STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555349	A. BUILDING _____ B. WING _____	05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VACAVILLE CONVALESCENT & REHAB	586 NUT TREE COURT VACAVILLE, CA 95687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the RECERTIFICATION survey. Representing the California Department of Public Health: Surveyor 39210, HFEN; Surveyor 37689, HFEN; Surveyor 37726, HFEN; Surveyor 32179, HFEN; and Surveyor 39199, HFEN. The survey team entered the facility on 5/13/19 at 0730 hours. The resident census was 102. GLOSSARY OF DEFINITIONS AND ABBREVIATIONS: ADL - activities of daily living CDC - Centers for Disease Control and Prevention CMS - Centers for Medicare and Medicaid Services CNA - Certified Nursing Assistant CPAP - Continuous Positive Airway Pressure (a device which used mild air pressure to a person via a nose piece or a face mask to keep your breathing airways open) DON - Director of Nursing DSD - Director of Staff Development DSS - Dietary Services Supervisor FDA - Food and Drug Administration gm - gram(s) iu - international unit LVN - Licensed Vocational Nurse MDS - Minimum Data Set (a standardized assessment tool) mg - milligram(s) P&P - policy and procedure RD - Registered Dietician RN - Registered Nurse	F 000	Please accept this plan of correction as our formal allegation of compliance. **F 578 Request / Refuse / Discontinue Treatment / Formulate Advance Directive** Facility will obtain copies of an advance directive whenever available for each resident to ensure their advanced care planning decisions regarding their health care and treatment options are being honored. Advance directive for Resident 27 has been obtained by North Station Unit Manager and placed in the clinical file on May 21, 2019. Advance directive for Resident 10 has been obtained by Assistant Director of Nursing and placed in the clinical file on May 22, 2019.	June 17, 2019

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

[signature] Administrator 20 June 2019 6/21/19

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.

Accepted 8/21/19

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F 000	Continued From page 1 SSD - Social Service Director	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 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	F 578	Assistant Administrator reviewed every resident's clinical file on June 3, 2019 to determine if an advance directive was available and if so, was it in the clinical file. All files were updated if appropriate. Medical Records will complete an audit of all current residents to ensure we have an advance directive in the clinical file if marked as executed. Licensed nurses will continue to ask new residents and/or responsible parties if there is an executed advance directive and request a copy for the clinical file. Licensed nurses will document discussion in resident's health status note, including documentation to show evidence the facility is making attempts to receive advance directive. Admission Coordinator will discuss advance directive with resident and/or responsible party when completing admission packet. Admission Coordinator will document discussion in social	

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F 578	Continued From page 2 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: Based on interview and medical record review, the facility failed to obtain a copy of an advance directive for one of 21 final sampled residents (Resident 27) and one nonsampled resident (Resident 10). This had the potential for the residents' advanced care planning decisions regarding their health care and treatment options not being honored. Findings: 1. Medical record review for Resident 10 was initiated on 5/13/19. Resident 10 was admitted to the facility on 10/28/18. Review of Resident 10's Advance Directive Acknowledgement form dated 10/28/18, showed Resident 10 had executed an advance directive. Review of Resident 57's medical record failed to show a copy of Resident 10's advance directive was obtained or an attempt was made to obtain a copy of Resident 10's advance directive. On 5/14/19 at 1340 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated if a resident had formulated an advance directive the facility would obtain a copy of the advance directive and place the copy in the resident's medical record. The SSD verified Resident 10's medical record did not contain a copy of Resident 10's advance directive	F 578	services note, including documentation to show evidence the facility is making attempts to receive advance directive. Medical Records Coordinator will continue conducting a new admission audit and include review for a copy of the advance directive. Interdisciplinary team will ask residents and/or responsible parties at quarterly care conferences if there has been any changes or updates to their advance directive and document findings in care conference notes. Administrator will inservice licensed nurses, Admission Coordinator, Medical Records Coordinator and Social Services Director on June 11 & 13, 2019 to obtain an executed advance directive, where to document attempts to obtain an advance directive, and what measures are in place to ensure we meet the residents wishes regarding their health care and treatment options.	

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F 578	Continued From page 3. or documentation showing staff had attempted to obtain a copy. 2. Medical record review for Resident 27 was initiated on 5/13/19. Resident 27 was readmitted to the facility on 7/27/18. Review of the Quarterly MDS dated 3/1/19, showed Resident 27 was moderately impaired in cognition. Review of the Advance Directive Acknowledgment form dated 7/28/18, showed Resident 27 had executed an advance directive. However, there was no documentation in the resident's medical record to show a copy of Resident 27's advance directive was obtained or requested. On 5/14/19 at 1356 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 reviewed Resident 27's current and previous medical records and verified she could not find a copy of the advance directive.	F 578	Facility will utilize SNFQAPI to monitor on every other month basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604	**F 604 Right to be Free from Physical Restraints** Facility will ensure all residents are free from physical restraints. The pull tab alarm for Resident 13 has been removed on May 21, 2019	June 17, 2019

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F 604	Continued From page 4 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, the facility failed to ensure one of 21 final sampled residents (Resident 13) was free from a physical restraint. The facility utilized a position change alarm while Resident 13 was in bed, which resulted in Resident 13 being afraid to move to avoid setting off the alarm. Findings: On 5/13/19 at 0900 hours, Resident 13 was observed lying in bed with bilateral side rails elevated. A position change alarm (bed alarm) was observed on each side of Resident 13's bed. On 5/14/19 at 0753 and 0816 hours, an observation and concurrent interview was	F 604	Social Services Designee and Unit Manager talked with resident and resident's responsible party on May 21, 2019, who both agreed to leave the pressure alarm on only at night when resident is in bed. All residents reviewed by Director of Nurses, Assistant Director of Nurses, Social Services Director and Unit Managers on May 23, 2019 to ensure they were free from physical restraints. No other residents were affected by this deficient practice. Licensed nurses will complete fall assessment on new admissions and at least quarterly. A post fall assessment is completed for each resident following a fall. Residents at high risk for falls will be assessed for the appropriateness of an alarm. All alternatives will be considered prior to applying alarm on resident. Facility interdisciplinary team will continue to meet monthly to review all residents with alarms. There is	

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F 604	Continued From page 5 conducted with Resident 13. Resident 13 was observed lying flat in bed with bilateral side rails elevated. A position change alarm was observed on each side of Resident 13's bed. Resident 13 stated she was not aware what the two alarms were for. Resident 13 stated there were a couple of times when the alarm went off and "...it scared the hell out of me." When asked how the alarm went off, Resident 13 stated she changed position in bed and the magnetic tab from the alarm pulled off triggering the alarm. Resident 13 stated she tried to stay in the same position while in bed so as not to trigger the alarm. Medical record review for Resident 13 was initiated on 5/13/19. Resident 13 was readmitted to the facility on 11/2/18. Review of Resident 13's quarterly MDS dated 2/8/19, showed Resident 13 was cognitively intact. Review of the medical record failed to show a physician's order for the use of bilateral bed alarms. Review of the plan of care showed a care plan problem dated 4/2/19, to address Resident 13's risk for falls. The interventions included to use the pressure and personal alarms in the chair and bed. On 5/15/19 at 1103 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 13 was capable of repositioning herself in bed. CNA 1 stated Resident 13 had two position change alarms in place while she was in bed or chair for safety. CNA 1 explained one was a pull-tab alarm (a string is attached magnetically to	F 604	no stop date for these meetings. The discussion includes appropriateness of alarm, alternatives to an alarm and the potential for any psychosocial concerns by utilizing the alarm. All staff will be inserviced by Administrator on June 11 & 13, 2019 to make the licensed nurse aware if a resident has any question or concern regarding the use of their alarm. Administrator will participate in the next three-monthly interdisciplinary meeting to ensure there is a discussion that includes appropriateness of alarm, alternatives to an alarm and the potential for any psychosocial concerns. Facility will utilize SNFQAPI to monitor on a monthly basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	

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F 604	Continued From page 6 the alarm and clipped to the resident's clothing) and the other one was a pressure alarm (a pressure-sensitive pad is placed underneath the resident). CNA 1 stated these devices were used for Resident 13's safety because one night Resident 13 was found sleep walking. On 5/15/19 at 1113 hours, an observation of Resident 13 was conducted with CNA 1. Resident 13 was observed lying flat in bed and there was a pull-tab alarm observed on the left side of Resident 13's bed. The alarm was connected by a string clipped to Resident 13's clothing (at her shoulder area.) The string was observed to not be long enough for Resident 13 to move in bed without setting off the alarm (the string was taut and there was no slack). Another alarm was observed on the right side of Resident 13 and connected to a pressure pad underneath the resident. Resident 13 stated she could not move because she did not want the alarms to go off. Resident 13 was observed to move slightly to her right which caused the string magnet pull from the alarm box; this caused the alarm to go off. Resident 13 startled, her face turned red, and she became tearful. CNA 1 immediately placed the string magnet back in place to stop the alarm from sounding and consoled Resident 13. Resident 13 stated, "...why do I have that? I am not going anywhere." On 5/15/19 at 1120 hours, the DON was informed of the above observation. The DON stated Resident 13 was not supposed to have the pull-tab alarm while she was in bed. On 5/15/19 at 1143 hours, an interview and concurrent medical record review for Resident 13 was conducted with LVN 6. LVN 6 verified	F 604		

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F 604	Continued From page 7 Resident 13 had two bed alarms. LVN 6 stated Resident 13 needed both alarms because the personal alarm or the tab alarm could alert the staff a lot quicker than the pressure alarm. LVN 6 could not locate a physician's order for the use of pull-tab alarm or the pressure alarm for Resident 13. LVN 6 could not find documentation to show an assessment was completed for the use of the two alarms for Resident 13. On 5/17/19 at 0847 hours, a follow-up interview was conducted with the DON. The DON stated the facility did not have a policy for the use of the pull-tab alarm or the pressure alarm.	F 604		
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 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	F 656	**F 656 Develop / Implement Comprehensive Care Plan** Facility will develop comprehensive person-centered care plans for each resident to avoid the risk of not providing appropriate, consistent and individualized care. Resident 27's care plan has been updated to reflect her impaired vision, hearing impairment and use of oxygen by North Station Unit Manager on May 21, 2019. MDS Coordinator's reviewed all other resident's care plans for completion and accuracy of a comprehensive person-centered	June 17, 2019

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F 656	Continued From page 8 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 medical record review, the facility failed to develop a comprehensive person-centered plan of care to reflect the individual care needs for one of 21 final sampled residents (Resident 27). The facility failed to develop a care plan to address Resident 27's impaired vision, hearing impairment, and use of oxygen. This failure posed the risk of not providing appropriate, consistent, and individualized care to Resident 27. Findings: On 5/13/19 at 1030 hours, Resident 27 was observed in bed, receiving oxygen at two liters per minute via a nasal cannula (flexible tubing used to deliver oxygen via the nostrils).	F 656	care plan on May 22, 23, 24, 2019. No other residents were affected by the deficient practice. Medical Records Coordinator audits for the completion of comprehensive person-centered care plans on admission and after any change of condition. Any findings are given to the licensed nurse responsible, the Director of Nurses and Administrator for follow-up and compliance. MDS Coordinator reviews care plans quarterly before each care conference to ensure the completion of a comprehensive person-centered care plan. Director of Nurses inserviced licensed nurses on June 14, 2019 to the requirement of completing a comprehensive person-centered care plan. Facility will utilize SNFQAPI to monitor on every other month basis through the continuous quality	

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F 656	Continued From page 9 Medical record review for Resident 27 was initiated on 5/13/19. Resident 27 was readmitted to the facility on 7/27/18. Review of the physician's order summary report showed a physician's order dated 8/25/18, to administer oxygen at two liters per minute through a nasal cannula every shift. Review of the MDS dated 8/30/18, showed Resident 27 had mild visual impairment and moderate hearing impairment. Documentation showed the resident's visual function hearing impairment were to be addressed in Resident 27's plan of care. However, review of Resident 27's plan of care failed to show any documentation to identify the resident's oxygen use, visual and hearing impairment. On 5/14/19 at 1401 hours, an interview and concurrent medical record review for Resident 27 was conducted with the MDS Coordinator. The MDS Coordinator reviewed the resident's medical record and confirmed there was no care plan problem(s) to address Resident 27's use of oxygen use, impaired vision or hearing loss.	F 656	improvement process. Administrator is responsible for monitoring the SNFQAPI program.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692	**F 692 Nutrition / Hydration Status Maintenance** Facility will ensure residents receive care and services to maintain acceptable nutritional status and usual body weight. Resident 95 is still a resident of the	June 17, 2019

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F 692	Continued From page 10 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 21 final sampled residents (Resident 95) who had significant weight loss received care and services to maintain acceptable nutritional status and her usual body weight. The facility failed to ensure the intake (percentage of meal consumed) of Resident 95's Boost Glucose Control (dietary supplement) was measured and documented. The facility also failed to ensure the RD's recommendations were implemented in a timely manner. These failures had the potential to place Resident 95 at risk for further unplanned weight loss. Findings: a. Review of the facility's P&P titled Weight Management Guidelines revised 11/17/17, showed residents with significant weight variance should be identified and appropriate interventions implemented. On 5/13/19 at 1505 hours, Resident 95 was observed seated in wheelchair in her room with a	F 692	facility. Registered Dietitian met with Resident 95 on May 15, 2019. regarding her preference of to not have chocolate flavored nutritional supplement. Resident 95's supplement was changed to vanilla flavored nutritional supplement on May 15, 2019. Resident 95 stated she did not like the vanilla flavored nutritional supplement on May 24, 2019. Registered Dietitian changed order to be Boost Breeze which has three flavors, wild berry, peach and orange. Dietitian reviewed each resident on May 27 & 28, 2019 to ensure there was documentation of supplement consumed. Dietitian also spoke to each resident on a supplement on May 27 & 28, 2019 to ensure that the flavor of the supplement was not the reason for lack of consumption. No other residents were affected by the deficient practice. Licensed nurses are documenting on the medication administration	

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F 692	Continued From page 11 container of chocolate flavored Boost Glucose Control supplement on her bedside table. Resident 95 was asked if she had finished the Boost supplement. Resident 95 stated she only took a sip of the Boost supplement because it was too sweet and she did not like the chocolate flavor. Resident 95 stated she had informed staff she did not like the chocolate flavored Boost supplement and they were supposed to replace it with a vanilla flavored supplement, but they have been bringing her the chocolate flavored supplement every day. Resident 95 stated she had lost about six or seven pounds since being admitted to the facility. Medical record review for Resident 95 was initiated on 5/14/19. Resident 95 was admitted to the facility on 4/21/19. Review of the Weight and Vitals Summary showed Resident 95 weighed 105 pounds on admission (4/21/19). On 5/13/19, approximately three weeks later, Resident 95 weighed 95 pounds, which was a 9.52% loss. Review of the Progress Notes showed an entry by the RD dated 5/1/19, showing Resident 95 was underweight per the Body Mass Index standards. The RD's recommendation was to provide Resident 95 Boost Glucose Control supplement two times a day (between meals) and record the percentage consumed on the Medication Administration Record to avert additional weight loss and promote gradual weight gain until Resident 95 returned to her usual body weight. Review of the Medication Review Report showed a physician's order dated 5/1/19, for the nurses to	F 692	record the percent of supplement consumed. Resident 95 is consuming an average of eighty-five percent. Resident receives supplement twice a day in between meals. Intake is documented on the medication administration record. Resident receives health shakes with meals and additional supplement during medication pass. Resident is on fluid restriction, secondary to COPD. In communication with the physician, he believes her admission weight was elevated secondary to her health issues and the weight loss was expected as her condition improved. Discharge plan for resident is to go home with husband. Facility has a daily weight review meeting for all residents on daily or weekly weights. Interdisciplinary team reviews each new weight to	

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F 692	Continued From page 12 give Resident 95 one can of Boost Glucose Control supplement two times a day and to record the percentage consumed. Review of Resident 95's Medication Administration Record for May 2019, failed to show documentation of the percentage of the Boost Glucose Control supplement that was consumed by Resident 95 from 5/1 to 5/14/19. On 5/14/19 at 1433 hours, an interview and concurrent medical record review was conducted with the RD. The RD stated the purpose of the Boost Glucose Control supplement was to offset Resident 95's weight loss. The RD verified the nurses were supposed to give Resident 95 the Boost Glucose Control supplement in between meals and document how much the resident consumed as a percentage on the Medication Administration Record. The RD stated it was important to document the percentage consumed because it was a way to track calorie consumption to determine the effectiveness of the supplement. The RD verified there was no documentation of the percentage of the Boost Glucose Control supplement that was consumed by Resident 95. b. Review of Resident 95's Progress Notes showed an entry by the RD dated 5/9/19, showing Resident 95 received Boost Glucose Control supplement twice a day; however, the RD recommended to change the supplement to vanilla flavored Ensure as the resident reported she did not like chocolate. Review of the Medication Review Report showed a physician's order dated 5/14/19, to discontinue the chocolate flavored Boost Glucose Control	F 692	make appropriate changes if necessary. Facility has a monthly weight meeting for all other residents not receiving daily or weekly weights. Any changes will be documented during the meeting in the resident's clinical file. Registered Dietitian will continue to review resident's clinical file as needed. Registered Dietitian will give a copy of her recommendations to the licensed nurse for follow-up. A copy of Registered Dietitian recommendations will also be given to Administrator and Director of Nurses. Director of Nurses will review recommendations the following morning during interdisciplinary team weight review to monitor for completion and compliance. Director of Nurses will inservice licensed nurses on June 14, 2019 to completing documentation for	

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F 692	Continued From page 13 supplement and give Resident 95 one Ensure supplement two times a day. The RD's recommendation was not implemented until five days later. Review of the Weights and Vitals Summary showed Resident 95 weighed 97 pounds on 5/8/19. On 5/13/19, Resident 95 weighed 95 pounds, which was a two-pound weight loss over one week. On 5/14/19 at 1433 hours, an interview and concurrent medical record review was conducted with the RD. The RD stated she would communicate her recommendations to the physician and carry out the physician's orders by the next day if the physician was in agreement with her recommendations. The RD verified she did not communicate her recommendation to change the chocolate flavored Boost supplement to vanilla flavored Ensure to the physician until five days after she documented her recommendation on Resident 95's assessment. Cross reference to F806, example #5.	F 692	Registered Dietitian recommendations in the clinical file. All staff will be inserviced on June 11 & 13 on informing the licensed nurse when resident's voice a concern outside their scope of care, i.e. changing the flavor of their supplement. Facility will utilize SNFQAPI to monitor on a quarterly basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	
F 695 SS=D	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:	F 695	**F 695 Respiratory / Tracheostomy Care & Suctioning** Facility will provide necessary treatment for all residents receiving respiratory therapy. Resident 83's CPAP machine has been cleaned by licensed nurse on May 21, 2019 according to facility	June 17, 2019

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F 695	Continued From page 14 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary treatments to three of 21 final sampled residents (Residents 83, 27, and 90) receiving respiratory therapy. * The facility failed to ensure Resident 83 received the necessary care for breathing treatment via a CPAP machine. * The facility failed to ensure Resident 27 and 90's nasal cannulas (tubing with two prongs used to deliver oxygen via the nostrils) were changed every five days in accordance with the physician's orders. These failures had the potential to negatively impact the residents' medical conditions. Findings: 1. Review of the facility's P&P titled CPAP/BIPAP Support dated 3/15, showed the staff is to clean the machine with with warm, soapy water and rinse at least once a week and as needed. The policy showed the washable filter needs to be rinsed under running water once a week to remove dust and debris. The CPAP mask, nasal pillows, and tubing are to be cleaned daily by placing in warm, soapy water and soaking or agitating for five minutes in a mild detergent and to rinse with warm water and allow it to air dry between uses. Medical record review for Resident 83 was initiated on 5/13/19. Resident 83 was admitted to the facility on 1/8/19. Review of Resident 83's physician's order dated	F 695	policy and procedure. Facility had licensed nurses clean all other CPAP/BIPAP machines in use on May 21, 2019 according to policy and procedure. All residents utilizing CPAP/BIPAP machines had their orders updated on May 21, 2019 to include cleaning of machine once a week with warm soapy water, cleaning the filter once a week and daily cleaning of the mask, nasal pillows, and tubing. Licensed nurses will document cleaning of CPAP/BIPAP machines in the medication administration record. Night shift licensed nurse is responsible for cleaning CPAP/BIPAP machines and document cleaning in medication administration record. Day shift Unit Manager will conduct rounds for four weeks to determine compliance with documentation and cleaning. Director of Nurses will randomly monitor for	

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F 695	Continued From page 15 5/13/19, showed Resident 83 had a CPAP machine on while asleep. On 5/13/19 at 1151 hours, an interview and observation of Resident 83's CPAP machine was conducted. LVN 5 was asked when the last time Resident 83's CPAP machine mask and tubing were cleaned and the filter was changed. LVN 5 stated there was an outside company to change it. LVN 5 acknowledged there was no date identified or documented to show when this was done. On 5/13/19 at 1210 hours, an interview and concurrent P&P review was conducted with RN 2. RN 2 was asked if there was any documentation to show when Resident 83's CPAP machine and tubing were cleaned and the filter was changed. RN 2 was unable to find any documentation show when the last time Resident 83's CPAP machine and tubing were last cleaned or a cleaning schedule. RN 2 stated the resident's plan of care should include the care and cleaning of the CPAP machine. 2. On 5/13/19 at 0904 hours, Resident 27 was observed in bed, receiving oxygen at two liters per minute through a nasal cannula. The nasal cannula tubing was dated "3/31." The nasal cannula was connected to a humidifier bottle dated 5/9/19. On 5/13/19 at 0910 hours, LVN 2 observed Resident 27's tubing and verified the nasal cannula was not changed since 3/31/19, even though the humidifier was changed on 5/9/19. LVN 2 stated the nasal cannula should have been	F 695	continuously going forward. Director of Nurses inserviced licensed nurses on June 14, 2019 to the facility policy and procedure for cleaning CPAP/BIPAP machines and their responsibility for documenting in the medication administration record. Medical Records Coordinator will audit medication administration record to monitor for completed documentation. Facility will ensure nasal cannulas are changed every five days in accordance with physician's orders. Resident 27 had her nasal cannula replaced on May 13, 2019 by licensed nurse. Resident 90 had her nasal cannula replaced on May 13, 2019 by licensed nurse. Licensed nurses are responsible for replacing the nasal cannulas and humidifier bottle for all residents receiving oxygen therapy every	

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F 695	Continued From page 16 changed every five days as ordered. Medical record review for Resident 27 was initiated on 5/13/19. Resident 27 was readmitted to the facility on 7/27/18. Review of the Order Summary Report showed a physician's order dated 7/27/18, to change the humidifier bottle and tubing every five days. Review of the Medication Administration Record for May 2019, showed the humidifier bottle and tubing were scheduled to be changed every five days on the night shift. The humidifier bottle and tubing was signed as changed on 5/3, 5/8, and 5/13/19. However, the tubing was labeled 3/31/19. 3. On 5/13/19 at 0915 hours, Resident 90 was observed in bed, receiving oxygen at two liters per minute through a nasal cannula. The nasal cannula tubing was dated 4/28/19. The nasal cannula was connected to a humidifier bottle dated 5/12/19. On 5/13/19 at 0918 hours, the DSD observed Resident 90 and verified above findings. Medical record review for Resident 90 was initiated on 5/13/19. Resident 90 was admitted to the facility on 1/7/16. Review of the Order Summary Report showed a physician's order dated 1/12/16, to change the humidifier bottle and tubing every five days. Review of the Medication Administration Record for May 2019, showed the humidifier bottle and tubing were scheduled to be changed every five	F 695	five days. Documentation of the replacement in maintained in the medication administration record. Director of Nurses inserviced licensed nurses on June 14, 2019to the responsibility of replacing nasal cannulas, humidifier bottles and documenting in the medication administration record. Director of Nurses will monitor for compliance with random checks of five resident's nasal cannulas and humidifier bottles each week for the first two months. Following the first two months the facility will assign the responsibility for checking to the day shift Unit Manager. Unit Manager will observe weekly each resident on their unit to ensure nasal cannulas and humidifier bottles have been replaced timely. Unit Manager will report findings to the Director of Nurses. Facility will utilize SNFQAPI to monitor on every other month basis through the continuous quality	

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F 695	Continued From page 17 days on the night shift. The humidifier bottle and tubing was signed as changed on 5/3, 5/8, and 5/13/19; however, the tubing was observed to be dated 4/28/19..	F 695	improvement process. Administrator is responsible for monitoring the SNFQAPI program.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure 10 of 21 final sampled residents (Residents 2, 13, 16, 17, 27, 31, 82, 87, 96, and 504) remained free from accident hazards due to the use of elevated side rails.	F 700	**F 700 Bedrails** Facility will ensure all residents are free from accident hazards due to the use of elevated side rails. Resident 2 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. IDT determined to remove one side rail for Resident 2. Resident 13 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. Side rails were removed for Resident 13. Resident 16 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. Side rails were removed for Resident 16. Resident 27 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. IDT	June 17, 2019

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F 700	Continued From page 18 * The facility failed to attempt alternative measures and review the risks and benefits with each resident and/or the resident's representative prior to the use of elevated side rails for Residents 2, 13, 16, 27, 31, 82, 87, 96, and 504. * The facility failed to follow the physician's order to elevate Resident 17's side rails during care only. These had the potential to put the residents at risk for entrapment and serious injury. Findings: Review of the FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed side rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, or acute urinary retention, etc., that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Review of the facility's P&P titled Proper Use of Side Rails revised 12/2016, showed the use of side rails as an assistive device will be addressed in the resident's care plan. Less restrictive interventions will be incorporated in the care planning. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. The risks and benefits of side rails will be considered for each resident. 1. Medical record review for Resident 27 was	F 700	determined to remove one side rail for Resident 27. Resident 31 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. Side rails were removed for Resident 31. Resident 82 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. Side rails were removed for Resident 82. Resident 87 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. Side rails were removed for Resident 87. Resident 96 was assessed for the use of side rails by interdisciplinary team on May 28, 2019. IDT determined to remove one rail for Resident 96. Resident 504 discharged from the facility on May 24, 2019. Resident 17 was assessed for the order to elevate side rails only during care by the interdisciplinary team on May 28, 2019. Resident	

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F 700	Continued From page 19 initiated on 5/13/19. Resident 27 was admitted to the facility on 7/27/18. Review of the quarterly MDS dated 3/1/19, showed Resident 27 had moderately impaired cognition. On 5/13/19 at 1030 hours, Resident 27 was observed in bed with bilateral side rails (at the head of the bed). The right side rail was observed elevated, while the left side rail was down. On 5/14/19 at 1316 hours, Resident 27 was observed lying in bed with elevated bilateral side rails. Review of the Order Summary Report showed a physician's order dated 7/27/18, for half side rails up for bed mobility - non restrictive. Review of the Physical Restraints/Assistive device Assessment/Consent dated 7/27/18, showed Resident 27's responsible party signed a consent for the use of quarter length side rails for bed mobility. There were no documentation to show alternative measures were attempted prior to the use of the elevated side rails. The area to document the risk and benefits were discussed with the resident and/or responsible party failed to show what the risk and benefits were reviewed. Review of Resident 27's plan of care showed a care plan problem to address the potential for falls. One of the interventions included bilateral half side rails to be elevated. On 5/15/19 at 1404 hours, an interview and concurrent medical record review was conducted	F 700	17 had some cognitive changes since the physician order dated June 7, 2012. Unit Manager spoke with resident's responsible party who stated she would like side rails in place for resident secondary to her cognition and history of falls. Interdisciplinary team, including Director of Nurses, Assistant Director of Nurses, Social Services Director, MDS Coordinators, Unit Managers and Administrator reviewed all residents using side rails on June 10, 2019. Any recommended changes have been completed and documented in the residents clinical file. Facility will document any alternative measures attempted prior to utilizing side rails in the interdisciplinary notes maintained in the clinical file. Facility will document in the medication administration record what utilization of the side rails is in place for each resident. Facility uses a form placed in the	

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F 700	Continued From page 20 with LVN 6. LVN 6 stated Resident 27 had bilateral quarter side rails were used for bed mobility. LVN 6 stated the facility did not have half side rails and they did considered quarter length side rails as the least restrictive device. LVN 6 verified there were no alternative measures attempted for Resident 27 and the risk and benefits identified prior to the use of elevated side rails for Resident 27. 2. On 5/13/19 at 0912 hours, Resident 87 was observed lying in bed with bilateral elevated side rails (from the head of the bed up to the waist level, measured 36.5 inches in length). Medical record review for Resident 87 was initiated on 5/13/19. Resident 87 was admitted to the facility on 7/31/18. Review of Resident 87's quarterly MDS dated 4/23/19, showed Resident 87 had moderately impaired cognition. Review of a physician's order dated 7/31/18, showed to provide quarter length elevated side rails for bed mobility - non restrictive. Review of the CNA's Documentation Survey Report for May 2019, showed Resident 87 required limited to total assistance of one person for bed mobility. Review of the Physical Restraints/Assistive device Assessment/Consent dated 7/27/18, showed the questions for alternatives considered and offered, and risks and benefits discussed, were answered N/A (not applicable). Review of Resident 87's plan of care showed a	F 700	resident's closet to inform certified nursing assistants of care guidelines for each resident. Licensed nurse will add utilization of side rails to this form. Interdisciplinary team will continue to meet monthly and discuss each resident utilizing side rails. Discussion will involve using the least restrictive approach. Director of Nurses will inservice licensed nurses on June 14, 2019 to complete a person-centered assessment of each resident upon admission to determine use of side rails. Alternative measures if appropriate will be attempted prior to utilizing side rails. Facility will utilize SNFQAPI to monitor on every other month basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	

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F 700	Continued From page 21 care plan problem to address the potential for falls. One of the interventions included bilateral quarter side rails to be elevated. On 5/15/19 at 1425 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 reviewed the medical record and verified there were no alternative measures attempted and risks and benefits were not reviewed prior to the use of side rails for Resident 87. 3. On 5/13/19 at 0900 hours, Resident 13 was observed lying in bed with bilateral side rails elevated. Medical record review for Resident 13 was initiated on 5/13/19. Resident 13 was admitted to the facility on 11/2/18. Review of the History and Physical dated 11/4/18, showed Resident 13's physician identified the resident did not have the capacity to understand or make decisions. Review of the CNA's Documentation Survey Report for May 2019 showed Resident 13 required limited to extensive assistance of one to two persons for bed mobility. Review of the Physical Restraints/Assistive device Assessment/Consent dated 11/2/18, showed Resident 13 signed the consent for the use of elevated quarter side rails. The questions for alternatives considered and offered prior to the use of side rails was answered N/A. There was no documentation to show what risk and benefits were reviewed with Resident 13 prior to the use of the side rails.	F 700		

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F 700	Continued From page 22 Review of Resident 13's plan of care showed a care plan problem dated 11/2/18, to address the potential for falls. One of the interventions included bilateral quarter side rails to be elevated. On 5/15/19 at 1359 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 reviewed the medical record and verified there were no alternative measures attempted and risks and benefits were not reviewed prior to the use of side rails for Resident 13. 4. On 5/13/19 at 0840 hours, Resident 82 was observed lying in bed with bilateral side rails elevated (from the head of the bed up to the waist level, measured at 36.5 inches in length). Medical record review for Resident 82 was initiated on 5/13/19. Resident 82 was admitted to the facility on 1/13/16. Review of Resident 82's quarterly MDS dated 4/11/19, showed Resident 82 had moderately impaired cognition. Review of the Medication Review Report showed a physician's order dated 7/10/17, for quarter elevated side rails up for bed mobility - non restrictive. Review of the CNA's Documentation Survey Report for May 2019, showed Resident 82 required extensive to total assistance of one to two persons for bed mobility. Review of Resident 82's plan of care showed a care plan problem dated 1/26/16, to address the	F 700		

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F 700	Continued From page 23 potential for falls. One of the interventions included bilateral quarter side rails to be elevated. There was no documentation alternative measures were attempted prior to the use of elevated side rails. On 5/15/19 at 1406 hours, an interview and concurrent medical record review for Resident 82 was conducted with LVN 6. LVN 6 verified there were no alternative measures attempted and risks and benefits were not reviewed prior to the use of side rails for Resident 82. 5. On 5/13/19 at 0924 hours, Resident 17 was observed lying in bed with bilateral side rails elevated. Medical record review for Resident 17 was initiated on 5/13/19. Resident 17 was admitted to the facility on 5/27/11. Review of resident 17's quarterly MDS dated 2/22/19, showed resident 17 was moderately cognitively impaired. Review of the Medication Review Report showed a physician's order dated 6/7/12, for quarter side rails to be elevated only during care. On 5/14/19 at 1317 hours, Resident 17 was observed lying in bed with bilateral side rails elevated. There was no staff in the room providing care to Resident 17. On 5/16/19 at 0826 hours, an interview was conducted with CNA 6. CNA 6 stated she kept the side rails elevated whenever Resident 17 was in bed to keep Resident 17 from falling.	F 700		

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F 700	Continued From page 24 On 5/16/19 at 0845 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 was informed and verified above findings. 6. On 5/13/19 at 0900 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed lying in her bed with bilateral side rails elevated at the head of the bed. Resident 2 stated she used the side rails for repositioning herself in bed and to transfer in and out of bed. Medical record review for Resident 2 was initiated on 5/13/19. Resident 2 was admitted to the facility on 7/19/18, and readmitted on 10/23/18. There was no documentation found to show alternatives were attempted prior to the use of side rails. Review of the physician's order dated 10/23/18, showed an order for side rails to be elevated for bed mobility. Review of Resident 2's History and Physical dated 10/25/18, showed Resident 2 had a history of a stroke with decreased strength on the left side of her body. Review of Resident 2's care plan problem titled Potential for Injury revised 2/11/19, showed Resident 2 was at risk for injury due to generalized weakness and gait/balance problems. On 5/14/19 at 1515 hours, an observation was conducted of Resident 2. Resident 2 was	F 700		

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F 700	Continued From page 25 observed lying in her bed asleep with bilateral side rails elevated at the head of the bead. On 5/15/19 at 0852 hours, an observation was conducted of Resident 2. Resident 2 was observed lying in her bed with bilateral side rails elevated at the head of the bed. On 5/15/19 at 1105 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. Review of Resident 2's Physical Restrains/Assistive Device Assessment/Consent form dated 10/23/18, showed a section to document alternatives considered and offered prior to assistive device (side rail) utilization. The documentation under the alternatives to side rails section only showed a physician's order was obtained for the use of side rails, and failed to show any alternatives were attempted prior to the use of elevated side rails. The DON verified alternatives were not attempted prior to the use of side rails for Resident 2. 7. On 5/14/19 at 0802 hours, an observation was conducted of Resident 31. Resident 31 was observed lying in her bed with bilateral side rails elevated at the head of the bed. Medical record review for Resident 31 was initiated on 5/13/19. Resident 31 was admitted to the facility on 5/25/18. Resident 31's medical record failed to show alternatives were attempted prior to the use of side rails. Review of the physician's order dated 5/25/18, showed an order for side rails to be elevated for bed mobility.	F 700		

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F 700	Continued From page 26 Review of Resident 31's History and Physical dated 1/7/19, showed Resident 31 had a diagnosis of dementia with behavioral disturbance. Review of Resident 31's care plan problem titled Potential for Falls related to dementia, with a target date of 6/6/19, showed an intervention for side rails to be elevated, and a goal for Resident 31 to remain free from fall related injury. On 5/15/19 at 0841 hours, an observation was conducted of Resident 31. Resident 31 was observed lying in her bed asleep with bilateral side rails elevated at the head of the bed. On 5/15/19 at 1000 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 31 used her side rails to assist with transferring in and out of bed. On 5/15/19 at 1051 hours, an interview and concurrent medical record review was conducted with the DON. Review of Resident 31's Physical Restrains/Assistive Device Assessment/Consent form dated 5/28/18, showed a section to document alternatives considered and offered prior to assistive device (side rail) utilization. The documentation under the alternatives to side rails section showed "n/a" and failed to show alternatives were attempted prior to the use of elevated side rails. The DON verified alternatives were not attempted prior to the use of side rails for Resident 31. 8. On 5/13/19 at 0804 and 1504 hours, Resident 96 was observed in bed with bilateral side rails elevated at the head. Medical record review for Resident 96 was	F 700		

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F 700	Continued From page 27 Initiated on 5/13/19. Resident 96 was admitted to the facility on 4/21/19. Review of Resident 96's medical record failed to show documentation alternatives were attempted prior to the use of the elevated side rails and failed to show documentation the risks and benefits of the side rails were identified and reviewed with the resident and/or the resident's representative. On 5/15/19 at 1413 hours, an interview and concurrent medical record review was conducted with RN 2. Review of the Physical Restraints/Assistive Device Assessment/Consent dated 4/21/19, for the use of bilateral quarter side rails failed to show documentation alternatives were attempted prior to the use of the elevated side rails. The section under "The following risks and benefits have been discussed with the resident ..." failed to identify what the risks and benefits of the side rails were. RN 2 verified the above findings and stated the facility did not attempt alternatives prior to using side rails. 9. On 5/13/19 at 0817 and on 5/14/19 at 1318 hours, Resident 504 was observed lying in bed with bilateral side rails elevated at the head. Medical record review for Resident 504 was initiated on 5/13/19. Resident 96 was admitted to the facility on 4/21/19. Review of Resident 504's medical record failed to show documentation alternatives were attempted prior to the use of the elevated side rails and failed to show documentation the risks and benefits of the side rails were identified and reviewed with the resident and/or the resident's	F 700		

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F 700	Continued From page 28 representative. On 5/15/19 at 1413 hours, an interview and concurrent medical record review was conducted with RN 2. Review of the Physical Restraints/Assistive Device Assessment/Consent dated 5/4/19, for the use of bilateral quarter side rails failed to show documentation alternatives were attempted prior to the use of the elevated side rails. The section under "The following risks and benefits have been discussed with the resident ..." failed to identify what the risks and benefits of the side rails were. RN 2 verified the above findings and stated the facility did not attempt alternatives prior to using side rails. 10. On 5/13/19 at 0814, 1011, and 1515 hours, on 5/14/19 at 1320 and 1518 hours, and again on 5/15/19 at 0918, 1401 hours, Resident 16 was observed lying in bed with bilateral side rails elevated. Medical record review for Resident 16 was initiated on 5/13/19. Resident 16 was originally admitted to the facility on 4/30/15 and readmitted on 5/20/17. Review of Resident 16's care plan problem titled at risk for falls dated 5/14/15, and revised on 3/6/18, showed Resident 16 was at risk for falls related to deconditioning, gait/balance problems, history of falls and stroke. Review of Resident 16's Physical Restraints/ Assistive Device Assessment/ Consent dated 5/20/19, showed the following: - Alternatives considered and offered prior to restrictive and assistive device utilization: ¼ side rails for bed mobility. - Risks and benefits discussed with the resident	F 700		

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F 700	Continued From page 29 and the responsible part relating to restrictive and assistive device utilization: ¼ side rails for bed mobility. - Resident and responsible party signature area(s) was blank. On 5/15/19 1511 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above findings. When asked about the alternatives prior to the use of side rails. LVN 1 stated there were not any alternative interventions attempted prior to the implementation of side rails for Resident 16. When asked if the risks and benefits were discussed on the use of side rails, LVN 1 stated no.	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757	**F 757 Drug Regimen is Free from Unnecessary Drugs** Facility will ensure residents are free from unnecessary medications. Resident 506 continues to be a resident of the facility. Assistant Director of Nurses spoke with physician for Resident 506 on May 23, 2019, and he stated that he did not want to put a parameter for the use of Lasix and blood pressure medications. Director of Nurses reviewed all other residents with blood pressure medication for the placement of	June 17, 2019

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F 757	Continued From page 30 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, the facility failed to ensure one nonsampled resident (Resident 506) was free from unnecessary medications. * The facility failed to ensure Resident 506's blood pressure medications had adequate monitoring or parameters for its use. When interviewed, the licensed nurses gave conflicting information regarding when they would administer or hold the resident's blood pressure medications. This had the potential for the resident to receive unnecessary medication and develop significant side effects such as hypotension (abnormally low blood pressure). Findings: Review of The Food and Drug Administration's (FDA) drug product information for Laxis, showed Lasix, when combined with angiotensin converting enzyme inhibitors (ACE inhibitors), may lead to severe hypotension. Changes in blood pressure must be carefully monitored when Lasix is used with other antihypertensive drugs. Review of Lexicomp (an online drug reference) showed concurrent drug therapy issues related to the use of hydralazine and nifedipine included drug to drug interactions that may potentially cause significant interactions, requiring additional monitoring. The drug reference showed nifedipine may enhance the hypotensive effects of beta blockers. For hydralazine, the drug	F 757	No other residents were affected by the deficient practice. Facility verifies each medication ordered, including parameters with the attending physician for each new admission residents. Consulted Pharmacy reviews medication orders for any new admission resident and for each new order with existing residents. Interdisciplinary team reviews the clinical file for all new admissions the next morning after the admit. Medication orders is included in the morning review. Facility completes recaps (review of all orders) for each resident on a monthly basis. As part of the recap process, Director of Nurses and Assistant Director of Nurses review and monitor for medications that could potentially need parameters or monitoring. Consultant Pharmacist reviews the clinical file monthly for each resident to ensure residents are free from unnecessary medications.	

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F 757	Continued From page 31 interactions included other blood pressure lowering agents, which may enhance the hypotensive effect of hydralazine. On 5/15/19 at 0809 hours, a medication administration observation for Resident 506 was conducted with RN 1. RN 1 prepared and administered Resident 506's medications, which included the following: - one tablet of carvedilol (blood pressure medication belonging to the drug class beta blockers) 3.125 mg, - one tablet of Lasix (diuretic with antihypertensive effects) 20 mg, - one tablet of lisinopril (blood pressure medication belonging to the drug class ACE inhibitors) 10 mg, and - one tablet of nifedipine ER (blood pressure medication) 60 mg. Review of the Medication Review Report showed physician's orders dated: - 5/3/19, to administer one tablet of nifedipine ER 60 mg one time a day for hypertension, - 5/3/19, to administer one tablet of lisinopril 10 mg one time a day for hypertension, and - 5/4/19, to administer one tablet of hydralazine 50 mg every eight hours for hypertension. The Medication Review Report failed to show parameters of when to hold the blood pressure medications (i.e. hold if the systolic blood pressure or heart rate was below a specified number). Review of Resident 506's plan of care showed a care plan problem dated 5/4/19, to address the resident being on diuretic therapy (Lasix). The goal was for Resident 506 to be free of any discomfort or adverse side effects of diuretic	F 757	Director of Nurses will inservice licensed nurses on June 14, 2019 of the residents right to be free from any unnecessary medications, and when they should administer or hold a resident's medications. Facility will utilize SNFQAPI to monitor on a every other month basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	

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F 757	Continued From page 32	F 757		

therapy. The interventions included "many other medications may interact with antihypertensives to potentiate their effect" and to monitor for interactions/adverse consequences.

On 5/15/19 at 0904 hours, an interview was conducted with the ADON. The ADON stated medications such as Lasix, lisinopril, and nifedipine, among other medications, could cause hypotension. The ADON stated parameters for medications were determined by the physician and the nurses could contact the physician to obtain parameters for the blood pressure medications.

On 5/16/19 at 0957 hours, an interview was conducted with the Medical Director. The Medical Director was asked about polypharmacy (the simultaneous use of multiple drugs to treat a single ailment or condition). The Medical Director stated parameters of when to administer or hold certain medications depended on the resident's condition and history, but it was good and/or safe practice to have parameters in place for the blood pressure medications.

On 5/16/19 at 1428 hours, an interview was conducted with RN 1. RN 1 was asked when would she administer or hold Resident 506's blood pressure medications. RN 1 stated she would use her nursing judgement to determine when she would hold the resident's blood pressure medications.

On 5/16/19 at 1454 hours, an interview was conducted with LVN 4. LVN 4 was asked when would she administer or hold the resident's blood pressure medications. LVN 4 stated each resident was different and she would hold the

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F 757	Continued From page 33 resident's blood pressure medications if the systolic blood pressure was less than 110 or 100 mmHg.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758	**F 758 Free from Unnecessary Psychotropic Medications / PRN Use** Facility will ensure licensed nurses accurately monitor the number of behavior episodes on the medication administration record for residents on a psychotropic medication to prevent the potential for affecting the resident's well-being and quality of life. Residents 16's Psychotropic Summary Sheet and medication administration record for May has been completed and accurate for the same number of behavior episodes by Medical Records Coordinator on May 28, 2019. Medical Records reviewed all other residents on psychotropic medications to ensure that the medication administration records matched with the psychotropic summary sheets on May 28, 2019. No other residents were affected by the deficient practice. Medical Records Coordinator is	June 17, 2019

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F 758	Continued From page 34 §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, medical record review, and facility document review, the facility failed to ensure one of 21 sampled residents (Resident 16) was free from unnecessary psychotropic medications. The facility failed to follow physician's order and accurately monitor the number of behavioral episodes associated with the use of Depakote (a medication used to treat symptoms of bipolar disorder) for Resident 16. These failures had the potential for affecting the resident's well- being and quality of life. Findings: Medical record review for Resident 16 was initiated on 5/13/19. Resident 16 was readmitted to the facility on 5/20/17. Review of Resident 16's Medication Review report showed a physician's order dated 5/20/19, to administer Depakote 500 mg one tablet twice a day by mouth for bipolar disorder with delusions manifested by becoming agitated, irritable, and	F 758	responsible for documenting the number of behavior episodes on the Psychotropic Summary Sheet. The Psychotropic Summary Sheet and medication administration record should both accurately reflect the same number of behavior episodes for the month. Pharmacy Consultant reviews the Psychotropic Summary Sheet each month during drug regimen review. Results of the drug regimen review are given to the Director of Nurses for any follow-up needed. Director of Nurses will monitor accuracy of Psychotropic Summary Sheet matching to medication administration record by auditing all residents receiving psychotropic medications monthly during recaps for three consecutive months and quarterly thereafter. Director of Nurses will inservice licensed nurses on June 14, 2019 of the responsibility of accurately reflecting all behaviors on the medication administration record.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 35 accusing staff of being rough. Review of Resident 16's Medication Administration Record for February, March, and April of 2019, showed entries to monitor behaviors of delusions manifested by accusatory statements towards staff and hopeless statements. In addition, the behaviors were coded as follows: 0 = No behaviors 1 = Delusions manifested by accusatory statements towards staff 2 = Hopeless statements Review of Resident 16's Psychotropic Summary Sheet used to document the total number behavior episodes per shift of agitation, irritability, and staff being rough showed Resident 16 had no behaviors for the month of February, March, and April 2019. Review of Resident 16's Medication Administration Record for April 2019, showed one entry with a coding of "1" and two entries with a coding of "2." Resident 16 had no documented behaviors for the month of February and March of 2019. The number of episodes of Resident 16's Medication Administration Record for the month of April 2019 was inconsistent with the numbers documented on the Psychotropic Summary Sheet. On 5/15/19 at 0806 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above findings and stated they needed to contact the physician to obtain specific behavior monitoring for the use	F 758	Facility will utilize SNFQAPI to monitor on a every other month basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	

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F 758	Continued From page 36 of Depakote.	F 758		
F 759 SS=E	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, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 10%. Three of three licensed nurses (RN 1, and LVNs 2 and 3) were found to have made errors during the medication administration observation. * The facility failed to ensure Resident 506's blood pressure and heart rate were taken prior to being administered carvedilol (blood pressure medication). This failure had the potential to cause Resident 506 to become bradycardic (abnormally slow heart rate) and/or hypotensive (abnormally low blood pressure). * LVN 3 failed to administer one medication as ordered by the physician for Resident 48. * LVN 2 failed to follow the manufacturer's specifications in the administration of an anti-diabetic medication to Resident 36. These failures had the potential to negatively affect the residents' health. Findings:	F 759	**F 759 Free of Medication Error Rates 5 Percent or More** Facility will ensure medication error rate is below five percent. Medications will be administered in a safe and timely manner, and as prescribed. Allergies to medications and vital signs, if necessary, will be checked prior to administering medications. Resident 506 is still a resident of the facility. Vital signs were completed following medication error each shift for three days to ensure resident was stable. RN 1 has been counseled by Administrator & Director of Nurses on May 20, 2019 and documentation of medication error has been placed in her personnel file. Resident 48 is still a resident of the facility. Medication for Resident 48 arrived the same day as error and administered to resident. Vital	June 17, 2019

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F 759	Continued From page 37 1. Review of the facility's P&P titled Administering Medications revised date 12/12 showed medications shall be administered in a safe and timely manner, and as prescribed. The following information must be checked/verified for each resident prior to administering medications: -allergies to medications, and -vital signs, if necessary. On 5/15/19 at 0809 hours, a medication administration observation for Resident 506 was conducted with RN 1. RN 1 prepared and administered Resident 506's medications, including one tablet of carvedilol 3.125 mg. RN 1 was not observed obtaining Resident 506's blood pressure and heart rate prior to administering the carvedilol. Medical record review for Resident 506 was initiated on 5/15/19. Resident 506 was admitted to the facility on 5/3/19. Review of the Medication Review Report showed a physician's order dated 5/3/19, to administer one tablet of carvedilol 3.125 mg two times a day for chronic diastolic (congestive) heart failure. The physician's order showed to hold the carvedilol if the systolic blood pressure was less than 100 mmHg or if the pulse was less than 50 beats per minute. On 5/15/19 at 0823 hours, an interview was conducted with RN 1. RN 1 verified she did not check Resident 506's blood pressure and heart rate prior to administering the carvedilol to the resident. RN 1 verified she should have checked Resident 506's blood pressure and heart rate prior to administering Resident 506 the carvedilol.	F 759	signs were completed following medication error each shift for three days to ensure resident was stable. LVN 3 was counseled by Administrator & Director of Nurses on May 20, 2019 and LVN 3 is no longer working for the facility. Resident 36 is still a resident of the facility. Licensed staff documented for three days if resident was continuing to have any stomach discomfort. No discomfort was noted. LVN 2 was counseled on May 20, 2019 by Administrator & Director of Nurses and documentation of medication error has been placed in her personnel file. Contracted Pharmacy Nurse will observe medication administration monthly for the next six months. If needed, we will continue with monthly observation. Director of Nurses reviewed each medication card and medication for	

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F 759	Continued From page 38 2. On 5/15/19 at 0809 hours, a medication pass observation was conducted with LVN 3 on the North Station. LVN 3 was observed preparing and administering the following oral medications to Resident 48: - aspirin (used for stroke prevention) 81 mg one tablet - multivitamins with minerals one tablet - vitamin C 500 mg one tablet - vitamin D 1000 iu two tablets - duloxetine hydrochloride (nerve pain medication) 60 mg one capsule - metformin (anti-diabetic medication) 1000 mg one tablet - benazepril (blood pressure medication) 20 mg one tablet - metoprolol tartrate (blood pressure medication) 25 mg half tablet This was a total of 8 1/2 pills. Review of the Order Summary report showed a physician's order dated 5/13/19, for gabapentin 100 mg one tablet by mouth once a day. Review of the Medication Administration Record for May 2019 showed gabapentin 100 mg was scheduled to be given daily at 0800 hours and showed it had been signed out and administered by LVN 3 on 5/15/19. However, this medication was not included in 8 1/2 pills administered to Resident 48 on 5/15/19 at 0809 hours. On 5/15/19 at 0906 and at 1041 hours, LVN 3 was informed and verified gabapentin 100 mg tablet was not administered to Resident 48. LVN 3 stated the gabapentin tablet was not in her medication cart and they were still looking for it.	F 759	all residents. No other residents were affected by deficient practice. Director of Nurses will also randomly observe medication administration monthly for the next six months. A copy of finding will be given to Administrator for review. Administrator will discuss finding with Director of Nurses for the possibility of disciplinary action. Contracted Pharmacy Nurse and Director of Nurses will inservice licensed nurses on June 14, 2019 to their responsibility of administering medications, including making zero errors, delivering medications in a safe and timely manner, checking or verifying for allergies and checking vital signs if necessary. Facility will utilize SNFQAPI to monitor on a monthly basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	

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F 759	Continued From page 39 On 5/15/19 at 1534 hours, the DON was informed of and acknowledged above the findings. 3. On 5/15/19 at 0825 hours, a medication pass observation was conducted at the North Station with LVN 2. LVN 2 was observed preparing Resident 36's medication of metformin hydrochloride 500 mg one tablet. The label in the bubble pack for metformin hydrochloride tablet showed to take with food. LVN 2 was observed asking Resident 36 if she had eaten her breakfast. Resident 36 stated she ate a little because she had a "...stomach problem." LVN 3 did not ask what time Resident 36 eaten her breakfast. LVN 3 proceeded to administer Resident 36's oral medications. According to Lexi-Comp (a reference guide for healthcare professionals), metformin tablet should be administered with a meal to decrease gastro-intestinal upset. Review of Resident 36's annual MDS dated 2/27/19, showed Resident 36 had no cognitive impairment. On 5/15/19 at 0855 hours, an interview was conducted with Resident 36. When asked what time she ate her breakfast that morning, Resident 36 looked at the clock in her room and stated she ate a little after 0730 hours but she had not eaten much as much as she normally did because of her stomach was upset. On 5/15/19 at 1152 hours, LVN 2 was informed and acknowledged the findings.	F 759		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)	F 806	**F 806 Resident Allergies, Preferences, and Substitutes** Facility will ensure the food preferences of residents will be honored. Registered Dietitian met with Resident 83 on May 15, 2019 regarding her statement of disliking scrambled eggs. Resident 83 stated that she would only eat eggs as long as they were cracked from a whole egg. Facility does not use powdered eggs and informed Resident 83 all her eggs would be from cracked whole eggs. Dietary preferences were updated on her	June 17, 2019

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F 806	Continued From page 40 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the food preferences were honored for five of 21 sampled residents (Resident 83, 93, 27, 33, and 95). * Resident 83 did not like scrambled eggs but was served scrambled eggs. * Resident 93 did not like prune juice but was served prune juices. * Resident 27 disliked syrup on her waffles, but her waffles had syrup on. * Resident 33 preferred to have bacon everyday but was not serve bacon for breakfast. * Resident 95 did not like chocolate flavored nutritional supplements but was served them several times. These had the potential to negatively impact the residents' nutritional intake and negatively impact the residents' feeling of being respected by staff.	F 806	dietary tray card and care plan. Registered Dietitian met with Resident 93 on May 15, 2019 regarding her dislike of prune juice. Resident 93's care plan was updated as well as her dietary tray card. Resident 93 will be given an alternative juice during her meals. Registered Dietitian met with Resident 27 on May 15, 2019 regarding her preference to have all sauces on the side, including syrup. Resident 27's care plan and dietary tray card have been updated. Registered Dietitian met with Resident 33 on May 15, 2019 regarding her preference to have bacon every morning with breakfast. Resident 33's care plan has been updated as well as her dietary tray card. Registered Dietitian met with Resident 95 on May 15, 2019 regarding her preference of to not have chocolate flavored nutritional supplement. Resident 95's supplement was changed to vanilla	

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F 806	Continued From page 41 Findings: 1. Review of facility's P&P titled Resident Food Preferences dated 11/15 showed if the resident refused or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with and agrees to comply with. On 5/14/19 at 0801 hours, Resident 83 stated she did not like or eat scrambled or powered eggs; however, almost everyday, she was served scrambled or powered eggs. Resident 83 stated she had informed the staff multiple times, but they still served the eggs. Observation of Resident 83's breakfast tray identified pancakes and eggs. CNA 2 came into Resident 83's room and acknowledged Resident 83 disliked scrambled eggs but had it on her breakfast tray. Resident 83 stated she did not understand why they served her eggs when they knew she would not eat them. On 5/15/19 at 0820 hours, an interview was conducted with CNA 2. CNA 2 was asked if she had informed the dietary staff or any licensed nurse about Resident 83's dislike for scrambled eggs. CNA 2 stated she had not informed anyone. Medical record review for Resident 83 was initiated on 5/13/19. Resident 83 was admitted to the facility on 1/8/19. Review of Resident 83's plan of care identified several care plan problems to address Resident 83's nutritional need and poor oral intake. However, there was no documentation why she had a poor oral intake or that she disliked eggs.	F 806	flavored nutritional supplement on May 15, 2019. Resident 95 stated she did not like the vanilla flavored nutritional supplement on May 24, 2019. Registered Dietitian changed order to be Boost Breeze which has three flavors, wild berry, peach and orange. Dietitian & Director of Dietary Services reviewed preferences for each resident on May 16 & 17, 2019 and no other residents were affected by the deficient practice. Licensed nurses are documenting on the medication administration record the percent of supplement consumed. Resident 95 is consuming an average of eighty-five percent. Administrator will inservice all staff June 11 & 13, 2019 to communicate any dietary preferences to the licensed nurse. Director of Nurses will inservice licensed nurses on June 14, 2019 to fill out duplicate dietary slip and send one copy to the kitchen and	

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F 806	Continued From page 42 2. On 5/14/19 at 0827 hours, Resident 93 was observed to have prune juice on her breakfast tray. Resident 93 stated she did not like prune juice. Resident 93 stated she took stool softener and has been having very soft stools. CNA 3 aware of it and would follow up with it. On 5/15/19 at 0825 hours, Resident 93 meal tray was observed with an unopened can of prune juice. Resident 93 stated, yes it was on her meal tray and she had informed facility staff on several occasions that she dislikes prune juice. CNA 4 confirmed Resident 93's meal tray contained prune juice. 3. On 5/13/19 at 0826 hours, Resident 27 was observed in her room with her breakfast tray in front of her. Her waffles had syrup on them. Resident 27 stated she could not eat the waffles because someone had pour syrup on them and she had informed facility staff she disliked syrup. Review of Resident 27's meal ticket showed she did not link syrup on her waffles. 4. On 5/13/19 at 0817 hours, a breakfast observation was conducted for Resident 33 who was in her room. Review of the meal ticket showed Resident 33 preferred to have bacon everyday. Resident 33's breakfast meal did not contain bacon. Resident 33 stated she did not receive bacon for breakfast. CNA 1 verified Resident 33's breakfast meal did not include bacon. 5. On 5/13/19 at 1505 hours, Resident 95 was observed seated in wheelchair in her room with a container of chocolate flavored Boost Glucose Control supplement on her bedside table.	F 806	maintain another copy in the clinical file. Registered Dietitian will inservice dietary staff June 13, 2019 on the importance of food preferences and effectively reading the dietary tray card for accuracy. Director of Dietary Services will discuss food preference with residents during quarterly assessment. Interdisciplinary Team will discuss dietary preferences at resident care conferences for any potential changes. IDT will complete a duplicate dietary slip for any changes and send one copy to the kitchen and maintain another copy in the clinical file. Director of Dietary Services will audit trays randomly during tray line for accuracy and to ensure we are meeting the resident's preferences. Facility will utilize SNFQAPI to monitor on a quarterly basis	

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F 806	Continued From page 43 Resident 95 was asked if she had finished the Boost supplement. Resident 95 stated she only took a sip of the Boost because it was too sweet and she did not like chocolate flavor Boost. Resident 95 stated she had informed facility staff she did not like the chocolate flavored Boost and they were supposed to replace it with a vanilla flavored supplement. Resident 95 stated the staff kept bringing her chocolate flavored supplement every day. Review of Resident 95's plan of care showed a care plan problem dated 4/21/19, to address the potential for altered nutritional pattern related to and as evidenced by weekly weight losses. The interventions included to honor Resident 95's food preferences. Review of the Progress Notes showed an entry by the RD dated 5/19/19, showing Resident 95 stated she did not like chocolate. The RD recommended to discontinue the chocolate flavored Boost supplement and start providing Resident 95 with vanilla flavored Ensure. The Progress Notes showed the RD updated Resident 95's food preferences. Cross reference to F692.	F 806	through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	
F 812 SS=E	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	F 812	**F 812 Food Procurement, Storage / Preparation / Serve – Sanitary** Facility will ensure food safety requirements are maintained in the kitchen to prevent the potential for food borne illnesses.	June 17, 2019

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F 812	Continued From page 44 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 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 and interview, the facility failed to ensure food safety requirements were met in the kitchen as evidenced by: * Food items stored in the walk-in refrigerator were not labeled with a received date or an expiration date. * Food items stored in the walk-in freezer were observed on the floor. These failures had the potential to cause food borne illnesses in a medically vulnerable population of residents who consumed food from the kitchen. Findings: Review of the CMS 672 Resident Census and Conditions of Residents completed by the facility dated 5/13/19, showed 101 of 101 residents residing in the facility received food prepared in the kitchen. On 5/13/19 at 0730 hours, an initial tour of the kitchen was conducted with the Food Service	F 812	The boxes containing twenty-five pounds of Russell potatoes, thirty pounds of red potatoes, fifteen sweet potatoes and twenty pears in the walk-in refrigerator were disposed of in the garbage on May 13, 2019 by Director of Dietary Services. The boxes containing 49.85 pounds of boneless pork loin and approximately five pounds of hash browns in the walk-in freezer were disposed of in the garbage on May 13, 2019 by Director of Dietary Services. All other food items were reviewed for safe storage and labeling. No other residents were affected by the deficient practice. Director of Dietary Services is responsible for ensuring food is stored, prepared, distributed and served in accordance with professional standards for food service safety, including proper labeling and storage.	

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F 812	Continued From page 45 Director. The following observations were made: a. The walk-in refrigerator was observed with the following unlabeled (no expiration date or date received) food items: - 1 box containing 25 lbs of Russell potatoes. - 1 box containing 30 lbs of red potatoes. - 1 box containing 15 sweet potatoes. - 1 box containing 20 pears. b. The Food Service Director verified the potatoes and pears were not labeled with a date received or an expiration date. The Food Service Director stated the facility practice required kitchen staff to label food items stored in the refrigerator with the date received, and based on the received date, staff then referenced the facility food storage guideline to determine the shelf life of the food. The Food Service Director stated the purpose of this facility practice was to avoid serving residents expired food. The walk-in freezer was observed with the following food items stored on the floor: - 1 box containing 49.85 lbs of boneless pork loin. - 1 box containing approximately 5 lbs of hash browns. The Food Service Director verified the findings. The Food Service Director stated food should not have been stored on the freezer floor, as it was not good practice, due to infection control and decreased air flow.	F 812	Director of Dietary Services will inspect food storage areas daily to ensure compliance. Registered Dietitian will audit food safety, including labeling and storage weekly for compliance. Registered Dietitian will inservice Director of Dietary Services and dietary staff on June 14, 2019 to proper food labeling and storage. Administrator will randomly, at least twice a week; check kitchen to ensure food safety is being followed, including food labeling and storage. Facility will utilize SNFQAPI to monitor on every other month basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly.	F 814	**F 814 Dispose Garbage and Refuse Properly** Facility will ensure garbage and refuse are properly stored to	June 17, 2019

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F 814	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the garbage and refuse were properly stored in one of one dumpsters on two days. Failure of the facility to keep the garbage covered had the potential to attract pests/rodents that carried diseases. Findings: On 5/13/19 at 0806 hours, an observation and concurrent interview was conducted with the Food Service Director. One of one dumpsters located outside of the facility adjacent to the building was observed with the lids propped open by trash bags full of garbage, preventing the lids from fully closing. The Food Service Director verified the findings. On 5/15/19 at 0745 hours, an observation and concurrent interview was conducted with the Food Service Director. One on one dumpsters located outside of the facility adjacent to the building was observed with the lids propped open by trash bags full of garbage, preventing the lids from fully closing. The Food Service Director verified the findings. On 5/16/19 at 1500 hours, an interview was conducted with the Administrator. The Administrator stated the trash company emptied the garbage dumpsters once per day with the exception of Sunday. The Administrator stated the facility could contact the trash company for additional garbage disposal as needed.	F 814	prevent the potential to attract pest / rodents. Facility added two covered Rubbermaid sheds to property to be utilized for extra refuse in the case the dumpster is full by Maintenance Supervisor on May 24, 2019. Facility has arranged for a double pick up from our local garbage company on Mondays, secondary to there being no pick up on Sundays, starting May 27, 2019. Maintenance Supervisor will monitor dumpsters each morning and determine if an extra pick up is necessary for the day and ensure the dumpster is covered with a lid. Administrator will inservice dietary and housekeeping staff of the responsibility of maintaining lid in closed position on June 11 & 13, 2019. Inservice will also include the responsibility of staff to inform Maintenance Supervisor in the event the lid to the dumpster will not close.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555349	A. BUILDING _____ B. WING _____	05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VACAVILLE CONVALESCENT & REHAB	585 NUT TREE COURT VACAVILLE, CA 95687

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F 881	Continued From page 47 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, facility document review, the facility failed to maintain an antibiotic stewardship program designed to reduce the use of unnecessary antibiotics. The facility failed to ensure three nonsampled residents (Resident 30, 101, and A) who were prescribed antibiotics for pneumonia, upper respiratory tract infection, and urinary tract infection met McGeer Criteria (criteria used by long-term care facilities to determine a true infection) to prevent unnecessary antibiotic use. This failure posed a risk of the residents continued use of inappropriate antibiotics and developing antibiotic resistant organisms. Findings: According to the CDC, overuse and misuse of antibiotics is a major cause of increases in drug-resistant bacteria. Every time a person takes antibiotics, sensitive bacteria are killed, but resistant ones may be left to grow and multiply. Antibiotic resistance is one of the most urgent threats to the public's health. Review of the McGeer Criteria for Long Term Surveillance Definitions for Infections for urinary	F 881	Facility will utilize SNFQAPI to monitor on a monthly basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program. **F 881 Antibiotic Stewardship Program** Facility will ensure residents who are prescribed antibiotics for pneumonia, upper respiratory tract infection and urinary tract infection meet McGeer Criteria to prevent unnecessary antibiotic use. Resident 30 remains a resident of the facility. Resident 30 completed her antibiotic on March 1, 2019. Resident was assessed with no symptoms since completion. Resident 101 discharged from the facility on March 25, 2019. Resident A discharged from the facility on January 18, 2019. ICP's reviewed each resident on an antibiotic on June 6, 2019. No	June 17, 2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VACAVILLE CONVALESCENT & REHAB	695 NUT TREE COURT VACAVILLE, CA 95687

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F 881	Continued From page 48 tract infections showed two criteria must be present: 1. Signs or symptoms of dysuria (pain when urinating), swelling or tenderness of the testes, epididymis, or prostate; fever or leukocytosis with excessive blood in the urine, new or marked increase in continence, urgency or frequency. In the absence of fever, suprapubic pain, excessive bleeding in the urine, or new or increase in incontinence, urgency, or in frequency. 2. Microscopic sub-criteria of at least 100,000 (colonies) of no more than two species of microorganisms in a urine sample. Review of the McGeer Criteria for Long Term Surveillance Definitions for Infections for bronchitis showed three criteria must be present: 1. Interpretation of chest radiograph (x-ray) not performed or negative results for pneumonia or new infiltrates, 2. At least two of the following respiratory sub-criteria: a. New or increased cough; b. New or increased sputum production, c. Oxygen saturation less than 94% on room air or a reduction in oxygen saturation of greater than 3% from baseline; d. New or changed lung examination abnormalities; e. Pleuritic chest pain; f. Respiratory rate of or greater than 25 breaths per minute. 3. At least one of the constitutional criteria Review of the McGeer Criteria for Long Term Surveillance Definitions for Infections for Pneumonia showed the resident must have a chest x-ray demonstrating pneumonia or a new infiltrate and must have at least one of the	F 881	other residents were affected by deficient practice. Facility hired a contracted Consultant Infectious Disease physician that can be utilized for any questions regarding infections and the use of antibiotics. Facility employs two trained Infection Control Preventionists that review each resident suspected of having an infection. Contracted Nurse Consultant will be meeting with ICP's on June 27, 2019 to review infections, MCGreer Criteria and facility best practices. Facility will be sending Infection Preventionists to California Statewide Infection Prevention Conference on October 22 & 23, 2019. Unit Manager will notify the ICP of suspected infection for review. ICP then utilizes the McGeer Criteria to determine if antibiotic use follows McGeer's Criteria. Facility will	

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F 881	Continued From page 49 following, 1. New or increased cough; 2. Oxygen saturation less than 94 percent, pleuritic chest pain; 3. Fever; 4. New or increased sputum production; 5. New or changed lung exam abnormalities; 6. Respiratory rate greater than 25 per minute; 7. At least one of the constitutional criteria (see table for Constitutional Criteria). On 5/16/19 at 1058 and at 1415 hours, an interview and concurrent facility document review was conducted with the DSD who was also the facility's Infection Control Preventionist (ICP). The ICP stated the facility utilized McGeer's Criteria for residents who were suspected of having an infection and for residents who were prescribed antibiotics to determine if a true infection exists. The ICP stated if a resident did not meet McGeer's Criteria, the nurse was to call and inform the physician. When asked how she was monitoring for antibiotic stewardship, the ICP stated she would go to each nurses' station and review a log for antibiotic use, and review each resident's medical record and determine if the antibiotic use followed McGeer's criteria. Then she would use this information to complete the line listing for reporting. A review of January and February 2019 Infection Control Surveillance Logs were reviewed with the ICP using the surveillance monitoring tool. The ICP verified Residents 30, 101, and C's conditions did not meet McGeer's Criteria as infections and the facility did not notify the physician of these findings.	F 881	notify physician of any potential concerns with the use of antibiotic, and document conversation in the clinical file. Facility IDT conducts Infection Control meeting on a monthly basis. Each resident on an antibiotic is discussed at the meeting. Facility Antibiotic Stewardship Committee meets on a quarterly basis. Contracted Infectious Disease physician participates in quarterly meeting. ICP will inservice licensed nurses to the McGeer's Criteria and the Unit Managers of their responsibility of notifying ICP of any suspected infection on June 14, 2019. Facility will utilize SNFQAPI to monitor on a monthly basis through the continuous quality improvement process. Administrator is responsible for monitoring the SNFQAPI program.	