none was provided.	F 756		
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		

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are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to evaluate, monitor and justify the continued use of a psychotropic medications for 1 of 1 residents (R16) reviewed for unnecessary medications.

Findings include:

R16's 14 day minimum data set (MDS) dated 10/18/18, indicated R16 was severely cognitively impaired and demonstrated no mood or behavior symptoms. Diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD) and recent urinary tract infection. The MDS also indicated that R16 was not receiving any antipsychotic, antianxiety or antidepressant medications.

Care area assessments triggered on 10/18/18, included cognitive loss/dementia, urinary incontinence, falls, nutritional status and pressure ulcer.

R16's care plan dated 10/19/18, indicated R16

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had impaired cognitive function/dementia or impaired thought processes related to dementia. Staff were directed to ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding residents capabilities and needs, cue, reorient and supervise as needed. Staff were also directed to monitor/document/report as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Additions made to care plan on 11/7/18 includes anti-anxiety med use & pain

Physician orders upon admission 10/4/18, included aspirin 325 milligrams (mg) daily; sulfamethoxazole/trimethoprim (antibiotic) 1 tablet twice daily (BID) for 2 days; guaifensin 600 mg daily PRN for congestion.
Additional medications were added as follows:
- on 10/18/18 lorazepam 1mg BID PRN for anxiety
- on 10/23/18 lorazepam 1mg BID for anxiety
- on 10/30/18 lorazepam 1mg every 6 hours PRN agitation (in addition to 1mg BID)
- on 11/6/18 risperidone 0.25 mg BID for mood disorder (antipsychotic medication)

Fax's sent to physician as follows:
- On 10/18/18, at 3:30 p.m. - R16 has been having increased confusion last 2 nights (16th & 17th). Pacing floor, walking out in hallway without oxygen, crying out. Can we get a PRN order for lorazepam or pain. Wondering if agitation is due to pain?
- On 10/18/18 at 4 p.m. - orders received for loreazepam 1 mg BID PRN

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F 758	Continued From page 49 - On 10/29/18, no time noted.: restless, agitated, yelling out severe complaints of pain. "feels like knife stabbing" located mid-upper back/spinal region between shoulder blades. Increase yelling with staff intervention, increase incontinence amount 7 frequency soiling bed & leaving puddles of urine on floor wile having brief on. Cold pack, 1:1 reassure, redirect, distraction all ineffective. Phone call to daughter re: dog effective short term (5-10) minutes Scheduled lorazepam & PRN Tylenol #3 effective in AM. Lorazepam scheduled at bedtime. PRN lorazepam discontinued when order received for scheduled. Requesting: OK for PRN lorazepam in addition to scheduled. - On 11/5/18, no time noted; - Continues present with anxiety re: placement & dog. Increases in PM, difficulty de-escalating with non-pharmalogical interventions. Crying depressed statements. Reassuring dog is with daughter & visits regularly - effective at times during day, decreased effectiveness in PM/night. PRN lorazepam utilized daily in addition to scheduled Lexapro 5mg every AM started 10-29-18. Requesting referral for in-house psych service Review of Medication Administration Records (MAR) indicated the following: - 5 does of PRN lorazepam was administered in October 2018 - 8 doses in November 2018 Review of October and November 2018 MAR's and treatment records lacked any documentation of R16's target behaviors and side effect monitoring for use of psychotropic medication (lorazepam). (was added to the MAR on 11/7/18) On 11/5/18, at 2:23 p.m. R16 was asking	F 758		

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F 758	Continued From page 50 surveyor to help find her dog - please look in the bathroom and outside. On 11/7/18 at 2:51 p.m. R16 was observed sitting on edge of bed trying to put on socks "oh god, oh god." On 11/08/18, at 8:23 a.m. R16 was asking "where's my puppy?" - At 8:46 a.m. licensed practical nurse (LPN)-B entered room with medications and R16 asked LPN-B where her dog was. - At 9:07 a.m. R16 was observed crying "Oh God, Oh God I want to die" Progress Notes reviewed as follows: - PN dated 10/5/18, at 12:41 p.m. has been calling out for her dog and has stated her white dog is dead on the road being eaten by a crow, redirection as her dog is with her daughter. Resident voiced that staff is lying to her and she can see her dog on the road. Attempts to redirect not consistently effective. - PN dated 10/17/18, at 11:29 p.m. resident wandering out in hallway looking for her dog. Staff redirected several times throughout the evening. - PN dated 10/19/18, at 2:14 p.m. resident agitated, came out to the nurse station and asked where my dog was. Writer told resident that her dog was at daughter's. Resident stated I saw my dog run down the hallway. Writer tried to redirect several times. Resident became irritated and went back to room. Left resident's door open for her reassurance that she thinks her dog may come back in. - PN dated 10/20/18, at 3:15 p.m. upset and crying this afternoon regarding dog. Call placed to daughter who will bring dog in this afternoon.	F 758		

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F 758	Continued From page 51 - PN dated 10/21/18, at 4:40 a.m. resident agitated and asking where her dog was. States she saw him go to the end of the hallway. Redirected. - PN dated 10/22/18, at 8:37 p.m. resident is visibly upset, crying that dog is missing. Tried to redirect. Resident verbalized is she had a gun she would "blow her brains out." lorazepam administered. Resident continued to exhibit signs of distress, 15 minute checks instilled but resident had been on 1:1 since 7:10 p.m. While staff was with resident she verbalized she was going to "slit her wrists" and "bust her head into the wall." Daughter called and wanted sent to emergency room. - PN dated 12:31 a.m. indicated resident was ready to return to facility - no longer suicidal just bored. - PN dated 10/25/18, at 5:11 a.m. resident agitated and looking for dog. Redirected, television turned on. Ineffective. Lorazepam given. - PN dated 10/25/18, at 3:44 p.m. resident anxious this AM looking for dog. Writer voiced dog was with daughter, resident voiced they were lying to her. - PN dated 10/29/18, at 12:19 p.m. anxious in AM regarding dog. Difficulty to reassure or distract. Attempted to call daughter x2 - no answer. - PN dated 11/1/18, at 11:36 p.m. anxious about dog thinks he is missing. Redirected. Resident crying and repeatedly saying "ow." States she feels like someone is stabbing her in the back and pain radiates around the front towards the ribs. Tylenol #3 administered. - PN dated 11/3/18, at 6:59 p.m. resident crying and yelling out at 6:30 p.m. from upper back and anxiety regarding dog. Distraction and redirection effective short term. Behaviors escalated early	F 758		

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afternoon, in similar fashion as AM. Crying regarding dog and upper back. Repeated interventions with similar effectiveness noted.

R16's current care plan did not include the use of lorazepam nor did it include any monitoring of target behaviors or side effects/adverse reactions related to the lorazepam use. (care plan was updated to include this on 11/7/18)

R16 did not have a consultant pharmacist visit since admission.

Requested dictation from physician visit which was not provided.

On 10/8/18, at 12:41 p.m. LPN-A & LPN-B stated R16 cries daily. We make sure she is comfortable but it is usually about her dog. R16's daughter brings the dog in daily but is weaning off the visits because it upsets R16 more after she sees her dog. We have not tried a stuffed animal or doll but not sure it would work. When a new medication is ordered it is because we have faxed the physician with symptoms. The local physician comes in every other Friday - due tomorrow. Non pharmacological interventions are tried before we give medications. A psychiatric evaluation has been requested (since the start of the survey) but is 3 weeks out. Some of R16's issues are back pain and other is Alzheimer's disease - we are looking into a possible unit for her to be transferred to. When we give PRN lorazepam we document what she is doing.
- 12:48 p.m. nursing assistant (NA)-A stated that R16 cries at least once per hour looking for her dog. R16 will yell and call you a liar.
- At 12:54 p.m. director of nursing (DON) stated she expected staff to be trying

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F 758	Continued From page 53 non-pharmacological approaches before administering medications. DON was unable to determine why risperdone was ordered this morning as there were not progress notes to indicate communication with physician. DON confirmed that they were not monitoring for target behaviors or side effects of the use of lorazepam for R16. DON could not provide a physician visit (face to face) or a pharmacy consultation for the continued use of lorazepam PRN past 14 days (was initiated 10/19/18). Review of undated Antipsychotic Medication Use policy indicated that antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatric, social and environmental causes of behavior symptoms have been identified and addressed. Antipsychotic medication will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. If antipsychotic medications are administered as PRN dosages repeatedly over several days, the physician should discuss the situation with staff and evaluate the resident as needed to determine whether the use is appropriate and the symptoms are responding to the mediations. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: - general/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation - cardiovascular: orthostatic hypotension, arrthythmias - metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; or	F 758		

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F 758	Continued From page 54 - neurological: akathisia, dystonia, extrapyramidal effects, akinesia, tardive dyskinesia, stroke	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 observation, interview and document review, the facility failed to be free from medication error rate of 5 percent or greater identified during observations of 27 medications with 3 errors for one resident (R22) which resulted in an error rate of 11.11% percent. Findings include: On 11/8/18, at 7:58 a.m. R22's medication set-up and pass had been observed and completed by licensed practical nurse (LPN)-B. LPN-B was observed to set up the 8:00 a.m. medications as follows: - Advair diskus aerosol one puff inhaled every morning and at bedtime for asthma - Escitalopram 10 milligrams (mg) one tablet one time a day for depression - Oxybutin 5 mg one tablet twice daily for urinary frequency - Metoprolol 50 mg 1 tablet two times a day for Hypertension - Senna-Docusate 8.6-50 mg 1 tablet daily for constipation - Furosemide 40 mg take 1 ½ tablet in the	F 759		

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morning for edema
- Gabapentin 400 mg capsule 1 three times daily for fibromyalgia
- Levothyroxine 25 micrograms (mcg) one tablet daily for hypothyroidism
-Potassium Chloride 10 milliequivalents (meq) 1 tablet daily for hypokalemia
-Zafirlukast 20 mg one tablet twice daily for asthma
-Ranitidine 150 mg 1 tablet daily for reflux
-fish oil 1000 mg twice daily
-Acetaminophen extended release 650 mg two tablets every 8 hours as needed for pain
-Vitamin C 500 mg 1 daily for health care maintenance

-at 8:07 a.m. R22 was observed sitting on the edge of her bed. R22's breakfast was on the over the bed table. R22 had begun eating her breakfast of eggs, bacon, toast, juice and milk. LPN-B handed R22 her Advair diskus and placed R22's dished medications with a cup of water on the over the bed table. R22 was observed to inhale the Advair diskus and handed it back LPN-B. LPN-B was not observed to provide or offer an oral rinse following the Advair diskus use. R22 was observed to pick up her medication cup and began taking her medications. R22 was observed to take and swallow with water the aforementioned medications. R22 continued to consume her breakfast.

-at 8:09 a.m. R22's medication administration was reviewed with LPN-B who confirmed R22 was not offered a swish and spit after administering her Advair. LPN-B stated R22's Levothyroxine and Zafirlukast should not be administered with food we will have to adjust the administration times. LPN-B stated R22 will at

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F 759	Continued From page 56 times refuse to swish and spit following the inhalation of the Advair diskus, LPN-B confirmed she did not provided R22 with the risks and benefits of completing a rinse following the administration of the medication. - at 8:20 a.m. interview with the director of nursing (DON) regarding the medication errors of R22's medications. The DON confirmed Levothyroxine, and Zafirlukast should not be administered with food, and a mouth rinse should have been provided after administering R22's Advair diskus. The DON said she would expect the nurse to administer the medications as required. The facility Administering Medications policy, undated, indicated medications shall be administered in a safe and timely manner, and as prescribed. FACILITY Medication Administration	F 759		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 921		

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review, the facility failed to ensure the all areas of the kitchen were free of dust and debris. This practice had the potential to affect all 25 residents residing in the facility.

Findings include:

On 11/8/18, at 11:00 a.m. the sanitation tour was completed with the registered dietitian (RD). A ceiling fan was observed to be on over the steam table and food service area. Cook-A was observed to be placing items in the steam table directly below the ceiling fan. The RD was observed to turn the ceiling fan off and a thick layer of dust, grease and unidentified black substance was observed to coat the blades of the ceiling fan. The RD stated the fan was to be clean if it was on over the food service area and the debris had the potential of falling into the food.

- At 11:10 a.m. the certified dietary manager (CDM)-A stated the fan was to be cleaned on a monthly basis. Upon observation of the ceiling fan, CDM-A confirmed the fan was covered with dust/debris and was in need of cleaning. CDM-A stated the fan would be cleaned after the noon meal.

- At 11:12 a.m. an isolating fan was observed blowing directly on the freshly cleaned dishes next to the dishwasher. CDM-A was observed to turn the fan off and a layer of thick black layer of dust and grease was observed on the fan blades. CDM-A stated the fan was to be clean while blowing onto the dishes. CDM-A stated the fan was to be washed weekly.

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F 921	Continued From page 58 Review of the undated, Sanitation checklist did not include a process to ensure the fans were cleaned. Review of the undated, Cleaning and Disinfection of Environmental Surfaces did not address the cleaning of the fans. - At 12:11 p.m. the RD stated he had updated the sanitation checklist and had added direction for the staff to clean the fans weekly and in addition he updated the policy to include directions to ensure the fans were cleaned weekly.	F 921		

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	245323	A. BUILDING ______ B. WING ______	11/08/2018

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on November 5, 6, 7, & 8th, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On November 5, 6, 7, and 8th, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H#5323021 was completed and found not to be substantiated.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		12/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2018

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 578	Continued From page 1 to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 578		

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F 578	Continued From page 2 Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 3 of 3 residents (R4, R22, R17) reviewed for advanced directives. Findings include: R4's admission Minimum Data Set (MDS) dated 7/05/18, identified R4 was cognitively intact. R4's current Order Summary Report did not identify a cardiopulmonary resuscitation (CPR) or do not resuscitate (DNR) status. R4's electronic medication administration form indicated full code status. R4's medical chart had a full code sticker on the binder of the chart. R4's Provider Orders for Life-Sustaining Treatment (POLST) undated, included: Section A for cardiopulmonary resuscitation (CPR) "patient has no pulse and is not breathing" section, directed staff to "Do Not Attempt" resuscitation/ DNR allow for a natural death. Section B indicated selective treatment, to include medical treatment, antibiotics, intravenous fluids, cardiac monitor, no intubation, all patients will receive comfort-focused treatments. Section E indicated trial period of artificial nutrition by tube. The POLST had been signed by R4, however, the POLST lacked a physician signature. On 10/24/2018, at 2:04 p.m. a nursing note indicated R4's care conference was held. R4 and facility staff were present. The note indicated to continue full code status.	F 578	1. Resident R22 have been discharged from facility. R4 and R17s charts were reviewed for most current POLST/Advanced Directive. Their wishes have been confirmed and placed in chart and chart label updated. 2. All Residents charts were reviewed for most current POLST/Advanced Directive, confirmed for accuracy and placed in chart. 3. Staff were educated on 12/3/2018 on where to find Advanced Directives/POLST in patients chart when needing to determine Life-Sustaining Treatment. Social Worker will address POLST at each quarterly care conference to make sure the wishes of the resident and/or their responsible party are up to date. 4. Social Worker will audit 5 charts per month for 3 months to make sure residents chart has most up to date POLST. Audits/Findings will be discussed in following months QAPI Meeting.	

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On 11/6/18, at 2:15 p.m., during an interview R4 stated she was not sure if she should be a full code or DNR. R4 stated "I would like my family to be involved with that decision".

On 11/7/18, at 2:30 p.m. R4's record review identified, C4's POLST had been signed by the medical director on 11/7/18. The clinical record lacked documentation indicating the facility had reviewed the POLST choice of DNR with R4 or her family.

-At 2:37 p.m. the director of nursing (DON) confirmed R4's clinical record and POLST presented conflicting information related to code status choices.

On 11/08/18, at 8:30 a.m. the director of nursing (DON) stated the medical director (MD) was located in Connecticut. The DON confirmed the POLST had been faxed to the MD for signature and returned to the facility via fax. The DON confirmed R4, her family, and primary medical physician had not been consulted prior to having R4's POLST signed by the MD.

The facility Advance Directives policy, reviewed 4/28/18, indicated a POLST would be added to all resident charts upon admission. Nursing contacts the attending physician to obtain appropriate orders for all advance directives. Social Services reviews and updates the Advance Directives as needed but at least quarterly in conjunction with the resident's plan of care.
R22's admission Minimum Data Set (MDS) dated 10/25/18, identified R22 was cognitively intact.

R22's current Order Summary Report did not

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F 578	Continued From page 4	F 578		

identify a cardiopulmonary resuscitation (CPR) or do not resuscitate (DNR) status. R22's medical chart had a full code sticker on the binder of the chart.

R22's Provider Orders for Life-Sustaining Treatment (POLST) dated 10/22/18, included: Section A for cardiopulmonary resuscitation (CPR) "patient has no pulse and is not breathing" section, directed staff to "Do Not Attempt" resuscitation/DNR allow for a natural death. Section B indicated selective treatment, to include medical treatment, antibiotics, intravenous fluids, cardiac monitor, no intubation, all patients will receive comfort-focused treatments. Section C was signed by R22, although not dated. Section D was signed by a physician and dated 10/22/18. Section E indicated no artificial nutrition by tube, use intravenous, intramuscular and oral antibiotics.

On 11/05/18, at 3:20 p.m. during an interview R22 stated she could not remember what she put down but wants to be full code (CPR).

On 11/06/18, at 1:38 p.m. licensed practical nurse (LPN)-B stated she would know the code status by checking the chart or the electronic medical chart. LPN-B stated, "I do most of the admissions so I pretty much know all the residents' code status'."

On 11/06/18, at 1:39 p.m. nursing assistant (NA)-C stated there should be stickers on door - green for go & red for no CPR. NA-C proceeded to demonstrate and checked the door of R22's room and the doors of two other residents. No stickers were observed on the room doors for R22 or the other 2 residents. NA-C then stated

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she would check the sticker on the outside of the medical record.

On 11/06/18, at 1:41 p.m. registered nurse (RN)-B stated she would check the POLST, electronic record or the sticker on the outside of the chart.

On 11/06/18, at 1:48 p.m. RN-C stated there should be something in their room that says if they are DNR/DNI [do not intubate] and RN-C looked in 3 rooms not able to determine. RN-C stated I should find out myself how they flag the rooms. RN-C stated she would not go by the stickers on the chart rather would look at the POLST.
- At 2:31 p.m. NA-B stated she would look at the NA care sheet that she carries with her. NA-B produced a care sheet from her pocket but then confirmed code status' were not on the NA care sheets.

On 10/8/18, at 12:55 p.m. during interview the director of nursing (DON) stated all staff should have been aware that a green star located by the resident's name, outside their room, would indicate the resident is Full Code. The DON stated she was not sure why R22's POLST did not match the sticker on the chart and the resident's wishes. The DON was unaware that R22's code status was not recorded in the electronic chart.

R17's quarterly Minimum Data Set (MDS) dated

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F 578	Continued From page 6 8/08/18, identified R17 had cognitive impairment. R17's current Order Summary Report identified a do not resuscitate (DNR) status ordered 8/14/18. R17's electronic medication administration form indicated DNR. R17's medical chart had full code sticker on binder of the chart. R17's Code Status Directive located in the front of paper chart indicated cardiopulmonary resuscitation (CPR), full code, and was dated 8/09/06. When interviewed on 11/06/18, at 7:19 p.m. R17 stated it was changed in August at her care conference, to DNR and confirmed this was her current wishes. When interviewed on 11/06/18, at 7:51 p.m. DON stated the Code Status Directive dated 8/09/06, was not updated after receiving an order for DNR after R17's care conference was held on 8/14/18. On 11/07/18, at 8:42 a.m. the DON stated the Provider Orders for Life-Sustaining Treatment (POLST) had been faxed to MD for signature and was received back to the facility to reflect R17's current wishes.	F 578		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		12/17/18

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F 655	Continued From page 7 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a baseline care	F 655	1. Resident R23□s Baseline Care Plan has been updated to reflect initial goals	

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F 655	Continued From page 8 plan was developed and implemented within 48 hours of admission which addressed the individualized needs for 1 of 1 resident (R23) recently admitted to the facility and 1 of 1 resident (R25) reviewed for closed discharge record. Findings include: R23's Resident Face Sheet indicated R23 was admitted to the facility on 10/19/18, with diagnoses including encephalopathy (brain disease, damage or malfunction), Parkinson's disease, congestive heart failure, adult failure to thrive, cardiac pacemaker, and diffuse large B cell lymphoma. R23's Care Area Assessment (CAA) dated 10/30/18 indicated R23 had confusion, disorientation and forgetfulness. R23 required extensive assistance with activities of daily living (ADL) and required extensive assistance with toileting, bed mobility and at risk for falls. R23's care sheet updated 11/5/18 indicated needs assist of one for eating, ADL's assist of one to stand, incontinent at times toilet every 2 hours, at high risk for falls related to Parkinson's disease and monitor frequently. R23's medical record lacked evidence of an initial care plan to direct the staff how to implement care and what interventions were required to care for him. On 11/08/18, at 12:58 p.m. registered nurse (RN)-A stated she could not find a baseline care plan for R23. RN went on to say one should have been done, it must not have been completed, and it should have been done upon admission.	F 655	based on Current Physician orders, Current Dietary orders, Current Therapy services, Current Social services and PASARR recommendations. 2. All Residents charts have been reviewed to make sure that their Baseline Care Plan reflects Initial goals based on Current Physician orders, Current Dietary orders, Current Therapy services, Current Social services and PASARR recommendations. 3. Nursing staff educated on timeline of Baseline Assessments and Care Plans to be completed within 48 hours of admissions. 4. An audit will be conducted 48 hours after new admission of resident to verify that Baseline Care Plan was created. Audits/Findings will be discussed in following months QAPI Meeting.	

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F 655	Continued From page 9 On 11/08/18, at 1:16 p.m. the director of nursing (DON) stated she could not locate the baseline care plan and stated it should have been completed upon admission. R25's resident face sheet indicated R25 was admitted to the facility on 8/24/18, with diagnoses including arthritis due to bacteria right knee, hypertension, type 2 diabetes mellitus, major depressive disorder and end stage renal disease. R25's medical record indicated he discharged to home on 8/31/18. R25's medical record lacked evidence of baseline care plan to direct staff how to care for his diabetes, hypertension, end stage renal disease, major depressive disorder and arthritis due to bacteria in right knee. On 11/08/18, at 12:58 p.m. RN-A stated R25 did not stay long in the facility and stated he should have had a baseline care plan completed within 48 hours. RN-A stated she was unable to locate one in his medical record. On 11/8/18, at 1:16 p.m. the DON stated R25 should have had a baseline care plan completed even though his stay was 8 days. The DON stated she was not able to locate a baseline care plan for R25. A policy related to baseline care plans was requested and was not provided.	F 655		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		12/17/18

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F 688	Continued From page 10 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the use of splints for upper extremity contractures for 1 of 1 residents (R10) observed with contractures. Findings include: R10's quarterly Minimum Data Set (MDS) dated 9/12/18, indicated R10 had severe cognitive impairment and diagnoses including: Parkinson's disease, quadriplegia and depression. The minimum data set (MDS) assessment dated 9/12/18, indicated R10 required total assistance of two staff for bed mobility, transfers and all activities of daily living (ADLs), and had bilateral functional limitation in range of motion of the upper and lower extremities. R10's ADL care area assessment (CAA) dated	F 688	1. Therapy, DON and spouse had meeting regarding splints and determined due to discomfort of splinting and no potential for rehabilitation splints will be discontinued. R10 has limited communicative ability but did agree with the plan. Spouse aware of potential for further decrease in ROM. DON has confirmed Care Plan and care sheets have been updated. 2. DON has identified any other residents that are currently using any assistive devices and confirm that the use of device is specified in Care Plan. 3. Staff have been educated on 12/3/2018 on monitoring for decline in ROM and assistive device application as well as watching for pressure areas from devices. Care plans will be assessed	

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F 688	Continued From page 11 6/29/18, indicated R10 required assistance with all ADLs, required extensive to total care due to Parkinson's disease and quadriplegia. The CAA indicated R10 was unable to perform tasks on his own and had contractures. The CAA also indicated R10 was at risk for ADL and range of motion (ROM) declines, worked with therapy on braces to arms, and was being monitored by staff for decline in ROM. R10's Therapy and Nursing Communication note dated 6/5/18, indicated all orthotics/splints were to be worn at all times with the exception of bathing, dressing and during daily stretching and passive range of motion (PROM) exercises. The note also indicated a need to watch for pressure areas and notify therapy, and indicated all nursing staff should be trained on ROM and splint application. An inservice training record dated 5/28/18, indicated 10 staff had received training on use of braces and PROM for R10. An Occupational Therapy (OT) Treatment Encounter note for R10 dated 4/25/18, indicated the OT had educated nursing staff present on proper application of bilateral elbow splints. Additionally, the note indicated staff had been educated on contracture management such as prolonged stretching of bilateral elbows, and benefits and importance of applying splints. R10's Order Summary Report dated 10/8/18, included an order stating all orthotics/splints were to be worn at all times with the exception of bathing, dressing and during daily PROM and stretching. The report indicated the order had been initiated 6/15/18.	F 688	quarterly and upon any significate change in status to assess assistive devices to be used. 4. DON will audit all residents with splints and assistive devices twice per week for one month to confirm appropriate use of assistive device. Audits/Findings will be discussed in following months QAPI Meeting	

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	245323	A. BUILDING ______ B. WING ______	11/08/2018

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F 688	Continued From page 12 R10's care plan dated 5/9/18, indicated R10 had experienced a decline in physical condition due to previous fracture, neurologic decline, and Parkinson's disease, as evidenced by poor ROM and inability to reposition. The care plan interventions directed staff to "apply hand splints at all times to reverse contractures- off for cares, dressing and bathing. May have off for 20 minutes per shift to allow skin to heal due to potential for impaired skin integrity." On 11/7/18, at 11:15 a.m. R10 was observed up in wheelchair in room. He was not observed to be wearing the elbow splints. Again at 2:47 p.m. on 11/7/18, the resident was not wearing the elbow splints. On 11/7/18, at 2:48 p.m. the director of therapy services was interviewed and stated she did not know where R10's splints were, but verified R10 was supposed to wear them at all times. On 11/7/18, at 2:53 p.m. nursing assistant (NA)-E stated she had worked at the facility since 9/5/18, and had never known R10 to wear any type of splints. On 11/8/18, at 7:06 a.m. R10 was observed sitting up in a wheelchair and did not have elbow splints on. R10's right arm was observed to be contracted, and R10 was holding his arm upwards across his chest. On 11/8/18, at 7:10 a.m. NA-A stated she provides R10 his PROM when he lays down after breakfast. On 11/8/18, at 8:10 a.m. the administrator wheeled R10 to his room. R10 was observed to	F 688		

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F 688	Continued From page 13	F 688		

have both arms curled up towards his chest.

On 11/8/18, at 8:54 a.m. the director of therapy services confirmed R10 was supposed to be wearing his splints. She searched throughout R10's room for his elbow & hand splints. The splints were located under items on the spare bed in room. At that time, NA-A stated she had been working at facility since April 2018, and had never seen R10 wearing the splints. After assisting R10 into bed, NA-A still did not apply the hand/elbow splints for R10.

On 11/8/18, at 11:04 a.m. licensed practical nurse (LPN)-B stated, "[R10] will yell at you when you try to splint him, he will yell non-stop."

On 11/8/18, at 11:11 a.m. the director of therapy services stated she'd spoken to the Physical Therapist (PT) by telephone and he'd reported being unaware R10 was not tolerating wearing his splints. In addition, the director of therapy services said the PT had stated, by seeing R10 in passing, he would say R10's contractures had worsened.
The PT was not available on-site for interview prior to exit.

Review of the interdisciplinary progress notes indicated R10 was not tolerating his splints on the following dates:
9/24, 9/25, 9/27, 9/28, 10/1, 10/6 - 10/9, 10/11, 10/14, 10/17 - 10/21, 10/25, 11/1, 11/2, 11/4, 11/5, 11/7 and 11/8/18. However, there was no documentation to indicate the Physical Therapy department was notified of R10's difficulty tolerating the splints.

On 11/8/18, at 11:28 a.m. the director of nursing

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F 688	Continued From page 14 (DON) stated the nurses had signed off that either R10 was tolerating, or was not tolerating, the use of splints. The DON verified most days the documentation reflected R10 was "not tolerating." The DON said physical therapy should have been contacted by now to let them know R10 had not been tolerating his splints. The facility's Splint Policy dated 3/8/18, included: ensure there is an order for the splinting device, ensure the splint is being put on according to care plan and physician order, ensure skin is protected around the splinted area and splint fits properly, all sprints need to be removed for periods of rest to ensure proper circulation, and if splint does not fit, refer to therapy or physician for new order. The policy further indicated: documentation may include any sign of discomfort, changes in skin, refusal of application, or changes to ROM.	F 688		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess pain and identify non-pharmacological interventions for 1 of 1 resident (R16) who voiced complaints of pain. This resulted in actual harm for R16 who complained of increased pain rated at an 8 out of 10 (10 the worst).	F 697	1. DON immediately care planned pain and appropriate interventions for R16. Included were symptoms of pain and documentation. Resident Has been discharged from the facility. 2. All Residents who are currently receiving standing orders for PRN pain medications who are showing signs and	12/17/18

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F 697	Continued From page 15 Findings include: R16's 14-day minimum data set (MDS) assessment dated 10/18/18, indicated R16 was severely cognitively impaired and had diagnoses including: dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD) and recent urinary tract infection. The MDS also indicated R16 had no pain, and was not receiving any scheduled or as needed (PRN) pain medications. Care area assessments triggered for R16 on 10/18/18, included: cognitive loss/dementia, urinary incontinence, falls, nutritional status and pressure ulcer. A Pain Evaluation completed on 10/4/18, indicated R16 had occasional pain in low back and legs. Analgesic pain medication was effective. Summary indicated use of as needed (PRN) analgesics, rest, movement and not staying seated in one place. R16's care plan did not address pain as a problem upon surveyor review. Physician orders upon admission 10/4/18, included: aspirin 325 milligrams (mg) daily; sulfamethoxazole/trimethoprim (antibiotic) 1 tablet twice daily (BID) for 2 days; guaifenesin 600 mg daily PRN for congestion. Additional pain medications were added as follows: On 10/16/18 acetaminophen 650 mg every 4 hours PRN for pain. On 10/18/18 acetaminophen with codeine #3 (Tylenol #3) give 1 tablet every 6 hrs (hours) PRN for pain.	F 697	symptoms of pain will have a comprehensive pain assessment completed with appropriate care plan put in place. 3. Nursing staff will be educated on 12/3/2018 on the necessary steps to take when a resident is having signs and symptoms of pain, including reaching out to doctor when necessary. 4. Audit of pain assessments will be completed weekly for 3 months to assess if completed accurately and intervention completed was appropriate.	

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F 697	Continued From page 16 The physician was informed about the resident's pain by facsimile (Fax) as follows: On 10/18/18, at 3:30 p.m. "[R16] has been asking for something for pain. Only thing she has is PRN 650 mg Tylenol. Wondering if agitation is due to pain?" The physician response was received on 10/18/18, at 4 p.m. with orders for Tylenol #3 one tablet every 6 hrs PRN. A physician response received 10/20/18 at 4:25 p.m. included, "change Tylenol to 500 mg 2 tablets every 6 hrs PRN- max 3000 mg (per day). A fax to the physician on 10/29/18, no time noted, included: "restless, agitated, yelling out severe complaints of pain. 'Feels like knife stabbing' located mid-upper back/spinal region between shoulder blades. Increased yelling with staff intervention. Cold pack, 1:1 reassure, redirect, distraction all ineffective. Phone call to daughter re: dog effective short term (5-10) minutes. Scheduled lorazepam & PRN Tylenol #3 effective in AM. PRN Tylenol #3 again at 3:45 ineffective. Lorazepam scheduled at bedtime. PRN lorazepam discontinued when order received for scheduled. Requesting: OK for PRN lorazepam in addition to scheduled. Urinalysis on 10/23 - increase Tylenol #3 to two tablets every 4 hours." Review of R16's Medication Administration Records indicated the following: 6 doses of PRN acetaminophen 650 mg were administered in October 2018; 13 doses of Tylenol #3 were administered in October 2018; 14 doses of Tylenol #3 were administered thru November 8, 2018. On 11/5/18, at 11:05 a.m. R16 stated she had significant pain in her back between her shoulder blades. At 11:56 a.m. R16 was observed to be	F 697		

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F 697	Continued From page 17 laying herself down in bed from a sitting position. R16 was grimacing and stated, "Oh God." On 11/7/18, at 2:51p.m. R16 was observed sitting on the edge of her bed trying to put on her socks. R16 was heard stating, "Oh god, oh god." On 11/8/18, at 8:46 a.m. licensed practical nurse (LPN)-B was observed to enter R16's room with medications. R16 complained of back pain and asked LPN-B where her dog was. On 11/8/18, at 9:07 a.m. R16 was observed crying and stating, "Oh God, Oh God I want to die." R16 had not eaten any breakfast. On 11/8/18, at 11:09 a.m. R16 told the surveyor the back pain was an 8 on a 1-10 scale with 10 being the worst. R16 stated, "The pain stops me from being able to move about and enjoy things." On 11/8/18, at 12:41 p.m. LPN-A and LPN-B stated, "[R16] cries daily, we assess her pain and give medications as prescribed." On 11/8/18, at 12:54 p.m. the director of nursing confirmed R16 had not been comprehensively assessed for pain and a care plan had not been developed to identify pharmacological and non-pharmacological interventions. A policy for pain management was requested but not provided.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		12/17/18

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F 698	Continued From page 18 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent monitoring of dialysis access sites and develop a comprehensive care plan for 1 of 1 resident (R21) reviewed for dialysis. Findings include: R21's admission record dated 11/8/18, indicated R21's had a diagnoses of End Stage Renal Disease (ESRD) and was dependent on dialysis. R21's admission Minimum Data Set (MDS) dated 9/12/18, indicated R21 was alert and orientated, was independent with transfers and mobility while utilizing a wheelchair. R21's assessment indicated he received dialysis. R21's Physician's Orders indicated R21 was to receive a renal diet with a 1200 cubic centimeter (cc) fluid restriction, dialysis three times a week on Monday, Wednesday and Friday and to monitor for dependent edema (fluid retention). R21's Physician's Orders did not direct the staff to monitor the dialysis access. (tunneled catheter) On 11/8/18, at 7:15 a.m. R21 was observed to have a tunneled catheter (dialysis port access) located in the right upper chest was that had two ends (double lumen) which was covered with a dressing. R21 stated the site was utilized for dialysis, however, the facility staff did not monitor the dialysis port and the dressing was changed at	F 698	1. Confirmed Resident R21□s care plan has been updated to reflect tunneled catheter and appropriate interventions related to monitoring port. Care Plan also reflects hemodialysis facility, fluid intake/diet restrictions, and what drugs will be dialyzed prior to Dialysis run. 2. Audit was completed to confirm that any other residents that are receiving hemodialysis have a care plan that identifies appropriate interventions related to port, hemodialysis facility information, fluid intake/diet restrictions, and medications dialyzed out of body before dialysis runs. 3. DON educated all nursing staff on how to properly care plan for residents who are receiving dialysis to insure all necessary interventions are in place. 4. DON will audit Dialysis Patients care plans once per month to make sure that interventions put in place are current. Audits/Findings will be discussed in following months QAPI Meeting.	

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F 698	Continued From page 19 the dialysis unit. R21's Medication Administration Record (MAR) and Treatment Administration Records (TAR) for 11/2018, lacked direction for monitoring of the dialysis port. R21's dialysis Care Plan dated 9/25/18, included the following: - Do not draw blood or take B/P (blood pressure) in arm with graft. - Encourage R21 to go for the scheduled dialysis appointments. - Dialysis 3 times a week- M-W-F. · - Monitor intake and output. - Monitor labs and report to doctor as needed. -Monitor/document/report as needed for signs and symptoms of renal insufficiency such as: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sound. -Monitor/document/report as needed for signs and symptoms of the following: bleeding, hemorrhage, bacteremia, and / or septic shock. - R21 has potential fluid deficit or fluid overload related to diuretic use, hemodialysis, CHF; R21 will drink/take in a minimum of 1100-1200 cc's each 24-hour period. -Monitor and document intake and output as per facility policy. R21's Care Plan misidentified that R21 had a graft in the arm, it did not identify R21 had a tunneled catheter (TC), and appropriate interventions related to the TC (such as dialysis unit completed the dressing changes, the catheter should be checked following dialysis and daily to minimize chances of bleeding, and interventions to implement should the catheter	F 698		

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F 698	Continued From page 20	F 698		

show signs of infection or get dislodged.) The care plan did not identify at which ESRD facility R21 received hemodialysis and how to contact them, appropriate diet restrictions including which foods R21 was restricted from eating in a renal diet. The care plan did not identify how R21's fluid would be delineated as far as how much R21 was allowed at each meal, and how much R21 was allowed to receive with each medication pass. Additionally, the care plan did not identify which drugs would be dialyzed out of R21's body when given at 8:00 a.m. prior to dialysis on Monday, Wednesday, and Friday.

R21's nursing progress notes from 10/18/18-11/4/18, were reviewed and almost daily the notes indicated R21 did not follow the fluid restrictions. The progress note lacked indication R21 had been educated regarding the risk and benefits of not following the fluid restrictions. Additionally, the care plan had not been developed to address R21's non-compliance with meeting the fluid restriction goal and alterative interventions for thirst or drinking water such as offering R21 hard candy, ice chips, frozen ice popsicles excreta.

On 11/6/18, at 3:35 p.m. the director of nurses (DON) confirmed the facility had not monitored R21's dialysis port since the admission to the facility. The risks and benefits of being fluid over loaded were not documented as explained to R21, and R21's care plan did not indicate the dialysis access site and interventions, fluid delineation and fluid goals, dialysis facility and contact information, renal diet choices, and meds that should and should not be given prior to dialysis.

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F 698	Continued From page 21 A policy related to dialysis dependent resident care was requested and none was provided.	F 698		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide person centered dementia care for 1 of 1 residents (R16) who exhibited behaviors related to dementia. Findings include: R16's 14 day minimum data set (MDS) dated 10/18/18, indicated R16 was severely cognitively impaired, demonstrated no mood or behavior symptoms and required limited assistance with most activities of daily living (ADL's). Diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD) and recent urinary tract infection. Care area assessments triggered on 10/18/18, included cognitive loss/dementia, urinary incontinence, falls, nutritional status and pressure ulcer. Recreation services assessment dated 10/5/18, indicated that R16 interests included crossword games, beading, television game shows, bingo, cards, cribbage, visiting the birds and 1:1's.	F 744	1. R16s Care plan updated to include person centered interventions which include: a. Assisting/cueing to eat meals while in room b. Redirection when discussing residents pet c. Her interests which included crossword games, beading, television game shows, bingo, cards, cribbage, visiting the birds and 1:1's in small group or in room activities. d. Need for items that interest her to be available in patients room for redirection when needed. Social worker has also charted on residents behaviors and where she is at with potentially placing resident in a more suitable setting for dementia diagnosis. Since survey R16 has been discharged. 2. All other residents with diagnosis of dementia/Alzheimerss care plans have been assessed to confirm person centered interventions are in place. 3. All staff will be educated on person center interventions for residents that	12/17/18

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F 744	Continued From page 22 Assessment indicated R16 preferred 1:1's, small group or in room activities. R16's care plan, dated 10/19/18, indicated R16 had impaired cognitive function/dementia or impaired thought processes related to dementia. Staff were directed to ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding resident's capabilities and needs, cue, reorient and supervise as needed. Staff were also directed to monitor/document/report as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. In the activity of daily living section, staff were directed to provide cues and redirection with meals. Additions made to care plan on 11/7/18 includes anti-anxiety medication use & pain. On 11/5/18, at 2:23 p.m. R16 was asking surveyor to help find her dog - please look in the bathroom and outside. On 11/07/18, at 2:44 p.m. R16 was being assisted back to bed by an unidentified staff person who stated she found R16 standing barefoot at the end of her bed. R16 was heard to be short of breath. On 11/7/18, at 2:51 p.m. R16 was observed to be sitting on edge of bed trying to put on socks stating, "Oh god, oh god". On 11/7/18, at 3:05 p.m. R16 was observed lying in bed on left side, facing window, with dress pulled up exposing her brief towards the open	F 744	have a diagnosis of dementia/Alzheimer□s as well person-centered interventions will all residents in facility to meet their emotional and psychosocial needs. 4. DON will audit 4 care plans of residents with a diagnosis of dementia once per week for 2 months to confirm care plan is updated with the most effective interventions for each resident. Audits/Findings will be discussed in following months QAPI Meeting.	

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F 744 Continued From page 23
door to the hallway.

On 11/08/18, from 7:05 a.m. until 8:22 a.m. R16 was observed lying in bed facing the wall on left side. R16 appeared asleep.

On 11/8/18, at 8:06 a.m. nursing assistant (NA)-A placed a covered tray of breakfast on over bed table.

On 11/8/18, at 8:23 a.m. R16 was sitting up in bed asking, "Where's my puppy?"

On 11/8/18, at 8:33 a.m. R16 had not began to eat breakfast and no staff have not been in to encourage R16 to eat.

On 11/8/18, at 8:44 a.m. R16's breakfast remained untouched and no staff have been to room to offer encouragement to eat meal.

On 11/8/18, at 8:46 a.m. licensed practical nurse (LPN)-B entered room with medications. R16 was asking for her dog and LPN-B indicated that R16's daughter had her dog. LPN-B removed covers from breakfast and reminded R16 that her breakfast was there. LPN-B then left the room.

On 11/8/18, at 9:07 a.m. R16 had not begun to eat meal and was observed to be crying, "Oh God, Oh God I want to die"

On 11/8/18, at 9:24 a.m. R16 had eaten a piece of bacon.

On 11/8/18, at 12:10 p.m. R16 was lying in bed on back, rubbing head - no TV on - no stimulation.

F 744

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F 744	Continued From page 24 Progress Notes (PN) reviewed as follows: - PN dated 10/5/18, at 12:41 p.m. has been calling out for her dog and has stated her white dog is dead on the road being eaten by a crow, redirection as her dog is with her daughter. Resident voiced that staff is lying to her and she can see her dog on the road. Attempts to redirect not consistently effective. - PN dated 10/17/18, at 11:29 p.m. resident wandering out in hallway looking for her dog. Staff redirected several times throughout the evening. - PN dated 10/19/18, at 2:14 p.m. resident agitated, came out to the nurse station and asked where my dog was. Writer told resident that her dog was at daughters. Resident stated I saw my dog run down the hallway. Writer tried to redirect several times. Resident became irritated and went back to room. Left resident's door open for her reassurance that she thinks her dog may come back in. - PN dated 10/20/18, at 3:15 p.m. upset and crying this afternoon regarding dog. Call placed to daughter who will bring dog in this afternoon. - PN dated 10/21/18, at 4:40 a.m. resident agitated and asking where her dog was. States she saw him go to the end of the hallway. Redirected. - PN dated 10/22/18, at 8:37 p.m. resident is visibly upset, crying that dog is missing. Tried to redirect. Resident verbalized is she had a gun she would "blow her brains out." Lorazepam administered. Resident continued to exhibit signs of distress, 15 minute checks instilled but resident had been on 1:1 since 7:10 p.m. While staff was with resident she verbalized, she was going to "slit her wrists" and "bust her head into the wall." Daughter called and wanted sent to emergency room.	F 744		

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F 744	Continued From page 25 - PN dated 12:31 a.m. indicated resident was ready to return to facility - no longer suicidal just bored. - PN dated 10/25/18, at 5:11 a.m. resident agitated and looking for dog. Redirected, television turned on. Ineffective. - PN dated 10/25/18, at 3:44 p.m. resident anxious this AM looking for dog. Writer voiced dog was with daughter, resident voiced they were lying to her. - PN dated 10/29/18, at 12:19 p.m. anxious in AM regarding dog. Difficulty to reassure or distract. Attempted to call daughter x2 - no answer. - PN dated 11/1/18, at 11:36 p.m. anxious about dog thinks he is missing. Redirected. Resident crying and repeatedly saying, "Ow." States she feels like someone is stabbing her in the back and pain radiates around the front towards the ribs. Tylenol #3 administered. - PN dated 11/3/18, at 6:59 p.m. resident crying and yelling out at 6:30 p.m. from upper back and anxiety regarding dog. Distraction and redirection effective short term. Behaviors escalated early afternoon, in similar fashion as AM. Crying regarding dog and upper back. Repeated interventions with similar effectiveness noted. On 11/8/18, at 12:37 p.m. activities director (AD) stated that R16 likes adult coloring books but does not have them in her room. AD stated R16 likes socializing in a small group but usually does not get up for morning activities. On 11/8/18, at 12:41 p.m. licensed practical nurses (LPN)-A & LPN-B stated R16 cries daily. We make sure she is comfortable but it is usually about her dog. R16's daughter brings the dog in daily but is weaning off the visits because it upset R16 more after she sees her dog. We have not	F 744		

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F 744	Continued From page 26 tried a stuffed animal or doll but not sure, it would work. When a new medication is ordered, it is because we have faxed the physician with symptoms. The local physician comes in every other Friday - due tomorrow. Non-pharmacological interventions are tried before we give medications. A psychiatric evaluation has been requested (since the start of the survey) but is 3 weeks out. Some of R16's issues are back pain and other is Alzheimer's disease - we are looking into a possible unit for her to be transferred to. On 11/8/18, at 12:48 p.m. nursing assistant (NA)-A stated that R16 cried at least once per hour looking for her dog. R16 will "yell and call you a liar." On 11/8/18, at 12:49 p.m. licensed social worker (LSW) stated staff reported R16 was constantly looking for her dog, and would accuse her daughter of taking the dog. The facility would allow the dog to live here but R16's daughter said that was not an option. "We tried a stuffed animal and R16 just got angry." The LSW was not aware of non-pharmacological interventions to use with R16 and has not had any contact with R16 except to take her back to her room. No LSW progress notes were found in R16's chart since admission on 10/4/18. On 11/8/18, at 12:54 p.m. the director of nursing (DON) stated she expected staff to be trying non-pharmacological approaches before administering medications. The DON confirmed that person centered interventions were not developed for R16 related to behavioral/emotional, dementia care or pain management.	F 744		

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F 744	Continued From page 27 A facility policy for provision of dementia care was requested, but not provided.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		12/17/18

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F 755	Continued From page 28 by: Based on observation, interview and document review, the facility failed to ensure procedures were established and implemented for appropriate disposition and storage of narcotic medication and prescription medications. This had the potential to affect all 25 residents who resided in the facility. In addition, the facility failed to ensure a mouth rinse was provided after the administration of medication via a dry powder inhaler as directed by the medication's manufacturer recommendations for 1 of 1 resident (R22) who received steroidal medication via a dry powder inhaler without a mouth rinse afterward. Finding include: On 11/8/18, at 2:00 p.m. the medication administration room was toured with registered nurse (RN)-A. A large plastic container approximately 12 inches by 12 inches by 6 inches deep and a paper box approximately 24 x 24 inches by 12 inches deep were observed to be overflowing with medications on the medication room counter. The boxes indicated "to be destroyed." RN-A explained when resident medications were discontinued or changed, the staff placed the medications into the boxes to be returned to the pharmacy or to be destroyed in house. RN-A stated she was unaware how the facility documented which medications were to be in the boxes to be destroyed. At 2:10 p.m. the medications boxes were observed with RN-A. Included in the boxes was 19 tablets of 1 milligram (mg) lorazepam (narcotic medication/anti-anxiety) for R27, 20 tablets of 0.5 mg Ativan for R276, 8 tablets of tramadol	F 755	1. Resident R22 has been discharged from facility. 2. Audit of all med rooms/nursing station will be conducted to make sure no other discontinued or expired medications are in facility and all residents currently receiving a dry powder inhaler have been reviewed to show their orders are properly updated to show rinsing mouth with water after use 3. All nursing staff were educated on proper disposal of expired or discontinued medication as well as being educated on proper interventions around the use of dry powder inhalers. 4. DON will audit Med Rooms for expired or discontinued medications once per week for three months. DON will audit all residents using dry inhalers to ensure proper mouth rinse after use once per week for 3 months. Audits/Findings will be discussed in following months QAPI Meeting.	

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F 755	Continued From page 29	F 755		

(narcotic pain medications) for R277 and 24 tablets of oxycodone 10 mg (narcotic pain medication) for R277. RN-A stated the narcotic medications were not to be in the boxes on the counter and should have been placed in a locked box until they were able to be destroyed with the pharmacist.

- At 2:13 p.m. the director of nursing (DON) observed the medication room. The DON confirmed all of the medications in the overflowing boxes had been discontinued. The medications included oral prescription medications, prescription eye drops, insulin and topical medications. The DON confirmed the boxes contained greater than 75 prescription medications. The DON stated the narcotic medications were to be locked in a narcotic cupboard until they were destroyed by the consultant pharmacist. The narcotic medications were not to be added to the random box of medications to be destroyed. The non-narcotic medications were to be added to a bottle of chemical solution which destroyed the medication. The staff were to document the medications which were destroyed.

Review of the narcotic log books indicated the following information:
- R275's 24 tablets of oxycodone had been destroyed on 10/8/18 buy two staff members.
- R277's 8 tablets of tramadol had been removed from the narcotic box on 10/8/18.
- R276's Ativan 0.5 mg had been locked in the narcotic cabinet by a staff member.
- R27's Ativan 1 mg 19 tablets had been discontinued without documentation as to why they were not in the medication cart.

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F 755	Continued From page 30 - At 2:20 p.m. the DON confirmed none of the narcotics were missing, however, the staff had incorrectly documented the disposition of the medications. The DON confirmed the facility had not followed their policy regarding medication destruction. The undated Medication Storage Policy, directed the staff to store controlled medications (narcotics) separately from the non-controlled medications. The Controlled Substances Policy dated 2/15/18, indicated all medications that are expired or no longer in use must be removed from the cart with note stating disposition in the narcotic book and signature of two nurses then given to the director of nursing or designees to put in double locked until are destroyed. The Pharmacy Service policy for Controlled Medication Disposal dated 4/2014, directed two witnesses observe the destruction of the controlled medications. The witness may included the administrator, DON and the pharmacist. The Pharmacy Services policy dated 4/2014, for Non-Controlled Medication Disposal indicated if the prescription medication was able to be returned to the pharmacy, the staff were to return the medications. If the medication could not be returned for credit, the medications were to be disposed of per state regulations.	F 755		

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F 755	Continued From page 31	F 755		

R22's current Physician Orders provided 11/7/18, included an order dated 10/18/18, for fluticasone furoate-vilanterol (steroidal medication) aerosol powder, breath activated, 1 inhalation every morning and 1 inhalation every evening for moderate persistent asthma. The ADVAIR HFA Medication Guide dated December 2017, indicated the possible side effects of the medication included fungal infection of the mouth or throat (thrush) and directed rinse mouth with water without swallowing after using ADVAIR HFA to help reduce the chance of getting thrush.

On 11/8/18, at 7:58 a.m. licensed practical nurse (LPN)-B was observed to approach R22 seated on her bed in her room with her morning medications. LPN-B handed an inhaler to R22. R22 placed the inhaler up to her mouth and inhaled the medication by herself. LPN-B provided a glass of water. R22 took a sip of water which she swallowed. LPN-B did not prompt R22 to rinse and spit after the inhalation of the medication. LPN-B proceeded to provide R22 her oral medications which she swallowed using the remainder of the water.

On 11/8/18, 8:09 a.m. LPN-B verified she should have had R22 do a swish and spit after use of the inhaler but had not done so. LPN-B verified R22 had swallowed the water.

On 11/8/18 8:20 a.m. the director of nursing (DON) stated her expectation would be for staff to have provided a swish and spit after the administration of the inhaled medication as directed by the manufacturer's recommendations.

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F 755	Continued From page 32 The facility Administering Medications policy, undated, indicated medications shall be administered in a safe and timely manner, and as prescribed.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		12/17/18

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F 756	Continued From page 33 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to act upon the consultant pharmacist recommendations of 1 of 5 residents (R19) reviewed for unnecessary medications. Findings include: R19's undated Face Sheet indicated R19 was admitted to the facility on 10/12/18, with diagnoses including left hip fracture, Parkinson's disease and major depressive disorder. R19's After Discharger Orders/ admission orders dated 10/10/18, included multiple orders for medications including Celexa 40 milligrams (mg) by mouth daily for the treatment of depression. R19's Consultant Pharmacist's Medication Review dated 10/15/18, indicated the pharmacist had identified R19's Celexa order as being double the recommended daily dose for people over 60 years old. The pharmacist indicated the Federal Drug Administration (FDA) had established the maximum does of Celexa for people over 60 years old to be 20 mg per day, due to the potential for cardiovascular complications and lack of documented efficacy at doses greater than 20 mg per day in patients. The pharmacists indicated if the patient is not displaying an adequate response with Celexa 20 mg daily, it was appropriate to switch R19 to a different	F 756	1. DON has sent recommendation from pharmacist and physician has acted on recommendations. 2. DON will confirm that all pharmacist recommendations have been reviewed, sent to physician for review, and implemented. 3. DON will be educated by RDCS on importance of reviewing these recommendations within 48 hours of receiving. Administrator will now be copied on the pharmacist□s recommendations as a secondary check to confirm that DON has reviewed in a timely manner (within 48 hours). 4. Administrator will audit all pharmacy recommendations with pharmacist on their monthly visit to facility. Audits/Findings will be discussed in following months QAPI Meeting.	

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F 756	Continued From page 34 antidepressant. The pharmacist indicated the physician was to address the concerns as soon as possible but no later than 30 days. R19's clinical record lacked indication the pharmacist concern had been addressed with the physician. R19's Medication Administration Record (MAR) dated 11/1/18, indicated R19 an order for Celexa 40 mg which was administered daily. On 11/8/18, at 12:14 p.m. the director of nurses (DON) stated she received the consultant pharmacist recommendations via email. The report was completed on 10/15/18, had been received on 10/16/18, however, she had not had a chance to look at them. The DON confirmed R19's report indicated the physician was to be notified as soon as possible. The DON confirmed she had not opened the email from the pharmacist until the State Agency staff asked for the most recent recommendations on 11/18/18, and was unaware of the identified concern. The DON stated she simply had not had a chance to look at the pharmacy reviews and R21's physican had not been contacted. The DON stated R19's report did not need to be looked at for another 7 days. A policy related to pharmacist reviews was requested and none was provided.	F 756		
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	F 758		12/17/18

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F 758	Continued From page 35	F 758		

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 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.

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F 758	Continued From page 36 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to evaluate, monitor and justify the continued use of psychotropic medications for 1 of 1 residents (R16) reviewed for unnecessary medications. Findings include: R16's 14 day minimum data set (MDS) dated 10/18/18 indicated R16 was severely cognitively impaired and demonstrated no mood or behavior symptoms. Diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD) and recent urinary tract infection. The MDS also indicated that R16 was not receiving any antipsychotic, antianxiety or antidepressant medications. Care area assessments triggered on 10/18/18, included cognitive loss/dementia, urinary incontinence, falls, nutritional status and pressure ulcer. R16's care plan dated 10/19/18 indicated R16 had impaired cognitive function/dementia or impaired thought processes related to dementia. Staff were directed to ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding resident's capabilities and needs, cue, reorient and supervise as needed. Staff were also directed to monitor/document/report, as	F 758	1. R16s PRN antipsychotic has been reviewed with physician and physician has provided a standing order for the PRN antipsychotic medication. R16 has been discharged from facility. 2. All residents with PRN antipsychotic orders have been reviewed and a gradual dose reduction plan has been put into place where appropriate. 3. Nursing staff educated on Antipsychotic Medication Use policy. 4. DON will audit all antipsychotic medications with pharmacist once per month Audits/Findings will be discussed in following months QAPI Meeting.	

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F 758	Continued From page 37 needed any changes in cognitive function, specifically changes in: decision-making ability, memory, recall and general awareness, difficulty-expressing self, difficulty understanding others, level of consciousness, mental status. Additions made to R16's care plan on 11/7/18 included anti-anxiety medication use & pain. Physician orders upon admission 10/4/18, included aspirin 325 milligrams (mg) daily; sulfamethoxazole/trimethoprim (antibiotic) 1 tablet twice daily (BID) for 2 days; guaifenesin 600 mg daily PRN for congestion. Additional medications were added as follows: - On 10/18/18 lorazepam 1mg BID PRN for anxiety - On 10/23/18 lorazepam 1mg BID for anxiety - On 10/30/18 lorazepam 1mg every 6 hours PRN agitation (in addition to 1mg BID) - On 11/6/18 risperidone 0.25 mg BID for mood disorder (antipsychotic medication) Faxes sent to physician as follows: - On 10/18/18, at 3:30 p.m. - R16 has been having increased confusion last 2 nights (16th & 17th). Pacing floor, walking out in hallway without oxygen, crying out. Can we get a PRN order for lorazepam or pain. Wondering if agitation is due to pain? - On 10/18/18 at 4 p.m. - orders received for lorazepam 1 mg BID PRN - On 10/29/18, no time noted: restless, agitated, yelling out severe complaints of pain. "Feels like knife stabbing" located mid-upper back/spinal region between shoulder blades. Increase yelling with staff intervention, increase incontinence amount 7 frequency soiling bed & leaving puddles of urine on floor while having brief on. Cold pack, 1:1 reassure, redirect, distraction all ineffective.	F 758		

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Phone call to daughter re: dog effective short term (5-10) minutes Scheduled lorazepam & PRN Tylenol #3 effective in AM. Lorazepam scheduled at bedtime. PRN lorazepam discontinued when order received for scheduled. Requesting: OK for PRN lorazepam in addition to scheduled.
- On 11/5/18, no time noted; - Continues present with anxiety re: placement & dog. Increases in PM, difficulty de-escalating with non-pharmalogical interventions. Crying depressed statements. Reassuring dog is with daughter & visits regularly - effective at times during day, decreased effectiveness in PM/night. PRN lorazepam utilized daily in addition to scheduled Lexapro 5mg every AM started 10-29-18. Requesting referral for in-house psych service

Review of Medication Administration Records (MAR) indicated the following:
- 5 doses of PRN lorazepam was administered in October 2018
- 8 doses in November 2018

Review of October and November 2018 MAR's and treatment records lacked any documentation of R16's target behaviors and side effect monitoring for use of psychotropic medication (lorazepam).

On 11/5/18, at 2:23 p.m. R16 was asking surveyor to help find her dog - please look in the bathroom and outside.

On 11/7/18 at 2:51 p.m. R16 was observed sitting on edge of bed trying to put on socks stating, "Oh god, oh god."

On 11/08/18, at 8:23 a.m. R16 was asking,

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F 758	Continued From page 39 "Where's my puppy?" On 11/08/18, at 8:46 a.m. licensed practical nurse (LPN)-B entered room with medications and R16 asked LPN-B where her dog was. On 11/08/18, at 9:07 a.m. R16 was observed crying, "Oh God, Oh God I want to die" Progress Notes (PN) reviewed indicated entries as follows: - PN dated 10/5/18, at 12:41 p.m. has been calling out for her dog and has stated her white dog is dead on the road being eaten by a crow, redirection as her dog is with her daughter. Resident voiced that staff is lying to her and she can see her dog on the road. Attempts to redirect not consistently effective. - PN dated 10/17/18, at 11:29 p.m. resident wandering out in hallway looking for her dog. Staff redirected several times throughout the evening. - PN dated 10/19/18, at 2:14 p.m. resident agitated, came out to the nurse station and asked where my dog was. Writer told resident that her dog was at daughters. Resident stated I saw my dog run down the hallway. Writer tried to redirect several times. Resident became irritated and went back to room. Left resident's door open for her reassurance that she thinks her dog may come back in. - PN dated 10/20/18, at 3:15 p.m. upset and crying this afternoon regarding dog. Call placed to daughter who will bring dog in this afternoon. - PN dated 10/21/18, at 4:40 a.m. resident agitated and asking where her dog was. States she saw him go to the end of the hallway. Redirected. - PN dated 10/22/18, at 8:37 p.m. resident is	F 758		

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F 758	Continued From page 40 visibly upset, crying that dog is missing. Tried to redirect. Resident verbalized is she had a gun she would "blow her brains out." Lorazepam administered. Resident continued to exhibit signs of distress, 15 minute checks instilled but resident had been on 1:1 since 7:10 p.m. While staff was with resident she verbalized, she was going to "slit her wrists" and "bust her head into the wall." Daughter called and wanted sent to emergency room. - PN dated 12:31 a.m. indicated resident was ready to return to facility - no longer suicidal just bored. - PN dated 10/25/18, at 5:11 a.m. resident agitated and looking for dog. Redirected, television turned on. Ineffective. Lorazepam given. - PN dated 10/25/18, at 3:44 p.m. resident anxious this AM looking for dog. Writer voiced dog was with daughter, resident voiced they were lying to her. - PN dated 10/29/18, at 12:19 p.m. anxious in AM regarding dog. Difficulty to reassure or distract. Attempted to call daughter x2 - no answer. - PN dated 11/1/18, at 11:36 p.m. anxious about dog thinks he is missing. Redirected. Resident crying and repeatedly saying, "Ow." States she feels like someone is stabbing her in the back and pain radiates around the front towards the ribs. Tylenol #3 administered. - PN dated 11/3/18, at 6:59 p.m. resident crying and yelling out at 6:30 p.m. from upper back and anxiety regarding dog. Distraction and redirection effective short term. Behaviors escalated early afternoon, in similar fashion as AM. Crying regarding dog and upper back. Repeated interventions with similar effectiveness noted. R16's current care plan did not include the use of	F 758		

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lorazepam nor did it include any monitoring of target behaviors or side effects/adverse reactions related to the lorazepam use.

R16 did not have a consultant pharmacist visit since admission.

Requested dictation from physician visit, which was not provided.

On 10/8/18, at 12:41 p.m. LPN-A & LPN-B stated R16 cries daily. We make sure she is comfortable but it is usually about her dog. R16's daughter brings the dog in daily but is weaning off the visits because it upsets R16 more after she sees her dog. We have not tried a stuffed animal or doll but not sure, it would work. When a new medication is ordered, it is because we have faxed the physician with symptoms. The local physician comes in every other Friday - due tomorrow. Non-pharmacological interventions are tried before we give medications. A psychiatric evaluation has been requested (since the start of the survey) but is 3 weeks out. Some of R16's issues are back pain and other is Alzheimer's disease - we are looking into a possible unit for her to be transferred to. When we give PRN lorazepam, we document what she is doing.

On 10/8/18, at 12:48 p.m. nursing assistant (NA)-A stated that R16 cries at least once per hour looking for her dog. R16 will yell and call you a liar.

On 10/8/18, at 12:54 p.m. the director of nursing (DON) stated she expected staff to be trying non-pharmacological approaches before administering medications. The DON was unable

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to determine why risperidone was ordered this morning, as there were not progress notes to indicate communication with physician. The DON confirmed that they were not monitoring for target behaviors or side effects of the use of lorazepam for R16. The DON could not provide a physician visit (face to face) or a pharmacy consultation for the continued use of lorazepam PRN past 14 days (was initiated 10/19/18).

Review of undated Antipsychotic Medication Use policy indicated that antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatric, social and environmental causes of behavior symptoms have been identified and addressed. Antipsychotic medication will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. If antipsychotic medications are administered as PRN dosages repeatedly over several days, the physician should discuss the situation with staff and evaluate the resident as needed to determine whether the use is appropriate and the symptoms are responding to the mediations. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician:
- general/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation
- cardiovascular: orthostatic hypotension, arrhythmias
- metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; or
- neurological: akathisia, dystonia, extrapyramidal effects, akinesia, tardive dyskinesia, stroke

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F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician who functioned as the medical director had a valid state license to practice medicine in the state, and was located in the same state as the facility was located in. This deficient practice had the potential to affect all 25 residents currently residing in the facility Findings include: The facility administrator was interviewed following the entrance conference on 11/5/18, 11:58 p.m. and indicated the facility had a new medical director, and stated he would provide the contract between the facility and the medical director. The "MEDICAL DIRECTOR CONTRACT" provided by the administrator indicated the contract was with Tapestry Telehealth and would commence on October 30, 2018, and would continue in full force until terminated in accordance with the procedures outlined in the contract. The contract had not identified the name of the medical director, and a physician had not signed the contract. The facility administrator had	F 841	1. Administrator continues to search for medical director in the area while continuing contract with current medical director. 2. Administrator will continue working with local area clinics and hospitals to identify a physician able to fill Medical Director position. 3. Administrator will continue working with local area clinics and hospitals to identify a physician able to fill Medical Director position and will report findings each month at QAPI. 4. Administrator will update QAPI every month on status	12/17/18

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F 841	Continued From page 44 signed the medical director contract on 8/30/18. The facility administrator was interviewed on 11/8/18, at 2:15 p.m. during which he stated that the medical director lived in the state of Connecticut and had been to the facility on one occasion in total and that visit occurred a few weeks prior. The administrator was not able to provide the exact dates of the medical director's onsite visit to the facility, but indicated all of the work the medical director completed for the facility was accomplished via telephone and e-mail. The administrator stated that he would provide the medical directors license to practice medicine in the state of Minnesota. The medical director's license to practice medicine in the state of Minnesota was reviewed, and revealed that the medical director did not have a license to practice medicine. The administrator provided a Telemedicine Registration card issued by the Minnesota Board of Medical Practice dated effective 9/17/18, and expired 12/31/18. Review of the letter that accompanied the telemedicine registration card revealed the following "...the Board of Medical Practice has approved your application for registration as a telemedicine doctor." The facility administrator was again interviewed on 11/8/18, at approximately 3:20 p.m. during which he confirmed the medical director contract had not been signed by the identified medical director, the medical director did not have a current license to practice medicine in the state of Minnesota, and the medical director resided in the state of Connecticut.	F 841		
F 921	Safe/Functional/Sanitary/Comfortable Environ	F 921		12/17/18

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F 921 SS=F	Continued From page 45 CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the all areas of the kitchen were free of dust and debris. This practice had the potential to affect all 25 residents residing in the facility. Findings include: On 11/8/18, at 11:00 a.m. the sanitation tour was completed with the registered dietitian (RD). A ceiling fan was observed to be on over the steam table and food service area. Cook-A was observed to be placing items in the steam table directly below the ceiling fan. The RD was observed to turn the ceiling fan off and a thick layer of dust, grease and unidentified black substance was observed to coat the blades of the ceiling fan. The RD stated the fan was to be clean if it was on over the food service area and the debris had the potential of falling into the food. - At 11:10 a.m. the certified dietary manager (CDM)-A stated the fan was to be cleaned on a monthly basis. Upon observation of the ceiling fan, CDM-A confirmed the fan was covered with dust/debris and was in need of cleaning. CDM-A stated the fan would be cleaned after the noon meal. - At 11:12 a.m. an oscillating fan was observed	F 921	1. All fans in kitchen area cleaned immediately during non-cooking hours. 2. All other fans in the kitchen have been cleaned during non-cooking hours. 3. Food Service Director will clean all fans in kitchen weekly during non-cooking/eating hours. 4. Administrator will audit kitchen fans once per month to confirm cleanliness.	

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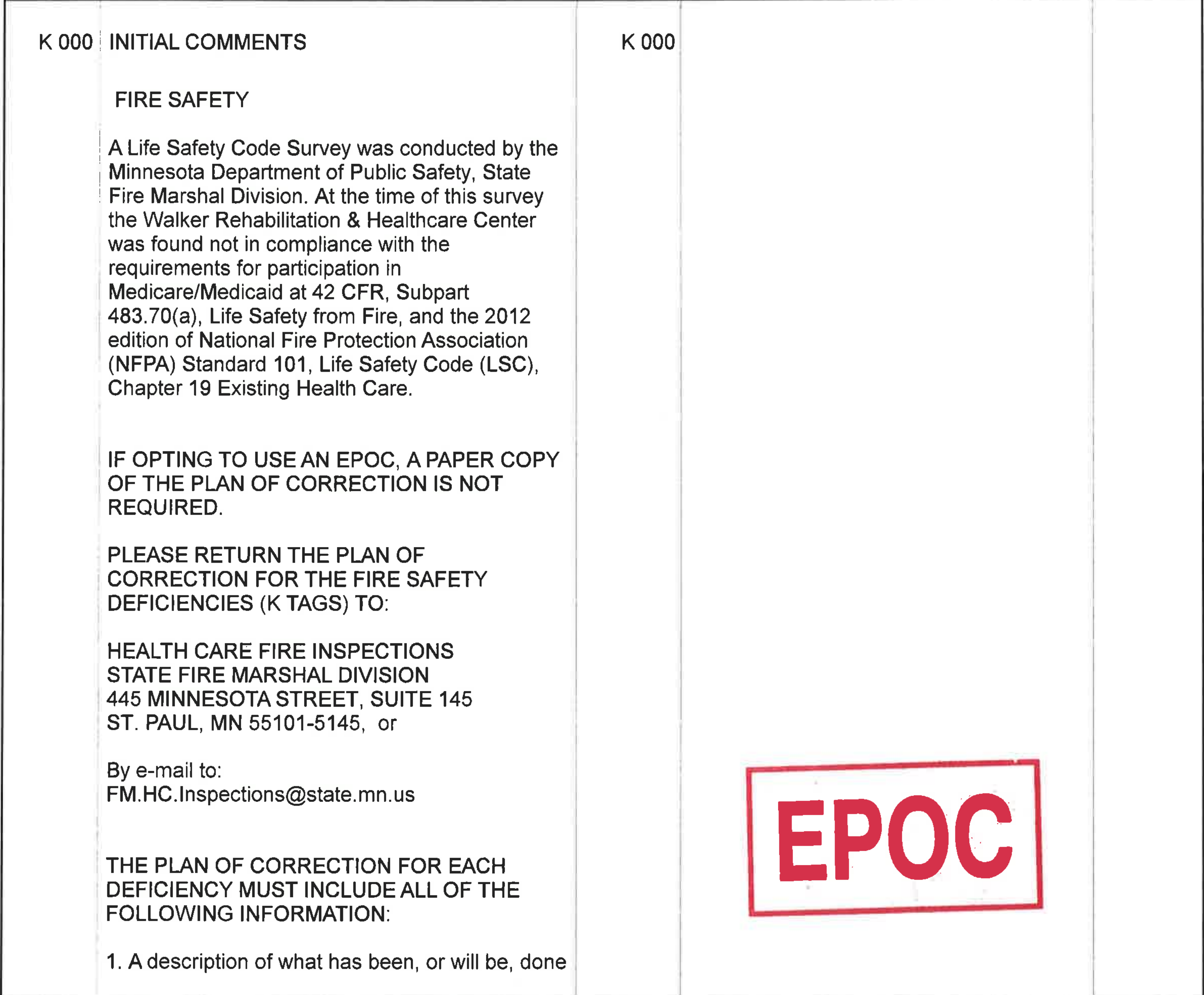
F 921	Continued From page 46	F 921		

blowing directly on the freshly cleaned dishes next to the dishwasher. CDM-A was observed to turn the fan off and a layer of thick black dust and grease was observed on the fan blades. CDM-A stated the fan was to be clean while blowing onto the dishes. CDM-A stated the fan was to be washed weekly.

Review of the undated, Sanitation checklist did not include a process to ensure the fans were cleaned.

Review of the undated, Cleaning and Disinfection of Environmental Surfaces did not address the cleaning of the fans.

On 11/8/18, at 12:11 p.m. the RD stated he had updated the sanitation checklist and had added direction for the staff to clean the fans weekly and in addition, he updated the policy to include directions to ensure the fans were cleaned weekly.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER REHABILITATION & HEALTHCARE CENTER	**209 BIRCHWOOD AVENUE WEST PO BOX 700** **WALKER, MN 56484**

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Walker Rehabilitation & Healthcare Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/06/2018**

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K 000	Continued From page 1 to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency This facility was surveyed as a single building. Golden Living Center of Walker is a 1-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1994, an addition was constructed to the east side of the building that was determined to be of Type II(111) construction and separated with a 2 hour fire barrier. The main level is divided into 3 smoke zones. The building is protected by a complete automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system and in common areas that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 25 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET.**	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		1/12/19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**11/06/2018**

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K 712	Continued From page 2 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 35 of 35 residents. Findings include: On facility tour between 9:00 a.m. to 12:00 p.m. on 11/06/2018, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was observed that the facility did not conduct an evening drill in the second quarter and a day shift drill in the third quarter. This deficient condition was confirmed by a Maintenance Supervisor.	K 712	1. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. 2. All future fire drills will be held at expected and unexpected times under varying conditions, at least quarterly on each shift. 3. Administrator Educated Maintenance Director on fire drill regulation. 4. Administrator will audit fire drill log once per month for 3 months to confirm accurate fire drills	