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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard (Complaint) survey was conducted 06/01/21 through 06/03/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Six complaints were investigated during the survey, VA00051869, VA00050271, VA00050388, VA00050020, VA00050667 and VA00051590. The census in this 102 certified bed facility was 97 at the time of the survey. The survey sample consisted of 2 current Resident reviews (Residents 1 through 2) and 5 closed record reviews (Residents 3 through 7).	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to follow professional standards of practice for transcribing physician directives into orders in the electronic clinical record, obtain weekly weights and assure the administration of a blood pressure medication for 3 of 7 residents in the survey sample, Resident #5, Resident #2 and Resident #6. The findings included: 1. Resident # 5 was admitted to the facility on	F 658	1. Residents #5, #2, and #6 no longer reside at the facility. 2. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and nurse management team conducted a review of orders of the admissions/readmissions for the past 30 days to verify orders were accurately transcribed and reviewed by physician. Discrepancies were immediately corrected in respective resident medical records, and MD was immediately	7/13/21

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

Electronically Signed | 06/25/2021

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F 658	Continued From page 1 1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis, Osteoporosis and Cerebral Vascular Accident. The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making. Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part, as follows: Medications: Home Medication List at Time of Discharge Take these medications: Vimpat 200 MG (milligram) tablet Generic drug: lacosamide 1 tablet, Oral 2 times a day Other Instructions: Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants. Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted. Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day	F 658	notified. Consultant recommendations were reviewed by the DON on Monday, 06/07/2021 to verify communication to the physician, orders obtained, or documentation of rationale of the decline. 3. On 06/04/2021 and on 06/07/2021, the DON/Designee educated nurses on conducting thorough review of admission orders, hospital discharge orders, reviewing discrepancies and clarifying orders with physician, entering orders into the medical record, then reconciling discharge orders against orders entered the medical record for each admission/readmission to verify orders have been accurately transcribed. The DON/Designee also educated nurses on reviewing consultant physicians other clinical service consultant recommendations (e.g. dietician, pharmacy consultants), communicating recommendations to the physician and obtaining orders. The DON/Designee will review records of each admission/readmission at next clinical morning meeting to verify discharge orders have been reconciled, discrepancies clarified and accurately transcribed. 4. The DON/Designee will review consultant recommendations to verify they have been communicated to the physician and resulting orders five days per week for two week, then random audits of 10	

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F 658	Continued From page 2 noted. Resident #5's Medication Reconciliation dated and locked on 1/9/21 at 8:54 P.M. by LPN (Licensed Practical Nurse) #5 was reviewed and is documented in part, as follows: Section A: 1. Complete medication reconciliation utilizing the following data sources (check all that apply); 1. History and Physical 2. Discharge Summary. Section B: 1. List Medications needing clarification: No Medication Issues Identified. Section C: Physician Contact 1. Physician Name-Blank 2. Date and Time Physician contacted-Blank 3. Physician contacted via-Blank On 6/3/21 at 10:15 A.M. a phone interview was conducted with LPN #5 regarding Resident #5's admission orders. LPN #5 was asked to to explain the process for transcribing admission orders. LPN #5 stated, "When I get the discharge summary from the hospital, I verify the orders with the medical doctor on call. Then I put the orders into the computer and send them to the pharmacy." On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, "Every morning during stand up meetings, with the Interdisciplinary team (IDT), new admissions are	F 658	consultant recommendations per week for four weeks, then 10 recommendations per month for two months or until resolved. The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved. 5. Date of Compliance: 07/13/2021	

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discussed and the 24 hour report also reveals important information. From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders. By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem."

The facility policy titled "4.1 Physician/Prescriber Authorization and Communication of orders to Pharmacy" last revised 10/1/18.

8. Facility should reconcile transfer/transition and admission orders before they are communicated to Pharmacy.
9. Facility should verify transfer/transition and admission orders with the resident's physician/prescriber before they are communicated to the pharmacy.

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F 658	Continued From page 4 9.1 Once admission orders are verified, staff should promptly transmit medication orders to the Pharmacy. On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM(Administrative Staff member) #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared. 2. The facility staff failed to follow their standard of practice to implement the hospital's orders for medications, as indicated in the hospital discharge summary for Resident #2. The resident was to continue Metoprolol for the treatment of high blood pressure upon admission to the nursing facility. Resident #2 was admitted to the nursing facility on 5/12/21 for skilled services due to status post fracture of left ankle. The resident was admitted with a diagnosis of high blood pressure. The Admission Minimum Data Set (MDS) assessment dated 5/18/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated she possessed independent and intact cognitive skills for daily decision making. The General Discharge Summary dated 5/10/21 identified metoprolol 75 milligram (mg) by mouth (po) as one of the medications the resident was taking daily in the hospital prior to her admission to the nursing facility. According to the General Discharge Summary, Metoprolol was to continue as a scheduled daily medication for the treatment and control of high blood pressure.	F 658		

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Upon review of the Medication Administration Records (MAR), Resident #2 was not started on the Metoprolol upon admission until 5/18/21. There were no physician orders, nurse practitioner (NP) orders nor entries in the nurse's notes to indicate that the medication was on hold.

On 6/1/21 at approximately 12:15 p.m., Resident #2 was interviewed to say she took Metoprolol as a long standing medication for years and questioned the nurse about why she was not taking the medication when she was first admitted to the nursing facility. She said, "It finally got on board."

On 6/3/21 at 5:00 p.m., according to the Unit Manager, Licensed Practical Nurse (LPN #2) the resident missed 5 or 6 days of Metoprolol from 5/12-17/21. She stated it was standard practice that the Interdisciplinary Team (IDT) review new admissions during their stand-up meetings, reviews all hospital discharge medications and verify's all orders. She said she spoke to the NP to determine if the medication was held for low blood pressure readings, but she could not recall if that was the case and there was no documentation to support holding the medication. LPN #2 stated, "We missed this medications for several days. No one knows how we discovered it was missed, but I am happy her blood pressure readings were okay until the medication was re-started here."

On 6/3/21 at approximately 6:30 p.m. during the debriefing, with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services, no further information was provided regarding the aforementioned issue.

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According to the facility's policy and procedures titled Administering Medications dated as revised on 4/2019, medications are administered in accordance with prescriber's orders, including any required time frame.

3. The facility staff failed to obtain weekly weights as recommended by the Registered Dietitian (RD.) Resident #6 was originally admitted to the nursing facility on 10/19/19.

Diagnosis for Resident #6 included but not limited to morbid obesity. Resident #6 Minimum Data Set (MDS) an annual assessment with an Assessment Reference Date of 09/01/20 coded Resident # 6 Brief Interview for Mental Status (BIMS) score of 08 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #6 total dependence of two with personal hygiene, total dependence of one with bathing and dressing, extensive assistance of two with bed mobility and toilet use and supervision with eating for Activities of Daily Living care.

Resident #6's person centered care plan with a revision date 09/03/20 documented a problem which read; has a nutritional problem or potential nutritional problem related to hypertension, anxiety, depression and obesity. The goal: will maintain adequate nutritional status as evidenced by maintaining weight, no signs or symptoms of malnutrition and consuming at least (50%) of meals daily. Some of the interventions to manage goal: Registered Dietitian (RD) to evaluate and make diet change recommendations as needed and obtain and monitor lab/diagnostic work as ordered and report results to the physician for follow up as indicated.

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The care plan also include a desired weight loss due to morbid obesity. The goal is to consume at least 50% of meals through 09/03/20 and will maintain a slow and steady weight loss. Some of the interventions to manage goal is to obtain labs as ordered and report results to the physician and ensure the dietitian is aware, monitor and evaluate any weight loss.

A phone interview was conducted with the RD on 06/02/21 at approximately 4:39 p.m. She said Resident #6's weight loss started off as a desired weight loss due to the possibility of having weight loss surgery. She said Resident #6 started pocketing food and her meal consumption was less than 50%. She said Resident #6 was seen on 10/19/20 with the recommendation to start weekly weights; there should have been a weight obtained on 10/22/20 and 10/29/20.

Review of the RD note written on 10/19/20 included the following information: There is a history of desired weight loss; however, this is a change with Resident #6 with swallowing issues. The following recommendation is made: monitor intake and weekly weights. During the review of Resident #6's weight summary revealed the last weight was obtained on 10/15/20 @ 256.2 lbs.

A phone interview was conducted with the Assistant Director of Nursing (ADON) on 06/03/21 at approximately 3:37 p.m. She stated, "I saw where the dietitian recommended weekly weights for Resident #6 starting on 10/19/20 but it was never taken off, transcribed and the weight was never done." The ADON was asked "What is the purpose for getting weekly weights" she replied, "To monitor for stabilization." She said the staff should have notified the physician , got

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F 658	Continued From page 8 an order for weekly weights, put the order in Point Click Care (PCC), obtain and documented the weights in Resident #6's clinical record. The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/03/21 at approximately 4:45 p.m. The facility did not present any further information about the findings. The facility's policy titled: Weighing the Resident with a revision date of (09/05/17.) Policy: Resident of the facility shall be weighed upon admission and monthly and as needed unless ordered otherwise by the physician. Procedure include but not limited: -Weights will be completed as indicated and documented in the clinical record.	F 658		
	COMPLAINT DEFICIENCY			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		7/13/21

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F 661	Continued From page 9 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and a complaint investigation the facility staff failed to make the necessary Post-Discharge medical services for continued care for one resident (Resident #4) in the survey sample of 7 residents upon discharge home. The findings included: Resident #4 was admitted to the facility on 01/16/21 and discharged on 02/25/21. Diagnoses for this resident included Metabolic Encephalopathy, history of COVID-19, fracture of right femur, muscle weakness, acute kidney failure, EOTH, anemia, unilateral Inguinal hernia, hypontremia, and dementia with behavioral disturbance. An Admission's Minimum Data Set (MDS) dated 1/22/21 assessed this resident in the area of Cognitive Impairment as scoring a (3) on the Brief	F 661	1. Resident #4 no longer resides at the facility. 2. Current residents have the potential to be affected. On 06/22/2021, reviews were conducted of current discharging resident's Discharge Summaries to ensure that Post-Discharge medical services were identified and arranged prior to respective discharges. 3. On 06/21/2021, Social Services Director and Assistant were educated by the Executive Director on policies and procedures related to Discharge Planning, and specifically related to the arrangement of Post-Discharge medical services. Social Services will review discharge plans including follow up appointments,	

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F 661	Continued From page 10 Interview for Mental Status (BIMS). In the area of Activity's for Daily Living (ADL'S) this resident was assessed as requiring one staff physical assistants with bed mobility, in the area of dressing this resident was coded as a (2/3) requiring one person physical assist. In the area of toileting and personal hygiene this resident was coded as requiring extensive assist. A Care Plan dated 1/28/21 indicated: Focus- Resident #4 plan to return to home where he lives with his wife. Referral to home health will be made according to his discharge needs. Goal- Resident #4's wife will be able to verbalize/communicate required assistance post-discharge and the services required to meet needs before discharge. Interventions- Establish a pre-discharge plan with Resident #4's wife/care givers and evaluate progress and revise plan as needed. Evaluate/record Resident #4's abilities and strengths, with representative/care givers/IDT. Determine gaps in abilities which will affect discharge. Address gaps by community referrals to needed agencies/disciplines. Resident #4 is able to (Specify communicate/describe needs, book appointments, ADL's, housekeeping, communication) on discharge to community. A hospital discharge summary dated 01/16/21 indicated: "Discharge Diagnosis: Large right inguinal hernia." "Hospital Course: Patient also was found to have large right inguinal hernia on CT, will follow with general surgery outpatient. Patient feels better and stable to be discharged to SNF to follow-up with his primary care physician, orthopedic, urology and general surgery outpatient." "Large right inguinal hernia-No	F 661	services, and equipment five times per week in daily clinical review meeting to ensure they are in place on the day of discharge. 4. Audit of Discharge Summaries and the arrangement of Post-Discharge medical services therein to be performed by the Executive Director weekly times six weeks then monthly for three months. He will report findings of reviews to the Quality Performance Improvement Committee monthly for three months or until resolved. 5. Date of Compliance: 07/13/2021	

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abdominal/inguinal pain Follow with general surgery outpatient."

A hospital history and physical dated 01/19/21 indicated: "Patient was found to have a large right inguinal hernia on CT and is to follow up with general surgery as an outpatient."

A nursing note dated 01/18/21 indicated: "Foley catheter patient with amber colored, noted to have large Rt. sided Inguinal Hernia. Requires extensive to total assist of 1-2 staff for the completion of ADL care."

A Nursing Note dated 02/24/21 indicated:
"Discharge summary: patient was recently seen for COVID 19 and sent here for progressive weakness and the need for inpatient therapy. Patient had a Foley which we removed during his stay but was recently reinserted by urologist and he will follow it on discharge. Resident denies chest pain, denies shortness of breath, denies abdominal pain, denies nausea or vomiting. Diagnoses include metabolic encephalopathy, COVID 19, hyponatremia, urinary trac infection, right hip fracture, alcohol abuse, inguinal hernia, medication see mar (medication administration record), exam alert oriented x 3 white male no acute distress. Normocephalic lungs are clear heart sounds are normal, abdomen is soft non tender Foley in place.
Assessment/Plan:
severe sepsis-resolved COVID 19, aki-monitor dementia, right hip fracture: s/p nailing therapy while inpatient, follow up outpatient surgery for hernia.
Follow up with pcp with in 2 weeks take medications as prescribed sending home with wheelchair due to inability to stand for long

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F 661	Continued From page 12 periods and tend to ADL's. Patient can propel himself freely through out the house on the first floor with a wheelchair. Will be discharging home to wife, home health pt/ot/sn/sw/aide eval and treat. Home health to follow Foley catheter care and change q month." During an interview at 9:23 a.m. on 06/03/21 with Resident #4's wife, she stated, "The facility never scheduled follow-up care hernia surgery." A review of the clinical records did not indicate that Resident #4 was provided with a physician's order for hernia surgery upon discharge from the facility. There was indication that arrangements were made for Resident #4's follow up care and post-discharge medical services. During an interview on 06/03/21 at 10:17 a.m. with the Director of nursing, she stated, Resident #4 was not given a prescription for hernia surgery by the discharging physician nor were arrangements made for out patient hernia surgery for Resident #4.	F 661		
F 711 SS=E	Complaint Deficiency Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress	F 711		7/13/21

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F 711	Continued From page 13 notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to ensure the Physician Review of Admission Orders based on the discharge summary was a reconciled/accurate for 3 of 7 residents in the survey sample in regards to a significant seizure medication, an anti-depressant and a anti-hypertensive, Resident #5, Resident #7 and Resident #2. The findings included: 1. Resident # 5 was admitted to the facility on 1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis, Osteoporosis and Cerebral Vascular Accident. Resident #5 was discharged from the facility on 1/17/21. The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making. Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part,	F 711	1. Residents #5, #7, and #2 no longer reside at the facility. 2. On 06/01/2021, the orders of the admissions/readmissions for the past 30 days were reviewed to verify orders were accurately transcribed. Discrepancies were clarified, and resulting new orders were obtained. 3. On 06/14/2021, the Executive Director and Director of Nursing (DON) educated physicians on conducting thorough reviews of admission/readmission orders to verify that hospital discharge orders are accurately transcribed and discrepancies clarified prior to signing. The DON/Designee will audit records of each admission/readmission on next clinical morning meeting to verify discharge orders have been reconciled, discrepancies clarified, and accurately transcribed. 4. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify that physician reconciliations have been completed within 72 hours, then randomly	

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F 711	Continued From page 14 as follows: Medications: Home Medication List at Time of Discharge Take these medications: Vimpat 200 MG (milligram) tablet Generic drug: lacosamide 1 tablet, Oral 2 times a day Other Instructions: Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants. Vimpat Medication Guide provide by OSM(Other Staff Member) #1 was reviewed and is documented in part, as follows: Vimpat is a prescription medicine (anticonvulsant) used to treat partial-onset seizures and with other medicines to treat primary generalized tonic-clonic seizures. What is the most important information I should know about VIMPAT?: DO not stop taking VIMPAT without first talking to your healthcare provider. Stopping VIMPAT suddenly can cause serious problems. Stopping seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus). How long does it take for Vimpat to kick in? After taking lacosamide, the highest blood levels are reached in 1 to 4 hours. It takes about 13 hours for the amount of medicine in the bloodstream to fall by at least 50%. This means that the medicine should be taken twice a day, about 12 hours apart.	F 711	audit five admissions/readmissions weekly for four weeks, then five admissions/readmissions per month for two months or until resolved. The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved. 5. Date of Compliance: 07/13/2021	

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Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.

Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.

Resident #5's Physician Medication Admit History and Physical dated 1/11/21 signed by ASM(Administrative Staff Member) #4 was reviewed and is documented in part, as follows:

History of Present Illness: The patient is a pleasant 56-year-old black female who has a history of seizure disorder.

Past Medical History: 12. Seizure Disorder

Medications: Medications have been reviewed. Please see MAR (Medication Administration Record).

Plan: Medications have been reviewed and signed.

On 6/2/21 at 5:00 P.M. a phone interview was conducted with ASM (Administrative Staff Member) #4 regarding Resident #5's anti-seizure medication Vimpat. ASM #4 was made aware that the medication was not transcribed from the discharge summary dated 1/8/21 and that Resident #5 had not received the Vimpat the entire facility stay. ASM #4 stated, "When I come

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in to see the patient I read over everything, the hospital records and the discharge summary then I go see the patient. I spend well over an hour with new admissions. If the Vimpat was on the discharge summary on the medication list, it should have been transcribed over. It shouldn't have happened, when I do admits I find lots of errors and correct them. This one got by me."

On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, "From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem."

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The facility policy titled "Medical Care/Standards of Practice" last revised 3/3/2021 was reviewed and is documented in part, a follows:

A physician supervises the medical care of each resident. Physician supervision includes, but is not limited to:
-Admission orders are consistent with the resident's current physical and mental status.
-Admission orders are verified on admission.

The attending physician will complete a history and physical on all residents as required by the applicable state law.
-The discharge summary completed by the physician at the time of discharge from the hospital may be used as the Admission history and physical provided the following conditions exist:
-The admitting physician verifies within 48 hours of admission to the Center the information is accurate and relevant and/or adds additional information as needed to update the discharge summary to reflect current resident status.

On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared.

2. For Resident #7 the facility staff failed to ensure the Physician Review of Admission Orders based on the discharge summary was accurate for an anti-depressant. As a result, Resident #7 received Zoloft/Sertraline for two days before the facility staff discontinued the

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medication.

Resident #7 was originally admitted to the facility on 04/05/21 and discharged on 04/13/2021 to the community. Diagnosis for Resident #7 included but not limited to Dysphagia, Oropharyngeal Phase, Unsteadiness on the Feet and Adult Failure to Thrive.

The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 4/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #7 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing and personal hygiene. Requiring set up help with eating. Requires limited assistance of one person with toileting. Requiring total dependence of one person with bathing.

The Care Plan Reads: Focus: Resident #7 is at risk for falls r/t (related/to) confusion. Goal: Minimize the risk of falls through next review date. (Director of Clinical Services, RN) Target Date: 04/24/2021 Minimize the side effects of medication(s) contributing to gait disturbance, balance disturbance, syncope, movement disorders; increasing the resident's fall risk will be reduced by the review date. Interventions: Ensure proper footwear, non-skid footwear. Ensure that the resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use

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it for assistance as needed.

The Physician order summary active orders as of 4/05/21 reads: Zoloft Tablet 25 MG Give 1 tablet by mouth in the evening related to adult failure to thrive. Order Date 4/05/21. Start Date 4/06/21.

A review of the MAR (Medication Administration Record) reveal that Resident #7 received 2 doses of Zoloft on 4/06/21 and 4/07/21 at 1700 (5:00 PM) before the medication was discontinued by the facility staff.

According to the MAR Zoloft 25 MG 1 Tablet by mouth in the evening was discontinued on 4/08/21 at 1521 (3:21 PM).

A review of the hospital discharge summary reads: STOP taking these medications: sertraline (ZOLOFT) 25 mg PO TABS. Comments: Reason for Stopping: Changed to Remeron.

A review of nursing notes dated 4/8/2021 at 15:15 (3:15 PM) reveal that Resident #7's daughter called and spoke with the DON (Director of Nursing/Admin. Staff #2) and with the unit managers regarding the list of the resident medications and requested for the Zoloft to be d/c (discontinued) and spoke with NP (Nurse Practitioner) to d/c the Zoloft per family request, per NP the medication was d/c'd.
Review of progress notes show 4/05/21- LPN (Licensed Practical Nurse) #7 received a drug (s) interaction warning on 4/5/2021 20:18 (8:18 PM).

The system has identified a possible drug interaction with the following orders: Zoloft Tablet 25 MG. Give 1 tablet by mouth in the evening related to ADULT FAILURE TO THRIVE (R62.7).

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Severity: Severe. Interaction: Additive serotonergic effects may occur during co administration of selective serotonin reuptake inhibitors (SSRIs) and Mirtazapine Tablet 7.5MG, and the risk of developing serotonin syndrome may be increased.

A review of progress notes reveal: 4/5/2021 20:18 Orders Progress Note Note Text: The order you have entered Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime related to ADULT FAILURE TO THRIVE.
Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction.

A review of the hospital clinical record reads: Prior to starting Remeron he (Resident #7 was on low-dose Zoloft which was discontinued.

Current Discharge Medication List reads: Stop taking these medications: Sertraline/Zoloft 25 MG. Comments: Reason for stopping: Changed to Remeron.

A review of the hospital medication administration record reveal that Sertraline/Zoloft 25 mg was ordered on 3/24/21 and discontinued on 3/27/21.

A review of the facility discharge prescriptions show no copy of Zoloft/Sertraline.

On 6/02/21 at approximately 4:35 PM., an interview was conducted with the OSM (Other Staff Member) #5 concerning Resident #7. She stated, ASM (Administrative Staff Member) #4 does the initial H&P (History and Physical). He was given Remeron to help pick up his eating. Even if he had the Zoloft for two days it's a low dose antidepressant that stays in the system for 2

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days. He was on Remeron to increase his appetite. He should have not been on Zoloft at all."

On 6/03/21 an interview was conducted with LPN (Licensed Practical Nurse) #7 at approximately 10:30 AM., concerning Resident #7. He stated, "I don't remember the resident." He was asked by the surveyor to explain flags on new admissions. He stated, "On new admissions it flags on the doctor if there is a black box warning. That goes on the 24 hour report. You have to get the meds verified by the doctor. No issues. When they are discharged we print out the prescriptions. Most discharged paper work is done by Social services.

An interview was conducted on 6/03/21 at approximately 12:20 PM with OSM #1 concerning Resident #7 being prescribed Zoloft and Remeron due to the black box warning. He stated, "Remeron helps with depression and sleep. They gave the Zoloft for a few days and stopped it! His discharge summary from the hospital reads on 4/05/21 it says stop taking Zoloft change to remeron. They missed the fact it was to be changed. It appears they should have stopped it. They were suppose to change from Zoloft to remeron.

On 6/03/21 at approximately 2:50 PM an interview was conducted with ASM #2 concerning Resident #7. She stated, "It was discontinued at the hospital. I got the NP (Nurse Practitioner) to discontinue the Zoloft. Per family request. Basically, on the discharge summary it stated to discontinue. It should have never been placed on there (the medication/Zoloft listed on the discharge summary)."

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On 6/03/21 at 5:00 PM a returned phone call was received from OSM #1 concerning Resident #7. He stated, the medication was already discontinued before I got there. It was missed by the admissions pharmacist. It said pretty clearly to stop the drug and they didn't."

On 6/03/21 at approximately 5:10 PM an interview was conducted with ASM #4 concerning Resident #7. When they (residents) come from the hospital. I verify the medications, go through the discharge summary. The nurses could have made a mistake and given it. Sometimes errors come from the hospital."

On 6/03/21 at approximately 5:21 PM an interview was conducted with ASM #1, ASM #2 and Corporate staff #1 concerning Resident #7's allegations. No questions were voiced.

On 6/03/21 at approximately 5:30 PM a return phone call was made from Others Staff Member #1(OSM/Pharmacist) concerning Resident #7. He stated, "When I visited the facility on 4/22/21 he was already discharged. The previous pharmacist did not have access to PCC (Point Click Care) at the time. She was doing a review based on limited information."

On 6/03/21 A phone call was made at 5:34 PM to the previous pharmacist mentioned in question by OSM #1. A voice message was left. No return phone call was received by surveyor.

On 6/03/21 at approximately 6:50 PM during the exit conference the Administrative Staff Members were asked to explain the admissions summary process concerning medications for a resident

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being admitted to their facility from the hospital. The ASM #2 stated, " When they come in with the admissions summary we will call the doctor or Nurse Practitioner to verify medications on the discharge summary and also they verify medications and diagnoses through the doctor as well. He will take 72 hours to review medications. We review new meds in the morning meeting and the doctor comes in within 48 hours to review the discharge summary."

On 6/03/21 at approximately 4:00 PM an email was sent to the facility Administrator asking him to email the following policies: Medication administration procedures. Significant medication errors and unnecessary medications.
None of the above policies were received.

Serotonin syndrome symptoms often begin hours after you take a new medication that affects your serotonin levels or after you raise your dose of a current drug. Symptoms may include: Confusion, Agitation or restlessness, Dilated pupils, Headache, Nausea, Vomiting, digestive disorders, digestive disorders, diarrhea, Loss of muscle control or twitching. In severe cases, serotonin syndrome can be life-threatening. Call 911 or go to the emergency room if you have any of these symptoms: High fever, Seizures, Uneven heartbeat, Passing out.
Serotonin Syndrome Causes and Risk Factors: Medications usually cause serotonin syndrome, especially certain antidepressants. You might be at higher risk if you take two or more drugs and/or supplements
<https://www.webmd.com/vitamins-and-supplements/lifestyle guide that affect your serotonin levels.
Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed class of

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antidepressants. They work by raising your serotonin levels. These drugs include: Sertraline/Zoloft. https://www.webmd.com/drugs/mono-8095-SERTRALINE+-+ORAL.aspx?drugid=35&drugname=zoloft+oral>) . https://www.webmd.com/depression/guide/serotonin-syndrome-causes-symptoms-treatments.
3. Resident #2's attending physician failed to include in the review of the total program of care to include reconciliation of all medications to be continued from the hospital, namely metoprolol for management of hypertension (high blood pressure).

Resident #2 was admitted to the nursing facility on 5/12/21 for skilled services due to status post fracture of left ankle. The resident was admitted with a diagnosis of high blood pressure.

The Admission Minimum Data Set (MDS) assessment dated 5/18/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated she possessed independent and intact cognitive skills for daily decision making. Resident #2 was not assessed for hypertension as an active diagnosis.

The General Discharge Summary dated 5/10/21 identified metoprolol 75 milligram (mg) by mouth (po) as one of the medications the resident was taking daily in the hospital prior to her admission to the nursing facility. According to the General Discharge Summary, Metoprolol was to continue as a scheduled daily medication for the treatment and control of high blood pressure.

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On 6/3/21 at 5:00 p.m., according to the Unit Manager, Licensed Practical Nurse (LPN #2) the resident missed 5 or 6 days of Metoprolol from 5/12-17/21. She stated the physician visits within 24-48 hours of a resident's admission, reconciles all medications with the hospital discharge summary's list of medications to make sure a continued flow of administered medications from the hospital. LPN #2 stated that they physician ordered the medication on 5/18/21, She said, "We missed this medications for several days. No one knows how we discovered it was missed, but I am happy her blood pressure readings were okay until the medication was re-started here."

On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "Every morning during stand up meetings, with the Interdisciplinary team (IDT), new admissions are discussed and the 24 hour report also reveals important information. From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders." It was determined the metoprolol was missed by the physician.

On 6/3/21 at approximately 6:30 p.m. during the debriefing, with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services, no further information was provided regarding the aforementioned issue.

COMPLAINT DEFICIENCY

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F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		7/13/21

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F 756	Continued From page 27 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: 3. The facility staff failed to reconcile and ensure accuracy of medications based on the hospital's discharge summary within 72 hours of admission to the nursing facility for Resident #2. Resident #2 was admitted to the nursing facility on 5/12/21 for skilled services due to status post fracture of left ankle. The resident was admitted with a diagnosis of high blood pressure. The Admission Minimum Data Set (MDS) assessment dated 5/18/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated she possessed independent and intact cognitive skills for daily decision making. Resident #2 was not assessed for hypertension as an active diagnosis. The General Discharge Summary dated 5/10/21 identified metoprolol 75 milligram (mg) by mouth (po) as one of the medications the resident was taking daily in the hospital prior to her admission to the nursing facility. According to the General Discharge Summary, Metoprolol was to continue as a scheduled daily medication for the treatment and control of high blood pressure. On 6/3/21 at 5:00 p.m., according to the Unit Manager, Licensed Practical Nurse (LPN #2) the resident missed 5 or 6 days of metoprolol from 5/12-17/21. She stated the pharmacy ensures all medications for the new admissions are reviewed reconciled and accurate within 72 hours of their admission, but it was not recognized the	F 756	1. Resident #7 no longer resides at the facility. 2. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and the nurse management team conducted an audit of the records of new admits/readmits within the last 30 days. Discrepancies were immediately corrected in respective resident medical records, and MD was immediately notified. No outstanding pharmacy reviews were noted. 3. On 06/10/2021, the pharmacy consultant was educated by the DON related to policy and procedure for completing review of orders on admissions/readmissions, ensuring accuracy and completeness within 72 hours. 4. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify that pharmacy reviews have ben completed, recommendations have been communicated to the physician, and that subsequent orders have been entered into the medical record. Random audits of five admissions/readmissions weekly for four weeks will then be conducted followed by another audit of five admissions per month for two months or until resolved.	

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metoprolol was not continued from the hospital. LPN #2 stated that they physician ordered the medication on 5/18/21, She said, "We missed this medications for several days. No one knows how we discovered it was missed, but I am happy her blood pressure readings were okay until the medication was re-started here."

On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, " By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents." It was determined that the pharmacy review failed to identify the metoprolol was not continued based on the discharge medication list.

On 6/3/21 at approximately 6:30 p.m. during the debriefing, with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services, no further information was provided regarding the aforementioned issue. Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to ensure a 72 hour new admission pharmacy review based on the discharge summary was reconciled/accurate for 3 of 7 residents in the survey sample in regards to a significant seizure medication, an anti-depressant and a anti-hypertensive, Resident #5, Resident #7, and Resident #2.

The findings included:

1. Resident # 5 was admitted to the facility on 1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis,

The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved.

5. Date of Compliance: 07/13/2021

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Osteoporosis and Cerebral Vascular Accident. Resident #5 was discharged from the facility on 1/17/21.

The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making.

Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part, as follows:

Medications: Home Medication List at Time of Discharge
Take these medications:

Vimpat 200 MG (milligram) tablet
Generic drug: lacosamide
1 tablet, Oral 2 times a day

Other Instructions:
Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants.

Vimpat Medication Guide provide by OSM(Other Staff Member) #1 was reviewed and is documented in part, as follows:

Vimpat is a prescription medicine (anticonvulsant) used to treat partial-onset seizures and with other medicines to treat primary generalized tonic-clonic seizures.

What is the most important information I should

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know about VIMPAT?: DO not stop taking VIMPAT without first talking to your healthcare provider. Stopping VIMPAT suddenly can cause serious problems. Stopping seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).

How long does it take for Vimpat to kick in? After taking lacosamide, the highest blood levels are reached in 1 to 4 hours. It takes about 13 hours for the amount of medicine in the bloodstream to fall by at least 50%. This means that the medicine should be taken twice a day, about 12 hours apart.

Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.

Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.

Resident #5's Progress Noted dated 1/13/21 was reviewed and is documented in part, as follows:

1/13/2021 14:45 Pharmacy Consultant Note Text: This resident ' s medical record including electronic documentation was reviewed on this date. See report for any noted irregularities and/or recommendations. Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgment that at such time, the resident's medication

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regimen contained no new irregularities (as defined in SOM Appendix PP 483.60(c)). For purposes of the foregoing statement, the term "irregularity" means an event or circumstance that is substantially inconsistent with customary, accepted clinical approaches to providing pharmaceutical products and services, or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes.

On 6/2/20 at 7:48 P.M. a phone interview was conducted with OSM(Other Staff Member) #1 regarding the medication Vimpat for Resident #5. OSM #1 stated, "I wasn't the pharmacist for this facility them, however I have access to see what was found on the 72 hour new admission pharmacy reconciliation for the resident. The discharge summary was in the system on 1/9/21 and it was reviewed by the pharmacist on 1/13/21. I see on the discharge summary the resident should have been on Keppra, Clobazam and Vimpat. I see where no errors were found by the pharmacist. I do see on the discharge summary the Vimpat was the second to last medication. It appears to me it was missed by the review."

On 6/3/21 at 2:30 P.M. a phone interview was conducted with the ASM #2 regarding Resident #5 not receiving Vimpat while a resident in the facility. The ASM #2 stated, "It was a situation that should not have happened. It should have been caught earlier, multiple people and hands here missed it. We need to pay more close attention."

On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON),

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the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, " By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem."

On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared.

2. For Resident #7, the facility staff failed to ensure a 72 hour new admission pharmacy review based on the discharge summary was reconciled/accurate for Resident #7 in regards to a significant anti-depressant.

Resident #7 was originally admitted to the facility

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on 04/05/21 and discharged on 04/13/2021 to the community. Diagnosis for Resident #7 included but not limited to Dysphagia, Oropharyngeal Phase, Unsteadiness on the Feet and Adult Failure to Thrive.

The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 4/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #X cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing and personal hygiene. Requiring set up help with eating. Requires limited assistance of one person with toileting. Requiring total dependence of one person with bathing.

The Care Plan Reads: Focus: Resident #7 is at risk for falls r/t (related/to) confusion. Goal: Minimize the risk of falls through next review date. (Director of Clinical Services, RN) Target Date: 04/24/2021 Minimize the side effects of medication(s) contributing to gait disturbance, balance disturbance, syncope, movement disorders; increasing the resident's fall risk will be reduced by the review date. Interventions: Ensure proper footwear, non-skid footwear. Ensure that the resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.

The Physician order summary active orders as of

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4/05/21 reads: Zoloft Tablet 25 MG Give 1 tablet by mouth in the evening related to adult failure to thrive. Order Date 4/05/21. Start Date 4/06/21.

A review of the MAR (Medication Administration Record show that Resident #7 received 2 doses of Zoloft on 4/06/21 and 4/07/21 at 1700 (5:00 PM).
According to the MAR Zoloft 25 MG 1 Tablet by mouth in the evening was discontinued on 4/08/21 at 1521 (3:21 PM).

A review of the hospital discharge summary reads: STOP taking these medications: sertraline (ZOLOFT) 25 mg PO TABS. Comments: Reason for Stopping: Changed to Remeron.

A review of the hospital clinical discharge notes dated 4/05/21 reads: Prior to starting Remeron he was on low-dose Zoloft which was discontinued.

Current Discharge Medication List dated 4/05/21 reads: Stop taking these medications: Sertraline/Zoloft 25 MG. Comments: Reason for stopping: Changed to Remeron.

A review of the hospital medication administration record reveal that Sertraline/Zoloft 25 mg was ordered on 3/24/21 and discontinued on 3/27/21.

A review of the facility discharge prescriptions show no printed copy of Zoloft/Sertraline was given at discharge on 4/13/21.

A review of nursing notes dated 4/8/2021 at 15:15 (3:15 PM) reveal that Resident #7's daughter called and spoke with the DON (Director of Nursing/Admin. Staff #2) and with the unit managers regarding the list of the resident

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medications and requested for the Zoloft to be d/c (discontinued) and spoke with NP (Nurse Practitioner) to d/c the Zoloft per family request, per NP the medication was d/c'd.

A Review of progress notes show on 4/05/21 that LPN (Licensed Practical Nurse) #7 received a drug (s) interaction warning on 4/5/2021 20:18 (8:18 PM).
The system has identified a possible drug interaction with the following orders: Zoloft Tablet 25 MG. Give 1 tablet by mouth in the evening related to ADULT FAILURE TO THRIVE (R62.7).
Severity: Severe
Interaction: Additive serotonergic effects may occur during co administration of selective serotonin reuptake inhibitors (SSRIs) and Mirtazapine Tablet 7.5MG, and the risk of developing serotonin syndrome may be increased.

On 6/02/21 at approximately 4:35 PM., an interview was conducted with the OSM (Other Staff Member) #5 concerning Resident #7. She stated, ASM (Administrative Staff Member) #4 does the initial H&P (History and Physical). He was given Remeron to help pick up his eating. Even if he had the Zoloft for two days it's a low dose antidepressant that stays in the system for 2 days. He was on Remeron to increase his appetite. He should have not been on Zoloft at all."

On 6/03/21 an interview was conducted with LPN (Licensed Practical Nurse) #7 at approximately 10:30 AM., concerning Resident #7. He stated, "I don't remember the resident." He was asked by the surveyor to explain flags on new admissions. He stated, "On new admissions it flags on the

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doctor if there is a black box warning. That goes on the 24 hour report. You have to get the meds verified by the doctor. No issues. When they are discharged we print out the prescriptions. Most discharged paper work is done by Social services.

An interview was conducted on 6/03/21 at approximately 12:20 PM with OSM #1 concerning Resident #7 being prescribed Zoloft and Remeron due to the black box warning. He stated, "Remeron helps with depression and sleep. They gave the Zoloft for a few days and stopped it! His discharge summary from the hospital reads on 4/05/21 it says stop taking Zoloft change to remeron. They missed the fact it was to be changed. It appears they should have stopped it. They were suppose to change from Zoloft to remeron.

On 6/03/21 at approximately 2:50 PM an interview was conducted with ASM #2 concerning Resident #7. She stated, "It was discontinued at the hospital. I got the NP (Nurse Practitioner) to discontinue the Zoloft. Per family request. Basically, on the discharge summary it stated to discontinue. It should have never been placed on there. (the medication/Zoloft listed on the discharge summary)."

On 6/03/21 at 5:00 PM a returned phone call was received from OSM #1 concerning Resident #7. He stated, the medication was already discontinued before I got there. It was missed by the admissions pharmacist. It said pretty clearly to stop the drug and they didn't."

On 6/03/21 at approximately 5:10 PM an interview was conducted with ASM #4 concerning

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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 756	Continued From page 37	F 756		

Resident #7. When they (residents) come from the hospital. I verify the medications, go through the discharge summary. The nurses could have made a mistake and given it. Sometimes errors come from the hospital."
On 6/03/21 at approximately 5:21 PM an interview was conducted with ASM #1, ASM #2 and Corporate staff #1 concerning Resident #7's allegations. No questions were voiced.

On 6/03/21 at approximately 5:30 PM a return phone call was made from Others Staff Member #1(OSM/Pharmacist) concerning Resident #7. He stated, "When I visited the facility on 4/22/21 he was already discharged. The previous pharmacist did not have access to PCC (Point Click Care) at the time. She was doing a review based on limited information.

On 6/03/21 A phone call was made at 5:34 PM to the previous pharmacist mentioned in question by OSM #1. A voice message was left. No return phone call was received from the pharmacist mentioned above.

On 6/03/21 at approximately 6:50 PM during the exit conference the Administrative Staff Members were asked to explain the admissions summary process concerning medications for a resident being admitted to their facility from the hospital. The ASM #2 stated, " When they come in with the admissions summary we will call the doctor or Nurse Practitioner to verify medications on the discharge summary and also they verify medications and diagnoses through the doctor as well. He will take 72 hours to review medications. We review new meds in the morning meeting and the doctor comes in within 48 hours to review the discharge summary."

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F 756	Continued From page 38	F 756		

On 6/03/21 at approximately 4:00 PM an email was sent to the facility Administrator asking him to email the following policies: Medication administration procedures. Significant medication errors and unnecessary medications.
None of the above policies were received.

Serotonin syndrome symptoms often begin hours after you take a new medication that affects your serotonin levels or after you raise your dose of a current drug. Symptoms may include: Confusion, Agitation or restlessness, Dilated pupils, Headache, Nausea, Vomiting, digestive disorders, digestive disorders, diarrhea, Loss of muscle control or twitching. In severe cases, serotonin syndrome can be life-threatening. Call 911 or go to the emergency room if you have any of these symptoms: High fever,Seizures, Uneven heartbeat,Passing out.
Serotonin Syndrome Causes and Risk Factors: Medications usually cause serotonin syndrome, especially certain antidepressants. You might be at higher risk if you take two or more drugs and/or supplements <https://www.webmd.com/vitamins-and-supplements/lifestyle guide that affect your serotonin levels. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed class of antidepressants. They work by raising your serotonin levels. These drugs include: Sertraline/Zoloft. https://www.webmd.com/drugs/mono-8095-SERTRALINE+-+ORAL.aspx?drugid=35&drugname=zoloft+oral>) . https://www.webmd.com/depression/guide/serotonin-syndrome-causes-symptoms-treatments.

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F 758	Continued From page 39	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		7/13/21

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F 758	Continued From page 40 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 staff interview and clinical record review, the facility staff failed to ensure 1 of 7 Residents were free of unnecessary medications, Resident #7, a closed record Resident. The findings included: Resident #7 was originally admitted to the facility on 04/05/21 and discharged on 04/13/2021 to the community. Diagnosis for Resident #7 included but not limited to Dysphagia, Oropharyngeal Phase, Unsteadiness on the Feet and Adult Failure to Thrive. The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 4/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #X cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing and personal hygiene. Requiring set up help with eating. Requires limited assistance of one person	F 758	1. Residents #5, #2, and #6 no longer reside at the facility. 2. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and nurse management team conducted an audit of the records of new admits/readmits within the last 30 days. Discrepancies were immediately corrected in respective resident medical records, and MD was immediately notified. Pharmacy reviews were verified as complete with none outstanding. 3. On 06/04/2021 and on 06/07/2021, the DON/Designee educated nurses on conducting thorough review of hospital discharge orders, reviewing discrepancies, clarifying orders with the physician, entering orders into the medical record, then reconciling discharge orders against orders entered into the medical record for each admission/readmission to verify orders have been accurately transcribed, including psychotropic medications.	

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F 758	Continued From page 41 with toileting. Requiring total dependence of one person with bathing. The Care Plan Reads: Focus: Resident #7 is at risk for falls r/t (related/to) confusion. Goal: Minimize the risk of falls through next review date. (Director of Clinical Services, RN) Target Date: 04/24/2021 Minimize the side effects of medication(s) contributing to gait disturbance, balance disturbance, syncope, movement disorders; increasing the resident's fall risk will be reduced by the review date. Interventions: Ensure proper footwear, non-skid footwear. Ensure that the resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The Physician order summary active orders as of 4/05/21 reads: Zoloft Tablet 25 MG Give 1 tablet by mouth in the evening related to adult failure to thrive. Order Date 4/05/21. Start Date 4/06/21. A review of the MAR (Medication Administration Record show that Resident #7 received 2 doses of Zoloft on 4/06/21 and 4/07/21 at 1700 (5:00 PM). According to the MAR Zoloft 25 MG 1 Tablet by mouth in the evening was discontinued on 4/08/21 at 1521 (3:21 PM). A review of the Physician's active Order summary as of 4/05/21 reads: Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime related to Adult Failure to Thrive. Order Date 4/05/21 and Start Date is 4/05/21.	F 758	On 06/10/201, the DON educated the pharmacy consultant related to the policy and procedure for completing review of orders for each admission/readmission, ensuring accuracy and completeness of psychotropic drug orders within 72 hours of admission. The DON/Designee will review records of each admission/readmission on next clinical morning meeting to verify discharge orders have been reconciled, and that discrepancies are clarified and accurately transcribed. 4. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify that pharmacy reviews have been completed within 72 hours, recommendations have been communicated to the physician and subsequent orders have been entered into the medical record. A random audit of five admissions/readmissions to be conducted weekly for four weeks, then another to be conducted monthly for two months or until resolved. The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved. 5. Date of Compliance: 07/13/2021	

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A review of the MAR show that Resident #7 received 8 doses of Mirtazapine 7.5 mg at 2100 (9:00 PM) from 4/05/21 - 4/12/21.

A review of the hospital discharge summary reads: STOP taking these medications: sertraline (ZOLOFT) 25 mg PO TABS. Comments: Reason for Stopping: Changed to Remeron.

A review of nursing notes dated 4/8/2021 at 15:15 (3:15 PM) reveal that Resident #7's daughter called and spoke with the DON (Director of Nursing/Admin. Staff #2) and with the unit managers regarding the list of the resident medications and requested for the Zoloft to be d/c (discontinued) and spoke with NP (Nurse Practitioner) to d/c the Zoloft per family request, per NP the medication was d/c'd.

Review of progress notes show on 4/05/21 that LPN (Licensed Practical Nurse) #7 received a drug (s) interaction warning on 4/5/2021 20:18 (8:18 PM). The system has identified a possible drug interaction with the following orders: Zoloft Tablet 25 MG. Give 1 tablet by mouth in the evening related to ADULT FAILURE TO THRIVE. Severity: Severe. Interaction: Additive serotonergic effects may occur during co administration of selective serotonin reuptake inhibitors (SSRIs) and Mirtazapine Tablet 7.5MG, and the risk of developing serotonin syndrome may be increased.

The above interaction warning reveal that Zoloft and Remeron should not be taken together due to having severe serontonergic effects.

A review of progress notes reveal: 4/5/2021 20:18 Orders Progress Note Text: The order you have

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F 758	Continued From page 43	F 758		

entered Mirtazapine Tablet 7.5 MG.

Give 1 tablet by mouth at bedtime related to ADULT FAILURE TO THRIVE.
Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction.

A review of the hospital discharge summary reads: Prior to starting Remeron he was on low-dose Zoloft which was discontinued.

A review of the current hospital discharge Medication List reads: Stop taking these medications: Sertraline/Zoloft 25 MG. Comments: Reason for stopping: Changed to Remeron.

A review of the hospital medication administration record reveal that Sertraline/Zoloft 25 mg was ordered on 3/24/21 and discontinued on 3/27/21.

A review of the facility discharge prescriptions show no copy of Zoloft/Sertraline.
On 6/02/21 at approximately 4:35 PM., an interview was conducted with the OSM (Other Staff Member) #5 concerning Resident #7. She stated, ASM (Administrative Staff Member) #4 does the initial H&P (History and Physical). He was given Remeron to help pick up his eating. Even if he had the Zoloft for two days it's a low dose antidepressant that stays in the system for 2 days. He was on Remeron to increase his appetite. He should have not been on Zoloft at all."
On 6/03/21 an interview was conducted with LPN (Licensed Practical Nurse) #7 at approximately 10:30 AM., concerning Resident #7. He stated, "I don't remember the resident." He was asked by the surveyor to explain flags on new admissions. He stated, "On new admissions it flags on the

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doctor if there is a black box warning. That goes on the 24 hour report. You have to get the meds verified by the doctor. No issues. When they are discharged we print out the prescriptions. Most discharged paper work is done by Social services.

An interview was conducted on 6/03/21 at approximately 12:20 PM with OSM #1 concerning Resident #7 being prescribed Zoloft and Remeron due to the black box warning. He stated, "Remeron helps with depression and sleep. They gave the Zoloft for a few days and stopped it! His discharge summary from the hospital reads on 4/05/21 it says stop taking Zoloft change to remeron. They missed the fact it was to be changed. It appears they should have stopped it. They were suppose to change from Zoloft to remeron.

On 6/03/21 at approximately 2:50 PM an interview was conducted with ASM #2 concerning Resident #7. She stated, "It was discontinued at the hospital. I got the NP (Nurse Practitioner) to discontinue the Zoloft. Per family request. Basically, on the discharge summary it stated to discontinue. It should have never been placed on there (the medication/Zoloft listed on the discharge summary)."

On 6/03/21 at 5:00 PM a returned phone call was received from OSM #1 concerning Resident #7. He stated, the medication was already discontinued before I got there. It was missed by the admissions pharmacist. It said pretty clearly to stop the drug and they didn't."

On 6/03/21 at approximately 5:10 PM an interview was conducted with ASM #4 concerning

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Resident #7. When they (residents) come from the hospital. I verify the medications, go through the discharge summary. The nurses could have made a mistake and given it. Sometimes errors come from the hospital."
On 6/03/21 at approximately 5:21 PM an interview was conducted with ASM #1, ASM #2 and Corporate staff #1 concerning Resident #7's allegations. No questions were voiced.

On 6/03/21 at approximately 5:30 PM a return phone call was made from Others Staff Member #1(OSM/Pharmacist) concerning Resident #7. He stated, "When I visited the facility on 4/22/21 he was already discharged. The previous pharmacist did not have access to PCC (Point Click Care) at the time. She was doing a review based on limited information.

On 6/03/21 A phone call was made at 5:34 PM to the previous pharmacist mentioned in question by OSM #1. A voice message was left. No return phone call was received by surveyor.

On 6/03/21 at approximately 6:50 PM during the exit conference the Administrative Staff Members were asked to explain the admissions summary process concerning medications for a resident being admitted to their facility from the hospital. The ASM #2 stated, " When they come in with the admissions summary we will call the doctor or Nurse Practitioner to verify medications on the discharge summary and also they verify medications and diagnoses through the doctor as well. He will take 72 hours to review medications. We review new meds in the morning meeting and the doctor comes in within 48 hours to review the discharge summary."

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F 758	Continued From page 46 On 6/03/21 at approximately 4:00 PM an email was sent to the facility Administrator asking him to email the following policies: Medication administration procedures. Significant medication errors and unnecessary medications. None of the above policies were received. Serotonin syndrome symptoms often begin hours after you take a new medication that affects your serotonin levels or after you raise your dose of a current drug. Symptoms may include: Confusion, Agitation or restlessness, Dilated pupils, Headache, Nausea, Vomiting, digestive disorders, digestive disorders, diarrhea, Loss of muscle control or twitching. In severe cases, serotonin syndrome can be life-threatening. Call 911 or go to the emergency room if you have any of these symptoms: High fever,Seizures, Uneven heartbeat,Passing out. Serotonin Syndrome Causes and Risk Factors: Medications usually cause serotonin syndrome, especially certain antidepressants. You might be at higher risk if you take two or more drugs and/or supplements <https://www.webmd.com/vitamins-and-supplements/lifestyle guide that affect your serotonin levels. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed class of antidepressants. They work by raising your serotonin levels. These drugs include: Sertraline/Zoloft. https://www.webmd.com/drugs/mono-8095-SERTRALINE+-+ORAL.aspx?drugid=35&drugname=zoloft+oral>) . https://www.webmd.com/depression/guide/serotonin-syndrome-causes-symptoms-treatments.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		7/13/21

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F 760	Continued From page 47 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to ensure that 1 of 7 residents in the survey sample was free of a significant medication error, Resident #5. The findings included: Resident # 5 was admitted to the facility on 1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis, Osteoporosis and Cerebral Vascular Accident. Resident #5 was discharged from the facility on 1/17/21. The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making. Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part, as follows: Medications: Home Medication List at Time of Discharge Take these medications:	F 760	1. Residents #5, #2, and #6 no longer reside at the facility. 2. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and the nurse management team conducted an audit of the records of new admits/readmits within the last 30 days to verify orders were accurately transcribed and reviewed by physician. Physician was immediately notified of discrepancies and new orders obtained. Pharmacy reviews were noted as complete with none outstanding. 3. On 06/04/2021 and on 06/07/2021, the DON/Designee educated nurses on conducting thorough review of hospital discharge orders, reviewing discrepancies and clarifying orders with physician, entering orders into the medical record, then reconciling discharge orders against orders entered into the medical record for each admission/readmission to verify orders have been accurately transcribed to prevent significant medication errors. DON educated pharmacy consultant on 06/10/2021 related to policy and procedure for completing review of orders on each admission/readmission, ensuring accuracy and completeness of drug	

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F 760	Continued From page 48 Vimpat 200 MG (milligram) tablet Generic drug: lacosamide 1 tablet, Oral 2 times a day Other Instructions: Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants. Vimpat Medication Guide provide by OSM (Other Staff Member) #1 was reviewed and is documented in part, as follows: Vimpat is a prescription medicine (anticonvulsant) used to treat partial-onset seizures and with other medicines to treat primary generalized tonic-clonic seizures. What is the most important information I should know about VIMPAT?: DO not stop taking VIMPAT without first talking to your healthcare provider. Stopping VIMPAT suddenly can cause serious problems. Stopping seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus). How long does it take for Vimpat to kick in? After taking lacosamide, the highest blood levels are reached in 1 to 4 hours. It takes about 13 hours for the amount of medicine in the bloodstream to fall by at least 50%. This means that the medicine should be taken twice a day, about 12 hours apart. Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.	F 760	orders within 72 hours of admission to prevent significant medication errors. The DON/Designee will review records of each admission/readmission in next clinical morning meeting to verify discharge orders have been reconciled, discrepancies clarified and accurately transcribed. 4. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify the pharmacy reviews have been completed within 72 hours, recommendations have been communicated to the physician, and that subsequent orders have been entered into the medical record. Random audits of five admissions/readmissions will then be conducted weekly for four weeks, then another five admissions/readmissions monthly for two months or until resolved. The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved. 5. Date of Compliance: 07/13/2021	

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Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.

Resident #5's Progress Note dated 1/13/21 at 9:36 P.M. was reviewed and is documented in part, as follows:

Type: Nursing Progress Note
Note Text: Resident had seizure activity at 19:55 (8:55) P.M. CNA (Certified Nursing Assistant) staff called for nursing staff. Resident was laying back on bed not responding but by sternal rub resident showed signs of responsiveness. Resident had fixed eyes and had chattering of the jaw, was unable to communicate. It lasted 3 minutes, resident came too and became combative. A few minutes later resident was able to relax and lay down. No further distress noted. NP (Nurse Practitioner), supervisor and MD (Medical Doctor) aware.

Resident #5's Medication Reconciliation dated and locked on 1/9/21 at 8:54 P.M. by LPN (Licensed Practical Nurse) #5 was reviewed and is documented in part, as follows:

Section A:
1. Complete medication reconciliation utilizing the following data sources (check all that apply);
1. History and Physical 2. Discharge Summary.
Section B:
1. List Medications needing clarification: No Medication Issues Identified.
Section C: Physician Contact
1. Physician Name-Blank 2. Date and Time

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Physician contacted-Blank 3. Physician contacted via-Blank

On 6/3/21 at 10:15 A.M. a phone interview was conducted with LPN #5 regarding Resident #5's admission orders. LPN #5 was asked to to explain the process for transcribing admission orders. LPN #5 stated, "When I get the discharge summary from the hospital, I verify the orders with the medical doctor on call. Then I put the orders into the computer and send them to the pharmacy."

Resident #5's Physician Medication Admit History and Physical dated 1/11/21 signed by ASM(Administrative Staff Member) #4 was reviewed and is documented in part, as follows:

History of Present Illness: The patient is a pleasant 56-year-old black female who has a history of seizure disorder.

Past Medical History: 12. Seizure Disorder

Medications: Medications have been reviewed. Please see MAR (Medication Administration Record).

Plan: Medications have been reviewed and signed.

On 6/2/21 at 5:00 P.M. a phone interview was conducted with ASM (Administrative Staff Member) #4 regarding Resident #5's anti-seizure medication Vimpat. ASM #4 was made aware that the medication was not transcribed from the discharge summary dated 1/8/21 and that Resident #5 had not received the Vimpat the entire facility stay. ASM #4 stated, "When I come

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in to see the patient I read over everything, the hospital records and the discharge summary then I go see the patient. I spend well over an hour with new admissions. If the Vimpat was on the discharge summary on the medication list, it should have been transcribed over. It shouldn't have happened, when I do admits I find lots of errors and correct them. This one got by me." ASM #4 was asked if Vimpat was a significant medication and if seizures were harmful. ASM #4 stated, "Yes it is a significant medication it is an anti-seizure medication. Seizures can be harmful because repeated seizures can affect the brain."

On 6/2/20 at 7:48 P.M. a phone interview was conducted with OSM(Other Staff Member) #1 regarding the medication Vimpat for Resident #5. OSM #1 stated, "I wasn't the pharmacist for this facility them, however I have access to see what was found on the 72 hour new admission pharmacy reconciliation for the resident. The discharge summary was in the system on 1/9/21 and it was reviewed by the pharmacist on 1/13/21. I see on the discharge summary the resident should have been on Keppra, Clobazam and Vimpat. I see where no errors were found by the pharmacist. I do see on the discharge summary the Vimpat was the second to last medication. It appears to me it was missed by the review." The OSM #1 was asked if Vimpat was considered a significant medication and if not having it was harmful to Resident #5. The OSM #1 stated, "Yes, it is because it is a seizure medication. There is nothing else that acts like Vimpat. In my professional opinion her not having the Vimpat, yes was harmful to her."

On 6/3/21 at 2:30 P.M. a phone interview was conducted with the ASM #2 regarding Resident

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#5 not receiving Vimpat while a resident in the facility. The ASM #2 stated, "It was a situation that should not have happened. It should have been caught earlier, multiple people and hands here missed it. We need to pay more close attention." The ASM #2 was also asked if Vimpat was a significant medication. The ASM #2 stated, "Yes, any seizure medication is significant."

On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, "Every morning during stand up meetings, with the Interdisciplinary team (IDT), new admissions are discussed and the 24 hour report also reveals important information. From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders. By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an

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F 760	Continued From page 53 extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem." The facility policy titled "4.1 Physician/Prescriber Authorization and Communication of orders to Pharmacy" last revised 10/1/18. 8. Facility should reconcile transfer/transition and admission orders before they are communicated to Pharmacy. 9. Facility should verify transfer/transition and admission orders with the resident's physician/prescriber before they are communicated to the pharmacy. 9.1 Once admission orders are verified, staff should promptly transmit medication orders to the Pharmacy. On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared. This is a Complaint Deficiency.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		7/13/21

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resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 55 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 7 residents (Resident #6) in the survey sample. The findings included: Resident #6 was originally admitted to the nursing facility on 10/19/19. Diagnosis for Resident #6 included but are not limited to Prediabetes and Morbid (severe) obesity. Resident #6 Minimum Data Set (MDS) an annual assessment with an Assessment Reference Date of 09/01/20 coded Resident # 6 Brief Interview for	F 842	1. Resident #6 no longer resides at the facility. 2. Current residents have the potential to be affected. A 30-day lookback audit of current resident MARS and TARS for missed documentation to be conducted by Director of Nursing (DON) and nurse management team with a completion date of 07/02/2021. Missed documentation to be addressed by means of immediate MD notification. 3. On 06/04/2021 and on 06/07/2021, the DON/Designee educated licensed nursing staff related to the policy and procedure of	

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F 842	Continued From page 56 Mental Status (BIMS) score of 08 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #6 total dependence of two with personal hygiene, total dependence of one with bathing and dressing, extensive assistance of two with bed mobility and toilet use and supervision with eating for Activities of Daily Living care. The MDS was coded for always incontinent of bowel and bladder. In addition, under section M (skin conditions) was coded to have an unstageable that was present upon admission/reentry into the building and under other skin problems was coded for Moisture Associated Skin Damage (MASD.) Resident #6's person centered care plan dated 09/03/20 had a problem which read; at risk for skin breakdown or pressure injury development r/t Severe Morbid Obesity, Impaired Immobility, Incontinence and Bilateral lower extremity lymphedema and Erythema Interigo. The goal: will have intact skin, free of redness, blisters or discoloration by the next review date of 12/02/20. Some of the interventions to manage goal: administer treatments as ordered and monitor for effectiveness, educate the resident/resident representative as to causes of skin breakdown. An assessment for predicting pressure ulcers (Braden Scale) was completed on 10/21/20 with a score of 14.0 indicating "moderate risk for developing pressure ulcers." Review of Resident #6's Weekly Skin Integrity Review dated 10/26/20 included the following areas: under abdominal fold red and yeasty, intact blister left iliac crest (front), under both breast-red and breaks in the skin (yeast), top of	F 842	reviewing the Electronic Medication Administration Record (eMAR) after medication pass or providing treatments, and at the end of each shift to verify that medications and treatments have been administered as ordered and documented accordingly. The DON/Designee will review for missed documentation in clinical morning meeting, follow up with nurses to verify medications/treatments administered, complete documentation and/or physician notification as indicated. Nurses will be re-educated and/or receive progressive performance reviews when missed medication/treatment administration and/or documentation identified. 4. The DON/Designee will review missed documentation in clinical morning meeting five days per week for two weeks. Random audit of missed documentation to then be conducted weekly for four weeks, then 10 times per month for two months or until resolved. The DON will report findings of the reviews to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved. 5. Date of Compliance: 07/13/2021	

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right chest-yeast rash with open area, under left and right under arm (yeast), multiple open areas to left and right gluteal fold.

Review of Resident #6's Weekly Skin Integrity Review dated 10/05/20 included the following areas: redness, rash, and skin tears under bilateral axilla and bilateral breast to the chest area, skin tears in abdominal folds, red rash to the abdomen, Moisture Associated Skin Disorder (MASD) to right and left thigh (rear), right and left buttock and sacrum, skin tears in folds to the left lower leg (front) and right lower leg (front.)

Review of Resident #6's Treatment Administration Record (TAR) for October 2020 indicated the following treatment orders:
1. Clean abdominal fold with soap and water; dry the skin, apply barrier ointment every day and evening shift for prevention starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (10/09, 10/11, 10/14, 10/17/20.)

2. Greer Goo Cream - apply to back of thighs topically every day and evening shift for wound healing. Apply to affected area as directed starting on 09/25/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (10/09, 10/11, 10/14, 10/17/20.)

3. Apply barrier ointment to buttock and posterior thighs every shift for preventions starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (10/09, 10/11, 10/14, 10/17/20.)

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Review of Resident #6's (TAR) for September 2020 indicated the following treatment orders:
1. Clean abdominal fold with soap and water; dry the skin, apply barrier ointment every day and evening shift for prevention starting on 07/30/20.
Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (09/05, 09/11, 09/20, 09/24, 09/25 and 09/30/20.)

2. Apply barrier ointment to buttock and posterior thighs every shift for preventions starting on 07/30/20.
Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (09/05, 09/11, 09/20, 09/24, 09/25 and 09/30/20.)

Review of Resident #6's (TAR) for August 2020 indicated the following treatment orders:
1. Clean abdominal fold with soap and water; dry the skin, apply barrier ointment every day and evening shift for prevention starting on 07/30/20.
Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (08/02, 08/03, 08/08, 08/12, 08/14, 08/17, 08/19 and 08/29/20.)

2. Apply barrier ointment to buttock and posterior thighs every shift for preventions starting on 07/30/20.
Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (08/02, 08/03, 08/08, 08/12, 08/14, 08/17, 08/19 and 08/29/20.)

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A phone interview was conducted with the Assistant Director of Nursing (ADON) on 06/03/21 at approximately 3:37 p.m. The ADON said the nursing staff are expected to follow the treatment as ordered and sign off when completed. She said if the treatment is not signed off on the TAR, there is no way to validate the treatment was actually done.

The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/03/21 at approximately 4:45 p.m. The facility did not present any further information about the findings.

The facility's policy titled: Clinical Guidelines Skin and Wound (Effective date 04/01/17.)
Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure ulcers.

Complaint deficiency.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to ensure 3 of 43 residents in the survey sample on admission had an advance directive or determined the residents wish to formulate an advance directive, Residents #61, #78 and #348. The findings included: 1. Resident #61 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS (Minimum Data Set) with an assessment reference date of 1/8/20 coded the resident with a score of 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact. A review of the Advance Directives Discussion Document dated 1/2/20 was not completed. The section that allows for the resident to indicate whether they possess any of the following: Advance Directive, Health Care Agent, Conservator of Person, Living Will, or Durable Power of Attorney was blank. There was no documentation in the clinical record that determined whether the resident wished to formulate an Advance Directive. The above findings was shared with the Director of Nursing on 1/27/20. She stated that upon admission the nurse is responsible for completing the Advance Directives Discussion Document with the resident. She stated the document was incomplete and stated that there was an opportunity for education. 2. Resident #78 was admitted to the facility on [DATE] and a readmission on 1/21/20 with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS with an assessment reference date of 11/20/19 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact. A review of the clinical record failed to evidence an Advance Directives Discussion Document or Advance Directive. There was no documentation in the clinical record that determined whether the resident wished to formulate an Advance Directive. The above findings was shared with the Director of Nursing on 1/27/20. She reviewed the clinical record for an Advance Directives Discussion Document or Advance Directive and stated, I don't see one, it's not here. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident # 348 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact. A review of the Advance Directives Discussion Document dated 1/11/20 was not completed. The section that allows for the resident to indicate whether they possess any of the following: Advance Directive, Health Care Agent, Conservator of Person, Living Will, or Durable Power of Attorney was blank. There was no documentation in the clinical record that determined whether the resident wished to formulate an Advance Directive. The above findings was shared with the Director of Nursing on 1/27/20. She stated that upon admission the nurse is responsible for completing the Advance Directives Discussion Document with the resident. She stated the document was incomplete and stated that there was an opportunity for education. The facility Policies and Procedures titled Advance Directives with a revision date of 11/14/18 read in part: Policy: The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by the resident and/ or resident representative. Process: 1. Upon admission, Social Service Director or Business Development Coordinator/ designee will: b) Determine whether the resident has an advance directive and, if not, determine whether the resident wishes to establish an advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility document review and during the course of a complaint investigation, the facility staff failed to notify the physician and Resident Representative after an unwitnessed fall for 1 of 43 residents in the survey sample, Resident #350. The findings include: Resident #350 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Approximately 48 hours later the resident was sent to the emergency room (ER) on 4/6/19 and admitted . The facility Admission/Readmission Data Collection document dated 4/4/19 assessed the resident as arriving to the facility at 5:30 p.m., oriented to person, usually makes self understood, understands, pleasant and content, no obvious behaviors, required one person assist with bed mobility, transfers, ambulation with use of a walker. Section N3. Fall Risk identified the resident did not have a history of falls in the last 30 to 90 days. The resident was oriented to the bathroom, activities, roommate, mealtimes, call light/bell and staff. The nurse documented, Very pleasant lady with no complaints for skilled nurdsing {sic}. The complainant alleged that on 4/6/19 upon arrival to the resident's beside at approximately 2:00 p.m., she immediately identified that there was something wrong with the resident. She described the resident as didn't respond to me, shaking her head from side to side and mumbling. The complainant went to the nurses station to ask the nurse what happened. She indicated the nurse came to the room and told her she had found the resident in the bathroom earlier that morning at approximately 8:00 a.m. The complainant asked why was she not notified of the fall, the nurses response was that they normally don't call family members that early, the complainant stated it was now 2:00 p.m. why had she not been called by now. The complainant also asked if the physician had been notified and the nurse stated no because she thought that was the resident's normal state. The complainant told the nurse that she needed to call the physician immediately. The nurse then called the physician and obtained an order to send the resident to the ER for evaluation. LPN #6 was no longer employed at the facility. A voicemail request for an interview was made on 1/27/20, however prior to exit LPN #6 had not returned the phone call. A review of LPN#6's employee record evidenced an Employee Corrective Action Form dated 4/9/19, date of infraction was 4/6/19. LPN #6 received a written warning for failure to perform fall procedure, failure to notify MD, and failure to assess patient and identify change in condition. LPN #6 declined to sign the form. Re-education was provided on 4/17/19 for fall protocol, neuro checks, notification of MD and Resident Representative (RR) immediately after a fall, any resident change in condition is to be documented and Resident Representative and MD to be notified. The Details of Hospital Stay-Hospital Course- .There was concern for seizures, therefore EEG was obtained which was suggestive of seizures, showing sharp waves emanating from the right tempoparietal region consistent with cortical irritability. Therefore, neurology started [MEDICATION(S)] (Anti-epileptic drug) 500 milligram bid (twice a day). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Primary Discharge Diagnosis- Principal Problem 1. Metabolic [CONDITION(S)] due to probable seizures 3. Acute right cerebellar [CONDITION(S)] (stroke). The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. The facility Policies and Procedures subject: Fall Management revised date 7/29/19 read in part, as follows: Purpose-Is to identify residents at risk for falls and establish/ modify interventions to decrease the risk of a future fall and minimize the potential for a resulting injury. C. Post Fall Strategies: 3. Notify the Physician and resident representative Complaint deficiency.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to evidence that an Advanced Beneficiary Notice was issued to one of 43 residents in the survey sample, Resident #92. The findings included: Resident #92 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #92's most recent MDS (minimum data set) assessment was an admission MDS assessment with an ARD (assessment reference date) of 6/12/19. Resident #92 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #92's census report revealed that she became long term care under Medicaid Pending on 6/25/19. Review of Resident #92's clinical record revealed a note from social services dated 6/25/19 that documented the following: SW (social work) spoke with daughter regarding skilled nursing services ending on 6/24/19. In addition, SW educated daughter on her mother transitioning to long term care status. There was no evidence that an Advanced Beneficiary Notice (SNF ABN) was issued to Resident #92 and/or her RP (representative) prior to skilled services being discontinued (cut). On 1/28/19 at 9:26 a.m., an interview was conducted with OSM (Other staff member) #3 , the former social worker. When asked when Resident #92 was cut from skilled services, OSM #3 stated that he could not remember and he no longer worked for the facility. OSM #3 stated that the facility staff should be able to locate the ABNs that he issued to Resident #92 and her daughter. OSM #3 stated that he used to keep a binder full of cut letters. When asked when an ABN should be issued, OSM #3 stated that the ABN should be issued at least 48 hours from being cut from skilled services. OSM #3 stated that the 48 hours notice gave the representative the right to appeal. OSM #3 stated that he thought he wrote a note documenting when he had presented the ABN to Resident #92's daughter. When asked why his note was documented the day she was cut from skilled services, OSM #3 stated that he must have documented late. OSM #3 stated that he should have documented a note sooner. On 1/28/19 at 10:05 a.m., ASM (administrative staff member) #1, the Administrator stated that she could not find the ABN for Resident #92. No further information was presented prior to exit. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled SNF (Skilled Nursing Facility) Advanced Beneficiary Notification (ABN) and Notice of Medicare Non-Coverage, documents in part, the following: SNFs must provide the Notice of Medicare Provider Non-Coverage and the SNF ABN to Medicare beneficiaries no later than two days (48 hours) before the effective date of the end of the coverage that their Medicare coverage will be ending. If the beneficiary does not agree that coverage should end, the beneficiary may request an expedited review of the termination decision by the Quality Improvement Organization (QIO) in the State. The provider then must furnish the Detailed Explanation of Non-Coverage (Detailed Notice) to the beneficiary explaining why services are no longer covered.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews and facility document review the facility failed to notify the State Long-Term Care Ombudsman of a facility discharge for 1 of 43 residents in the survey sample, Resident #94. The findings included: Resident #94 was admitted tot he facility on 11/05/19 with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The most recent Minimum Data Set (MDS) was a Discharge Assessment-return not anticipated with an Assessment Reference Date (ARD) of 11/25/19. Under Section A0310 G. Type of discharge Resident #94 was coded as 1 (Planned). Under Section A2000 discharge date Resident #94 was coded as 11-25-2019. Under Section A2100 Discharge Status Resident #94 was coded 01 (Community). Resident #94's Discharge Plan and Instructions document dated 11/25/19 was reviewed and is documented in part, as follows: Summary of Discharge: g. Date and time of Discharge: 11/25/19 12:00. h. Your Discharge Destination: 4. Other h1. Describe Other: Home with home health services. On 1/28/20 at 10:30 A.M. an interview was conducted with the Admissions Director regarding discharge notifications being submitted to the Ombudsman. The Admissions Director stated, I only send notices to the Ombudsman for residents who are discharged to the hospital. I think the Social Worker was sending them about the the residents discharged home. On 1/28/20 at 10:40 A.M. an interview was conducted with the State Ombudsman regarding notifications of residents that had been discharged home from the facility. The Ombudsman stated, I am getting notified when a resident goes to the hospital, but I don't recall seeing then on residents who go home. On 1/28/20 at 10:45 A.M. the Administrator stated, We don't have any documentation to show that the notices wee sent to the Ombudsman for the residents who were discharged home. The facility policy titled Transfer/Discharge Notification and Right to Appeal revised 3/26/2018 was reviewed and is documented in part, as follows: POLICY: Transfer and discharges of residents, initiated by the center will be conducted according to Federal and/or State regulatory requirements. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timing of the Notice: Notices to the Ombudsman can be sent when practicable, such as a list on a monthly basis. On 1/29/20 at 4:43 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing, the Vice President of Operations and the Clinical Corporate Nurse where the above information was shared. Prior to exit no further information was provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to develop/complete a baseline care plan within 48 hours of a resident's admission for 4 of 43 residents in the survey sample, Residents # 61, #78, #348 and #351. The findings include: 1. Resident #61 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS (Minimum Data Set) with an assessment reference date of 1/8/20 coded the resident a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. Review of the clinical record evidenced a Baseline Care Plan and Summary dated 1/2/20. The document was not completed as the Orders and Services failed to include [CONDITION(S)] services. The section for nurse and resident signatures and dates of those participating in the initial baseline care plan development were blank. On 1/27/20 at 5:15 p.m., the Director of Nursing was asked to review the baseline care plan. She reviewed the document and stated, It wasn't completed, it should have been signed and completed within 48 hours. The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. 2. Resident #78 was admitted to the facility on [DATE] and with a readmission on 1/21/20 with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS with an assessment reference date of 11/20/19 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. Review of the clinical record failed to evidence a 48 hour baseline care plan. On 1/27/20 at 5:15 p.m., the Director of Nursing was asked about the care plan. She reviewed the record and stated, It should be in here. She then stated she remembered seeing one for the resident and asked for an opportunity to go to the unit and look for it. The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. 3. Resident # 348 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. A Baseline Care Plan and Summary dated 1/10/20 was found in the record but was not filled out. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/20 at 5:15 p.m., the Director of Nursing was asked to review the baseline care plan. She reviewed the document and stated, It wasn't completed. 4. Resident #351 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS (Minimum Data Set) had not been completed prior to survey. Clinical record review failed to evidence a 48 hour baseline care plan for Resident #351. On 1/28/19 a request to review the 48 hour baseline care plan was made. The Corporate Nurse stated there was no 48 hour baseline care plan found for Resident #351. The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #77, the facility staff failed to ensure the resident was invited to her care plan meetings. Resident #77 was admitted to the facility on [DATE]. diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #77's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/13/2019 coded Resident #77 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. On 01/27/2020 at 9:03 a.m., an interview was conducted with Resident #77, when asked if she attended care plan meetings, Resident #77 stated, No. When asked if she had been invited, asked by anyone to attend a care plan meeting to discuss her care, Resident #77 stated, No, I've never been invited to a care plan meeting. On 01/27/2020 documentation was requested to evidence that Resident #77 was invited to care plan meetings. Social Service's Progress Note dated 05/10/2019 was reviewed and documented in part, as follows: Letter was taken to resident to see if they wanted to attend the care plan meeting and invite RP (Responsible Party) received signature from resident. An interview was conducted with Registered Nurse (RN) #3, MDS Coordinator, on 01/28/2020 at 9:30 a.m., when asked who sends out invitations to care plan meetings, RN #3 stated, Social Services has a calendar and they send out invitations to care plan meetings. On 01/28/2020 requested documentation evidencing that Resident #77 was provided an invitation to attend care plan meetings since May 2019. On 01/28/2020 at approximately 4:00 p.m., an interview was conducted with Divisional ED (Executive Director), when asked if the facility could provided documentation evidencing Resident #77 was invited to care plan meetings since May 2019, Divisional ED stated, There are no invitation notes to care plan. The Administrator and Director of Nursing were informed of the finding at the pre-exit meeting on 01/09/2020 at approximately 4:45 p.m. The facility did not present any further information about the findings. The facility policy titled - Care Plan Invitation Revision Date: 09/25/2017 Policy: The resident and/or the resident representative shall be invited to attend each of the interdisciplinary Care Planning Conferences for the specified resident. 3. The facility staff failed to revise the Comprehensive Care Plan for Resident #61 to include [CONDITION(S)] three times a week scheduled on Mondays, Wednesdays and Fridays. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 61 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS (Minimum Data Set) with an assessment reference date of 1/8/20 coded the resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. Review of the Comprehensive Care Plan failed to evidence a revision of the comprehensive person-centered plan of care for the resident's hemodialysis treatments three times a week. On 1/27/20 at 10:00 a.m., Resident #61 was at the [CONDITION(S)] center receiving treatment. On 1/27/20 at 5:15 p.m., the Director of Nursing was asked if comprehensive care plan should have been revised to include a [CONDITION(S)] care plan, she stated, Yes, there should have been a care plan for [CONDITION(S)] .the MDS staff should have ensured it was done. The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. The facility's Policies and Procedures titled Plans of Care with a revision date of 90/25/17 read, in part: Policy- An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/ or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Procedure 4. Review, update and/ or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment (except discharge assessment), and as needed. Based on Resident and staff interviews, and review of the clinical record, the facility failed to provide advanced notice of the Care Plan Conference for 2 residents, Resident #75 and Resident #77, out of 43 residents in the survey sample; and failed to revise the care plan for one resident, Resident #61, out of 43 sampled residents. The findings included: 1. Resident #75 was admitted to the facility on [DATE] with admitting diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #75's most recent MDS (Minimum Data Set) was an Annual Assessment with an ARD (Assessment Review Date) of 11/13/2019. Resident #75 was coded as severely impaired in cognitive functioning, scoring a 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #75's Person-Centered Care Plan dated 1/02/2019 incorporated as a Focus: (Resident #75) has impaired cognitive function/dementia or impaired thought processes due to Dx (diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Goal: (Resident #75) will be able to communicate basic needs on a daily basis through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Allow (Resident #75) and Guardian from (Representative Agency) time to express feelings, concerns, and fears as needed. On 1/26/2020 at approximately 4:00 p.m., Resident #75 was asked about participation in Care Plan meetings. Resident #75 responded, What is that? I don't know what that is. On 1/28/2020 at approximately 11:12 a.m., the facility Administrator was asked for copies of Care Plan meeting invitations for Resident #75. The facility Administrator responded, We don't have Care Plan invitations for Resident #75 from the last year. The Facility Policies and Procedures regarding Care Plan Invitations state: The resident and/or the resident representative shall be invited to attend each of the interdisciplinary Care Planning Conferences for the specified resident. Procedure: Deliver a Care Planning Invitation to the resident 7-14 days prior to the date of the conference. Place a copy of the invitation in the medical record. If resident has capacity, ask if they wish to have the resident representative at the care conference. Per resident choice or determination of capacity, mail Care Planning Invitation to the resident representative 7-14 days prior to the date of the conference. Place a copy of the invitation in the medical record. Request that the resident and/or resident representative contact the facility designee to confirm or reschedule the date/time for the resident's conference. Have all attendees to the Care Planning Conference, including resident and resident representative sign the Care Plan Conference Record to verify their attendance. These findings were reviewed with the Facility Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility documentation review and clinical record review the facility staff failed to meet professional standards of practice for transcribing physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The findings included: Resident #192 was admitted to the facility on [DATE]. diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #192's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 01/15/2020 coded Resident #192 with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. On 01/27/2020 at approximately 3:30 p.m., review of Resident #192's clinical record revealed the following: Order Summary Report dated with Active Orders As Of: 01/27/2020 revealed an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident 192's Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . On 01/27/2020 at 4:45 p.m., an interview was conducted with Registered Nurse (RN) #1, ADON (Assistant Director of Nursing). Resident #192's Order Summary Report was reviewed with RN #1 and when asked if the orders for Respiratory: Suction as needed and [CONDITION(S)] care as needed should be on the MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . When asked if the orders were on the TAR, RN #1 stated, No, they aren't there. RN #1 stated, When the nurse enters the physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . The Administrator and Director of Nursing were informed of the finding on 01/28/2020 at approximately 4:45 p.m. at the pre-exit meeting. The facility staff did not present any further information about the finding. The facility policy titled - Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] Procedure: admission orders [MEDICAL RECORD OR PHYSICIAN ORDER] . ROUTINE ORDERS: The order is transcribed to all appropriate areas (MAR, TAR, etc.) or electronic equivalent.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility document review and during the course of a complaint investigation the facility staff failed to provide ongoing assessments, monitoring and identification of a change in condition after an unwitnessed fall for 1 of 43 residents in the survey sample, Resident #350. Subsequently, six hours later the Resident Representative visited the resident, identified a change in condition and requested the staff call the physician. The resident was sent to the emergency room and found to have an acute encephalopathic (brain) change as a result of new onset [CONDITION(S)] in addition to an acute/subacute infarct right cerebellar hemisphere (stroke), resulting in harm. The findings include: Resident #350 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Approximately 48 hours later the resident was sent to the emergency room (ER) on 4/6/19 and admitted . The facility Admission/Readmission Data Collection document dated 4/4/19 assessed the resident as arriving to the facility at 5:30 p.m., oriented to person, usually makes self understood, understands, pleasant and content, no obvious behaviors, required one person assist with bed mobility, transfers, ambulation with use of a walker. Section N3. Fall Risk identified the resident did not have a history of falls in the last 30 to 90 days. The resident was oriented to the bathroom, activities, roommate, mealtimes, call light/bell and staff. The nurse documented, Very pleasant lady with no complaints for skilled nurdsing {sic}. The Physical Therapy Initial Evaluation conducted on 4/5/19 documented the resident presented with decreased overall endurance and cadence as well as CGA (contact guard assist) for all mobility. The resident had a history of [MEDICAL RECORD OR PHYSICIAN ORDER] . The resident was identified as having one fall in the last year and ambulated at home utilizing a single point cane. The skilled nursing note dated 4/5/19 entered at 1:07 p.m., documented the resident was aware of self and surroundings with episodes of confusion, able to make needs known, and needs assistance with activities of daily living. The complainant alleged in the complaint form received at the Office of Licensure and Certification, that on 4/6/19 upon arrival to the resident's beside at approximately 2:00 p.m., she immediately identified that there was something wrong with the resident. She described the resident as didn't respond to me, shaking her head from side to side and mumbling. The complainant went to the nurses station to ask the nurse what happened. She indicated the nurse came to the room and told her she had found the resident in the bathroom earlier that morning at approximately 8:00 a.m. The complainant asked why was she not notified of the fall, the nurses response was that they normally don't call family members that early, the complainant stated it was now 2:00 p.m. why had she not been called by now. The complainant also asked if the physician had been notified and the nurse stated no because she thought that was the resident's normal state. The complainant told the nurse that she needed to call the physician immediately. The nurse then called the physician and obtained an order to send the resident to the ER for evaluation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further investigation evidenced the identified nurse as Licensed Practical Nurse (LPN) #6. LPN #6 failed to provide ongoing assessments and monitoring for an acute change in condition for Resident # 350 following the unwitnessed fall in the bathroom from approximately 8:30 a.m. through 2:30 p.m., a total of six hours. There were no assessments, monitoring or neurological evaluations conducted per the facility's policies and procedures; also the incident was not documented until four days later on 4/10/19. The two late entries dated 4/10/19 from LPN #6 were as follows: at 10:54 a.m., resident was found sitting up on the floor in the bathroom with both legs in one pajama pant leg. Also noted to have pull-up half way pulled up. No apparent injuries noted. Able to move all extremities as before. Transferred back to bed with 2 person assist and made comfortable. Noted to be sluggish but responsive to writer. VS-127/73-74-96.9-20-94% RA (room air). Resting quietly in bed at this time. Call bed in reach. The second entry at 11:13 p.m., read as follows: Daughter was in to visit around 2:30 PM and stated that this is not her (the resident) normal self and wanted to know if anything happened to her. Daughter was made aware of resident being found on floor in bathroom. Laying in bed sluggish and now unable to respond or answer questions. VS-126/71-85-97.1 AX (axillary)-98% on room air-18. On-call made aware and new order received to send to ER. LPN #6 was no longer employed at the facility. A voicemail request for an interview was made on 1/27/20 however, prior to exit LPN #6 had not returned the phone call. A review of LPN#6's employee record evidenced an Employee Corrective Action Form dated 4/9/19, date of infraction was 4/6/19. LPN #6 received a written warning for failure to perform fall procedure, failure to notify MD, and failure to assess patient and identify change in condition. LPN #6 declined to sign the form. Re-education was provided on 4/17/19 for fall protocol, neuro checks, notification of MD and Resident Representative (RR) immediately after a fall, any resident change in condition is to be documented and Resident Representative and MD to be notified. LPN#6's employee file and the staffing as worked schedule evidenced date of hire was 3/9/19, facility classroom orientation on 3/27/19, 3/29/19, and 4/1/19. The first work shift on the unit was 4/6/19. There was no orientation staff identified as assigned with LPN #6 on 4/6/19, there was no RN supervisor scheduled until the 3 p.m.-11 p.m. shift. The hospital records evidenced the following documentation, diagnostics and findings: On 4/6/19 at 4:57 p.m.-Presented in the ED (Emergency Department) with altered mental state. Patient was found in the bathroom floor with change in mental status. There was no witnessed fall. On presentation in the ED CT of the head was done (4/6/19 at 7:13 p.m.) with no acute intracranial abnormality. Chest x-ray done shows evidenced of early CHF (congestive heart failure) .Patient was given [MEDICATION(S)] IV (a diuretic). Will admit patient for altered mental status work up to rule out stroke. Physical exam-appears lethargic. 4/7/19 at 12:02 a.m.-MRI results-1. Abnormal study 2. Acute/subacute infarct (obstruction of the blood supply/stroke) right cerebellar hemisphere. 4/9/19-Neurology Consult-MRI of brain demonstrated several new areas of ischemia (blood flow is restricted) including right cerebellum. Also EEG (electroencephalogram-a test that detects electrical activity in the brain) with sharp waves arising from the left parietal area. Consistent with cortical irritability and decreased threshold for seizures. She has not been on AED therapy (Anti-epileptic drug) .They report that the day prior she had been conversational. Was able to get herself ready and was walking with a walker. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Details of Hospital Stay-Hospital Course- .There was concern for seizures, therefore EEG was obtained which was suggestive of seizures, showing sharp waves emanating from the right tempoparietal region consistent with cortical irritability. Therefore, neurology started [MEDICATION(S)] (anti-epileptic drug) 500 milligram bid (twice a day). Primary Discharge Diagnosis- Principal Problem 1. Metabolic [CONDITION(S)] due to probable seizures 3. Acute right cerebellar [CONDITION(S)] (stroke). The Nurse Practitioner who gave the order to send the resident to the ER was interviewed on 1/28/20 at 1:15 p.m. She stated when a resident falls they can present without injuries. The main reasons neuro checks are conducted after falls it to catch altered mental status changes/ injuries and assist with determining whether a resident needs to be sent to the ER for emergency interventions. She stated, The neuro checks definitely should have been done. The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. The facility Policies and Procedures subject: Fall Management revised date 7/29/19 read in part, as follows: Purpose-Is to identify residents at risk for falls and establish/ modify interventions to decrease the risk of a future fall and minimize the potential for a resulting injury. C. Post Fall Strategies: 2. Initiate Neurological checks as per policy or directed by physician order 3. Notify the Physician and resident representative The facility Policies and Procedures subject: Neurological Evaluation revised 8/22/17 read in part, as follows: Perform neurological checks as follows unless otherwise ordered by the physician: Every 15 minutes for 1 hour. Every hour for the next 4 hours. Every 4 hours for the next 19 hours. Document neurological checks, vital signs and observations on the appropriate form. Place in medical record. Notify physician of any changes in condition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The neurological assessment includes; level of consciousness-alert, drowsy, stuporous, coma, pupil response, hand grasps, extremities and pain response. Complaint deficiency.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff interviews and facility document review the facility failed to ensure a verbal telephone order for the discontinuation of an indwelling Foley catheter was written and transcribed at the time of the order on 1/26/20, for 1 of 43 resident's in the survey sample, Resident #21. The findings included: Resident #21 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #21's most recent comprehensive Minimum Data Set (MDS) was a Significant Change with an Assessment Reference (ARD) of 1/6/2020. The Brief Interview for Mental (BIMS) was a 14 out of a possible 15 which indicates that Resident #21 was cognitively intact and capable of daily decision making. Under Section H Bladder and Bowel Resident #21 was coded as having an indwelling (urinary) catheter. On 1/26/20 at 1:30 P.M. Resident #21 was observed in bed with no visible indwelling catheter. On 1/27/20 at 12:15 P.M. Resident #21 was once again observed in bed lying on the left side with no visible indwelling catheter. LPN (Licensed Practical Nurse) #6 was asked about Resident #21's indwelling catheter. LPN #6 stated, He is hospice and he had a catheter I will check on it. On 1/28/20 at 11:00 A.M. Resident #21 was again observed in bed with no visible Foley catheter. Resident #21's Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] 11/27/19: Foley Catheter 16 French 10 milliliters. Catheter care every shift and as needed. 1/27/20 16:15 (4:15) P.M. Discontinue foley. 1/28/20 14:25 (2:25) P.M. leave foley out, please monitor for bladder distention and pain. Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows: 1/28/20 14:04 (2:04) P.M. Note written by the Director of Nursing: Late Entry: On 1/26/2020, this writer was notified by nurse on unit that the foley had become dislodged. Hospice and NP (Nurse Practitioner) were notified and the recommendation from both was not to reinsert the foley and to observe resident for any signs of urinary distention. On 1/28/20 at approximately 2:00 P.M. an interview was conducted with the Nurse Practitioner (NP) regarding Resident #21's indwelling catheter. The NP stated, I got a call on Sunday around 4:00 P.M. that the Foley had come out and I gave an order to leave the Foley out and to see how he did and if there was no urine or any bladder distention to put it back in. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/20 at 2:15 P.M. an interview was conducted with the Director of Nursing and she was asked what would have been her expectations for new resident orders. The Director of Nursing stated, I would expect any orders that the NP gives to be put in and followed and for the residents to be monitored and to chart if there is any distention or discomfort with the resident.: The facility policy titled Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] Routine Orders: A nurse may accept a telephone order from the Physician, Physician Assistant or Nurse Practitioner. The order shall be repeated back to the Physician, Physician Assistant or Nurse Practitioner for his/her verbal confirmation. The order is transcribed to all appropriate areas (MAR (medication administration record), TAR (treatment administration record) , etc) or electronic equivalent. The nurse shall sign off the orders upon completion or verification of transcription. On 1/29/20 at 4:43 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing, the Vice President of Operations and the Clinical Corporate Nurse where the above information was shared. Prior to exit no further information was provided.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 43 residents in the survey sample received the appropriate care and services for the management of a PICC line, Resident #348. A PICC line is a peripherally inserted central catheter, a form of intravenous access that can be used for a prolonged period of time (e.g., for extended antibiotic therapy). The findings include: Resident #348 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. Section O. Special Treatments, Procedures, and Programs indicated the resident was receiving IV medications. The physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On 1/26/20 during the initial tour the resident was observed in bed. A PICC line was noted to the resident's right arm. The dressing was dated 1/18/20 and loose on the right lower edge. The January 2020 Treatment Administration Record (TAR) was reviewed. The TAR indicated by documentation of the nurses initials that the PICC dressing was changed on Monday 1/20/20, however the PICC dressing was dated as last changed on 1/18/20. On 1/27/20 at 2:45 p.m., the Licensed Practical Nurse (LPN# 1) was observed preparing and administering the [MEDICATION(S)] 2 gram IV dose. She observed the PICC dressing was dated 1/18/ 20 and stated, It should have been changed on the 25th (1/25/20), the standard is to change the PICC dressing once a week. She then stated, I'm going to change it and I will let my ADON (Assistant Director of Nursing) know about it. The above finding was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. The facility policy and procedure titled 4.10 Midline Catheter Dressing Change, revised 7/1/12 read in part: Guidance 1. Sterile dressing change using transparent dressings is performed: 1.2 At least weekly 1.3 If the integrity of the dressing has been compromised (wet, loose or soiled)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of Facility documentation, the facility failed to provide the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The findings included: A review of the facility as-worked staffing documentation revealed that on the date of 08/16/2019, there was no coverage provided by a RN (Registered Nurse) within a 24-hour time-frame. An interview with the Director of Nursing (DON) on 01/27/2020 at approximately 6:30 p.m. when asked about RN coverage for 8/16/2019 the DON responded, I agree that there was no RN coverage documented for 8/16/2019. These findings were reviewed with the facility Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m. No further information was provided prior to exit.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and facility posting information, the facility staff failed to provide the current staffing information to residents and visitors. Findings included: Upon entrance of the facility on 01/26/2020 at approximately 11:05 a.m., the posted staff information was observed to not be current to date, listing staffing information for 01/24/2020. During an interview with Licensed Practical Nurse (LPN) #1, on 01/26/2020 at approximately 11:37 a.m. regarding the posted staffing information, LPN #1 stated, she called the facility Administrator and said Please go make sure that (as-worked scheduled) is changed. LPN #1 stated that 25th, 26th and 27th were behind the 24th as worked schedule. LPN #1 stated that all she had to do was flip the 26th in front, and that she usually has a liaison on weekends that will change out the schedule. She also stated, I only work a few hours on weekends and then I leave. When asked who was responsible for doing the As-Worked scheduled, LPN #1 stated, 'I couldn't tell you. I am just a floor nurse. These findings were reviewed with the Facility Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m. No further information was provided by facility staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility documentation review, and staff interviews, the facility kitchen staff failed to ensure that food was stored, labeled, and served under sanitary conditions. The findings included: During an initial inspection of the facility kitchen occurring on 01/26/2020 at approximately 11:21 a.m., the following was observed: 1. Partially covered Salisbury steak in the refrigerator. 2. No dates for 2 rolls of raw hamburger stored in the refrigerator. 3. No use by dates for milk stored and purposed for fluid restriction diets. 4. No use by dates for thickener stored in the refrigerator. 5. Undated, dried noodles in the storage room. During an interview on 01/26/2020 at approximately 12:00 p.m. with the Dietary Manager yielded, We just hired another cook, he has not been here that long. He should have known better. During an interview on 01/28/2020 at approximately 1:53 p.m. with the Dietary Manager, the Dietary Manager stated, Once staff open items, they are supposed to label and date items. I agree with you regarding the items discovered unlabeled and not covered. Facility provided policy dated 09/2017 regarding Food Storage: Dry Goods included the following: All dry goods will be appropriately stored will be appropriately stored in accordance with the FDS Food Code. Procedures: 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. Facility provided policy dated 04/2018 regarding Food Storage: Cold Foods stated the following: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. Procedures: 5. All foods will be stored, wrapped, or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These findings were reviewed with the Administrator during a meeting on 01/28/2020 at approximately 4:30 p. m. No further information was provided by facility staff.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility staff failed to ensure that the garbage disposal area was free from debris and refuse. The findings included: During an initial inspection of the facility's disposal dumpsters occurring on 01/26/2020 at approximately 12:30 p.m., debris to include paper and plastic soda bottles were discovered around the garbage disposal dumpsters. During an interview on 01/26/2020 at approximately 12:30 p.m. with the Dietary Manager, the Dietary Manager stated We are supposed to check the area daily. During an interview on 01/28/2020 at approximately 1:53 p.m. the Dietary Manager stated, Normally we check dumpsters everyday. I will meet with my cooks to direct them to keep dumpster area clean. Facility provided policy dated 08/2017 regarding Dispose of Garbage and Refuse: All garbage and refuse will be collected and disposed of in a safe and efficient manner. Procedures: 1. The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. These findings were reviewed with the facility Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m. No further information was provided by facility staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The facility staff failed to ensure the Treatment Administration Record (TAR) was accurate for Resident #348's PICC dressing change date. A PICC line is a peripherally inserted central catheter, a form of intravenous access that can be used for a prolonged period of time (e.g., for extended antibiotic therapy). Resident #348 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. Section O. Special Treatments, Procedures, and Programs indicated the resident was receiving IV medications. The physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On 1/26/20 during the initial tour the resident was observed in bed. A PICC line was noted to the resident's right arm. The dressing was dated as changed on 1/18/20; the dressing was loose on the right lower edge. The January 2020 Treatment Administration Record (TAR) was reviewed. The TAR indicated by documentation of the nurses initials that the PICC dressing was changed on Monday 1/20/20, however, the PICC dressing was dated as last changed on 1/18/20. The above finding was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. 3. Resident #192 was admitted to the facility on [DATE]. diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #192's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 01/15/2020 coded Resident #192 with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #192 as requiring supervision with setup help only for bed mobility, dressing, eating and personal hygiene and supervision with assistance of 1 for transfer and toilet use and total dependence of 1 for bathing. On 01/26/2020 at approximately 1:30 p.m., during initial tour of facility, Resident #192 was observed lying in bed. Resident was observed to have a [CONDITION(S)] stoma. (A [CONDITION(S)] is a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing. mayoclinic.org). On 01/27/2020 at approximately 3:30 p.m., review of Resident #192's Order Summary Report dated with active orders as of : 01/27/2020 revealed the following orders dated 1/9/2020: Keep extra [CONDITION(S)] tube at bedside and [CONDITION(S)] - Assess skin around stoma site and under ties during [CONDITION(S)] care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495340	A. Building B. Wing	01/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Registered Nurse (RN) #1, the ADON (Assistant Director of Nursing), on 01/27/2020 at 4:45 p.m. When asked if Resident #192 has a [CONDITION(S)] tube, RN #1 stated, No, the resident does not have a [CONDITION(S)] tube, he only has a stoma. Reviewed order Keep extra [CONDITION(S)] tube at bedside with RN #1, and when asked if it was an accurate order, RN #1 stated, No, the order should not have been entered into PCC (Point Click Care). When asked if Resident #192 has ties around his [CONDITION(S)], RN #1 stated, No. When asked if the order [CONDITION(S)] - Assess skin around stoma site and under ties during [CONDITION(S)] care was an accurate order, RN #1 stated, No, the order should reflect what the resident has which is a [CONDITION(S)] button, not ties. RN #1 stated, I expect the nurses to put orders in accurately and actually reflect the resident and the orders need to reflect what is being done. The facility policy titled - Clinical / Medical Records Revision Date: 08/25/2017 included: Policy: Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The Administrator and Director of Nursing were informed of the findings on 01/28/2020 at approximately 4:45 p.m. at the pre-exit meeting. The facility did not present any further information about the finding. Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for three of 43 residents in the survey sample, Resident #92, #348, and #192. The findings included: 1. Resident #92 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #92's most recent MDS (minimum data set) assessment was an admission MDS assessment with an ARD (assessment reference date) of 6/12/19. Resident #92 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #92 was coded as requiring limited assistance with one staff member with bed mobility, dressing, toileting, and personal hygiene; total dependence on staff with bathing; and supervision only with all other ADLS (activities of daily living). Review of Resident #92's June POS (physician order [MEDICAL RECORD OR PHYSICIAN ORDER] 1. [MEDICATION(S)] R (1) Solution 100 unit/ml inject as per sliding scale if 200-249 = 2 units 250 - 299 = 4 units 300 -349 = 6 units; 350-399 = 8 units under 60 and above 400 call MD (medical doctor). 2. Insulin NPH-insulin (2) 70/30 Inject 10 units under the skin 2 (two) times a day before meals. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #92's June 2019 MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . The following code was documented: Insulin not required. A nursing note dated 6/6/19 documented the following: 16:30 (4:30 p.m.) The patient's BS (blood sugar) read HI on the glucometer, and she was given Hum. ([MEDICATION(S)] R (regular)) coverage for greater than 400 per protocol and then I advised I would check her blood sugar in one hour. At 5:30 p.m. her BS again read HI and coverage was given (for a second time) and her routine dose of insulin 10 units. Shortly after she ate dinner and again her BS was tested and registered 496. (Name of NP) was made aware of the patient's status and her family came in and asked about her BS and decided they wanted to take her to the hospital. (NP) made aware of family request and patient was taken to the hospital by family. Review of the Emergency Department Visit Summary revealed that Resident #92 was seen for [CONDITION(S)] with a blood sugar reading of 413 at 8:51 p.m. There were no new orders on the after visit summary. Review of a 6/7/19 note revealed that Resident #92 returned back to the facility at 12:15 a.m. from the ER with no new orders. On 1/26/20 at 11:36 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #1, the nurse who worked on 6/6/19 with Resident #92. When asked how many units of insulin Resident #92 received on 6/6/19 when her sugar read HI, LPN #1 stated that it must have been 10 units per standard scale of insulin protocol. LPN #1 then stated that she notified the Nurse Practitioner per physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . LPN #1 stated that she rechecked Resident #92's blood sugar an hour later and her level was still high. LPN #1 stated that she notified the NP for the second time and was told to administer 10 units of [MEDICATION(S)] for a second time as well as her 10 units of scheduled NPH insulin. LPN #1 stated that Resident #92's blood sugar read 496 right after dinner. LPN #1 stated that Resident #92's daughter had decided to take the resident to the hospital. LPN #1 stated that she documented the latest blood sugar of 496 on the MAR. LPN #1 stated that she did not administer any further insulin after the reading of 496. When asked if it should be documented how many units of insulin is given to a resident in the Resident's clinical record, LPN #1 stated that she should have documented in the clinical record the amount of insulin administered and should have documented who gave her the orders. LPN #1 stated, I can assure you I called the NP because she (Resident #92) was a brittle diabetic. LPN #1 also confirmed that she did not write an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 1/27/20 at 12:15 p.m., an interview was conducted with ASM (administrative staff member) #3, the Nurse Practitioner. When asked about the incident on 6/6/19, ASM #3 stated that she was not able to remember if she was notified regarding the insulin that was given to Resident #92 prior her being sent to the hospital. ASM #3 stated that she would expect the nurses to notify her of an elevated blood sugar so she could give an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . ASM #3 stated that typically for a type one diabetic she would not give an order to give SSI a second time because they typically are so brittle. ASM #3 stated that she would expect the nursing staff to notify her prior to administering a second dose of SSI. ASM #3 stated that the nurse may have received the order from the on-call physician or Resident #92's physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/20 at 12:30 p.m., further interview was conducted with LPN #1. LPN #1 stated again that everything she did that day on 6/6/19 was verified with the NP prior to administering the two doses of SSI to Resident #92. On 1/27/20 at 3:55 p.m., an interview was conducted with ASM #4, the Physician. ASM #4 stated that he could not recall the above allegation. ASM #4 stated that he could not remember that far back. On 1/28/19 at 4:35 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #2, the Divisional Executive Director were made aware of the above concern. (1) [MEDICATION(S)] R (regular)/[MEDICATION(S)] R (regular)- Both brand names for same type of insulin; fast acting insulin used to improve glycemic control in patients with diabetes. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=11f9e71d-249d-4de5-be02-a6eb8bf373cd. (2) NPH insulin- An intermediate-acting insulin used in the treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . https://www.cancer.gov/publications/dictionaries/cancer-drug/def/insulin-nph.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, clinical record review and facility documentation review the facility staff failed to ensure infection control practices were followed during wound care for 1 of 43 residents in the survey sample, Resident #57. The findings included: Resident #57 was admitted to the facility on [DATE]. diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #57's Minimum Data Set (MDS assessment protocol) with as Assessment Reference Date of 12/19/2019 coded Resident #57 with short-term memory problems, long-term memory problems and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #57 as requiring extensive assistance of 1 for toilet use, extensive assistance of 2 for bed mobility, dressing and personal hygiene and total dependence of 1 for eating. On 01/28/2020 at 10:17 a.m., Registered Nurse (RN) #2 provided wound care to Resident #57's sacral pressure ulcer. After setting up to perform the wound care appropriately, the following was observed: RN #2 removed the old dressing and packing from Resident #57's sacral wound and disposed of dressing in a plastic bag, removed her dirty gloves, and applied hand sanitizer. RN #2 applied clean gloves, cleaned the sacral wound with gauze 4x4 and Normal Saline, disposed of dirty 4x4 gauze, cleaned skin around sacral wound with 4x4 gauze and Normal Saline, removed dirty gloves, and applied hand sanitizer. RN #2 applied clean gloves, and as she was drying around the residents wound with a gauze 4x4 the resident began to expel feces (bowel movement). RN #2 continued drying the resident's skin and then used the gauze 4x4 to clean the feces from the residents buttocks and then disposed of the soiled 4x4. RN #2 picked up a clean package of Calcium Alginate and opened the package. RN #2 did not remove per dirty gloves and perform hygiene after wiping feces from the residents buttocks. RN #2 placed the opened package of Calcium Alginate back down on the barrier drape. RN #2 removed her dirty gloves, applied hand sanitizer, went out to the treatment cart outside of the room and obtained the scissors laying on top of the cart and placed them on the barrier. RN #2 washed her hands with soap and water, applied clean gloves, removed the Calcium Alginate from the package and cut it with the scissors. RN #2 then placed the Calcium Alginate in the sacral wound, opened package of 4x4 gauze dressing and dipped the 4x4 gauze in Normal Saline and folded it up and placed it over the Calcium Alginate. RN #2 placed a dry 4x4 gauze dressing over packing in wound and applied dated tape to borders of dressing. RN #2 disposed of left over supplies and barrier drape in plastic trash bag and removed her dirty gloves. RN #2 washed her hands with soap and water, removed scissors and hand sanitizer from room and placed them on top of the treatment cart. RN #2 pushed the treatment cart up next to the Medication Cart and obtained alcohol swabs from the med cart and proceeded to clean the blades of the scissors. RN #2 did not clean the handles of the scissors. RN #2 took the bottle of hand sanitizer from the top of the treatment cart without cleaning it and placed it on the medication cart. A copy of facility Policy and Procedure titled Dressing Change was received on 01/28/2019 at approximately 11:45 a.m. and included: The facility policy titled - Dressing Change (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used only if specifically ordered. On 01/28/2020 at 12:05 p.m., conducted an interview with RN #2 and discussed observations during wound care. When asked if she should have performed hand hygiene after she wiped the feces from Resident #57's buttocks, RN #2 stated, Yes I should have removed my gloves, used hand sanitizer and applied clean gloves. When asked if she should have cleaned the scissors and bottle of hand sanitizer before coming out of the residents room, RN #2 stated, Yes. When asked why you should clean the scissors and hand sanitizer before coming out of the room, RN #2 stated, To prevent spread of infection from dirty to clean. When asked if she cleaned the handles of the scissors, RN #2 stated, No. When asked if she should have cleaned the handles in addition to the blades of the scissors, RN #2 stated, Yes I should have. I had my hands on it. When asked if her dirty gloves were also touching the handle of the scissors, RN #2 stated, Yes. On 01/28/2020 at approximately 4:00 p.m., the wound care observations were reviewed with the Director of Nursing. The Administrator and Director of Nursing was informed of the finding on 01/28/2020 at approximately 4:45 p. m. at the pre-exit meeting. The facility did not present any further information about the findings.

(Tags: Newport News Nursing home attorney, Newport news malpractice attorney, Virginia nursing home lawyer, Virginia nursing home attorney, pressure sores claim, , bed sores attorney, wrongful death attorney, attorney handling medication errors, assisted living facility abuse attorney, nursing home abuse attorney, assisted living attorney, assisted living accidents, malnutrition claim, Virginia elder abuse attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose claim, legal liability for overdose, nursing home abuse lawyer, wrongful death case or claim, Virginia Nursing abuse attorney, Virginia nursing home attorney, pressure sores, Virginia malpractice attorney, Warwick County attorney, nursing home malpractice attorney, Newport News Nursing and Rehab Center, Newport News)