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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to provide 1 of 14 sampled residents an appropriate cushion for his/her wheelchair. (#16) Findings included: - Resident #16's quarterly (MDS) Minimum Data Set assessment, dated 12/18/17, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 3, which indicated severely impaired cognition. The assessment revealed the resident required extensive staff assistance with bed mobility, transfers, used a wheelchair for mobility, was at risk for pressure ulcers, and provided pressure reducing devices for bed and wheelchair. The 9/18/17 pressure ulcer (CAA) Care Area	F 558		

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

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

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Assessment documented the resident at risk for pressure ulcer development and required pressure reducing mattress and pressure reducing wheelchair cushion.

The 12/18/17 care plan directed the staff to seat the resident in a wheelchair with a pressure reducing cushion.

On 1/29/18 at 10:10 AM, observation revealed the resident lying in his/her bed. Further observation revealed a wheelchair beside the resident's bed with a cushion on the seat of the wheelchair, which had numerous tears and rips on the seat of the cushion.

On 1/29/18 at 3:00 PM, observation revealed the resident seated in his/her wheelchair in his/her room.

On 1/30/18 at 10:30 AM, observation revealed the resident lying in his/her bed, the wheelchair beside the bed, and a cushion in the seat with numerous tears in the cushion.

On 1/31/18 at 1:45 PM, Nurse Aide P verified the resident's wheelchair cushion had numerous tears. Nurse Aide P also verified the resident was at risk for pressure ulcers and was to have a pressure reducing cushion in the seat of the wheelchair. Nurse Aide P verified the cushion in the wheelchair needed replaced.

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F 558	Continued From page 2 On 1/31/18 at 2:50 PM, Administrative Nurse D verified the resident required a cushion in his/her wheelchair to prevent skin breakdown and the cushion in the wheelchair needed replaced. The 6/1/17 Facility Resident Rights policy documented resident accommodation of needs and services will be met for residents' individual needs and services. The facility failed to provide Resident #16 with a wheelchair cushion in good working condition, placing the resident at risk for skin breakdown.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		

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all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to notify the physician of changes in condition for 2 of 14 sampled residents. Resident #11 had a non-healing pressure ulcer and developed a new pressure ulcer, and Resident #13 experienced uncontrolled pain.

Findings included:

- Resident #11's quarterly (MDS) Minimum Data

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Set assessment, dated 12/11/17, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 15 (cognitively intact). The resident was independent with bed mobility and transfers, had impaired balance, and was unable to walk. The resident received (prn) as needed pain medications and the resident had no pain during the 7 day look back assessment period.

The 06/12/17 annual (CAA) Care Area Assessment for falls recorded the resident was at risk for falls due to his/her below the knee amputation, use of a mobility device, and not asking for staff assistance.

The 12/20/17 care plan recorded the resident was at risk for falls related to his/her below the knee amputation and use of mobility devices. The care plan recorded the resident was cognitively intact and able to make his/her needs known.

The 01/23/18 at 9:30 AM, fall report recorded the resident became dizzy, lost his/her balance, and fell, while transferring from his/her bed to the wheelchair. The report recorded the resident stated he/she struck his/her head, during the fall, and staff noted bruising and swelling on the resident's forehead. The report further recorded the resident complained of right hip pain and staff sent the resident to the (ER) Emergency Room for an evaluation and x-ray.

The 01/23/18 Radiology Report recorded the resident had no hip fracture and the resident returned to the facility.

The facility's Neurological Assessment flow sheet (assessment of sensory and motor responses, especially reflexes, to determine whether the

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nervous system is impaired), dated 01/23/18, recorded the resident was alert and oriented, and complained of right hip pain on 01/23/18 at 12:00 PM, 1:00 PM and 2:00 PM. Continued review of the flow sheet revealed no documentation of the resident's pain assessment from 01/23/18 at 2:00 PM until 01/25/18 at 2:00 PM (48 hours), when staff sent the resident to the emergency room for severe pain and emesis (vomit).

The 01/23/18 physician's order directed staff to administer Norco (narcotic pain medication used to relieve moderate to severe pain), 5/325 (mg) milligrams, 1 tablet, every 4 to 6 hours (prn) as needed for the resident's pain.

The January 2018 (MAR) Medication Administration Record directed staff to administer Norco 5/325 mg every 6 hours, as needed, to the resident for pain. Review of the MAR revealed the following information:
01/23/18 at 8:30 PM, Norco administered and at 9:45 PM the resident's pain was better.
01/24/18 at 12:30 AM, Norco administered and at 1:30 AM the resident had no complaints of pain.
01/24/18 at 9:00 AM, Norco administered with no results recorded.
01/24/18 at 9:00 PM, medication refused.
01/25/18 at 3:00 AM, medication refused.
01/25/18 at 9:00 AM, medication refused.

Review of the resident's medical record revealed no documentation staff assessed the resident's pain level from 01/24/18 at 1:30 AM to 01/25/18 at 2:00 PM (approximately 36 hours), when staff transferred the resident to the emergency room. Continued review of the resident's medical record lacked evidence staff notified the physician about the resident's uncontrolled pain, during this time

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period.

On 01/30/18 at 10:50 AM, observation revealed the resident returned from the hospital, seated in a wheelchair, and propelled by staff.

On 02/01/18 at 11:12 AM, Administrative Nurse D stated nursing staff should complete post fall assessments and notify the physician of worsening changes in condition or pain. Administrative Nurse D stated nursing staff should closely monitor the residents pain level and notify the physician if the resident's pain was not managed by their current pain medications.

The facility's 2017 Pain Policy directed staff to provide prompt assessments and treatments to manage the resident's pain. The policy directed staff to notify the physician, as needed, to ensure the resident's pain was controlled.

The facility failed to notify the physician of Resident #11's uncontrolled pain, placing the resident at risk for worsening pain.

- Resident #13's quarterly (MDS) Minimum Data Set assessment, dated 01/17/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 00 (severe cognitive impairment) exhibited verbal behaviors, and rejected cares. The resident required extensive to total staff assistance with bed mobility, transfers, toileting and personal hygiene, had an indwelling urinary catheter, and was frequently incontinent of bowel. The MDS further recorded the resident was at risk for the development of pressure ulcers, currently had no pressure ulcer, had a pressure reducing device on the bed and chair, and was on a repositioning/turning program.

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The 09/08/17 admission (CAA) Care Area Assessment for pressure ulcers recorded the resident was at risk for the development of pressure ulcers due to limited mobility caused by a CVA (cerebrovascular accident) (a stroke), and currently had a Stage 2 pressure ulcer on his/her right buttock.

The 11/11/17 Braden Assessment (assessment tool commonly used to quantify a patient's degree of risk for developing a pressure ulcer) recorded a score of 15 (at risk to develop pressure ulcers).

The 01/17/18 care plan recorded the resident was at risk for development of pressures ulcers and directed staff to reposition the resident and avoid exposure to moisture. The care plan also directed staff to report skin breakdown to the physician, assess and monitor existing open areas, and report worsening wounds/open areas to the physician. The care plan lacked evidence of nutritional interventions and the use of a ROHO cushion (air cell cushion provides proper positioning and redistributes pressure to prevent skin breakdown for immobile individuals, who spend significant time seated) in the resident's recliner and wheelchair.

The 01/22/18 nursing skin assessment recorded the resident had a 1.7 (cm) centimeter by 1.0 cm shear (produced by pressure or friction) wound on the left buttock. The resident's medical record lacked evidence of any assessments of the resident's pressure ulcers after 01/22/18.

The 01/22/18 physician's order directed staff to apply zinc oxide ointment (ointment acts as skin barrier to prevent and heal minor wounds) to the

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resident's wound every day and as needed, and monitor the wound daily until healed.

The January 2018 (TAR) Treatment Administration Record documented, from 01/22/18 to 02/01/18, staff recorded the initials mx (monitored) every day on the pressure ulcer flow sheet. Continued review of the TAR flow sheet lacked evidence staff assessed the resident's pressure ulcer for description, measurements, change in condition, drainage, or infection. Continued review of the flow sheet revealed no documentation of the new pressure ulcer observed by the surveyor on 01/31/18.

Review of the resident's medical record lacked evidence staff notified the physician that the resident's existing Stage 2 pressure ulcer on the upper left buttock was not healing or the development of a new Stage 2 pressure ulcer on his/her upper left buttock.

On 01/31/18 at 9:15 AM, observation revealed the resident, seated on a commode, with the sit to stand lift used to assist the resident to maintain his/her balance. Continued observation revealed Nurse G and Nurse Aide M used the lift to assist the resident to stand to provide the pressure ulcer treatment. Continued observation revealed the resident's upper left buttock near the coccyx (small triangular bone near the base of the spine) had 2 pressure ulcers: upper open area measured approximately 1.0-1.5 cm in diameter (Nurse G verified this was a new open area) and lower open area measured approximately 1.5-2.0 cm in diameter (Nurse G verified this was the existing pressure ulcer on the TAR). Continued observation revealed the area surrounding the resident's 2 pressure ulcers had purple colored

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F 580	Continued From page 9 skin and Nurse G applied zinc oxide ointment on the pressure ulcers. Continued observation revealed the resident said "ouch", when Nurse G cleaned the pressure ulcers and applied zinc oxide ointment. On 02/01/18 at 11:25 AM, Administrative Nurse D stated the facility had no wound nurse, but nurses should assess the resident's pressure ulcer and document on the TAR to appropriately monitor the pressure ulcer. Administrative Nurse D stated staff should notify the physician and (RD) Registered Dietician about worsening or new pressure ulcers to ensure appropriate wound treatment and nutritional interventions were in place. The facility's 2017 Pressure Ulcer Policy directed staff to identify residents at risk to develop pressure ulcers and implement necessary interventions to prevent or heal pressure ulcers. The policy directed staff to notify the physician and RD to ensure appropriate treatment and nutritional interventions to prevent and/or heal pressure ulcers. The facility failed to notify the physician about a Stage 2 pressure ulcer not healing and the development of a new Stage 2 pressure ulcer for Resident #13, placing the resident at risk for worsening skin issues.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

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resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The

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sample included 14 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for fluid restriction for 1 of 14 sampled residents. (#18)

Findings included:

- Resident #18's (POS) physician's order sheet, dated 12/30/17, documented the resident had diagnoses of diabetes mellitus type 2 (when a body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), and (copd) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The quarterly MDS, dated 9/18/17, recorded the resident had a (BIMS) Brief Interview for Mental Status Score of 15, which indicated intact cognition. The assessment revealed the resident required extensive assistance of 1 staff for bed mobility, dressing, and extensive assistance of 2 staff for transfers and toileting. The assessment further revealed the resident was independent with set up assistance for eating and had a therapeutic diet.

The quarterly (MDS) Minimum Data Set assessment, dated 12/18/17, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 13, which indicated intact cognition. The assessment revealed the resident required the same staff assistance as the 9/18/17 quarterly MDS recorded.

The nutrition (CAA) Care Area Assessment,

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dated 7/3/17, documented the resident was on a 2000 (cc) cubic centimeter fluid restriction and a 1800-2000 calorie (ADA) American Diabetes Association diet.

The 9/27/17 care plan directed staff to document food and fluid intake at meals on dietary intake forms. The 1/3/18 updated care plan recorded the resident was on a 2000 cc fluid restriction and had the potential for dehydration. Review of the care plan lacked staff direction regarding the physician's order for the fluid restriction or how to monitor for dehydration (a dangerous lack of water in the body resulting from inadequate intake of fluids or excessive loss through sweating, vomiting, or diarrhea).

The 3/20/17 physician's order recorded a 2000 cc fluid restriction for the resident and lacked a diagnosis for the fluid restriction.

On 1/31/18 at 10:30 AM, observation revealed the resident sat in his/her recliner, and had a full 32 (oz) ounce mug of water on his/her bedside table. Further observation revealed at 2:40 PM, the mug still had 32 oz of water.

On 2/1/18 at 9:56 AM, Licensed Nurse G stated, the nurses write on the resident's care plan as needed.

On 2/1/18 at 2:57 AM, Administrative Nurse D stated after the resident was placed on a fluid restriction, the care plan should have specific instructions to direct staff on how to monitor the

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F 656	Continued From page 13 resident's fluid status. The facility's October 2010 Encouraging and Restricting fluids directed staff to review the resident's care plan and assess for any special needs. The facility failed to develop a comprehensive care plan for Resident #18's fluid restriction, placing the resident at risk for dehydration or fluid overload.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		

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§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to provide the necessary care and services to maintain good personal hygiene for 1 of 14 sampled residents. (#12)

Findings included:

- Resident #12's (POS) physician's order sheet, dated 12/28/17, documented the resident had diagnoses of dementia without behavior disturbance (progressive mental disorder characterized by failing memory and confusion), hypertension (elevated blood pressure), and major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The quarterly (MDS) Minimum Data Set assessment, dated 12/4/17, documented the resident had a (BIMS) Brief Interview for Mental Status score of 11, which indicated moderately impaired cognition. The assessment revealed the

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resident was independent with all (ADLs) Activities of Daily Living, except for personal hygiene and bathing that required supervision and set-up assistance. The assessment further revealed the resident was continent of bladder and bowel.

The 3/6/17 (CAA) Care Area Assessment for ADL's documented the resident forgets to change his/her clothes at night and required staff assistance with putting on night clothes and leaving out clothes for the next day. The CAA further documented the resident required assistance with personal cares, and encouragement and cueing from staff to take a bath.

The 12/13/17 care plan documented the resident was limited in his/her ability to dress and undress him/herself related to dementia and would leave clothes on and not change them daily. The care plan directed staff to assist the resident with changing his/her clothes at night and remove soiled clothes so he/she would dress with new clothing the next day.

On 1/29/18 at 3:40 PM, observation revealed the resident seated in his/her recliner in rust colored pants, rust colored shirt, and a cream colored vest. Further observation revealed the resident's hair was flat and uncombed in the back.

On 1/30/18 at 10:52 AM, observation revealed the resident in his/her room in the same clothes as the previous day.

On 1/31/18 at 8:30 AM, observation revealed the resident ambulating down the hall, hair uncombed in the back and wearing the same clothes as the

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F 676	Continued From page 16 previous two days. On 2/1/18 at 9:56 AM, Licensed Nurse G stated staff should offer assistance the resident for changing his/her clothes, but the resident often refused. On 2/1/18 at 10:11 AM, Nurse Aide M stated staff checked on the resident and removed his/her clothing, assisted the resident to change his/her clothing, and comb his/her hair. On 2/1/18 at 2:36 PM, Administrative Nurse D stated staff should encourage the resident to change his/her clothing, and make sure the resident's hair was combed. Upon request, the facility failed to provide a policy for ADL care and assistance. The facility failed to provide care and services to maintain grooming for Resident #12, who wore the same clothing 3 days in a row and had unkempt hair, which placed the resident at risk for poor hygiene.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

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by:
The facility had a census of 29 residents. The sample included 14 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to obtain blood glucose checks (measures the amount of sugar in the blood) for 1 of 5 sampled residents. (#18)

Findings included:

- Resident #18's (POS) physician order sheet, dated 12/30/17, documented the resident had diagnoses of diabetes mellitus type 2 (when a body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and (copd) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The quarterly (MDS) Minimum Data Set assessment, dated 12/18/17, recorded the resident had a (BIMS) Brief Interview for Mental Status Score of 13, which indicated intact cognition. The assessment revealed the resident required extensive assistance of 1 staff for bed mobility, dressing, and extensive assistance of 2 staff for transfers and toileting. The assessment further revealed the resident received 7 days of insulin (a hormone produced in the pancreas that regulates the amount of glucose (sugar) in the blood).

The 7/3/17 (CAA) Care Area Assessment for nutrition recorded the resident received a 1800-2000 calorie (ADA) American Diabetes Association diet.

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The 1/3/18 care plan recorded the resident was on a therapeutic diet due to diabetes and directed staff to monitor glucose levels (blood sugar), pulse and pain.

The 3/20/17 physician's order directed staff to administer Novolog 70/30 (a man-made insulin used to control high blood sugar in adults with diabetes mellitus), 22 units, (sq) subcutaneous, daily, for the diagnosis of diabetes mellitus type 2.

The 3/20/17 physician's order directed staff to administer Levemir, (long-acting insulin used to control high blood sugar in adults with diabetes mellitus) 5 units, sq, at bedtime, for the diagnosis of diabetes mellitus.

The 3/20/17 physician's order directed staff to administer Novolog flex pen (a prefilled insulin syringe that allows for accurate measurement by dialing the number of units to administer), sliding scale, administered for the following blood sugars:
0 - 119, administer 0 units
120 - 180, administer 2 units
181 - 240, administer 4 units
241 - 300, administer 6 units
301-360, administer 8 units
361 - 399, administer 10 units
if 400 - 600 call the physician

The 3/20/17 physician's order directed staff to obtain the resident's blood sugar 4 times a day during the timeframes of 7- 9 AM, 11 AM - 1 PM, 5- 7 PM, and 8- 10 PM.

Review of the (MAR) Medication Administration Record lacked documentation staff obtained the resident's blood sugar on the following days and

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F 684	Continued From page 19 time frames: 1/1/18 - 7-9 AM, 11 AM - 1 PM, 5 - 7 PM, and 8 - 10 PM 1/2/18 - 11 AM- 1 PM 1/6/18 - 8 - 10 PM 1/8/18 - 8 - 10 PM 1/15/18 - 8 - 10 PM 1/17/18 - 7 AM - 1 PM On 1/31/18 at 10:49 AM, observation revealed the resident seated in his/her recliner. On 2/1/18 at 9:56 AM, Licensed Nurse G stated, staff obtain the resident's blood sugars 4 times a day and verified the lack of documentation of the blood sugars in the MAR. On 2/1/18 at 3:01 PM, Administrative Nurse D stated after staff obtained the resident's blood sugars they document in the MAR. Administrative Nurse D verified the lack of documentation in the MAR. The undated facility Medication Administration Policy directed staff to record in the MAR, the initials of the nurse or medication aide who gave the medication. The policy further documented, if the resident refused the medication, the medication was circled and recorded in the nurse's notes. The facility failed to obtain Resident #18's physician ordered blood sugars, placing the resident at risk for uncontrolled blood sugars.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to provide the necessary treatment and services to promote healing of a facility acquired Stage 2 pressure ulcer (partial thickness loss of dermis, presenting as a shallow wound) and prevent the development of a new Stage 2 pressure ulcer for 1 of 1 sampled resident. (#11)

Findings included:

- Review of Resident #11's physician order sheet, dated 01/02/18, revealed the following diagnoses: Diabetes Mellitus (when the body can not use glucose related lack of insulin production or the body can not respond to insulin), (CVA) cerebrovascular accident (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain), dysphagia (swallowing difficulty) and dementia (progressive mental disorder characterized by failing memory and

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confusion).

The quarterly (MDS) Minimum Data Set assessment, dated 01/17/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 00 (severe cognitive impairment) exhibited verbal behaviors, and rejected cares. The resident required extensive to total staff assistance with bed mobility, transfers, toileting and personal hygiene, had an indwelling urinary catheter, and was frequently incontinent of bowel. The MDS further recorded the resident was at risk for the development of pressure ulcers, currently had no pressure ulcer, had a pressure reducing device on the bed and chair, and a repositioning/turning program.

The 09/08/17 admission (CAA) Care Area Assessment for pressure ulcers recorded the resident was at risk for the development of pressure ulcers due to limited mobility caused by the CVA, and currently had an Stage 2 pressure ulcer on his/her right buttock.

The 11/11/17 Braden Assessment recorded a score of 15 (at risk to develop pressure ulcers).

The 01/17/18 care plan recorded the resident was at risk for the development of pressures ulcers and directed staff to reposition the resident and avoid exposure to moisture. The care plan also directed staff to report skin breakdown to the physician, assess and monitor existing open areas, and report worsening wounds/open areas to the physician. The care plan lacked evidence of nutritional interventions and the use of a ROHO cushion (air cell cushion provides proper positioning and redistributes pressure to prevent skin breakdown for immobile individuals, who

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spend significant time seated) in the resident's recliner and wheelchair.

The 01/22/18 nursing skin assessment recorded the resident had a 1.7 (cm) centimeter by 1.0 cm shear (produced by pressure or friction) wound on the left buttock. The resident's medical record lacked evidence of any assessments of the resident's pressure ulcers after 01/22/18.

The 01/22/18 physician's order directed staff to apply zinc oxide ointment (ointment acts as skin barrier to prevent and heal minor wounds) to the resident's wound every day and as needed, and monitor the wound daily until healed.

The January 2018 (TAR) Treatment Administration Record documented, from 01/22/18 to 02/01/18, staff recorded the initials mx (monitored) every day on the pressure ulcer flowsheet. Continued review of the TAR flowsheet lacked evidence staff assessed the resident's pressure ulcer for description, measurements, change in condition, drainage, or infection. Continued review of the flowsheet revealed no documentation of the new pressure ulcer observed by the surveyor on 01/31/18.

The 01/24/18 (RD) Registered Dietician Progress Notes recorded the resident had a recent hospitalization and weight loss, and the resident needed an average meal intake of 100% to maintain his/her weight and protein levels. Continued review of the progress note revealed no documentation of nutritional interventions to promote wound healing.

Review of the resident's medical record lacked evidence staff notified the physician that the

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existing Stage 2 pressure ulcer on the upper left buttock was not healing or the development of a new Stage 2 pressure ulcer on the upper left buttock.

On 01/30/18 at 2:02 PM, observation revealed the resident's ROHO cushion (air cell cushion provides proper positioning and redistributes pressure to prevent skin breakdown for immobile individuals, who spend significant time seated) was deflated on the resident's unoccupied wheelchair seat.

On 01/30/18 at 4:47 PM, observation revealed the resident, seated in a wheelchair with the ROHO cushion in place, at the dining room table.

On 01/31/18 at 9:15 AM, observation revealed the resident, seated on a commode, with the sit to stand lift used to assist the resident to maintain his/her balance. Continued observation revealed Nurse G and Nurse Aide M used the lift to assist the resident to stand to provide the pressure ulcer treatment. Continued observation revealed the resident's upper left buttock near the coccyx (small triangular bone near the base of the spine) had 2 pressure ulcers: upper open area measured approximately 1.0-1.5 cm in diameter (Nurse G verified this was a new open area) and lower open area measured approximately 1.5-2.0 cm in diameter (Nurse G verified this was the existing pressure ulcer on the TAR). Continued observation revealed the area surrounding the resident's 2 pressure ulcers had purple colored skin and Nurse G applied zinc oxide ointment on the pressure ulcers. Continued observation revealed the resident said "ouch", when Nurse G cleaned the pressure ulcers and applied zinc oxide ointment.

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On 01/31/18 at 9:25 AM, Nurse G stated the resident spent a lot of time seated in his/her recliner and wheelchair, staff ensured a cushion was in place, and repositioned the resident every 2 hours. Nurse G stated the resident had a history of skin problems on his/her buttocks, and staff provided treatments as ordered by the physician and documented the wound information on the TAR. Nurse G stated staff had not used PUSH Tool (PUSH Tool was developed by the National Pressure Ulcer Advisory Panel (NPUAP) as a quick, reliable tool to monitor the change in pressure ulcer status over time) to monitor the resident's pressure ulcers and that was the reason for lack of assessment documentation on the resident's medical record. Nurse G stated staff should notify the physician if the resident's pressure ulcer was not healing or a new pressure ulcer developed. Nurse G stated he/she was not aware if staff notified the (RD) Registered Dietician about the resident's skin issue or if the resident had nutritional interventions to promote wound healing.

On 01/31/18 at 10:15 AM, Nurse Aide M stated the resident required extensive staff assistance with repositioning, transfers and had a history of skin problems on his/her buttocks. Nurse Aide M stated the resident spent a lot of time, seated in his/her recliner or wheelchair, and staff ensured the cushion was in place. Nurse Aide M stated staff reported the resident's ROHO cushion was deflated several days ago and staff continued to use the ineffective cushion, until the new cushion arrived.

On 01/31/18 at 10:30 AM, Nurse Aide N stated the resident required extensive staff assistance

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for repositioning and staff used a sit to stand lift to transfer the resident. Nurse Aide N stated the resident had a history of pressure ulcers on his/her buttocks, and the resident spent most of the day, seated in his/her recliner or wheelchair. Nurse Aide N stated staff reported the resident's ROHO cushion was not inflated to the charge nurse, several weeks ago, and staff continued to use the deflated cushion in the resident's recliner and wheelchair.

On 01/31/18 at 1:01 PM, Dietary Staff BB stated the resident had not received nutritional interventions to promote wound healing.

On 02/01/18 at 11:25 AM, Administrative Nurse D stated the facility did not have a wound nurse, but nurses should assess the resident's pressure ulcer and document on the TAR to appropriately monitor the pressure ulcer. Administrative Nurse D stated staff should notify the physician and RD about worsening or new pressure ulcers to ensure appropriate wound treatment and nutritional interventions were in place. Administrative Nurse D stated staff identified the ROHO cushion was deflated and a new cushion was ordered.

On 02/06/18 at 9:10 AM, Registered Dietician GG stated staff had not informed him/her or the facility's dietary manager about the resident's pressure ulcers. Registered Dietician GG further stated the resident had recent weight loss and needed nutritional interventions to promote wound healing.

The facility's 2017 Pressure Ulcer Policy directed staff to identify residents at risk to develop pressure ulcers and implement necessary

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F 686	Continued From page 26 interventions to prevent or heal pressure ulcers. The policy directed staff to notify the physician and RD to ensure appropriate treatment and nutritional interventions to prevent and/or heal pressure ulcers. The facility failed to provide the necessary treatment and services to promote healing of a facility acquired Stage 2 pressure ulcer and prevent the development of a new Stage 2 pressure ulcer for cognitively impaired dependent Resident #11, identified at risk for pressure ulcers.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to ensure the resident environment remained free of accident hazards including storage of chemicals, for 4 cognitively impaired, independently mobile residents. Findings included: - On 1/29/18 at 3:15 PM, observation revealed the unused whirlpool room on the west hallway	F 689		

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F 689	Continued From page 27 with the door open. Further observation revealed an unlocked cabinet which contained a 1 quart spray bottle of Quaternary Disinfectant Cleaner. The label stated "keep out of reach of children," can be harmful if swallowed or sprayed in eyes. On 1/29/18 at 3:22 PM, Nurse G verified the unlocked cabinet in the whirlpool room, and the 1 quart bottle of spray disinfectant should be in a locked cabinet. Nurse G also stated the facility had 4 cognitively impaired, independently mobile residents. On 1/31/18 at 11:50 AM, Administrative Nurse D verified the cabinets in the whirlpool room should remain locked. The 6/1/17 Facility Control of Hazardous Chemicals policy, documented the facility is committed to eliminating and controlling hazards that can cause injury or illness to their elders. All substances with warning labels, including "keep out of reach of children," will be locked and inaccessible at all times. The facility failed to ensure chemicals were kept in a locked cabinet, placing the 4 cognitively impaired, independently mobile residents, who reside in the facility, at risk for injury.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		

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ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to provide adequate fluids and monitor hydration status for 2 of 2 sampled residents, #11 and #18 and prevent weight loss for Resident #11.

Findings included:

- Resident #18's (POS) physician's order sheet, dated 12/30/17, documented the resident had diagnoses of diabetes mellitus type 2 (when a body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), and (copd) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The quarterly (MDS) Minimum Data Set

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assessment, dated 9/18/17, recorded the resident had a (BIMS0 Brief Interview for Mental Status score of 15, which indicated intact cognition. The assessment revealed the resident required required extensive assistance of 1 staff for bed mobility, dressing, and extensive assistance of 2 staff for transfers and toileting. The assessment further revealed the resident was independent with set up assistance for eating.

The quarterly MDS, dated 12/18/17, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 13, which indicated intact cognition. The assessment revealed the resident required the same staff assistaance as the 9/18/17 quarterly MDS documents.

The nutrition (CAA) Care Area Assessment, dated 7/3/17, documented the resident was on a 2000 (cc) cubic centimeter fluid restriction and a 1800-2000 calorie (ADA) American Diabetes Association diet.

The 9/27/17 care plan directed staff to document food and fluid intake at meals on dietary intake forms. The 1/3/18 updated care plan recorded the resident was on a 2000 cc fluid restriction and had the potential for dehydration (a dangerous lack of water in the body resulting from inadequate intake of fluids or excessive loss through sweating, vomiting, or diarrhea). Review of the care plan lacked staff direction regarding the physician's order for the fluid restriction or how to monitor for dehydration.

The 3/20/17 physician's order recorded a 2000 cc fluid restriction for the resident and lacked a diagnosis for the fluid restriction.

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The 10/20/17 laboratory report recorded the resident's (CMP) comprehensive metabolic panel (a blood test that serves as a broad medical screening tool) was within normal limits.

Review of the November 2017 resident's fluid intake recorded the following:

11/1/17- 1385 cc
11/2/17- 1470 cc
11/3/17- 1330 cc
11/4/17- 1280 cc
11/6/17- 1760 cc
11/7/17- 1240 cc
11/8/17- 1100 cc
11/9/17- 1430 cc
11/10/17- 0 cc
11/11/17- 1310 cc
11/12/17- 1430 cc
11/13/17- 550 cc
11/14/17- 1095 cc
11/15/17- 450 cc
11/16/17- 390 cc
11/17/17- 450 cc
11/18/17- 1620 cc
11/19/17- 1100 cc
11/20/17- 840 cc
11/21/17- 530 cc
11/22/17- 580 cc
11/23/17- 1270 cc
11/25/17- 1580 cc
11/26/17- 730 cc
11/27/17- 1010 cc
11/28/17- 1540 cc
11/29/17- 1780 cc
11/30/17- 1270 cc

Review of the residents daily fluid intake revealed the resident consumed an average of 1,017 (cc)

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cubic centimeters per day.

Review of the December 2017 resident's fluid intake recorded the following:

12/1/17- 1465 cc
12/2/17- 1730 cc
12/3/17- 1720 cc
12/4/17- 790 cc
12/5/17- 650 cc
12/6/17- 490 cc
12/7/17- 1575 cc
12/8/17- 1250 cc
12/10/17- 1370 cc
12/11/17- 50 cc
12/12/17- 615 cc
12/13/17- 700 cc
12/14/17- 780 cc
12/15/17- 930 cc
12/16/17- 300 cc
12/17/17- 1130 cc
12/18/17- 1030 cc
12/19/17- 410 cc
12/20/17- 1210 cc
12/21/17- 510 cc
12/22/17- 1390 cc
12/23/17- 350 cc
12/24/17- 1740 cc
12/26/17- 1250 cc
12/27/17- 1105 cc
12/28/17- 970 cc
12/29/17- 1040 cc
12/30/17- 1785 cc
12/31/17- 865 cc

Review of the residents daily fluid intake revealed the resident consumed an average of 942 cc per day.

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Review of the January 2018 resident's fluid intake recorded the following:

1/1/18- 525 cc
1/2/18- 1590 cc
1/3/18- 415 cc
1/4/18- 1025 cc
1/5/18- 685 cc
1/6/18- 1425 cc
1/7/18- 540 cc
1/8/18- 750 cc
1/9/18- 295 cc
1/10/18- 365 cc
1/11/18- 870 cc
1/12/18- 245 cc
1/13/18- 730 cc
1/14/18- 895 cc
1/15/18- 1345 cc
1/16/18- 1090 cc
1/17/18- 970 cc
1/18/18- 905 cc
1/19/18- 760 cc
1/20/18- 865 cc
1/21/18- 925 cc
1/22/18- 870 cc
1/23/18- 1280 cc
1/24/18- 920 cc
1/25/18- 490 cc
1/26/18- 980 cc
1/27/18- 1240 cc
1/28/18- 1480 cc
1/29/18- 600 cc
1/30/18- 880 cc

Review of the residents daily fluid intake revealed the resident consumed an average of 865 cc per day.

On 1/31/18 at 10:30 AM, observation revealed the

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resident sat in his/her recliner, and had a full 32 (oz) ounce mug of water on his/her bedside table. Further observation revealed at 2:40 PM, the mug still had 32 oz of water.

On 1/31/18 at 1:48 PM, Dietary Staff BB stated the resident had a fluid restriction, the dietary staff recorded the resident's fluids at meal times, and nurse aides record the intakes at the end of the shift and documented on the resident's (MAR) Medication Administration Record.

On 2/1/18 at 9:56 AM, Licensed Nurse G stated, nurse aides monitor the resident's water pitcher and document the resident's intake on a sheet kept in the resident's bathroom. Licensed Nurse G further stated dietary staff monitor the resident's fluid intakes at meals, and the total from the dietary staff and nurse aides were documented in the resident's MAR daily.

On 2/1/18 at 10:11 AM, Nurse Aide M stated staff documented the resident's fluid intake from his/her water pitcher was on a sheet in the resident's bathroom and gave the daily total to the nurse at shift change. Nurse Aide M further stated the resident drinks well and staff rarely have to encourage him/her to drink.

On 2/1/18 at 2:57 AM, Administrative Nurse D stated staff documented the resident's fluid intake in the MAR and the sheet should reflect the correct intake amounts.

The facility's undated 2017 Intake and Output Policy directed staff to keep an accurate record of the resident's actual fluid intake and output, as ordered by the physician, and document the exact amount of fluid to be given over the 24 hour shift

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period. The policy further directed staff to document the exact amount of fluid received each shift and record the amounts in the appropriate column on the intake and output form. The nurse should make sure the output for each of the residents are up to date, totalled and recorded before going off duty.

The October 2010 facility's Encouraging and Restricting Fluids Policy documented staff should follow specific instructions concerning fluid intake and restrictions, and be accurate when recording fluid intake policy further directed staff to record fluid intake on the intake side of the intake and output recorded and to record fluids in (ml) milliliters. When the resident has been placed on restricted fluids, remove the water pitcher and cup from the resident room, if the resident has refused the water pitcher to be removed, notify the supervisor and the physician. The policy further documented to be sure an intake and output record was maintained.

The facility failed to monitor and document Resident #18's physician ordered fluid restriction, placing the resident at risk for dehydration.

- Resident #11's quarterly (MDS) Minimum Data Set assessment, dated 01/17/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 0 (severe cognitive impairment). The MDS also recorded the resident required extensive staff assistance with most (ADLs) Activities of Daily Living and limited staff assistance with eating. The MDS further recorded

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the resident weighed 264 pounds, had no recent weight loss, and received a mechanically altered diet.

The 09/08/17 admission (CAA) Care Area Assessment for nutrition recorded the resident received a pureed diet (mechanical altered diet to a pudding like consistency) with honey thickened liquids due to dysphagia (swallowing problem). The CAA also recorded the resident was on a physician ordered 2000 (ml) milliliter a day fluid restriction.

The 01/17/18 care plan recorded the resident received a pureed diet with thickened liquids due to dysphagia and a 2000 ml a day fluid restriction related to Diabetes Mellitus (body cannot use glucose due to not enough insulin produced or the body does not respond to insulin) and (CHF) Congestive Heart Failure (a condition with low heart output and the body becomes congested with fluid). The care plan directed staff to assist the resident, as needed, with eating and drinking, and obtain and follow (RD) Registered Dietician recommendations.

The December 2017 Intake/Output flow sheet recorded the resident's average fluid intake was 902 ml a day.

The 12/18/17 Nutrition Assessment recorded the resident had a recent weight loss and a low albumin level (blood test used to measure the amount of protein in the blood, used in part to determine a person's nutritional status). The assessment recorded the RD recommended the facility notify the physician of the resident's nutrition concerns.

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Review of the resident's medical record revealed no documentation the facility notified the physician about the resident's nutrition concerns.

The RD Nutritional Assessment, dated 01/17/18, recorded the resident's estimated fluid needs were 2375 ml a day.

The January 2018 Intake/Output flow sheet recorded the resident's average fluid intake was 841 ml a day.

The 01/22/18 nursing skin assessment recorded the resident had a 1.7 (cm) centimeter by 1.0 cm shear (produced by pressure or friction) wound on the left buttock.

The 01/22/18 physician's order directed staff to apply zinc oxide ointment (ointment acts as skin barrier to prevent and heal minor wounds) to the resident's wound every day and as needed, and monitor the wound daily until healed.

The 01/24/18 (RD) Registered Dietician Progress Notes recorded the resident had a recent hospitalization and weight loss, and the resident needed an average meal intake of 100% to maintain his/her weight and protein levels. Continued review of the progress note revealed no documentation of nutritional interventions to promote wound healing.

On 01/30/18 at 11:29 AM, observation revealed the resident, sat in a wheelchair, at the dining room table, and drank thickened liquids independently.

On 01/31/18 at 10:15 AM, Nurse Aide M stated

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staff provided the resident thickened liquids and the resident was on a 2000 ml a day fluid restriction. Nurse Aide M stated the (CNA) Certified Nurse Aide records the resident's intake every shift and gives to the charge nurse.

On 01/31/18 at 1:01 PM, Dietary Staff BB stated the resident was on a 2000 ml a day fluid restriction, and dietary staff recorded the resident's fluid intake at meals and gave it to the night nurse to record the daily totals. Dietary Staff BB stated the resident had not received nutritional interventions to promote wound healing.

On 01/31/18 at 2:50 PM, Nurse I stated the night nurse totaled the resident's daily fluid intake and recorded the total on the Intake/Output flow sheet on the (MAR) Medication Administration Record. Nurse I stated the resident was on a 2000 ml a day fluid restriction, and he/she was not aware, who monitored the resident's fluid intake.

On 02/01/18 at 11:25 AM, Administrative Nurse D stated the resident was on a physician ordered 2000 ml a day fluid restriction, and staff should accurately document and monitor the resident's fluid intake. Administrative Nurse D stated staff should notify the physician and RD about changes in the resident's nutritional status and follow the physician's orders and RD recommendations to ensure the resident maintained acceptable parameters of nutritional status.

On 02/06/18 at 9:10 AM, Registered Dietician GG stated staff had not informed him/her or the facility's dietary manager about the resident's pressure ulcers. Registered Dietician GG further

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F 692	Continued From page 38 stated the resident had recent weight loss and needed nutritional interventions to promote wound healing. The facility failed to accurately monitor a physician ordered fluid restriction to ensure proper hydration and provide interventions to ensure acceptable parameters of nutritional status for Resident #11, placing the resident at risk for dehydration and further skin breakdown.	F 692		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to ensure adequate pain management for 1 of 14 sampled residents, who had a fall with a head injury and fractured hip. (#13) Findings included: - Review of Resident #13's physician order sheet, dated 01/02/18, revealed the following diagnoses: Diabetes Mellitus (when the body can not use glucose related lack of insulin production or the body can not respond to insulin), left leg below the knee amputation and End Stage Renal Disease (terminal disease due to irreversible	F 697		

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damage to the kidneys, usually requires dialysis).

The quarterly (MDS) Minimum Data Set assessment, dated 12/11/17, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 15 (cognitively intact). The resident was independent with bed mobility and transfers, had impaired balance, and was unable to walk. The resident received (prn) as needed pain medications and the resident had no pain during the 7 day look back assessment period.

The 06/12/17 annual (CAA) Care Area Assessment for falls recorded the resident was at risk for falls due to his/her below the knee amputation, use of a mobility device, and not asking for staff assistance.

The 12/20/17 care plan recorded the resident was at risk for falls related to his/her below the knee amputation and use of mobility devices. The care plan recorded the resident was cognitively intact and able to make his/her needs known.

The facility's 01/23/18 at 9:30 AM, fall report recorded the resident became dizzy, lost his/her balance, and fell, while transferring from his/her bed to the wheelchair. The report recorded the resident stated he/she struck his/her head, during the fall, and staff noted bruising and swelling on the resident's forehead. The report further recorded the resident complained of right hip pain and staff sent the resident to the (ER) Emergency Room for an evaluation and x-ray.

The 01/23/18 Radiology Report recorded the resident had no hip fracture and the resident returned to the facility.

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The facility's Neurological Assessment flow sheet (assessment of sensory and motor responses, especially reflexes, to determine whether the nervous system is impaired), dated 01/23/18, recorded the resident was alert and oriented, and complained of right hip pain on 01/23/18 at 12:00 PM, 1:00 PM and 2:00 PM. Continued review of the flow sheet revealed no documentation of the resident's pain assessment from 01/23/18 at 2:00 PM until 01/25/18 at 2:00 PM (48 hours), when staff sent the resident to the emergency room for severe pain and emesis (vomit).

The 01/23/18 physician's order directed staff to administer Norco (narcotic pain medication used to relieve moderate to severe pain), 5/325 (mg) milligrams, 1 tablet, every 4 to 6 hours (prn) as needed for the resident's pain.

The January 2018 (MAR) Medication Administration Record directed staff to administer Norco 5/325 mg every 6 hours, as needed, to the resident for pain. Review of the MAR revealed the following information:
01/23/18 at 8:30 PM, Norco administered and at 9:45 PM the resident's pain was better.
01/24/18 at 12:30 AM, Norco administered and at 1:30 AM the resident had no complaints of pain.
01/24/18 at 9:00 AM, Norco administered with no results recorded.
01/24/18 at 9:00 PM, medication refused.
01/25/18 at 3:00 AM, medication refused.
01/25/18 at 9:00 AM, medication refused.

Review of the resident's medical record revealed no documentation, staff assessed the resident's pain level from 01/24/18 at 1:30 AM to 01/25/18 at 2:00 PM (approximately 36 hours), when staff transferred the resident to the emergency room.

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Continued review of the resident's medical record lacked evidence staff notified the physician about the resident's uncontrolled pain, during this time period.

The 01/25/18 Hospital Transfer Report recorded the resident had a fall on 01/23/18, and hit his/her head and right hip. The report recorded the resident has had no pain relief since the fall and now had dark emesis with coffee ground consistency and foul odor. The report also recorded the resident complained of pain all over his/her body, and the resident was unable to move, due to increased pain with movement.

The 01/26/18 Hospital Transfer Report recorded the resident had a fall on 01/23/18, and x-ray to the resident's right hip did not reveal an injury. The report recorded the resident had increased pain since the fall. The last Norco was administered on 01/24/18 at 9:00 AM (32 hours prior to the resident's transfer to the hospital), and the resident vomited for more than 24 hours.

The 01/26/18 hospital admission record documented the resident fell out of bed on 01/23/18, landed on his/her right hip and head, and prior imaging did not reveal a fracture. The admission record documented the resident had increased right frontal headache pain and right hip pain since the fall. The admission record documented the resident had severe right hip pain, that radiated into his/her knee and developed bilious emesis (forcible ejection of vomit containing bile (greenish/brown fluid secreted in the liver). The admission record documented the resident's head (CT) Computed Tomography scan (test that uses x-ray technology to make multiple cross-sectional views of organs

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and bones) revealed no acute injuries and the resident's CT pelvis scan revealed a displaced fracture of the hip.

On 01/30/18 at 10:50 AM, observation revealed the resident returned from the hospital, seated in a wheelchair, and propelled by staff.

On 01/31/18 at 9:25 AM, Nurse G stated the resident was alert and oriented, and could accurately report his/her pain. Nurse G stated the resident had a fall, the x-ray was negative for a fracture and the resident complained of worsening right hip pain. Nurse G stated the facility obtained a physician's order for prn pain medication, but the resident refused the pain medication several times, due to nausea and vomiting. Nurse G further stated nursing staff should assess residents for changes in condition and/or pain after falls and notify the physician to ensure the resident's pain was managed.

On 01/31/18 at 10:30 AM, Nurse Aide N stated the resident was alert and oriented, and able to accurately report his/her pain. Nurse Aide N stated the resident complained of increased right hip pain, especially with movement, and the resident began to refuse cares due to the pain. Nurse Aide N further stated he/she reported the resident's worsening pain to the nurse.

On 01/31/18 at 11:19 AM, Nurse Aide O stated the resident was alert, always involved in his/her cares and could accurately report his/her pain. Nurse Aide O stated the resident complained of severe hip pain for 2 days after the fall and the resident began vomiting the day before he/she discharged to the hospital. Nurse Aide O further stated he/she reported the resident's pain to the

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nurse several times a day and was told the resident refused pain medications.

On 02/01/18 at 8:38 AM, Nurse Aide P stated the resident could accurately report his/her pain and was always involved in his/her cares. Nurse Aide P stated the resident complained of severe right hip pain that increased with movement, did not want staff to touch him/her due to the hip and leg pain and refused dialysis (the clinical purification of blood). Nurse Aide P further stated the resident's pain was reported to the nurse, and the nurse stated several times the resident refused pain medication due to his/her nausea and vomiting.

On 02/01/18 at 9:17 AM, Nurse H stated the resident was alert and oriented and able to accurately report his/her changes in condition and/or pain. Nurse H stated the resident complained of worsening hip pain and headaches, and refused the prn Norco at times due to nausea and vomiting. Nurse H stated he/she was not aware if nursing staff notified the physician of the resident's worsening pain and a need for a change in pain medication, or if staff assessed and recorded the resident's status prior to discharge to hospital. Nurse H further stated the resident refused his/her scheduled dialysis treatment and the dialysis staff told the facility to send the resident to the hospital.

On 02/01/18 at 11:12 AM, Administrative Nurse D stated nursing staff should complete post fall assessments and notify the physician of worsening changes in condition or pain. Administrative Nurse D stated nursing staff should closely monitor the resident's pain level and notify the physician if the resident's pain was

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F 697	Continued From page 44 not managed by their current pain medications. On 02/06/18 at 10:32 AM, Physician's Nurse HH stated the facility notified the physician about the resident's pain, on 01/24/18, and the physician told the facility, he/she would assess the resident at dialysis and prescribe a stronger pain medication, if needed. Physician's Nurse HH stated the resident refused dialysis on 01/24/18, and the next day (01/25/18) the physician ordered the facility to transfer the resident to the hospital for evaluation. The facility's 2017 Pain Policy directed staff to provide prompt assessments and treatments to manage the resident's pain. The policy directed staff to notify the physician as needed to ensure the resident's pain was controlled. The facility failed to ensure adequate pain management for Resident #13, who had a fall with a head injury and hip fracture.	F 697		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		

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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 when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 14 residents of which 5 were reviewed for unnecessary medication and pharmacy services. Based on observation, record review and interview, the facility's pharmacy consultant failed to identify and address the facility's failure to monitor blood glucose checks and medication administration for 1 of 5 residents. (#18)

Findings included:

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- Resident #18's (POS) physician order sheet, dated 12/30/17, documented the the resident had a diagnosis of (COPD) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and Diabetes Mellitus type 2 (when a body cannot use glucose, not enough insulin made or the body cannot respond to the insulin),

The quarterly (MDS) Minimum Data Set assessment, dated 9/18/17, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition. The assessment revealed the resident required extensive assistance of 1 staff for bed mobility, dressing, and extensive assistance of 2 staff for transfers and toileting. The assessment further revealed the resident had not exhibited shortness of breath or require the use of oxygen, and received 7 days of insulin (a hormone produced in the pancreas that regulates the amount of glucose (sugar) in the blood.

The quarterly MDS, dated 12/18/17, recorded the resident had a BIMS of 13, which indicated intact cognition. The assessment revealed the resident required the same staff assistance as the 9/18/17 quarterly MDS recorded.

No (CAA) Care Area Assessment exists for respiratory status. The CAA for nutrition recorded the resident received a 1800-2000 calorie (ADA) American Diabetes Association diet.

The 1/3/18 care plan directed staff to obtain pharmacy consultation reviews.

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The 3/20/17 physician's order directed staff to obtain the resident's blood sugar 4 times a day at the timeframes of 7- 9 AM, 11 AM - 1 PM, 5 - 7 PM, and 8- 10 PM.

The 3/20/17 physician's order directed staff to administer ipratropium bromide (a medication that prevents the release of substances in the body that cause inflammation), 0.02%, 1 vial, 4 times a day for the diagnosis of COPD.

The 7/28/17 physician's order directed staff to administer albuterol sulfate (a drug that relaxes and dilates the bronchi), 2.5 mg/3 ml, 1 vial, 3 times a day for the diagnosis of COPD.

Review of the (MAR) Medication Administration Record for December 2017 lacked documentation staff administered the ipratropium bromide on the following days and time frames to the resident:

7 AM - 9 AM- 12/7, 12/8, 12/12, 12/14, 12/15, 12/16, 12/19, 12/23, 12/24, 12/26
11 AM - 1 PM- 12/5, 12/7, 12/12, 12/13, 12/14, 12/15, 12/16, 12/19, 12/20, 12/23, 12/26
5 PM - 7 PM- 12/5, 12/6, 12/7, 12/8, 12/10, 12/12, 12/13, 12/14, 12/15, 12/19, 12/23, 12/26
8 PM - 10 PM- 12/23, 12/24 (a total of 35 missed doses)

Review of the (MAR) Medication Administration Record for December 2017 lacked documentation staff administered the albuterol sulfate on the following days and time frames to the resident:

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F 756	Continued From page 48 7 AM - 9 AM - 12/7, 12/8, 12/12, 12/14, 12/16, 12/19, 12/23, 12/26 11 AM - 1 PM - 12/5, 12/7, 12/8, 12/12, 12/13, 12/14, 12/15, 12/16, 12/19, 12/20, 12/21, 12/23, 12/25, 12/26, 12/29 7 PM - 9 PM - 12/23, 12/24 (a total of 24 missed physician ordered doses) Review of the January 2018 (MAR) Medication Administration Record lacked documentation staff obtained the resident's blood sugar on the following days and time frames: 1/1/18 - 7-9 AM, 11 AM - 1 PM, 5 - 7 PM, and 8 - 10 PM 1/2/18 - 11 AM- 1 PM 1/6/18 - 8 - 10 PM 1/8/18 - 8 - 10 PM 1/15/18 - 8 - 10 PM 1/17/18 - 7 AM - 1 PM (a total of 9 missed doses out of 68 physician ordered doses) Review of the Pharmacy Consultation records for 12/21/17 and 1/25/18 revealed no documentation of the lack of blood sugar checks and the lack of missing documentation for administration of medications. On 1/20/18 at 10:49 AM, observation revealed the resident seated in his/her recliner, feet elevated, reading a newspaper. On 2/1/18 at 3:01 PM, Administrative Nurse D stated staff document medications and treatments in the MAR after administration. Nurse D verified the lack of documentation in the MAR for the blood sugars and medication administration.	F 756		

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F 756	Continued From page 49 Upon request, a policy for Pharmacy Consultation was not provided from the facility. The facility's pharmacist consultant failed to identify and address the facility's failure to obtain blood sugars and administer physician ordered medications for Resident #18, placing the resident at risk for a decline in condition.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 14 residents of which 5 were	F 757		

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reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to administer physician ordered medication for 1 of 14 residents. (#18)

Findings included:

- Resident #18's (POS) physician order sheet, dated 12/30/17, documented the the resident had a diagnosis of (COPD) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The quarterly (MDS) Minimum Data Set assessment, dated 9/18/17, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition. The assessment revealed the resident required extensive assistance of 1 staff for bed mobility, dressing, and extensive assistance of 2 staff for transfers and toileting. The assessment further revealed the resident had not exhibited shortness of breath or require the use of oxygen, and received 7 days of insulin (a hormone produced in the pancreas that regulates the amount of glucose (sugar) in the blood.

The quarterly MDS, dated 12/18/17, recorded the resident had a BIMS of 13, which indicated intact cognition. The assessment revealed the resident required the same staff assistance as the 9/18/17 quarterly MDS recorded.No (CAA) Care Area Assessment exists for the resident's respiratory status.

The 1/3/18 care plan directed staff to assess and record effectiveness of medication and to position the resident for comfort with physical support as

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necessary.

The 3/20/17 physician's order directed staff to administer ipratropium bromide (a medication that prevents the release of substances in the body that cause inflammation), 0.02%, 1 vial, 4 times a day for the diagnosis of COPD.

The 7/28/17 physician's order directed staff to administer albuterol sulfate (a drug that relax's and dilates the bronchi (major air passages of the lungs that diverge from the windpipe), 2.5 mg/3 ml, 1 vial, 3 times a day for the diagnosis of COPD.

Review of the (MAR) Medication Administration Record for December 2017 lacked documentation staff admnistered the ipratropium bromide on the following days and time frames to the resident:

7 AM - 9 AM- 12/7, 12/8, 12/12, 12/14, 12/15, 12/16, 12/19, 12/23, 12/24, 12/26
11 AM - 1 PM- 12/5, 12/7, 12/12, 12/13, 12/14, 12/15, 12/16, 12/19, 12/20, 12/23, 12/26
5 PM - 7 PM- 12/5, 12/6, 12/7, 12/8, 12/10, 12/12, 12/13, 12/14, 12/15, 12/19, 12/23, 12/26
8 PM - 10 PM- 12/23, 12/24 (a total of 35 missed doses)

Review of the (MAR) Medication Administration Record for December 2017 lacked documentation staff administered the albuterol sulfate on the following days and time frames to the resident:

7 AM - 9 AM - 12/7, 12/8, 12/12, 12/14, 12/16, 12/19, 12/23, 12/26

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F 757	Continued From page 52 11 AM - 1 PM - 12/5, 12/7, 12/8, 12/12, 12/13, 12/14, 12/15, 12/16, 12/19, 12/20, 12/21, 12/23, 12/25, 12/26, 12/29 7 PM - 9 PM - 12/23, 12/24 (a total of 24 missed doses) Review of the January 2018 (MAR) Medication Administration Record lacked documentation staff obtained the resident's blood sugar on the following days and time frames: 1/1/18 - 7-9 AM, 11 AM - 1 PM, 5 - 7 PM, and 8 - 10 PM 1/2/18 - 11 AM- 1 PM 1/6/18 - 8 - 10 PM 1/8/18 - 8 - 10 PM 1/15/18 - 8 - 10 PM 1/17/18 - 7 AM - 1 PM (a total of 9 missed doses out of 68 physician ordered doses) On 1/20/18 at 10:49 AM, observation revealed the resident seated in his/her recliner, feet elevated, reading a newspaper. On 2/1/18 at 9:56 AM, Licensed Nurse D stated he/she documented in the MAR after the resident received a breathing treatment. On 2/1/18 at 3:01 PM, Administrative Nurse D stated medications and treatments are documented in the MAR after administration. Nurse D verified the lack of documentation in the MAR. The undated facility Medication Administration Policy directed staff the record in the MAR with the initials of the nurse or medication aide who gave the medication. The policy further documented, if the resident refused the	F 757		

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F 757	Continued From page 53 medication, the medication was circled and recorded in the nurse's notes. The facility failed to administer physician ordered breathing treatments to Resident #18, placing him/her at risk for a decline in condition.	F 757		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 838		

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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 838	Continued From page 54 (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 14 residents. Based on interview and record review, the facility failed to complete the facility assessment to determine what resources were necessary to provide care and services competently during both the day to day operations and emergencies, for the 29 residents who reside in the facility.	F 838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	02/01/2018

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F 838	Continued From page 55	F 838		

Findings included:

- On 1/29/18 at 9:57 AM, during the entrance conference with Administrative Staff A, a copy of the facility assessment was requested, as directed by (CMS) Center for Medicare and Medicaid Services for the new Long-Term Care Survey Process. Upon request the facility did not provide the facility assessment.

On 1/20/18 at 1:51 PM, Administrative Staff A verified staff had not completed the facility assessment.

Upon request, a policy for the facility assessment was not provided.

The facility failed to complete the facility assessment to determine what resources were necessary to provide care and services competently during both day-to-day operations and emergencies, for the 29 residents who reside in the facility, placing the residents at risk for inadequate care and services.