Accepted 4/5/18 #1404r

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. BUILDING _____ B. WING _____	03/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY OAKS POST ACUTE CARE CENTER	3850 E. ESTHER ST. LONG BEACH, CA 90804

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification Survey. Representing the Department of Public Health: Surveyor ID No: 33638, RN, HFEN Surveyor ID No: 34178, RN, HFEN Surveyor ID No: 36904, RN, HFEN Highest Severity and Scope: E Total Resident Population: 55 Total Resident Sample: 16 Total Randomly Selected Residents: 6 Total Closed Record Samples: 3	F 000	"This plan of correction is prepared as required by law. By submitting the Plan of Correction, **Regency Oaks Post Acute Care Center** does not admit that the deficiency listed in this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency statements, facts, and conclusions that from the basis of the deficiency."	
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the	F 640	**F Tag identifier: F 640** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -MDS completions for Residents 1,2,3,4,5,6,7 & 8 were electronically transmitted to CMS on 3/10/18. **Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -MDS Coordinator reviewed and checked other resident assessments and submission dates. No other residents were affected.	

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

Administrator 4-2-18

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 640	Continued From page 1 CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete and submit a Minimum Data Set ([MDS] a standardized assessment and care screening tool) to the Center for Medicare and Medicaid Services (CMS) timely for eight of 8 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, and 8).	F 640	**F Tag identifier: F 640** **Facility measures and systemic changes to ensure the deficient practice does not recur:** -MDS coordinator was provided education from the Administrator on 3-12-18 regarding the importance of electronically transmitting the completed assessments to CMS in a timely manner. MDS coordinator was also educated again on 3-21-18 by the DON to confirm the understanding of the education provided by the administrator and to confirm the process is complete and effective. -MDS Coordinator will print out weekly submissions and keep them in a binder in the MDS office. **Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:** -Administrator, DON or designee will review the MDS binder weekly to assure continued compliance -Findings from audits and quality assurance checks will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Completion Date(s): 4/02/2018** 4-2-18	

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F 640	Continued From page 2	F 640		

This deficient practice placed the residents at risk of not receiving needed care, access to services and may result in not identifying a potential decline in their functional and psychosocial status.

Findings:

On 3/10/18, during a review of the facility Minimum Data Set ([MDS] a standardized assessment and care screening tool) data completion and submission activities, the Administrator was asked to provide CMS submission reports of Residents 1, 2, 3, 4, 5, 6, 7, and 8.

On 3/10/18 at 9 p.m., during an interview, the Administrator stated the facility's MDS Coordinator could not come to work during the survey period. The Administrator could not provide information about how the facility tracked their MDS completions and electronic submission/transmission of MDS records to CMS.

The following revealed:
1. A review of Resident 1's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late: The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment." The Z0500B indicated a date of 1/5/18. The report indicated the MDS assessment for Resident 1 was submitted to CMS on 3/10/18.

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F 640	Continued From page 3	F 640		

2. A review of Resident 2's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late: The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment " The Z0500B indicated a date of 1/12/18. The report indicated the care plan and MDS assessment completion date was late. The report indicated Resident 2's MDS record was submitted to CMS on 3/12/18.

3. A review of Resident 3's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late: The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment." The Z0500B indicated a date of 1/12/18. The report indicated Resident 3's MDS record was submitted to CMS on 3/12/18.

4. A review of Resident 4's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late: The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment." The report indicated that the MDS assessment completion date was late. The Z0500B indicated a date of 1/12/18. The report indicated Resident 4's MDS record was submitted to CMS on 3/12/18.

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F 640	Continued From page 4 5. A review of Resident 5's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late. The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment." The report indicated that the MDS assessment completion date was late. The Z0500B indicated a date of 1/12/18. The report indicated Resident 5's MDS record was submitted to CMS on 3/12/18. 6. A review of Resident 6's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late: The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment." The report indicated that the MDS assessment completion date was late The Z0500B indicated a date of 1/12/18. The report indicated Resident 6's MDS record was submitted to CMS on 3/12/18. 7. A review of Resident 7's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late: The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment." The report indicated that the MDS assessment completion date was late. The Z0500B indicated a date of 1/12/18. The report indicated Resident 7's MDS record was submitted to CMS on 3/12/18.	F 640		

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F 640	Continued From page 5 8. A review of Resident 8's CMS Submission Report - MDS 3.0 NH Final Validation Report indicated "Record Submitted Late: The submission date (to CMS) was more than 14 days after Z0500B (The date RN Assessment Coordinator signed assessment as complete) on the new assessment." The report indicated that the MDS assessment completion date was late. The Z0500B indicated a date of 1/12/18. The report indicated Resident 8's MDS record was submitted to CMS on 3/12/18. According to CMS's Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 5: Submission and Correction of the MDS Assessments, indicated the following timelines criteria to meet: a. MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600). b. The CAA (Care Area Assessments) Completion Date (V0200B2) must be no later than 14 days from the ARD (Assessment Reference Date - A2300). c. Comprehensive assessments must be transmitted electronically to CMS within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS Assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days) The CMS's RAI Version 3.0 Manual indicated that the facility was responsible in evaluating each fatal and non-fatal errors and warnings reported in the CMS Final Validation Report to identify necessary corrective actions.	F 640		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		

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F 686 SS=D	Continued From page 6 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of 16 sampled residents (Resident 1) remained free from a pressure injury (localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device) to the left posterior (back) ear by failing to promptly assess the ears while receiving oxygen through a nasal cannula (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the ears). Resident 1, who was using oxygen requiring the use of a nasal cannula was observed on 3/8/18 at 8:58 p.m., with a Stage II pressure injury (partial thickness loss of dermis) to his left posterior ear. This deficient practice had the potential for Resident 1's left posterior ear Stage II injury to not be discovered and had the potential to get larger, become painful, and get infected.	F 686	**F Tag Identifier: F 686** **Immediate corrective action(s) for those Residents affected by the deficient practice:** Resident 8's physician was notified immediately of the reopening of his stage II on the left posterior ear. Nursing staff obtained a treatment order for the reopened stage II on the left posterior ear. It was noted and carried out immediately. LVN 11 also applied the cannula ear cushion to the tubing of the nasal cannula as an intervention immediately the evening of 3-8-18. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents who have oxygen administered via nasal cannula tubes have the potential to be affected. -All residents were assessed by RN Supervisor and the charge nurses the evening of 3-8-18 and no other residents were affected by the deficient practice. -All residents who were receiving oxygen via nasal cannula were also given cannula ear cushions as an intervention on 3-8-18 to prevent skin breakdown or decubitus formation to their posterior ears.	

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F 686	Continued From page 7	F 686		

Findings:

During an observation on 3/8/18 at 8:58 p.m., Resident 1 was lying in bed and had a nasal cannula that was fitted over the ears. During the same observation, a licensed vocational nurse (LVN 11) removed the nasal cannula and stated Resident 1's left posterior ear developed a "reopened Stage II," and required a "cushion," behind his ears to protect from pressure while he used the nasal cannula.

A review of Resident 1's Record of Admissions indicated readmitted to the facility on 11/28/17 with a diagnosis of severe sepsis (a potentially life-threatening complication of an infection).

A review of Resident 1's History and Physical form dated 12/2/17, indicated the resident did not have the capacity to understand and make decisions.

A review of Resident 1's Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 12/24/17, indicated the resident had severe impairment in cognitively skills and was total dependent for bed mobility, transfers, and personal hygiene.

A review of Resident 1's Physician Orders, with an order date of 11/28/17, indicated oxygen via nasal cannula at two liters per minute as needed

Facility measures and systemic changes to ensure the deficient practice does not recur:

-Nursing staff (consisting of C.N.A's & Licensed nurses) were educated on 3-23-18 regarding importance of skin checks to be done on their shift as well as the importance of turning and repositioning

dependent residents and also the risk for potential infection of pressure ulcers per the policy and procedures. Thorough communication between C.N.A's and Licensed staff was also emphasized regarding any skin breakdown findings to assure treatment was ordered promptly to avoid potential infection.

-Treatment nurses were inserviced on 3-16-18 regarding the importance of assuring that cannula ear cushions were applied to all those residents that receive oxygen via nasal cannula.

-Charge nurses will also do daily rounds during medication pass to ensure that cannula ear cushions are applied for their patients who are receiving oxygen via nasal cannula. If ear cushions are missing charge nurses will immediately apply the intervention and report to DON and Administrator at daily stand up meetings

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F 686	Continued From page 8 (PRN) for oxygen saturation (a test that measures the amount of oxygen being carried by red blood cells) less than 90%. A review of Resident 1's Physician and Telephone Order, dated 3/8/18 at 9:30 p.m., indicated to cleanse reopened healed left posterior ear Stage II with normal saline (sterile water), pat dry, and to apply Venelex (medication used to promote wound healing) ointment. A review of Resident 1's Multidisciplinary Progress Record, dated 3/8/18 at 9:30 p.m., indicated treatment initiated as ordered to Resident 1's reopened healed left posterior ear Stage II. A review of the facility's policy and procedure titled "Pressure Ulcer Risk Assessment," with a revised date of September 2013, indicated pressure ulcers were usually formed when a resident remained in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroyed the tissues and that the most common site of pressure ulcer was where the bone was near the surface of the body including the back of the head around the ears. The same policy indicated that if pressure ulcers were not treated when discovered, they had the potential to become larger, painful and infected.	F 686	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** DON Designee or DSD will do random clinical rounds and follow up appropriately to ensure continued compliance of cannula cushions. -Any deficient practice will be corrected immediately, and the findings of the quality-assurance checks will be documented and submitted at the Monthly Quality-Assurance and Performance Improvement meeting. **Date of Compliance: 4.02.18**	4-2-18
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		

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F 688	Continued From page 9 §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 record review, the facility failed to provide range of motion ([ROM] the full movement potential of a joint) exercises as indicated in the plan of care for one of 16 sampled residents (Resident 26). Resident 26 was assessed with impairment to one upper (left) and one lower (left) extremities, but did not receive ROM exercises to help increase joint mobility. This deficient practice had the potential for Resident 26 to experience a decline in ROM and the potential not to be evaluated by a physical therapist ([PT] health professionals use a variety of techniques, called modalities, to restore function, improve mobility) to ensure services were provided if deemed necessary.	F 688	**F Tag Identifier: F 688** **Immediate corrective action(s) for those Residents affected by the deficient practice:** Resident 26 was re-assessed on 3-14-18 by Rehab Specialist and nursing staff with no further decline observed. Due to the potential of decline because of resident's diagnosis, MD was notified of assessment done by Rehab Specialist and nursing and MD did agree to start resident on Restorative Nursing Program for Range of Motion on 3-15-18. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents who have decreased mobility have the potential to be affected. -Rehab Specialist, Nursing Staff and Restorative Nursing Aides did rounds on 3-14-18 emphasizing range of motion and no other residents were affected by this deficient practice	

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F 688	Continued From page 10 Findings. During an observation on 3/8/18 at 8:15 a.m., Resident 26 was observed lying in bed awake and could not move her left arm. During an interview on 3/10/18 at 11:23 a.m., a certified nursing assistant (CNA 2) stated she did not do any ROM exercises for the Resident 26. A review of Resident 26's Record of Admissions indicated readmitted to the facility on 6/10/17 but did not indicate the first admission date. A review of Resident 26's History and Physical Examination form dated 6/27/17, indicated the resident did not have the capacity to understand and make decisions and had diagnoses of dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and generalized weakness. A review of Resident 26's Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 1/2/18, indicated the resident had severe impairment in cognitively skills and was total dependent for transfers and personal hygiene. The MDS indicated Resident 26 had impairment to one side of her upper extremity (shoulder, elbow, wrist, hand) and one side of her lower extremity (hip, knee, ankle, foot).	F 688	**Facility measures and systemic changes to ensure the deficient practice does not recur:** -Rehab specialist provided re-education to licensed staff as well as restorative nursing assistants regarding appropriate treatment and services to increase or maintain range of motion to appropriate residents on 3-16-18 & 3-23-18. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Rehab Specialist and nursing staff will perform quality of life rounds emphasizing range of motion weekly. Findings will be reported to the DON or designee on a weekly basis. The collections of findings for the month will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of Compliance: 4/02/18**	4-2-18

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F 688	Continued From page 11 A review of Resident 26's care plan for Activities of Daily Living Function (ADL) dated 10/3/17, indicated that resident was at risk for decreased functional mobility and the interventions were to render ROM exercises as tolerated. A review of Resident 26's weekly Progress Notes dated 3/4/18, indicated the resident was not receiving rehabilitation services and was not in the restorative nursing assistant program ([RNA] helps patients gain an improved quality of life by increasing their level of strength and mobility). During an interview on 3/10/18 at 11:30 a.m., licensed vocational nurse (LVN 5) stated Resident 26's medical record did not contain any PT evaluations for ROM and did not have physician orders for ROM exercises. LVN 5 stated there was a potential for decline for Resident 26's ROM if the ROM were not done. A review of the facility's policy and procedure titled "Range of Motion Exercises," revised October 2010, indicated the purpose of the procedure was to exercise the resident's joints and muscles and to verify there was a physician order for the procedure and if there was no order for treatment, to contact the attending physician to obtain treatment orders.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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	056378	A. BUILDING _____ B. WING _____	03/11/2018

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F 689	Continued From page 12 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the attic/ceiling access door in one of 16 sampled residents bathroom (Resident 148) was closed and there was no wire exposed to protect the safety of the residents, visitors, and or the staff This deficient practice had potential to expose hazardous electrical shock to the resident, visitor, and or the staff Findings: On 3/08/18 at 7:15 p.m., during the initial tour Resident 148's attic/ceiling access door from the bathroom was open. There was exposed wire extending out from the opening down. On 3/08/18 at 7:20 p.m, during tour with director of staff developer (DSD) while in Resident 148's bathroom, observed attic/ceiling access door was left open. The DSD stated they fixed wire up on the ceiling for WIFI and the door should not have been left open. On 3/08/18 at 8:00 p.m., during a tour with	F 689	**F Tag Identifier: F 689** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -Resident 148's bathroom attic access door was closed on 3-8-18. Resident in 148 is incontinent and does not use the bathroom and did not have a roommate at the time. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -Administrator did do facility rounds on 3-8-18 to be sure that all attic access doors were closed after the necessary work was completed. -No other residents or resident rooms were affected by this deficient practice. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Administrator and/or Maintenance director will do facility rounds after contracted workers are at the facility doing work. -Staff was also inserviced on 3-23-18 regarding safety rounds and educated to look out for exposed wires and open attic doors while performing care. They were also educated on the electrical hazardous risk when wires are exposed.	

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F 689	Continued From page 13 administrator whle in Resident 148's bathroom, he observed the attic/ceiling access door left open. He stated the ceiling should not have been left open. On 3/09/18 at 6:27 p.m., during an interview with maintenance supervisor, he stated the attic/ceiling access door to the attic in Resident 148's bathroom was a metal door. When the attic access door was opened, there was a blue wire visible. The maintenance supervisor stated the attic/ceiling access door should have been closed all the time. The maintenance supervisor further stated "We don't have policy on ceiling attic Administrator told me this morning about the attic access opening in Resident 148's bathroom."	F 689	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Findings from facility rounds by administrator, maintenance, DSD, DON, and charge nurses will be reported to daily stand up meetings. Findings will then be collected for the month will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of compliance: 4/02/18**	4.2.18
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the supplemental oxygen was correctly administered per the physician order for two of 16 sampled residents (Residents 98 and 1), when oxygen saturation (a measurement of blood oxygen) was measured above 90 percent on room air.	F 695	**F Tag Identifier: F 695** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -Resident 98 & Resident 1 s PRN oxygen was immediately removed as the saturation was above 90. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents with PRN oxygen orders have the potential to be affected by the deficient practice. -All other residents who had orders for oxygen PRN were monitored by the charge nurses and no other residents were affected by the deficient practice.	

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F 695	Continued From page 14 This deficient practice had the potential to cause the residents adverse effects from receiving too much oxygen such as; toxicity resulting in damage to the lungs causing pain and difficulty in breathing. Findings: a. A review of Resident 98's Record of Admissions indicated the resident was admitted to the facility on 3/5/18. The History and Physical form dated 3/6/18 indicated Resident 98's diagnoses included congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). A review of Resident 98's Physician and Telephone Orders, dated 3/7/18 indicated orders to monitor the resident's oxygen saturation every shift while breathing room air and to administer supplemental oxygen via nasal cannula as needed (PRN) when oxygen saturation fell below 90 percent (normal oxygen saturation is 95 to 99% in healthy adults). A review of Resident 98's care plan dated 3/6/18 indicated the resident's respiratory status was impaired. The interventions included monitoring oxygen saturation, observing signs and	F 695	**Facility measures and systemic changes to ensure the deficient practice does not recur:** Licensed nurses were re-educated by the DON regarding the risks and benefits of oxygen administration using the policy and procedure on 3-23-18. Importance of making sure the ordered amount of oxygen was also explained. Return demonstration on obtaining oxygen saturation was also performed during the educational session. Emphasis on hyperoxygenation and hypooxygenation was presented with signs and symptoms to look for. -During the inservice on 3-23-18 DON also explained the importance of accurate PRN documentation of all medication including the administration of PRN oxygen as it is also a medication. -Charge nurses will make daily rounds upon their med pass to assure that oxygen that is being delivered is necessary and is matching the physician's orders. DON or designee and/or DSD will make random clinical rounds weekly to assure that oxygen being administered is also matching the physician orders. -Findings of deficient practice will be brought forth to daily stand up meetings and be reported by charge nurses DSD and/or DON and or designee.	

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F 695	Continued From page 15 symptoms of respiratory distress, and assessing lung sounds. During an observation and interview, on 3/8/18 at 8:20 p.m., Resident 98 was awake, verbally responsive and was lying in bed with supplemental oxygen via nasal cannula. The licensed vocational nurse (LVN 3) stated Resident 98 receives the supplemental oxygen as needed for oxygen saturation of less than 90%. During an observation and interview, on 3/8/18 at 8:30 p.m., Resident 98's assigned licensed nurse (LVN 1) was asked about the resident's oxygen saturation during her shift (3 to 11 p.m. shift). LVN 1 read from what she had documented in the MAR and stated it was 94%. LVN 1 was asked why Resident 98 needed supplemental oxygen for a 94% oxygen saturation. LVN 1 stated "I will check it again right now, and remove it." LVN 1 was observed checking Resident 98's oxygen saturation level when breathing room air after several minutes of removing the oxygen. The resident's oxygen saturation was 98% while breathing room air. During the course of the observation and interview, Resident 98 stated she felt alright without the supplemental oxygen and she was not short of breath or uncomfortable. A review of Resident 98's Medication Records indicated the resident's oxygen saturation while breathing room air every shift was between 94 to 98%. The MAR did not indicate the resident had	F 695	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** Findings from facility rounds by DSD, DON, and charge nurses will be reported to daily stand up meetings. Findings will then be collected for the month will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of Compliance: 4/02/18**	4-2-18

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F 695	Continued From page 16 any documented oxygen saturation below 90%. The Nurse's Notes at the back of the MAR did not indicate assessments of respiratory distress or lung sounds and documentation about a reason for oxygen administration (if oxygen saturation was less than 90%) A review of the facility's policy and procedures titled "Oxygen Administration," revised on October 2010, indicated after completing the oxygen set-up for the resident, the facility staff should record all assessment data (signs and symptoms of respiratory distress and lung sounds) obtained before, during and after the procedure, and the reason for the PRN administration. b. During an observation on 3/8/18 at 8:58 p.m., Resident 1 was lying in bed receiving oxygen via nasal cannula (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears) at 2 1/2 liters per minute. During the same observation, a licensed vocational nurse (LVN 7) removed Resident 1's nasal cannula and stated she (LVN 7) did not know if Resident 1 required the oxygen. During an interview on 3/8/18 at 9:20 p.m., a certified nursing assistant (CNA 1) stated she was assigned to Resident 1 and he (Resident 1) had the oxygen since she (CNA 1) arrived at 3 p.m., until LVN 7 removed the oxygen. A review of Resident 1's Record of Admissions indicated Resident 1 was readmitted to the facility on 11/28/17 with a diagnosis of severe sepsis (a potentially life-threatening complication of an	F 695		

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F 695	Continued From page 17 infection). A review of Resident 1's History and Physical form dated 12/2/17, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set ([MDS] a standardized resident assessment and care screening tool, dated 12/24/17, indicated the resident had severe impairment in cognitively skills for daily decision making and was totally dependent on staff for bed mobility, transfers, and personal hygiene. A review of Resident 1's Physician Orders dated 11/28/17, indicated for resident to receive oxygen via nasal cannula at 2 liters per minute as needed (PRN) for oxygen saturation (a test that measures the amount of oxygen being carried by red blood cells) less than 90%. A review of Resident 1's Physician Orders dated 11/28/17, indicated to monitor oxygen saturation frequency every shift on room air. A review of Resident 1's Medication Records dated from 3/1/18 through 3/31/18, indicated on 3/9/18 the resident's oxygen saturation was 96% during the 7 a.m. to p.m., shift while on room air. During an observation on 3/8/18 at 9:14 p.m., LVN 7 stated Resident 1's oxygen saturation (a	F 695		

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F 695	Continued From page 18 test that measures the amount of oxygen being carried by red blood cells) was at 97% on room air and Resident 1 did not require the use of oxygen based on his level of oxygen saturation. A review of the facility's policy and procedure titled "Oxygen Administration," revised October 2010, indicated the purpose of the procedure was to provide guidelines of safe oxygen administration and for staff to verify that there was a physician's order for the procedure and to review the physician's orders or the facility protocol for oxygen administration.	F 695		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758	**F Tag Identifier: F 758** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -Resident 37's psychiatrist was contacted on 3-9-18 and it was confirmed that a visit was made on 3-6-18 by the nurse practitioner. His progress note was emailed to the Social Service Director on 3-10-18. The order for her Ativan was renewed for another 14 days. -Resident 41's nurse practitioner was contacted and due to the continued restless behavior, f resident 41, her order for Ativan was renewed on 3-14-18 for 14 days by her NP.	

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F 758	Continued From page 19 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure as needed (PRN) orders for two of 16 sampled residents who was receiving psychotropic medications were limited to 14 days, except if the prescribing practitioner extended the order beyond 14 days the practitioner should document their rationale in the resident's medical record and indicate the duration for the PRN order. (Resident 37 and 41) This deficient practice had the potential to result in unnecessary use of psychotropic medications	F 758	**Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** - RN supervisor and charge nurses reviewed and completed a facility chart audit of those receiving PRN psychotropic medication between 3-10-18 and 3-14-18. Those residents that needed PRN renewals, their physicians were contacted, and orders were renewed as needed. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Pharmacist inserviced the nurses who were at the facility on 3-12-18 regarding the new Mega rule regarding PRN psychotropic medications and the necessity of them being renewed every 14 days. -DON re-educated the licensed staff on 3-23-18 regarding new regulation and the importance of reassessing patient for the use of any PRN psychotropic medication after 14 days. Emphasized the importance of contacting the physician, nurse practitioner or the psychiatry team assigned to get the medication re-ordered if necessary. -Medical Records Director or designee will do random audits to assure that PRN	

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F 758	Continued From page 20 beyond the 14 days. Findings: a. A review of Resident 37's Record of Admission indicated the resident was admitted in the facility on 1/1/18, with diagnoses that included end stage renal disease and altered mental status. A review of Resident 37's History and Physical form dated 1/9/18, indicated the resident had diagnoses of paranoia and bipolar disorder. The History and Physical indicated the resident does not have the capacity to understand and make decisions. A review of the Physician and Telephone Orders indicated a handwritten order of the resident's psychiatric physician to administer one milligram of Ativan (antianxiety) every six hours as needed for anxiety manifested by inability to relax for 14 days. A review of Resident 37's Physician Orders between 3/1/18 to 3/31/18 (recapped physician orders) which was reviewed by a licensed nurse on 2/27/18. The Physician Orders indicated the physician ordered one milligram (mg) of Ativan every six hours for anxiety manifested by overly concerned with non-health related issues to be given for 14 days, dated 2/21/18. A review of Resident 37's Medication	F 758	psychotropic medication is being renewed or discontinued in a timely manner. -Pharmacy consultant will also continue to do the monthly recommendations and send notes to the following physicians and nursing will follow up with physicians as needed **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** - Findings from facility random audits will be reported to daily stand up meetings for corrections. Findings will then be collected for the month will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of Compliance: 4/02/18**	4-2-18

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F 758	Continued From page 21 Administration Records (MARs) for February and March 2018 indicated the resident had been receiving one mg of Ativan as needed for anxiety from 2/1/18 and discontinued on 2/17/18. The MAR indicated the Ativan was reordered on 2/21/18 and started receiving Ativan again as needed for anxiety from 2/21/18 up to 3/9/18 (17 days). The MAR did not indicate the physician reordered the Ativan after 14 days when the Ativan was restarted on 2/21/18. The MAR indicated Resident 37 received five doses (3/7/18 to 3/9/18) more after the 14th day (3/6/18) when the Ativan was supposed to be discontinued per physician's order. During a concurrent review of the MAR, on 3/10/18 at 3:30 PM with the licensed vocational nurse (LVN 4), stated the facility staff should have called the physician to find out if Resident 37's Ativan medication should be reordered. LVN 4 stated the facility protocol was to notify the physician if the medication was still helping the resident's anxiety of being overly concerned with non-related health issues. LVN 4 stated the resident should not have received the Ativan on 3/7/18 and onward. During an interview with the social services director (SSD), on 3/10/18, at 1 p.m., stated the psychiatrist would email the progress note, dated 2/21/18, to her that day. SSD stated the psychiatrist would usually see residents in the facility and email the progress notes to the SSD after a few days. The SSD stated she did not know why the psychiatrist did not provide the facility with a progress note. At around 3:30 p.m., the SSD handed over the psychiatrist progress	F 758		

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F 758	Continued From page 22 note, with date of service 2/21/18, and indicated the facility's psychiatrist electronically signed the progress note on the same day, 3/10/18 at 3:12 p.m. A review of the facility policy and procedures titled "Psychotropic Medication Use," dated 10/2017, indicated PRN psychotropic drugs were limited to 14 days and would receive the medication if necessary to treat a diagnosed specific condition that was documented in the clinical record. The prescribing practitioner should indicate their rationale for ordering PRN (as needed) psychotropic medications and document in the resident's medical record and indicate duration for the PRN order. b. A review of Resident 41's Record of Admissions indicated admitted to the facility on 9/30/15, with diagnoses that including Alzheimer's disease (is progressive metal deterioration of the brain that cause problems with memory, thinking and behavior), and hypertension (high blood pressure). A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/13/18, indicated Resident 41's cognitive skill for daily decision making was severely impaired, and required limited to total dependence support from staff for the daily activities. A Physician Orders for Resident 41 dated 12/14/17, indicated to administer Ativan 0.5 milligram (mg) by mouth two times a day as needed for anxiety manifested by random	F 758		

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F 758	Continued From page 23 aggressive outburst with dry apparent reason On 3/10/18 at 5:39 p.m., during a review of Resident 41's clinical records with director of staff developer (DSD), DSD stated physician ordered the Ativan on 12/14/17. The DSD stated the Ativan 0.5 mg by mouth two time a day PRN manifested by aggressive outburst with dry apparent reason. A review of the Medication Administration Records (MAR) dated for month of February, and March 2018, indicated Resident 41 received Ativan 0.5 mg PRN on 2/17, 2/18, 2/22, 3/1 and 3/8 for the reason outburst and restlessness. On 03/10/18 at 05:39 p.m., while continued reviewing Resident 41's Physician Progress Notes, the DSD stated on 12/21/17, 1/4/18, 1/11/18, 1/18/18, 1/25/18, and 2/1/18, physician did not give new order for the Ativan be administered. The DSD stated on 12/20/17 Resident 41 had seen psychiatrist and there was no new ordered for Ativan order to be renewed. On 3/10/18 06:16 p.m., during a telephone interview with the facility's pharmacy consultant, stated the new regulation limited psychotropic medications as PRN orders to 14 days. The pharmacy consultant stated "I would recommend physician duration to document in the charge, and I tell the nurse to call physician." The facility's policy and procedure titled	F 758		

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F 758	Continued From page 24 "Psychotropic Medication Use" dated October 2017, indicated the facility should comply with the State Operations Manual, and all other applicable law relating to the use of psychoactive medications, including gradual dose reductions. The policy indicated the psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. Resident 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. PRN orders for psychotropic drugs are limited to 14 days. For psychotropic PRN medications, excluding antipsychotic, 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.	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	**F Tag Identifier: F 812** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No residents were affected by this deficient practice as dinner was over and no food was present at time of rounds	

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F 812	Continued From page 25 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to wear a hair net while in kitchen at all times to maintaining a high standard of food service for one of three dietary aids. This deficient practice had potential for cross contamination from hair and hair particle falling on to foods. Findings: On 3/08/18 at 6:41 p.m., during an initial tour of the kitchen there were two female dietary aid and one male dietary aid (1). The male dietary aid 1 was observed with no hair net when washing dishes. A concurrent interview male dietary aid 1, when asked why he was not wearing a hair net, did not answer but just shook his head. On 3/09/18 at 6:27 p.m., during an interview with dietary supervisor, stated "I told dietary aid 1 to use hair net all time while in kitchen. I gave him an in-service." The facility policy and procedure titled "Dress Code for Women and Men" dated 2018, indicated hair restraints are important to avoid cross	F 812	**Plan Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents of the facility have the potential to be affected by this deficient practice. -No foodborne illness was noted in the facility at this time, therefore no residents were affected by this deficient practice. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Male dietary aide that was observed without hair net was given 1:1 in-service by the Dietary manager on 3-9-18 regarding importance of wearing a hair net while in the kitchen. -All kitchen staff were given inservice on 3-9-18 by the Dietary manager using the policy and procedure regarding dress code and infection control as well as the risk for cross contamination. **Facility plan to monitor corrective actions and sustain compliance; integrate QA Process:** - Findings from random audits from Dietician and Administrator will be reported to daily stand up meetings for corrections. Findings will then be collected for the month will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations.	

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F 812	Continued From page 26 contamination with food.	F 812	Date of Completion: 4/02/18	4-2-18
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842	**F Tag Identifier: F 842** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -Resident s 1, 26, & 31 s orders for "may crush all crushable medications could be crushed together and administered together" were discontinued between 3-12-18 to 3-16-18. -Resident 37's psychiatrist was contacted on 3-9-18 and it was confirmed that a visit was made on 3-6-18 by the nurse practitioner. His progress note was emailed to the Social Service Director on 3-10-18. The order for her Ativan was renewed for another 14 days per psychiatrists progress note.	

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F 842	Continued From page 27 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the Physician Orders for four of 16 sampled residents (Resident 1, Resident 26, and Resident 31) contained the most current standard of practice guidelines for the administration of crushable medications and Resident 37's medical records contained actual experiences of the resident and included enough	F 842	**Plan Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -Charge nurses, RN supervisor, MDS coordinator and DON as well as DSD contacted primary care physicians of all residents that had the order of "may crush all crushable medications and administer together" to explain the risks for administering medications together and received orders to discontinue the order between 3-12-18 through 4-2-18. - RN supervisor and charge nurses reviewed and completed a facility chart audit of those receiving PRN psychotropic medication between 3-10-18 and 3-14-18. Those residents that needed PRN renewals, their physicians were contacted, and orders were renewed as needed.	

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F 842	Continued From page 28 information to provide a picture of the resident's progress, including response to treatments and/or services, changes in his/her condition, plan of care goals, objectives and/or interventions. Resident 1, Resident 26, and Resident 31's Physician Orders indicated all crushable medications could be crushed and administered together. This deficient practice had the potential for the licensed nurses to follow the Physician Orders which could potentially cause a chemical drug interaction and could cause side effects to the residents. Findings: a. A review of Resident 1's Record of Admission indicated that Resident 1 was readmitted to the facility on 11/28/17 with a diagnosis of severe sepsis (a potentially life-threatening complication of an infection). A review of Resident 1's History and Physical form dated 12/2/17, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 1's Physician Orders dated from 3/1/18 through 3/31/18, with an order date of 11/28/17, indicated all crushable medications could be crushed and administered together.	F 842	**Facility measures and systemic changes to ensure the deficient practice does not recur:** -DON educated Licensed nurses on 3-23-18 on the risks of mixing all medications together and the potential for a chemical drug reaction which could cause side effects. -DON re-educated the licensed staff on 3-23-18 regarding new regulation and the importance of reassessing patient for the use of any PRN psychotropic medication after 14 days. Emphasized the importance of contacting the physician, nurse practitioner or the psychiatry team assigned to get the medication re-ordered if necessary. -Director of Medical Records will also audit charts upon monthly recaps to be sure that order to mix all medications are discontinued. -Medical Records Director or designee will do random audits to assure that PRN psychotropic medication is being renewed or discontinued in a timely manner.	

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F 842	Continued From page 29 b. A Review A review of Resident 26's Record of Admission indicated the resident was readmitted to the facility on 6/10/17 A review of Resident 26's History and Physical Examination form dated 6/27/17, indicated that resident did not have the capacity to understand and make decisions and had diagnosis of cementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and generalized weakness. A review of Resident 26's Physician Orders dated from 3/1/18 through 3/31/18, with an order date of 6/10/17, indicated that all crushable medications could be crushed and administered together. c. A review of Resident 31's Record of Admission indicated that resident was admitted on 1/8/16 and had a diagnosis of muscle wasting and facial weakness. A review of Resident 31's History and Physical dated 1/9/18, indicated that resident had fluctuating capacity to understand and make decisions. A review of Resident 31's Physician Orders dated from 3/1/18 through 3/31/18, with an order date of 1/8/16, indicated all crushable medications could be crushed and administered together.	F 842	**Facility plan to monitor corrective actions and compliance; Integrate QA Process:** - Findings from facility random audits will be reported to daily stand up meetings for corrections. Findings will then be collected for the month will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of Completion:** 4/02/18	4-2-18

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F 842	Continued From page 30	F 842		

During an interview on 3/10 18 at 8:46 a.m., licensed vocational nurse (LVN 10), stated crushed medications should not be administered together because mixing different medications could cause a bad reaction.

A review of the facility's policy and procedure titled "Health Information Record Manual," with a revised date of 3/6/03, indicated all physician orders would be reviewed and recapped once a month and that nursing staff were responsible to check recaps.

According to the Centers for Medicare and Medicaid Services (CMS) State Operational Manual (SOM), indicated the standard of practice was that crushed medications should not be combined and given all at once and that crushing and combining medications could result in physical and chemical incompatibilities leading to an altered therapeutic response.

d. A review of Resident 37's Record of Admission indicated that the resident was admitted to the facility on 1/1/18, with diagnoses that included end stage renal disease and altered mental status.

A review of Resident 37's History and Physical form dated 1/9/18 indicated the resident has diagnoses of paranoia and bipolar disorder. The History and Physical indicated the resident did not have the capacity to understand and make decisions.

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F 842	Continued From page 31	F 842		

A review of Resident 37's Medication Administration Records (MARs) for February and March 2018 indicated the facility had been monitoring the resident's behavior for receiving one mg of Ativan as needed for anxiety manifested by overly concerned with non-health related issues. The MAR also indicated Resident 37 was monitored by facility staff for behaviors of making false statements accusing staff and other residents of coming into her room and taking things and striking out. The MAR indicated Resident 37 was receiving Seroquel 100 mg for these behaviors.

A review of Resident 37's Physician and Telephone Orders dated 2/21/18, indicated a handwritten order signed by the physician that indicated to administer one milligram (mg) of Ativan every six hours as needed for anxiety manifested by inability to relax for 14 days.

A review of Resident 37's medical records did not indicate a physician evaluated the resident on 2/21/18 for anxiety before writing an order to administer Ativan 1 mg as needed for 14 days.

During an interview with the social services director, on 3/10/18, at 1 p.m., social services director (SSD) stated that the psychiatrist would email the progress note, dated 2/21/18 to her that day. SSD stated the facility's psychiatrist would usually see residents in the facility and email the progress notes to the SSD after a few days. The SSD stated she did not know why the psychiatrist

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F 842	Continued From page 32 did not provide the facility with the progress notes. The SSD handed over a psychiatrist progress note dated 1/31/18. The SSD stated, "This is all I have for now and will come back for the other progress notes." At around 3:30 p.m., the SSD handed over the psychiatrist progress note dated 2/21/18, that indicated, "Electronically signed by the facility's psychiatrist on 3/10/2018, timed at 3:12 p.m." At around 3:55 p.m., the SSD handed over another psychiatrist progress note dated 3/6/18, that indicated, "Electronically signed by the facility's psychiatrist on 3/10/2018, timed at 4:12 p.m." A review of the facility's policy and procedures titled "Psychotropic Medication Use," dated 10/2017, indicated the prescribing practitioner should indicate their rationale for ordering PRN (as needed) psychotropic medications and document in the resident's medical record.	F 842		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the attic/ceiling access door wire was not exposed and a call light (a bedside button tethered to the wall, which directs signals the nursing station) was in good condition for two of 16 sampled residents (Resident 148 and 198) as indicated in the facility's policy.	F 908	**F Tag Identifier: F 908** **Immediate corrective action(s) for those Residents affected by the deficient practice:** --Resident 148's bathroom attic access door was closed on 3-8-18. Resident in 148 is incontinent and does not use the bathroom and did not have a roommate at the time. -Resident 198's call light was immediately replaced by the DSD on 3-8-18.	

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F 908	Continued From page 33 This deficient practice had potential to expose hazardous electrical shock to the resident, visitor, and or the staff. Findings: On 3/08/18 at 7:15 p.m., during the initial tour Resident 148's attic/ceiling access door from the bathroom was open. There was exposed wire extending out from the opening down. On 3/08/18 at 7:20 p.m., during tour with director of staff developer (DSD) while in Resident 148's bathroom, observed attic/ceiling access door was left open. The DSD stated they fixed wire up on the ceiling for WIFI and the door should not have been left open. On 3/08/18 at 8:00 p.m., during a tour with administrator while in Resident 148's bathroom, he observed the attic/ceiling access door left open. He stated the ceiling should not have been left open. On 3/09/18 at 6:27 p.m., during an interview with maintenance supervisor, he stated the attic/ceiling access door to the attic in Resident 148's bathroom was a metal door. When the attic access door was opened, there was a blue wire visible. The maintenance supervisor stated the attic/ceiling access door should have been closed all the time. The maintenance supervisor further stated "We don't have policy on ceiling attic. Administrator told me this morning about the attic	F 908	**Plan Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -Administrator did do facility rounds on 3-8-18 to be sure that all attic access doors were closed. DSD and charge nurses did facility rounds on 3-8-18 to assure that call lights in each room and bed did not have exposed wires. -No other residents or resident rooms were affected by this deficient practice. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Staff was also inserviced on 3-23-18 regarding safety rounds and educated to look out for exposed wires and open attic doors while performing care. They were also educated on the electrical hazardous risk when wires are exposed. Staff was asked to use Maintenance Log book at the stations to document any findings and Maintenance Director will replace hazardous objects immediately. -Administrator and/or Maintenance director will do facility rounds at least twice a week to assure no wires are exposed	

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F 908	Continued From page 34 access opening in Resident 148's bathroom." b. During an observation on 3/8/18 at 6:58 p.m., Resident 198 was lying in bed and the call light was within reach. Resident 198's call light was torn and wires were exposed. During the same observation, a licensed nurse (LVN 7) stated the call light should be fixed because the wires were exposed. A review of Resident 198's Record of Admission indicated that resident was admitted to the facility on 3/1/18 with diagnoses of constipation (a condition in which there is difficulty in emptying the bowels) and being underweight. A review of Resident 198's care plan dated 3/1/18, indicated the resident was at risk for fall or injury and one of the interventions were to encourage resident to use the call light. During an interview on 3/9/18 at 6:28 p.m., the facility's maintenance supervisor stated the call lights should not have torn wires and the call light should be maintained at all times. A review of the facility's policy and procedure titled "Electrical Safety for Residents," revised January 2011, indicated the facility staff would inspect electrical outlets, extension cords, power strips, and electrical devices as part of routine fire safety and maintenance inspections.	F 908	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Findings from facility rounds by administrator, maintenance, DSD, DON, and charge nurses will be reported to daily stand up meetings. Findings will then be collected for the month will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of Completion: 4/02/18**	4-2-18
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		

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F 921	Continued From page 35 §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 record review, the facility failed to ensure to clean a lint catch/screens every two hours as scheduled, and document the laundry hot water temperature log per facility policy and procedures to provide a safe, functional for two of two dryer machines. This deficient practice had potential fire hazardous from the lint catch/screen. Findings: On 3/10/18 at 7:25 a.m., during an inspection the facility's laundry department, observed house keeper 1 put clothes into two drier and house keeper 2 folded linens, and pads. House keeper 1 put dirty clothes into washer machine. During an inspection with house keeper 1, observed two dryer machine lint catch compartment were full of lint. House keeper 1 stated it is time for clean and the lint may be cleaned every 1-2 hours. On 3/10/18 at 7:50 a.m., during an observation and interview with maintenance supervisor, question what happen with the Laundry Hot Water Temperature Log which had been documented in advanced. The maintenance supervisor stated Laundry Hot Water Temperature log should not be logged ahead of	F 921	F Tag Identifier: F 921 **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No residents were affected by this deficient practice -Lint catch compartment was emptied immediately and logged at 7:45 am on 3-10-18 -Water temp log for the 3-10-18 was re-done correctly for the day on a separate log. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -Other logs were reviewed immediately by the Maintenance supervisor and no other logs were documented in advance. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Maintenance Supervisor gave the housekeeper 1:1 inservice on 3-10-18 regarding the importance of logging in accurate information at the right time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. BUILDING _____ B. WING _____	03/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 36 time for today 3/10/18 at 12:00 p.m., and 2 p.m., and the Lint Trap Log was not logged in on 3/10/18 at 6 a.m. According to an undated facility's policy and procedure titled "General Maintenance of Dryer" indicated lint catch/screens should be cleaned every two (2) hours, every few months, remove the lint catch and with a bristle brush, wash the screen clean. All directives pertaining to laundry procedures and cleaning schedules will be in writing. Every laundry and housekeeping staff member will be trained to follow them.	F 921	-Maintenance Supervisor also gave the Housekeeping staff an inservice on 3-22-18 regarding the importance of the logs and emphasized the importance of timely log ins. -Maintenance supervisor and Administrator will do random checks of the logs at different times of the day to assure on going compliance. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** Findings from random checks by administrator and maintenance director will be collected for the month and will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of Completion:** 4/02/18	4-2-18