STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055698	A. BUILDING _____ B. WING _____	**09/19/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIREMONT HEALTHCARE & WELLNESS CENTRE, LLC	**8060 FROST STREET SAN DIEGO, CA 92123**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0154 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Tell the resident completely about his or her health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain a consent for treatment upon admission for 1 of 56 sampled residents (80). As a result Resident 80's Responsible Party may not have been informed of their right to refuse or consent for examinations, treatment or procedures. Findings: Resident 80 was readmitted to the facility on [DATE] per the Facility Face Sheet. According to the same Face Sheet, Resident 80 had a Responsible Party for health decisions, which was a family member. During a chart review on 9/2/14, at 1:30 P.M., the Medical Records Director said, all records should be completed and this included the consent for treatment. The Admission consent for treatment was not completed for Resident 80. Per the facility policy, Informed Consent, undated, I. Informed Consent is defined as the voluntary agreement of a resident (or a representative of an incapacitated resident) to accept a treatment or procedure II. The informed consent will be documented and placed in the resident's medical record 2. The resident or representative must sign an informed consent form.
F 0157 **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 the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 45's physician was notified of an unplanned significant weight loss. As a result of not notifying the physician of a resident's significant change in condition, such as significant weight loss, there could be delayed assessment and intervention by the practitioner responsible for the care of the resident. Findings: On 9/9/14 at 9:33 A.M., Resident 45's medical record was reviewed. Resident 45 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 5/10/13 the physician ordered a mechanical soft, chopped meat diet. According to Resident 45's Weekly/Monthly Weight Trend Assessment the following were the documented weights: 1/1/14 - 149.2 lbs 2/2/14 - 151 lbs 3/2/14 - 151 lbs 4/1/14 - 146.6 lbs 5/1/14 - 143 lbs 6/1/14 - 142 lbs 7/1/14 - 139 lbs 8/1/14 - 135 lbs 8/11/14 - 136 lbs 8/18/14 - 135 lbs 9/1/14 - 136 lbs 9/8/14 - 135 lbs Per an interdisciplinary meeting (IDT) note, dated 8/4/14, IDT met today to discuss weight loss .weight loss of 16 lbs -10.6% x 6 months . The same IDT note documented an intervention to add fortified (adding calories to food) to the diet order, and to change the monitoring of weight from monthly to weekly. RD 1 verified that the IDT had not documented possible underlying causes for the weight loss. RD 1 stated that it was the facility's process to obtain a physician's order for fortified diet, but was unable to find a physician's order. On 9/9/14 at 1:43 P.M., a licensed nurse (LN 2) verified that there was no physician's order for fortified diet, and stated, There should be a physician order (for fortified diet). On 9/10/14 at 8:34 A.M., LN 11 reviewed Resident 45's medical record that included the IDT note from 8/4/14, and a quarterly nutrition assessment dated [DATE] that noted a 11.8 % significant weight loss in 6 months. LN 11 verified there was no documentation that the physician had been notified of the significant weight loss. The facility's policy and procedure (P & P) entitled Nutrition Care; Subject: Weight Variance Policy and Procedure (undated) indicated, 5. A re-weigh must be obtained within 24 hours if a weight change that meets the following criteria is met: Interval .6 months -10% of body weight change ., 6. Charge nurses will notify the physicians .of significant weight changes via fax/phone .with responses documented in the resident's/patient's medical record/computer and necessary disciplines notified of any new changes . The facility's P & P entitled Diet Orders (undated) indicated, Policy: Diet orders as prescribed by the Physician will be provided by the dietary department . The facility's P & P entitled Change of Condition Notification (undated) indicated, Purpose; To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner ., 'Change of Condition' related to Attending Physician notification is defined as when the Attending Physician must be notified when any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the Attending Physician and a change in the treatment plan .
F 0159 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly hold, secure and manage each resident's personal money which is deposited with the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not refund 1 of 24 sampled residents (95) Trust Account monies, as per facility policy and procedure. As a result, Resident 95 did not have any personal monies available for 6 days.

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

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F 0159 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Findings: Resident 95's record was reviewed on 9/2/14. Resident 95 was admitted to the facility on [DATE], per the Face Sheet. Resident 95 was discharged from the facility on 6/11/14. On 9/2/14 at 1:15 P.M., the BOM said, Resident 95 only had a Social Security income of $50.00 per month, and she did not know of any other income sources for Resident 95. Per the BOM Resident 95 had accumulated $1692.73 in a trust account, (an account of personal monies held by the facility), as of 6/20/14. Resident 95 was transferred to a Board and Care facility on 6/11/14, according to the Medical Records Director. According to the Psychiatrist note dated 3/22/14, Resident 95 did not have the capacity to make financial decisions. On 9/4/14 at 1:30 P.M., a copy of the Trust Account check was reviewed with the Administrator. The Administrator confirmed the signature on the check was the PDON. The signature of the receiver was the Board and Care Manager dated 6/23/14. The check was dated 6/20/14, 9 days after discharge. According to the facility policy dated 1/1/10, M. Upon discharge of a resident, a refund will be issued within the following guidelines . California permanent discharged resident = 3 days.
F 0202 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide written records when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently, 1. document discharge planning by the bioethics committee for 2 of 24 sampled residents (95,96) and 4 unsampled residents (99,113,114,121), 2. completed physician discharge records for 8 unsampled residents (101, 103, 114, 115, 124, 123, 125, 122), and 3. obtain discharge orders for 1 of 24 sampled residents (96) and 1 unsampled discharged residents (98). As a result, discharge planning was incomplete, records were missing discharge orders and discharge summaries. Findings: Clinical records were reviewed on 9/2/14 for Residents 99, 101, 103, 113, 114, 115, 121, 122, 124 and 125. 1a. Resident 95 was admitted to the facility on [DATE], per the Face Sheet. According to the same Face Sheet in the the space for Responsible Party, Bioethics was designated. Resident 95 was discharged to a Board and Care facility on 6/11/14. Clinical records were reviewed on 7/30/14. No discharge planning was located in the clinical records. On 8/6/14 at 9:30 A.M., the facility Board and Care (B & C) manager, for Resident 95 was interviewed by phone. The B & C manager said Resident 95 only stayed 3 days, before being transferred to the hospital. 1b. Resident 96 was admitted to the facility on [DATE], per the Face Sheet. According to the same Face Sheet in the space for Responsible Party, Bioethics was designated. Resident 96 was discharged to a Board and Care facility on 6/11/14. On 8/6/14 at 9:30 A.M., the facility Board and Care manager, for Resident 96, was interviewed by phone. She said Resident 96 only stayed 2 or 3 hours at the facility and was transferred from the Board and Care to another facility on 6/11/14. During a clinical record review on 7/30/14, a physician's discharge order was not located in the clinical record. 1c. Resident 99 was admitted to the facility on [DATE], per the Face Sheet. According to the same Face Sheet in the space for Responsible Party, Bioethics was designated. Resident 99 was discharged to a Board and Care facility on 6/17/14. Clinical records were reviewed on 9/2/14. No Bioethics minutes for discharge planning was located in the records. 1d. Resident 113 was admitted to the facility on [DATE], per the Face Sheet. According to the same Face Sheet, in the space for Responsible Party, Bioethics was designated. Clinical records were reviewed on 9/2/14. Resident 113 was transferred to the hospital on [DATE]. Bioethics recommendations were not located in the clinical records. 1e. Resident 121 was readmitted to the facility on [DATE], per the Face Sheet. According to the same Face Sheet there is no Responsible Party designated. Clinical records were reviewed on 9/2/14. Resident 121 was transferred to the hospital on [DATE]. Bioethics recommendation were not located in the clinical records. 1f. Resident 114 was admitted to the facility on [DATE], per the Face Sheet. According to the same Face Sheet, Resident 114 was her own Responsible Party and had documented a second contact with two phone numbers. During a clinical record review, on 8/14/14, a form for Bioethics recommendations were incomplete for discharge planning. Furthermore Resident 114 did have a designated Responsible Party listed on the Face Sheet. Located in the records, during a chart review, on 9/2/14 was a Bioethics Committee Meeting Minutes form dated 4/29/14 for Resident 114. Resident cannot participate in decision making and does not have a personal representative to participate in medical decisions . After Bioethics committee gathered relevant information & considered different options & opinion they (Bioethics) came to a conclusion that the Facility will provide tx (treatment) & make decisions in the best interest of the resident since res. (resident) has no responsible party & has a COC (change of condition). No other Bioethics minutes were located in the records during the chart reviews. The Bioethics minutes were requested from the Nurse Consultant 1, the ADM, and the PDON on 8/14/14, and 9/4/14. The facility Nurse Consultant 1 said that the facility should have Bioethics meeting records for residents which included discharge plans on 8/14/14 at 1:30 P.M. According to the facility policy, Bioethics Committee, undated, Policy No.-SS-16, .III. The bioethics Committee will document its considerations and determination on the bioethics Committee Minutes. 2a. Resident 101 was admitted to the facility on [DATE], per the Face Sheet. Resident 101 was discharged from the facility on 5/2/14. Resident 103 was admitted to the facility on [DATE], per the Face Sheet. Resident 103 was discharged from the facility on 5/8/14. Resident 114 was admitted to the facility on [DATE], per the Face Sheet. Resident 114 was discharged from the facility on 5/1/14. Resident 115 was admitted to the facility on [DATE], per the Face Sheet. Resident 115 was discharged from the facility on 5/27/14. Resident 122 was admitted to the facility 5/13/14, per the Face Sheet. Resident 122 was discharged from the facility on 5/30/14. Resident 123 was admitted to the facility on [DATE], per the Face Sheet. Resident 123 was discharged from the facility on 5/1/14. Resident 124 was admitted to the facility on [DATE], per the facility Face Sheet. Resident 124 was discharged from the facility on 6/9/14. Resident 125 was admitted to the facility on [DATE], per the Face Sheet. Resident 125 was discharged from the facility on 5/19/14. The clinical records for Residents 101, 103, 114, 115, 122, 123, 123 and 125 were reviewed on 9/2/14. Residents 101, 103, 114, 115, 122, 123, 124, and 125 all had the same primary physician. On 9/5/14 at 4:40 P.M., the Medical Records Director said the nursing staff filled in the Admission [DIAGNOSES REDACTED]. Upon reviewing the charts, the ADM said, I cannot get the physicians to complete their charts. 3. Resident 98's clinical record was reviewed on 9/2/14. Resident 98 was admitted to the facility on [DATE], per the Face Sheet. Resident 98 was discharged according to the Medication Transfer Sheet on 6/7/14. A physician discharge order was not located in the clinical records On 8/13/14, the PDON said there should always be discharge order from the physician prior to discharge. According to the facility policy, Transfer of Resident, Policy No. -AD-XX page 3, .B. The medical record will contain written documentation from the resident's Attending Physician if the resident is transferred. The facility did not address completion of this form.
F 0203 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough notice before discharging or transferring a resident.**

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F 0203 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to give Notice of Proposed Transfer/Discharge (a letter with appeal process instruction), or when given the notice, the facility failed to ensure the correct contact information, was given to appeal the discharge for 3 of 24 sampled residents, (34, 95 ,96) and 12 unsampled residents (98, 99,100,101, 102, 103, 104, 105, 107, 108, 109, 110). The facility also did not honor a request for transfer to a specific city for 1 sampled residents (97). As a result, the facility did not provide current information and correct information for the appeal process and Resident 97 was not given the choice to transfer to his requested destination. Findings: 1. Resident 95 was admitted to the facility on [DATE] per the Face Sheet. Clinical records were reviewed for Resident 95 on 7/30/14. Resident 95 was discharged on [DATE]. Resident 95 did not have capacity to make decisions, and her Responsible Party listed was Bio Ethics. Resident 96 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed for Resident 96 on 7/30/14. Resident 96 was discharged from the facility 6/11/14, to a Board and Care facility. Resident 96 did not have capacity to make decisions, and her Responsible Party listed was Bio Ethics. Resident 99 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed for Resident 99 on 8/13/14. Resident 99 was discharged on [DATE] to a Board and Care facility, according to Interdisciplinary Team notes. Resident 99 did not have capacity to make decisions, and her Responsible Party listed was Bio Ethics. There were no notices found in the medical records for Residents, 95, 96, 99, according to the Facility Consultant (FC) 1 on 8/31/14 at 1 P.M. Resident 98 was readmitted to the facility on [DATE], per the facility Face Sheet. The clinical records were reviewed on 8/13/14. Resident 98 was discharged from the facility on 6/7/14. According to the Face Sheet, Resident 98 had a Responsible Party (RP), who signed paperwork and consents at the facility. Resident 98's RP did sign the, Notice of Proposed Transfer/Discharge sheet on 6/7/14. During a record review with the FC 1, on 8/13/14 at 1 P.M., she said the address and phone number to contact the Department of Health was incorrect. 2. Resident 100 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 100 was discharged from the facility on 6/16/14. According to the Face Sheet, Resident 100 was his own Responsible Party. The Notice of Proposed Transfer/Discharge was signed by Resident 100 on 6/16/14. During a record review with the Facility Consultant (FC) 1, on 8/13/14 at 1 P.M., she said the address and phone number to contact the Department of Health listed on the notice was incorrect. 3. Resident 34 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 34 was discharged from the facility on 6/4/14. Resident 34 was his own Responsible Party. Resident 101 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 101 was discharged from the facility on 5/2/14. Resident 101 was his own Responsible Party. Resident 102 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 102 was discharged from the facility on 6/3/14. Resident 102 was his own Responsible Party. Resident 103 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 103 was discharged from the facility on 5/8/14. Resident 103 was her own Responsible Party. Resident 104 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 104 was discharged on [DATE]. Resident 104 had a designated family member as his Responsible Party. Resident 105 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 105 was discharged from the facility on 5/19/14. Resident 105 was his own Responsible Party per the Face Sheet. The Notice of Proposed Transfer/ Discharge was signed by Resident 105 on 5/19/14. Resident 107 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 107 was discharged from the facility on 5/24/14. Resident 107 was her own Responsible Party. Resident 108 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 108 was discharged from the facility on 5/30/14. Resident 108 was his own Responsible Party. Resident 109 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 109 was discharged from the facility on 6/25/14. Resident 109 was his own Responsible Party. Resident 110 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 8/13/14. Resident 110 was discharged from the facility on 6/25/14. Resident 110 was his own Responsible Party. Residents 34, 101, 102, 103, 105, 107, 108, 109 and 110, all signed their own Notice of Proposed Discharge/Transfer. Resident 104, did not have a signature on the notice in the records. During a record review with FC 1, on 8/13/14 at 1 P.M., she said the address and phone number to contact the Department of Health on the notice was incorrect for Residents 34, 101, 102, 103, 104, 105, 107, 108, 109, and 110. On 8/13/14, FC 1 said at 1:30 P.M. said she was unable to find the notices for Residents, 95, 96, and 99. She said all residents should have the notice in their charts. On 9/4/14 at 1:30 P.M., the ADM said she knew the Department of Health phone number by heart and she said the number she recited did not match the number listed on the notice for Resident 98. According to the facility policy, entitled, Discharge Plan and Post-Discharge Care Plan, Policy No. -AD-10, undated .V. Discharge Care Plan, Vii. That an appropriate notice was provided to the resident and/or representative. 4. Resident 97 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 9/4/14. Resident 97 was discharged from the facility on 5/2/14. Resident 97 was his own Responsible Party. A joint record review was conducted with the SSD and ADM on 9/4/14 at 1:30 P.M. Per the Social Services notes dated 4/24/14, Resident 97 had requested to be transferred to a specific city. At 2:15 P.M. on 9/4/14, the SSD said she had called 2 facilities in the requested city, but her notes only documented she had contacted one facility. The SSD said the facility she phoned was unable to accept Resident 97. The SSD said she was not aware there were at least 2 other facilities in the city requested by Resident 97. The SSD said she knew of another facility with the same owners as this facility and offered the resident a transfer to that sister facility. The SSD said she told Resident 97 a bed was available in another city and he accepted that transfer on 5/2/14. On 8/25/14 at 1:30 P.M., facility 1 was phoned in to inquire if beds were available on 5/2/14 (the discharge date of Resident 97) in their facility. Facility 1 was located in the city desired by Resident 97. Facility 1 did not have a bed available on the discharge date which suited the gender of Resident 97. When facility 2 was phoned on 8/25/14 at 2:15 P.M., the Admissions Coordinator said there were 9 available beds and they would have screened Resident 97 for admission. Facility 2 was located in the city desired by Resident 97. When Facility 2's coordinator was given general care information regarding Resident 97, she said she felt Resident 97 would have met their admission criteria, and would have been accepted. According to the VPCS, on 9/5/14 at 12:55 P.M., there was no specific policy for a facility to facility transfer.
F 0205 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Tell the resident or the resident's representative in writing how long the nursing home will hold the resident's bed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and inform 2 of 24 sampled residents (55, 80), and 3 unsampled residents (112,113,114) transferred to the hospital, a written bed hold notice which provided the amount of time a bed may be held for a resident when they were not in the facility. As a result the residents were not informed of their rights to have a bed held at the facility during their absence. Findings: 1. Resident 55 was admitted to the facility on [DATE], per the Face Sheet. Per the Patient Transfer Form, Resident 55 was transferred to the hospital on [DATE].

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F 0205 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) The chart was reviewed on 9/2/14, and there was no signature for Bed Hold Informed Consent, Confirmation of Transfer & Bed Hold Provision. 2. Resident 80 was admitted to the facility on [DATE], per the Face Sheet. Per the the Patient Transfer Form, Resident 80 was transferred to the hospital on [DATE]. The chart was reviewed on 9/2/14, and there were no signatures on the Bed Hold Informed Consent, in the Admission section or the Confirmation of Transfer & Bed Hold Provision. 3. Resident 112 was admitted to the facility on [DATE], per the Face Sheet. Per the Patient Transfer Form, Resident 112 was transferred to the hospital on [DATE]. The chart was reviewed on 9/2/14, and there was no signature on the, Bed Hold Informed Consent, section, Confirmation of Transfer & Bed Hold Provision. 4 . Resident 113 was admitted to the facility on [DATE], per the Face Sheet. Per the same Face Sheet, Resident 113 had a conservator as his payee and was managed by Bioethics (a committee to determine needs of residents). Per the Patient Transfer Form, Resident 113 was transferred to the hospital on [DATE]. The chart was reviewed on 9/2/14, and Resident 113 signed his own consent for Bed Hold Informed Consent on 3/6/14 upon admission, and the section titled, Confirmation of Transfer & Bed Hold Provision, was blank on the signature and date lines when he was transferred to the hospital. According to the History and Physical dated 3/11/14, Resident 113 did not have the capacity to understand and make decisions. 5. Resident 114 was admitted to the facility on [DATE], per the Face Sheet. Per the Patient Transfer Form, Resident 114 was transferred to the hospital on [DATE]. The chart was reviewed on 9/2/14, and there was no signature for, Bed Hold Informed Consent, Confirmation of Transfer & Bed Hold Provision. On 9/2/14, at 3 P.M. the Medical Records Director said the Bed Hold Records were not complete and should have been signed. According to the undated facility policy titled, Transfer of Resident, .III Bed Hold .B. At the time of transfer, the Facility will provide to the resident and a family member or personal representative written notice which specifies the duration of the bed-hold policy, and will inform the resident of his or her right to exercise a bed hold provision.
F 0206 **Level of harm** - Actual harm **Residents Affected** - Few	**Establish and follow a written policy that permits a resident to return to the nursing home after hospitalization.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to re-admit 1 of 24 sampled residents (40) to the facility. As a result, Resident 40 had no behavior issues during his stay in the emergency room and was admitted to the hospital due to the facility's refusal to accept the resident for re-admission. Findings: Resident 40 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 9/10/14 at approximately 5:40 P.M., Resident 40 was transferred to the emergency room for the evaluation of his behavior and adjustment of his medications, per the Resident Transfer Record. On 9/11/14 at approximately 8 A.M., the Ombudsman handed a note to the survey team that he received a call from the acute hospital regarding the facility's refusal to re-admit Resident 40. On 9/11/14 at 3 P.M., an interview with the acute hospital staff was conducted. EDRN 3 stated Resident 40 was admitted to the emergency room for behavior issues. EDRN 3 stated throughout Resident 40's 18 hour stay in the emergency room , the resident demonstrated no behavior issues. The EDRN said, He calls for attention and he's not thrashing. The EDRN 3 further stated, that Resident 40 would be admitted to the acute hospital. EDRN3 also stated, that the nursing home would not accept the resident back. On 9/12/14 at 4 P.M., a record review of the Emergency Records was conducted. EDRN 1 documented on 9/10/14 at 9:15 P.M., that a call was made to the facility requesting to send Resident 40 back. EDRN 1 documented, .AIT .unwilling to take back patient due to his behavior. EDRN 1 further documented the AIT was informed Resident 40's current behavior was cleared by the hospital's psychiatrist and that the psychiatrist cleared Resident 40 for discharge back to the facility. On 9/12/14 at 9:25 P.M., EDRN 2 documented he spoke to LN 6. EDRN 2 informed LN 6 that Resident 40 was medically and psychiatrically discharged from the emergency room . EDRN 2 documented LN 6, Stated, we are not accepting the patient back to our facility I have spoken to the administrator and we are aware of the penalties and fines for patient dumping and do not care. On 9/18/14 at 3:11 P.M., LN 6 was interviewed. LN 6 recalls the telephone conversation with an EDRN and confirmed she informed the EDRN that the facility would not re-admit Resident 40. LN 6 stated they told me they would not accept Resident 40. When asked who they were , LN 6 stated, The AIT, ADM and VPCS were in the room. LN 6 recalled that it was the AIT who responded first. On 9/18/14 at 3:29 P.M., a telephone interview with the AIT was conducted. The AIT recalled the telephone conversation with the ED staff. The AIT stated the facility conducted an Interdisciplinary Team Meeting on 9/9/14 at 2:30 P.M., to transfer the resident to the emergency room due Resident 40 .posed a danger towards others. The AIT was informed that there was no documentation of the Interdisciplinary Team Meeting in Resident 40's clinical record. The AIT stated, I prefer not to make a comment on this case. According to the facility's undated policy and procedure entitled, Bed Hold, In the event that the resident .meets the standards for skilled nursing care .the Facility will readmit the resident to the first available bed in a semi-private room. The ADM was aware of the complaint lodged by the hospital regarding the refusal to readmit Resident 40 on 9/10/14.
F 0221 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 24 sampled residents (30) were free from restraints. As a result, 1 resident did not have freedom of movement. Findings: During the initial resident tour on 9/8/14 at 3 P.M., Resident 30 was observed in bed. The head of the bed was in the low position and the foot of the bed in a high position. There were 1/2 side rail at the head of the bed on each side. On 9/8/14 at 4:45 P.M., CNA 5 said Resident 30's legs were elevated to prevent her from getting out of the bed. On 9/8/14 at 4:50 P.M., LN 3 said Resident 30's legs were elevated to decrease swelling and to prevent her from getting out bed and that this practice was used to prevent falls. On 9/9/14 at 9:30 A.M., Resident 30 was observed in the dining room. Her left leg was elevated and the right leg/foot hung down. Resident 30 also had a self-release seat belt around her waist. Resident 30's clinical record was reviewed on 9/10/14. Resident 30 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Per the Physician orders [REDACTED]. Per the Physician orders, dated 6/19/12, Tab alarm while in bed for fall preventive measures ., and per Physician orders [REDACTED]. Per the CNA Daily Charting Form, dated July through August 2014, Resident 30 was total assist and needed 1-2 staff to turn resident in bed and to reposition her. Resident also needed a staff member to feed her. Per the nursing notes, Resident was incapable of the simplest tasks and needed 1-2 staff to position her feed her, dress and perform hygiene tasks for her. Resident 30's plan of care was reviewed. Documentation that addressed assessment of using restraints, head of bed flat with the foot of bed elevated to prevent from getting out of bed, or the use of a self-release seat beat, could not be located in the clinical record. Resident 30's IDT notes were reviewed. Documentation that addressed assessment of the use of restraints was not located in the clinical record.

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F 0221 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) On 9/10/14 at 11:30 A.M., an attempt was made to interview Resident 30, but Resident 30 was unable to track interviewer, unable to speak, unable to do simple commands such as release the seat belt, or to touch the seat belt. On 9/17/14, Resident 30's Family Member was interviewed. Family Member said Resident 30 was incapable of following simple commands and that she needed 1-2 staff members to do everything for her. On 9/18/14 at 8:30 A.M. the DON said during an interview, Resident 30's seat belt was for safety reasons because of her mental [MEDICAL CONDITION]. The DON said she was unaware the staff positioned the head of the bed down and the feet up to prevent Resident 30 from getting out of bed. The DON further stated, That is not our practice here. The facility's policy and procedure, Restraints, undated, An interdisciplinary team shall assess each restrained resident for the least restrictive restraint possible .Restraints shall be reassessed at least quarterly by reviewing the care plan entry for the restraints.
F 0224 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 24 sampled residents (26) was free from mishandling. Also, the facility failed to keep Resident 95's Trust Account safe, when they gave her trust monies to a Board and Care manager. As a result, 2 resident were mentally and/or physically abused, placing other residents at risk for the same behaviors from the facility staff. Findings: 1. Resident 26 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 9/12/14, Resident 26 was observed laying in bed. Resident 26 usually smiled at people that walked by her door. At 3 P.M. Resident was asked if she was ok. Resident 26 stated, I am mad, very mad! CNA 3 was so rough in handling me when she turned me. She did it by herself and didn't ask for help! Resident 26 further stated, I don't want her to turn me, she hurts me. It has to be two people and wouldn't get anyone. On 9/12/13 at 3:05 P.M., CNA 3 was interviewed. CNA 3 said, she had not handled Resident 26 alone. CNA 3 stated, CNA 9 assisted her in changing Resident 26's adult brief and repositioning her (Resident 26.) On 9/12/14 at 3:15 P.M., CNA was interviewed. CNA 9 stated, After CNA 3 cleaned her up, I was called to help re-position her .CNA 3 had already changed her (adult brief.) On 9/12/14 at 3:25 P.M., Resident 26's allegation of abuse was reported to the CDON. On 9/12/14 and 9/13/14, two separate complaints made by Resident 26 regarding rough handling were called into the Department. Both complaints were investigated and found to be substantiated. 2. Resident 95 was admitted to the facility on [DATE], per the Face Sheet. Per the same Face Sheet, Resident 95 did not have a Responsible Party. Clinical records were reviewed on 7/30/14. Bioethics (a committee to make medical and financial decisions) was listed as Resident 95's Responsible Party. Resident 95 was discharged from the facility on 6/11/14, per the physician's orders [REDACTED]. According to the Psychiatric Evaluation dated 3/22/14, Resident 95, This pt (patient) is not competent for medical legal financial purpose. On 9/2/14 at 1:15 P.M., the BOM said, Resident 95 only had a Social Security income of $50.00 per month, and she did not know of any other income sources for Resident 95. Both the BOM and SSD said they though residents could apply for additional monies through Social Security, but were unable to determine how a resident without capacity to make decision and without a Responsible Party, such as Resident 95 were able to sign legal documents. Per the BOM, Resident 95 had accumulated $1692.73, in a trust account, (an account of personal monies held by the facility), as of 6/20/14. Per the BOM Resident 95's Trust Fund check was issued to a Board and Care Manager on 6/23/14. The check had the authorized signature of the PDON dated 6/20/14. The amount of the check was $1692.73, in the memo section was typed, TO CLOSE ACCOUNT. According to the Board and Care manager on 8/6/14 at 9:30 A.M., she charged residents $2,500.00 per month. The Board and Care manager also said the SSD told her she could take Resident 95 to the Social Security office to have Resident 95 apply for additional monies. According to the facility policy, Resident Abuse-Recognizing Signs and Symptoms, undated. Misappropriate of Resident Property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents, investigate, and report allegations of abuse for 1 of 24 sampled residents (40), that exhibited assault behaviors toward the residents on multiple occasions. The facility also failed to investigate and report 1 of 24 sampled resident (50) regarding an allegation of abuse. As a result, the facility's failure to protect residents, investigate, and report the allegations of abuse had the potential to place all residents at risk for further abuse in the facility. Due to the facility's failure to: 1. Investigate and report the 2 allegations of abuse; and 2. Protect the residents in the facility by: A. Assessing the dangerous behavior of Patient 40; B. Implementing a behavior plan and preventing Resident 40 from assaulting other residents; C. Ensuring all staff members protect residents and report incidents of abuse; D. Utilize IDT and QA for guidance with difficult issues that are not immediately addressed regarding resident safety and abuse. the survey team called an Immediate Jeopardy on [DATE] at 1:04 P.M., and informed the ADM and VPCS. The team requested the ADM and the VPCS provide the survey team with immediate measures the facility would implement to ensure the safety of the residents. Five days later, on [DATE], the survey team received and reviewed the POC presented by the facility. According to the POC: 1. The facility investigated Resident 40 and Resident 50 incidents related to abuse; 2. The staff involved were placed on investigational leave; 3. The facility staff were inserviced on the facility's Abuse Policy and Procedure; 4. The Department Managers would observe how the staff were treating residents and would monitor signs and symptoms of abuse for any resident within the facility on a daily basis; 5. The Department Managers were inserviced on the facility's Abuse Policy and Procedure with emphasis on reporting to the Abuse Coordinator (ADM) immediately; 6. The contracted services (Rehab) would jointly investigate any allegation of abuse as it pertained to contracted services staff members; 7. The Abuse Coordinator (ADM) would report on a monthly basis, all allegations of abuse investigations to the Quality Assurance Committee from resident satisfaction surveys and observations. The survey team accepted the Allegation of Removal of Immediate Jeopardy (POC) and informed the ADM at 4:20 P.M., the Immediate Jeopardy was abated. Findings:

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 5) 1. Resident 40 was re-admitted to the facility on [DATE], according to the facility's Face Sheet. Resident 40's clinical record was reviewed on [DATE]. On [DATE], a [MEDICAL CONDITION] Medication Review was completed by the psychiatrist. The Physician noted, Pt (patient) has shown increasing aggressive behaviors when upset. States that it happened today with a pt telling him to get out of here. The Nurses Notes were also reviewed. On [DATE] at 2 P.M., LN 8 documented a request for a psychiatric evaluation for Resident 40 related to inappropriate behaviors. Five days later, on [DATE] at 1:45 P.M., located in the nursing documentation was; the nursing staff left a message for the psychiatrist and requested a referral for a psychiatric evaluation. At 2:30 P.M., the primary physician ordered a psychiatrist evaluation secondary to increased agitation and increased episodes of inappropriate behavior. Again on [DATE] at 3 P.M., a nurse documented, Resident 40 had increased episodes of aggression and agitation, towards staff and other residents. The nurse also documented that Resident 40 threatened the staff when they counseled him about his inappropriate touching of staff and female residents. A Psychologist note dated [DATE], documented, Psych consulted requested due to reoccurrence of behavioral, agitation, lability .poor impulse control, inappropriate touching of female staff and peers and poor boundaries .Intermittent [MEDICAL CONDITION] . On [DATE] at 1:15 P.M., LN 8 documented, a CNA reported that Resident 40 was observed touching a female resident's thigh close to her genital area. LN 8 also documented that while attempting to pull Resident 40 away from the female resident, Resident 40 struck the CNA in the mouth. The CNA sustained an upper lip laceration. The MD was notified the MD and again recommended a psychiatric consultation (3rd time requested: ,[DATE], ,[DATE], and ,[DATE].) On [DATE] at 2 P.M., the nurse documented in the nurses notes, inappropriate behavior by Resident 40 when he flipped his middle finger at the physician. On [DATE], the physician ordered [MEDICATION NAME] (A hormone medication), 10 mg every morning for sexual deviation as exhibited by Sexually touching etc., of staff and demented residents . According to the Nurses Weekly Summary dated [DATE], documented by a nurse; (Resident 40) with episodes of increased aggression and agitation. According to the Interdisciplinary Team Meeting notes dated [DATE], No behavioral issues identified . On [DATE] at 9:45 A.M., the Nurses Notes indicated that the physician was contacted and informed of Resident 40's aggressive behavior towards another female resident. On [DATE], after the facility was informed by a surveyor, of a failure to report, investigate, and protect other residents, the facility self-reported the abuse which occurred on [DATE] to the Department, 68 days after the date of the abuse incident. According to the Nurses Notes, dated [DATE], Resident 40 was transferred to an acute hospital for evaluation and adjustment of medication ., On [DATE] at 1:45 P.M., Resident 41 was interviewed. Resident 41's room housed three residents. Resident 39 was located in Bed A, Resident 40 was located in Bed B, and Resident 41 was located in Bed C. Resident 41 stated, We still have problems with Resident 40. Resident 41 said that residents are scared of Resident 40 because he hits people. Resident 41 also said he had not been hit, but he had seen Resident 40 hit Resident 39 many times and that staff were aware of the incidents. He further stated, Resident 39 and Resident 40 are like oil and vinegar. Resident 41 added, Administration keeps saying if he does it one more time, he is out. Resident 41 said he did not understand why Resident 40 was not moved to another room. Resident 41 stated, He could go off anytime, he is dangerous. Resident 41 said that he tried to be the peace keeper and tried to keep it calm in their room. On [DATE], the ADM was interviewed. The ADM was unaware of the incident on [DATE], until the abuse was identified by the Department during a complaint investigation on [DATE]. On [DATE] at 8:50 A.M., LN 8 was interviewed. She confirmed her documentation of the [DATE] incident. She stated that she separated the 2 residents and had another CNA remove Resident 40 from the main dining room. She further stated that she informed the PDON of the incident and did not know if an investigation by the facility was conducted. At the time of this annual recertification survey, PDON was no longer employed by the facility, and was not available for interview. 2. Resident 50 was re-admitted to the facility on [DATE], according to the facility's Face Sheet. On [DATE] at 10:30 A.M., Resident 50 was interviewed. During the interview, Resident 50 stated, that in [DATE], he told PTA 1, he was considering leaving him some money when he died . Resident 50 further stated, PTA 1 shared this information with PTA 2 without his permission. PTA 2 informed Resident 50, he was gong to run a background check on him to verify if he had the money. Resident 50 stated he was very worried that PTA 2 had done the background check on him. Resident 50 further stated he was fearful the 2 PTAs would discover his entire financial status. On [DATE], Resident 50's clinical record was reviewed jointly with LN 9. According to the nurse's note, dated [DATE] at 9 A.M., LN 9 documented, Resident making statements that PT staff member has it out for him and that another PT staff member ruined his chances .LN 9 confirmed her documentation dated [DATE] at 9 A.M. LN 9 had to reassure the resident he was safe and that no one was out to get him. LN 9 stated she reported the allegation to the PDON on [DATE]. There were no Interdisciplinary Team Meeting notes regarding the allegation of abuse in the clinical record. On [DATE] at 8:30 A.M., the RDPT, was interviewed. He was unaware of the incident and reviewed the Therapy Staff meeting minutes. The RDPT was able to find documentation of the incident, but did not know if an investigation had been conducted by the facility. According to the facility's undated policy and procedure, entitled, Resident Abuse - Recognizing Symptoms, To protect residents from abuse, neglect, and mistreatment by ensuring that all facility personnel, volunteers, and visitors promptly report any incident or suspected incident of resident neglect, abuse, mistreatment, or misappropriation of residents property to the Administrator. D. The Administrator will report the alleged incident to the Department of Public Health within 24 hours; and E. An immediate investigation will be initiated . At the time of this annual recertification survey, PDON was no longer employed by the facility, and was not available for interview. On [DATE] at 9:34 A.M., the ADM was interviewed and was unaware of the incident. She confirmed that no investigation had been conducted regarding the incident. During the same interview, the ADM further acknowledged that the facility's policy and procedure was not followed and the facility did not report the [DATE] allegation of abuse to the Department until [DATE], 49 days after the allegation.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to respect the dignity of 3 of 24 sampled residents (1, 38, 26). As a result: 1. Resident 1's urinary incontinence needs were not met in a timely manner. 2. Resident 38's privacy curtain was not drawn closed during personal care. 3. Resident 26 was provided care while staff were talking in a foreign language not understood by the resident. Findings: 1. Resident 1 was admitted to the agency on 2/10/13, with [DIAGNOSES REDACTED]. Per the MDS (Minimum Data Set) dated , Per the MDS (Minimum Data Set) dated 8/22/14, Resident 1's BIMS (Brief Interview for Mental Status) was scored at 12, meaning the Resident had moderately impaired cognitive functioning. Resident 1 was also coded as occasionally incontinent. On 9/18/14 at 8:50 AM, Resident 1 was observed in sitting in a wheelchair in the dining room. Resident 1 was reading the

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) paper but appeared to doze off intermittently. When asked about the timeliness of having staff assist him with his incontinence, Resident 1 stated, I can't think of anything at this time, but sometimes it takes a while. When asked if he was incontinent on occasion, Resident 1 stated, No I don't have that problem. On 9/18/14 at 10:15 AM, Activity Assistant 1 stated during a phone interview she worked in the afternoons. According to the AA, there have been several times when she has asked nursing staff to assist residents with incontinence issues, and their response has not been timely. On 9/18/14 at 10:15 AM, the AA stated there have been recent incidents of nursing staff failing to respond to assist the activities staff on the afternoon shift. The AA stated there is no call light in the activity room, and therefore has to utilize the telephone to call the nurses station. According to the AA, the nursing staff answer the phone but take time to respond to her requests for assistance with residents who have incontinence needs. According to the AA, a couple of weeks ago, Resident 1's daughter came to visit the resident and found him incontinent of urine. The resident's daughter was upset her father was wet of urine and asked how long he had been sitting in his urine. The AA stated she told the daughter she had been calling for assistance for Resident 1 for about 25 minutes, but there had been no response by the nursing staff. According to the AA, the daughter went to find a nurse to assist in incontinent care for her father. The AA stated she had complained in the past to her immediate supervisor and the Administrator in Training regarding nursing staff not responding to resident issues in a timely manner. Per the facilities Investigative Report initiated by the VPCS on 9/17/14, Called and spoke to resident family RP (Responsible Party (name of resident's daughter) and asked her regarding a report regarding her dad. Per RP she was informed by the activity assistant (name of activity assistant) that her Dad was sitting in pee for 3-4 hours in the dining room last August 9, 2014 but did not witnessed the incident. RP said in some occasions during her visits she smells her dad like pee and didn't look had a shower. Once in a while she witness her dad pee him self and it take 30-40 minutes to be changed . Per the VPCS on 9/18/14 at 3:45 PM, the VPCS confirmed a conversation with the AA, and per the VPCS the AA confirmed the issue of Resident 1 not receiving incontinence care in a timely manner as described by the resident's daughter. Per the undated Policy and Procedure entitled Resident Rights-Quality of Life, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality .XII. Facility staff treats cognitively impaired residents with dignity and sensitivity. When caring for these residents, Facility Staff will address the underlying motives or root causes for behavior, and will not challenge or contradict the resident's beliefs or statements. 2. Resident 38 was re-admitted to the facility on [DATE], according to the facility's Face Sheet. According to Resident 38's MDS (an assessment tool), the resident's cognitive status was 6 out of 15. This represented the resident was unable to make decisions independently. On 9/9/14 at 9:55 A.M., Resident 38 was observed lying in bed taking to herself. She stated, they called me a derogatory slang word. When asked who called her the derogatory slang word, Resident 38 stated, What does that mean? On 9/9/14 at 1:30 P.M., Resident 38 was found lying in bed. Her hospital gown was at the foot of the bed and part of her chest was covered a bed sheet. Her left leg was exposed. On the right side of her room was a window and the curtains were opened. The opened curtain exposed the resident for anyone who passed by her window. On 9/11/14 at 9:24 A.M., a loud voice was heard from Resident 38's room. HK 1 stood at the resident's doorway and continued to mop the floor of her room. The resident was found lying in bed, with her privacy curtain opened. The resident's chest and private area were partially covered with a white sheet and both legs were exposed. The curtains to the window on the right side of her bed was opened. The HK 1 continued to mop the floor and was asked, what do you do when a resident is exposed, the HK 1 smiled and said, I don't know what you mean. CNA 8 entered Resident 38's room. The CNA did not draw Resident 38's privacy curtain and did not draw the curtain to her window. According to the facility's undated policy and procedure entitled, Resident Rights - Quality of Life, To ensure that all residents are treated with the level of dignity they are entitled to while residing at the Facility. 3. On 9/9/14 at 9:06 A.M., Resident 26 was interviewed. Resident 26 said that staff spoke foreign languages in her room while providing care to her. Resident 26 stated, I ask them to speak English, but they won't. Resident further stated, They are not friendly. On 9/9/14 at 10:03 A.M., the confidential group interview was conducted. Four of six residents said staff spoke foreign languages in the hallways or in their rooms when providing care. One of six residents said she was advised to speak slowly to them. Another resident said there was a staff member that spoke foreign languages all the time, and 3 residents said it was uncomfortable when the staff spoke foreign languages. On 9/9/14 at 12:01 P.M., CNA 6 said, staff spoke Tagalog when in the residents' room providing care. CNA 6 further stated, 80-90% of the staff are Filipino and they speak it all the time. We ask them to speak English but they ignore us and continue speaking Tagalog. It bothers us. On 9/18/14 at 8:30 A.M., the CDON stated, The staff must speak English, unless they are speaking the residents preferred language. On 9/18/14, the facility's policy, untitled and undated, said the staff should speak in the language the resident spoke in, however, further in the policy indicated, it was ok to use foreign languages if the resident would be better served.
F 0250 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure discharged residents had adequate income for payment at a lower level of care for 1 of 24 sampled residents (95), and 5 unsampled residents discharged (115, 116, 117, 118, 119). As a result residents may not have had adequate income for payment of services at a lower level of care. Findings: 1. Resident 95 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 7/30/14. Resident 95 was discharged to a Board and Care facility on 6/11/14. According to the Psychiatric report dated 3/22/14, Resident 95 was not competent for medical, legal and financial purposes. Per the Face Sheet, Resident 95's decisions were managed by Bioethics (committee to make decisions when resident is unable, has no designated party, or does not have capacity). On 9/3/14 at 1:30 P.M., the BOM produced a record of Resident 95's income, her sum total was $50 per month. Resident 95 had no means of paying for housing and personal items. 2. Resident 115 was admitted to the facility 4/14/14, per the Face Sheet. Clinical records were reviewed on 7/30/14. Resident 115 was discharged on [DATE] to a lower level of care. The BOM said on 9/3/14 at 1:30 P.M., did not know if Resident 115 had adequate income to pay for housing and personal items. 3. Resident 116 was readmitted to the facility on [DATE] per the Face Sheet. Clinical records were reviewed on 7/30/14. Resident 116 was discharged to a lower level of care on 5/23/14. Per the Face Sheet, Resident 116 had a Responsible Party for decisions. The BOM said on 9/3/14 at 1:30 P.M., she did not know if Resident 116 had adequate income to pay for housing and personal items. 4. Resident 117 was admitted to the facility 4/3/14, per the Face Sheet. Clinical records were reviewed on 7/30/14. Resident 117 was discharged to a lower level of care on 6/14, per the facility discharge listing sheet. The BOM said on 9/3/14 at 1:30 P.M., she did not know if Resident 117 had adequate income to pay for housing and personal items. 5. Resident 118 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on 9/2/14. Resident 118 was discharged to a lower level of care on 6/9/14. The BOM said on 9/3/14 at 1:30 P.M., she did not know if Resident 118 had adequate income to pay for housing and personal items. 6. Resident 119 was admitted to the facility 4/27/14, per the Face Sheet. Clinical records were reviewed on 9/2/14. Resident 119 was discharged to a lower level of care on 6/17/14. The BOM said on 9/3/14 at 1:30 P.M., she did not know if Resident

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F 0250 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) 119 had adequate income to pay for housing and personal items. On 7/30/14 at 1 P.M., the PDON said she thought Board and Care Managers and other facility managers could assist residents with Social Security funding by taking the resident to the Social Security office and having the resident sign new paperwork. PDON said she was uncertain if residents who were not capable of signing paperwork due to physical or mental capacity and without a Responsible Party were able to obtain additional funds. The PDON said she did not know how to determine if the funds were adequate to pay the facilities. On 9/2/14 at 1:16 P.M., the BOM said she worked with the Social Services Director and obtained information for resident's funds or payments. The BOM said Resident 95 had an income of $50.00 per month from all sources. During a joint interview on 9/2/14, at 2:30 P.M., both the SSD and BOM said they thought residents who were discharged to other facilities received more monies, but they were not aware if this was adequate for full payment to the facility. According to the VPCS, on 9/5/14 at 12:55 P.M., the facility did not have a specific policy which determined resident income prior to discharge to a lower level of care.
F 0271 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide doctors orders for the resident's immediate care, at the time the resident was admitted.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a physician's order was obtained for 1 of 24 sampled residents (80). As a result, Resident 80 had an indwelling urinary catheter without a physician's order and potentially increase the risk for urinary tract infection. Findings: Resident 80 was re-admitted to the facility on [DATE], according to the facility's Face Sheet. On 9/8/14, Resident 80 was observed with a indwelling urinary catheter. A record review was conducted on 9/10/14 at 11:20 A.M. There was no physician's order for Resident 80's indwelling urinary catheter. A concurrent record review was conducted with the CDON and LN 8 on 9/10/14 at 11:32 A.M. The CDON confirmed there was no physician's order for Resident 80's indwelling urinary catheter. She further acknowledged the LNs should have contacted the physician for an order. The CDON confirmed Resident 80 had an indwelling urinary catheter from 7/23/14 through 9/10/14 without a physician's order for 50 days. According to the undated facility's policy and procedure entitled, Physician Orders, This will ensure that all physician orders are complete and accurate. The CDON acknowledged the LNs did not follow the facility's policy and procedure.
F 0274 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Review or revise the resident's care plan after any major change in a resident's physical or mental health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a MDS significant change was conducted in a timely manner for 1 of 6 sampled residents (55). As a result, Resident 55's MDS did not reflect a change in condition. Findings: Resident 55 was readmitted to the facility on [DATE], according to the facility's Face Sheet. On 2/7/15 at 12:15 P.M., Resident 55 was observed eating solid food in the RNA dining room in her wheelchair. Resident 55 fed herself independently, with oversight by a RNA. On 2/8/15 at 3:30 P.M., CNA 33 was interviewed. CNA 33 confirmed Resident 55 was in the RNA program for meals. CNA 33 further stated, Resident 55 was able to feed herself independently. A clinical record review was conducted on 2/8/15 at 8:35 A.M. On 12/4/14, a 3 day trial, Thur 12/4 through Sat 12/6/14, 3 meals daily NCS (no concentrated sugar) puree diet, PO (by mouth) medications whole, one at a time with tsp(s) water. Hold tube (feeding) 0400 (4 A.M.), restart 1900 (7 P.M.), until RD consult completed, per physician order. A review of the RD notes and nurses note during Resident 55's 3 day trial of food and PO medications was reviewed. Resident 55 was able to eat and drink without difficulty. On 12/12/14, the physician ordered, .begin NCS mechanical soft, ground meat diet, thin liquids . The facility utilized RAI Version 3.0 Manual for their reference for policy and procedure. According to RAI 3.0, Significant Change in Status Assessment, A significant change is a decline or improvement in a resident's status . During an interview on 2/9/15 at 2 P.M., with MDS 1, she stated, there should have been a MDS significant change for Resident 55 because she, eats now. MDS 1 further stated, Resident 55's change in diet should had been discussed with the team. MDS 1 also stated a change of condition MDS for Resident 55 should had been initiated.
F 0276 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Check and assess each resident's assessment at least every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Quarterly Review Assessment (QRA) was done for 1 of 24 sample residents (82). As a result, Resident 82's QRA was not completed when the resident returned to the facility on [DATE]. Findings: Review of Resident 82's clinical record on 9/12/14, showed resident was transferred to the hospital for evaluation and treatment for [REDACTED]. On 7/6/14, Resident 82 was discharged from the hospital and readmitted to the facility. On 9/15/14 at 3:58 P.M., The MDSN said Resident 82's QRA was overlooked and not done on 7/6/14 when the resident returned from the hospital. She also stated Resident 82's last QRA was done on 4/4/14. She acknowledged the missing QRQ and said it was her responsibility to ensure Resident 82's quarterly assessment was completed. Per facility's policy revised 10/2013 entitled, RAI OBRA Required Assessment Summary, QAR are to be done every 3 months.
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS-an assessment tool) for 4 of 24 sampled residents, (30, 41, 45, 56,) As a result, there was a potential for inaccurate care planning for the residents with the following: 1. A lap buddy (a soft wait restraint belt) (Resident 56) 2. A restraint (a side rails, seat belt and foot bed position) (Resident 30); 3. Weight Loss (56); and 4. Activities of Daily Living Functions (Resident 41) Findings: 1. Resident 56 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the physician's orders [REDACTED]. On 6/17/14 the facility initiated a quarterly MDS for Resident 56. According to the section related to restraints, (section P), the facility did not select the use of restraints. On 9/18/14 at 2:55 P.M., the MDSN nurse was interviewed. She acknowledged, that the restraint section for Resident 56's quarterly MDS was inaccurate.

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F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) 2. During the initial resident tour on 9/8/14 at 3 P.M., Resident 30 was observed in bed. The head of the bed was in the low position and the foot of the bed in a high position. There were 1/2 side rails at the head of the bed on each side that were in the up position. On 9/8/14 at 4:45 P.M., CNA 5 said Resident 30's legs were elevated to prevent her from getting out of the bed. On 9/8/14 at 4:50 P.M., LN 3 said Resident 30's legs were elevated to decrease swelling and to prevent her from getting out bed and that it is used to prevent falls. On 9/9/14 at 9:30 A.M., Resident 30 was observed in the dining room. Her left leg was elevated and the right leg/foot hung down. Resident 30 also had a self-release seat belt around her waist. Resident 30's clinical record was reviewed on 9/16/14. Resident 30 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Per the Physician orders [REDACTED]. Per the Physician orders, dated 6/19/12, Tab alarm while in bed for fall preventive measures ., and per Physician orders [REDACTED]. Resident 30's plan of care was reviewed. There was no documentation that addressed using restraints, head of bed flat with the foot of bed elevated to prevent from getting out of bed, or the use of a self-release seat beat. Resident 30's MDS' dated, 3/10/14 and 7/14 indicated no restraints of any type were used on Resident 30. The side rails, seat belt, and raising foot of bed, to prevent Resident 30 from getting out of bed was not listed on the MDS. On 9/18/14 at 2:45 P.M., MDSN said during an interview, that there are accuracy issues and timeliness issues with the MDSs. According to the facility's policy, RAI Process, undated, To provide residents assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal data submission requirements. 3. On 9/9/14 at 9:33 A.M., Resident 45's medical record was reviewed. Resident 45 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to Resident 45's Weekly/Monthly Weight Trend Assessment the following were the documented weights; 1/1/14 - 149.2 lbs 2/2/14 - 151 lbs 3/2/14 - 151 lbs 4/1/14 - 146.6 lbs 5/1/14 - 143 lbs 6/1/14 - 142 lbs 7/1/14 - 139 lbs 8/1/14 - 135 lbs 8/11/14 - 136 lbs 8/18/14 - 135 lbs 9/1/14 - 136 lbs 9/8/14 - 135 lbs On 9/9/14 at 10:00 A.M., the annual assessment from the minimum data set (MDS), dated [DATE], for Section K; Swallowing/Nutritional Status was reviewed with the MDS Coordinator. Under the K section indicated, 58, 147 pounds, and was coded as a 2 which indicated Loss of 5% or more in the last month or loss of 10% or more in the last 6 months; 2 - Yes, not on physician-prescribed weight-loss regiment. The MDS Coordinator (MDSN) was asked if the K section as listed above was accurate when it reflected that Resident 45 had lost 5% of body weight in the lst month, or 10% or more in the last 6 months. MDSN stated that the K section was completed by the dietary services supervisor who no longer worked at the facility. MDSN was asked who was responsible to sign the completed MDS to verify it was an accurate resident assessment, and she stated, I am the RN who signs the document verifying the MDS is accurate. MDSN reviewed the K Section and stated that the code of 2 was correct. MDSN was asked to demonstrate the calculations on how she verified the information was correct and the date reference frames and weight for that time frame that was being used to determine the code of 2. MDSN stated the last month weight reference would be a weight of 146.6 pounds on 4/1/14 compared to a weight of 143 pounds on 5/1/14. MDSN stated the reference times and weights for the last 6 months would be from 11/2/13 - weight 145.8 lbs as compared to 5/1/14 - weight of 143 pounds. MDSN was unable to demonstrate how to calculate percent body weight loss, and acknowledged without that knowledge she would be unable to verify if the K section was completed accurately. On 9/9/14 at 10:25 A.M., a registered dietitian (RD 1) verified that the above dates,time frames and weights would be the refernce data to complete the K section of the MDS at that time. MDSN observed RD 1 completing the calculations, and RD 1 verified that the MDS was not completed accurately, as Resident 45 had not had a 5% weight loss in the past month, or a 10% weight loss in the past 6 months at that time. During the same interview, the quaretly MDS, dated [DATE], for section K was reviewed with MDSN and RD 1. The quarterly MDS, dated [DATE], indicated Resident 45 was 58 and weighed 136 pounds. Under the K0300 weight loss section, was a code of 1 that indicated a loss of 5% or more in the last month or loss of 10% or more in the last 6 months, and 1. Yes, on physician-prescribed weight-loss regimen. On 9/9/14 at 10:53 A.M., RD 1 verified that at that time Resident 45 had a weight loss of 10% of body weight in the last 6 months, but that Resident 45 was not on a physician -prescribed weight-loss regimen. RD 1 confirmed that the MDS was inaccurate when it was coded as a 1, as it should have been coded as a 2. A 2 indicated that the resident had a 10% weight loss in last 6 months, and 2. Yes, not on physician-prescribed weight-loss regimen. MDSN acknowledged that the MDS was not coded accurately. According to the facility's policy, RAI Process, undated, To provide residents assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal data submission requirements. 4. Resident 41 was re-admitted to the facility on [DATE], per the facility's Face Sheet. On 9/9/14 at 1:30 P.M. Resident 41 was observed walking around in his room without assistance and without his front wheel walker. On 9/10/14 at 8:15 A.M., Resident 41 was interviewed. During the interview Resident 41 said, the staff make his bed and assisted him when he needed something. Resident 41 said he did not need their assistance with dressing, ambulating, getting out of bed, eating, or showering. Resident 41 further said, staff were present and gave a little assistance with showering to prevent him from falling. On 9/12/14, Resident 41's clinical record was reviewed. The MDS dated , 4/11/14 and 7/11/14, indicated Resident 41 had no mental or cognitive issues. The MDS also indicated Resident 41 needed limited assistance (staff provide guided maneuvering of limbs or other non-weight-bearing assistance) in transfers, walk in room, walk in corridor, dressing, toilet use, and personal hygiene. The MDS also indicated Resident 41 needed supervision (oversight, encouragement or cueing) in bed mobility, locomotion on unit, and eating. Resident 41 was observed 9/9-18/14 in hallways, activity room, dining room and his room, and no staff were observed assisting him. Resident 41 was observed not to need staff to set up his meal tray or to assist with eating. On 9/18/14 at 2:45 P.M. Resident 41's MDS was reviewed with the MDSN. The MDSN acknowledged that Resident 41's MDS was inaccurate and was not conducted in a timely manner. According to the facility's policy, RAI Process, undated, To provide residents assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal data submission requirements.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the following:

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In addition NP 1 ordered the resident to have Fibersource HN (liquid nutrition) @ 55 cc's every 24 hours with a flush of 150 cc's of water q 8 hours through his gastrostomy tube. Per the Nursing Dehydration Assessment Score dated 3/15/14, the resident's score was assessed at 70. According to the Dehydration Assessment sheet, High Risk-50+. Per the Nutrition Nursing Care Plan dated 3/15/14, the resident was at risk for weight loss and dehydration due to difficulty swallowing. Per the Nutritional Screening assessment dated , 3/17/14, the Dietary Services Supervisor (DSS) documented Residents 77's weight as 137.2 lbs, and a Body Mass Index (a number calculated from a person's weight and height that provides a reliable indicator of body fatness) of 25.1. Based on the Nutritional Screening Assessment, the residents enteral nutrition (the delivery of nutrients in liquid form directly into the stomach) was to provide 1320 cc's of fluid, 1584 calories and 71 gm's of protein. In addition the DSS documented the following TF (tube feeding trial), Res (Resident) tolerating TF well, spoke to ST (Speech Therapist) who stated the trial for po (by mouth) tolerance is going well and has been consuming 100% of B (breakfast), could not get a hold of family to find out UBW (usual body weight). Per the Nutrition Care Plan Dated 3/15/14, Risk for Weight Loss, Risk for Dehydration. Potential for Dehydration r/t (related to) TF (Tube Feeding). On 3/18/14, NP 1 ordered for Speech and Language services 5 times a week for 4 weeks due to Resident 77's difficulty swallowing. Per the RD (Registered Dietician) 1 notes dated 3/20/14, meds/labs/skin noted, rec'd to change TF to Fibersource HN @ 70 ml x (times) 18 hours to provide 1260 ml/1512 kcal (kilocalories)/1020 ml of water to begin a 9 am until finished. Goals (1) Will tolerate TF (2) No sig (significant) wt change (3) BM (bowel movement q (every) 1-3 d (days) (4) No s/s (signs and symptoms of dehydration, continue to monitor F/U (Follow Up) PRN (as needed). Per the Laboratory Report dated 3/26/14, Resident 77's BUN (Blood Urea Nitrogen-A common blood test, the blood urea nitrogen (BUN) test reveals important information about how well your kidneys and liver are working) was 28 H (high). Normal BUN reference levels are 7-25 mg\dl (milligrams per deciliter). Per Resident 77's Laboratory Report dated 3/31/14, Glucose 112 H (High-Normal Range 70-99); BUN 29 H High BUN Normal 7-25 mg\dl (milligrams per deciliter); WBC (White Blood Count) 12.7 High-Normal Range 4.8-10.8; Hgb (Hemoglobin- the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues) 11.7 L Low Normal Range 12.0-16.0; Hct (Hematocrit-is the proportion, by volume, of the blood that consists of red blood cells) 35.6% L Low-Normal range 37.0-47.0 % Per the Laboratory Report dated 4/21/14, Resident 77's BUN was 30 H High Normal 7-25 mg\dl (milligrams per deciliter); and his Chloride (is a type of electrolyte. It works with other electrolytes such as potassium, sodium, and carbon [MEDICATION NAME] (CO2). These substances help keep the proper balance of body fluids and maintain the body's acid-base balance) 110 H High Normal Range 98-107. There was no documentation by the NP to acknowledge the residents abnormal laboratory values on 3/26/14, 3/31/14, or 4/21/14. There was no documentation by the NP suggesting a change in the plan of care related to abnormal lab values. There was no documentation by the NP which suggested Resident 77 was discussed in a Interdisciplinary Team meeting/Case Conference . Between 3/15/14 to 7/9/14, there were 18 separate Speech Therapy and/or Diet Clarification orders written for Resident 77. Review of the Nursing Care Plans revealed no updates to Resident 77's Hydration Nursing Care Plans based on the Resident's abnormal laboratory results and/or the 18 separate changes in the Speech Therapy orders. Review of a Resident Care Plan entitled Nutrition and Hydration dated 4/01/14, contained, Monitor for signs and symptoms of dehydration and notify MD as indicated; Dietician to assess nutrition and hydration as needed. There was no update to the Nutrition and Hydration care plan dated 4/1/14 or after the dietician's last visit note dated 5/7/14. In fact, the resident was not seen by a dietician after 5/7/14, making it impossible for the dietician to update the care plan. On 9/17/14 at 1:35 PM, RD 2 stated the Nutrition Care plan for Resident 77 was not updated because the dietician, Did not have the allotment of time to meet the needs of the resident. Per the undated facility policy entitled Care Planning, It is the policy of this facility to provide person centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well being. I. A Licensed Nurse and/or other Interdisciplinary Team (IDT) members will initiate a Care Plan for the resident following admission in accordance with the initial assessment of the resident's medical, nursing, mental, and psychosocial needs. In addition, a Care Plan may be initiated upon identification of a change in condition and/or any new needs. 1 b. During the initial resident tour on 9/8/14 at 3 P.M., Resident 30 was observed in bed. The head of the bed was in the low position and the foot of the bed in a high position. There were 1/2 side rails at the head of the bed on each side, in the up position. On 9/8/14 at 4:45 P.M., CNA 5 said Resident 30's legs were elevated to prevent her from getting out of the bed. On 9/8/14 at 4:50 P.M., LN 3 said Resident 30's legs were elevated to decrease swelling and to prevent her from getting out bed and that it is used to prevent falls. On 9/9/14 at 9:30 A.M., Resident 30 was observed in the dining room. Her left leg was elevated and the right leg/foot hung down. Resident 30 also had a self-release seat belt around her waist. Resident 30's clinical record was reviewed on 9/10/14. Resident 30 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Sheet. Per the Physician orders [REDACTED]. Per the Physician orders, dated 6/19/12, Tab alarm while in bed for fall preventive measures ., and per Physician orders [REDACTED]. Per the CNA Daily Charting Form, dated July through August 2014, Resident 30 was total assist and needed 1-2 staff to turn resident in bed and reposition. Resident also needed a staff member to feed her. Per the nursing notes, Resident was incapable of the simplest tasks and needed 1-2 staff to position her feed her, dress and perform hygiene tasks for her. Resident 30's plan of care was reviewed. There was documentation that addressed assessment of using restraints, head of bed flat with the foot of bed elevated to prevent from getting out of bed, or the use of a self-release seat beat, in the clinical record. Resident 30's IDT notes were reviewed. There was no documentation that addressed assessment of the use of restraints in the clinical record. On 9/18/14 at 8:30 A.M. the DON said during an interview, Resident 30's seat belt was for safety reasons because of her mental [MEDICAL CONDITION]. The DON said she was unaware the staff positioned the head of the bed down and the feet up to prevent Resident 30 from getting out of bed. The DON further said, That is not our practice here. The facility's policy and procedure, Restraints, undated, An interdisciplinary team shall assess each restrained resident for the least restrictive restraint possible .Restraints shall be reassessed at least quarterly by reviewing the care plan entry for the restraints. 1 c. Resident 56 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 56 was identified as a high risk for falls due to a history of falls prior to admission to the facility. On 9/8/14 at 2:40 P.M., Resident 56 was observed in his room. The resident's bed was in a low position, with a landing pad

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) on the floor to the left side of his bed. On 9/9/14 at 9:42 A.M., CNA 5 was interviewed. He stated Resident 56 is a 2 person assist for transfers out of bed and transfers out of wheelchair. When asked why the resident's bed was in a low position, CNA 5 stated, so he won't roll out of bed. On 9/9/14 at 2:15 P.M., Resident 56 was observed in the main dining room participating in activities. The resident was able to answer questions and was slow in his speech. In addition, Resident 56 had a black helmet on the table. When asked why he owned a helmet, the resident tapped the right side of his temple. On 9/15/14 a record review was conducted. According to the nurse's note dated 5/30/14, Resident 56 had fallen and had a swollen cheek as a result of the fall. On 8/8/14, the LN documented Resident 56 had a fall with no injury. On 8/15/14 the LN documented Resident 56 had a fall with no injury. Resident 56 sustained 3 falls during the period of 5/30/14 through 8/15/14 with no major injury. A review of Resident 56's care plan entitled Risk for Injury/Fall was reviewed. The care plan was dated 3/15/14 and included the helmet for protection due to Resident 56's history for falls. During a concurrent review of Resident 56's care plan on 9/15/14 at 4:15 P.M., was conducted with the CDON. She confirmed the Resident 56's care plan did not address the 3 falls and it was not documented if Resident 56 had his helmet on with the 3 falls. The CDON stated the facility had a falls committee that reviewed resident falls and notes would be taken by the Interdisciplinary Team. On 9/16/14 the CDON acknowledged there was no Interdisciplinary Team Meeting notes regarding the resident's multiple falls. According to the facility's undated policy and procedure entitled, Charting Guidelines - Documentation, B. Care Plans are to be updated at the time of the weekly summary .Problems/goals on the care Plan will be documented. The CDON confirmed the facility did not follow the policy and procedure. 1 d. On 9/9/14 at 9:33 A.M., Resident 45's medical record was reviewed. Resident 45 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per an interdisciplinary meeting (IDT) note, dated 8/4/14, IDT met today to discuss weight loss .weight loss of 16 lbs -10.6% x 6 months . The same IDT note documented an intervention to add fortified (adding calories to food) to the diet order, and to change the monitoring of weight from monthly to weekly. RD 1 verified that the IDT had not documented possible underlying causes for the weight loss. On 9/9/14 at 10:53 A.M., the facility's consultant registered dietitian (RD 1) stated that Resident 45 was not on a physician -prescribed weight-loss regimen. RD 1 verified that the kitchen was providing Resident 45 a fortified diet since 8/4/14 as a result of the IDT meeting. A quarterly nutrition review dated 8/12/14 noted Resident 45 had a 11.8 % significant weight loss in 6 months. During the same interview, RD 1 reviewed Resident 45's nutrition care plan and verified that it had not been updated and revised to reflect the status of significant weight loss, the intervention of fortified diet, and had not included a root cause analysis for the significant change in condition, and should have. The facility failed to update and revise the nutrition care plan to reflect a significant weight loss, and failed to document a planned nutrition intervention of the addition of fortified to the diet with measurable time frames to monitor for effectiveness of the nutrition plan of care. According to the facility's policy and procedures (P & P) entitled Nutritional Screening/Assessment/Resident Care Planning (undated), Policy: The resident's nutritional status and his nutritional needs will be assessed. A nutrition program specific to his needs will be planned and implemented, and then reassess periodically for progress. Procedure: .All residents will be reviewed quarterly. The Dietary Services Supervisor (DSS) will also chart on any resident with changes in weight, eating habits .as these problems arise. Change in eating habits ., weight and other problems will be recorded in the dietary progress notes and resident care plan . The facility's P & P entitled Care Plans (undated) indicated, Purpose: 1. To assure that all disciplines coordinate the care of each resident. Procedure: 1. Assess the resident upon admission and initiate a plan of care for the key problems or possible problems identified. The care plan will be completed within seven days. 2. All goals will be measurable. 3. All entries will be time limited. 4. All disciplines will have input on the care plan .6. After the Resident Assessment Protocol is completed, the care plan will be updated to include any additional information gained within seven days of completion, 7. Any changes in the resident's status will be put on the care plan as they occur. 2 a. Resident 20 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 9/11/14, a record review was conducted. Resident 20 was visited by the Hospice nurse on the following dates 8/12/14, 8/15/14 and 9/8/14. According to the Hospice nurse's documentation on 8/12/14, the Hospice nurse documented, The following were in involved in and verbalized understanding and agreement with the Plan of Care: Facility Nurse. According to the Hospice nurse's documentation on 8/15/14, the Hospice nurse documented, Coordination plan of care with: Facility Nurse. According to the Hospice nurse's documentation on 9/8/14, the Hospice nurse documented, Coordination plan of care with: Facility Nurse. A concurrent record review was conducted with the CADON on 9/18/15 at 8:50 A.M. A review of the Licensed Personnel Weekly Progress Notes were reviewed. The CADON confirmed, there was no documentation made by the LNs that a Hospice visit was made during 8/12/14, 8/15/14 and 9/8/14. The CADON stated, each Hospice visit, The nurse taking care of the Resident should document in the chart. On 9/18/14 at 2:30 P.M., an interview with the CDON was conducted. The CDON confirmed that the nurse assigned to the resident should document in the nurse's notes each Hospice visit. According to the facility's undated policy and procedure entitled, Hospice Care of Residents, Hospice notes will be included in the Facility Progress Notes. The CDON acknowledged that the nursing staff did not follow the facility's policy and procedure. 2 b. Resident 27 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Per the MDS (Minimum Data Set) dated 8/1/14, Resident 27's BIMS (Brief Interview for Mental Status) was scored at 15, meaning the Resident 27's cognitive functioning was intact. Per the physician's orders [REDACTED]. A Hospice Certification and Plan of Care for the period 7/11/14 through 10/8/14 was present in the clinical record. According to the Plan of Care, a Licensed Nurse was to visit the resident 1 x per week and PRN (as needed). Review of the clinical record not reveal a coordinated Hospice Care and facility care plan for Resident 27. Per an Initial Integrated Hospice and Facility Plan dated 7/11/14, there was no assessment updates in the clinical record indicating the hospice agency and the facility were coordinating Resident 27's needs as outlined in the through Care Conferences or through an Interdisciplinary Team. A review of Resident 27's clinical did not reveal any coordination of care between the hospice social worker and the facility social worker. Per the Initial Integrated Hospice and Facility Plan of Care dated 7/11/14, the Hospice Social Worker intervention was Hospice Social Worker 1 X evaluation/assessment. Per the Initial Integrated Hospice and Facility Plan of Care dated 7/11/14, the Hospice Spiritual Counselor intervention was Spiritual Counselor 1 X evaluation/assessment. Per a Nursing Facility Social Service Progress Note dated 8/8/14, SSD (name of social worker) and Administrator in Training (name of AIT) conducted interview with resident (name of resident) re: suspected resident to resident abuse during afternoon Bingo activity .Nurse (name of nurse) conducted full body assessment no c/o (complaint) of pain or discomfort. Psychologist and psychiatrist aware to f/u (follow up) on patient's emotional well-being post alleged abuse. Will continue to monitor and f/u as necessary. There was no further documentation in the record indicating the SNF coordinated with the hospice in updated the resident's care plan. On 9/17/14 at 2:55 PM, LN 11 stated The only thing I would write to coordinate care with hospice is if there was a change and I notified hospice. I sometimes document it, sometimes I don't. We talk about what's going on with the patient such as pain.

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) On 9/18/14 at 2:30 PM, the DON stated the facility should be doing care conferences. A joint clinical record review with the DON failed to produce any documented Interdisciplinary Team meeting notes, or Case Conference notes for Resident 27. Per the DON, Case Conferences were to be done upon admission, quarterly or as needed if the patient's situation changed. Per the facility's undated Policy and Procedure entitled Care Planning, It is the policy of this Facility to provide person-centered comprehensive and interdisciplinary care that best reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well being .A Licensed Nurse and/or other Interdisciplinary Team (IDT) member will initiate a Care Plan for the resident following admission in accordance with the initial assessment of the resident's medical, nursing, mental, and psychosocial needs. In addition a Care Plan may be initiated upon identification of a change of condition and/or any new needs.
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to carry out and/or clarify physician's order as related to an order for [REDACTED]. As a result of nursing not clarifying physician orders, there was potential to affect the residents' health and safety. Findings: 1. On 9/12/14 at 9:33 A.M., Resident 82's medical record was reviewed. Resident 82 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per physician orders, dated 7/6/14, there was an order for [REDACTED].>On 9/15/14 at 2:44 P.M., RD 2 stated that healthshakes was started on 9/11/14 due to weight loss. On 9/16/14 at 11:00 A.M., RD 2 was asked what the physician's order for nourishment was, and she stated, I don't know what that means. Means nothing. On 9/16/14 at 1:47 P.M., LN 11 was asked how the physician order for [REDACTED]. LN 11 then stated, Nourishment means snacks. The kitchen will be implementing as snacks. LN 11 was asked to show the documentation to show a physician's order was implemented related to the nourishment, and was unable to. At that time, RD 2 stated that an order for [REDACTED]. LN 11 acknowledged that nursing staff were unclear on how to implement an order for [REDACTED]. 2. On 9/16/14 at 10:40 A.M., Resident 35 was re-admitted to the facility on [DATE]. Per physician orders dated 9/1/14, there was a checkmark next to nourishment on the pre-printed physician's admission orders [REDACTED] On 9/16/14 at 11:00 A.M., RD 2 was asked what the physician's order for nourishment was, and she stated, I don't know what that means. Means nothing. On 9/16/14 at 1:47 P.M., LN 11 was asked how the physician order for [REDACTED]. The kitchen will be implementing as snacks. At that time, RD 2 stated that an order for [REDACTED].# wt (weight) loss within last yr (year). During the same interview, RD 2 stated the dietary consult order from 9/3/14 was completed by an RD on 9/5/14. RD 2 stated the RD recommended 4 ounce healthshakes two times a day and a fortified diet due to variable po (by mouth) intake and unplanned weight loss. RD 2 verified that the facility had not acted upon a physician order for [REDACTED]. 3. On 9/15/14 at 9:42 A.M., Resident 20's medical record was reviewed. Resident 20 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 6/9/14 the physician ordered a puree diet with thickened liquids. On 9/15/14 at 9:45 A.M., the Assistant Director of Nurses (ADON) reviewed Resident 20's physician order for [REDACTED]. ADON and RD 2 reviewed Resident 20's medical record and verified that the order for thickened liquids was not clarified until 6/14/14 when there was an order for [REDACTED].>RD 2 stated that she was unable to determine what type of thickened liquid was being provided by the kitchen in the meanwhile, as they had not stored old dietary tray tickets, and the dietary services supervisor during that time was no longer employed at the facility. RD 2 stated she was able to find nursing/communication forms during that time and there was no documentation that the order for thickened liquids had been clarified, prior to 6/14/14. 4. On 9/11/14 at 8:05 A.M., Resident 80's medical record was reviewed. Resident 80 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 7/23/14, per physicians admission orders [REDACTED]. Next to the Diet area on the pre-printed physician admission orders [REDACTED]. See order. On 7/23/14, Resident 80's physician prescribed fibersource HN (a liquid nutrition formula) at 50 cc/HR (hour) x 20 hrs via [DEVICE] feeding. Per the September 2014 recapitulated physician orders, as of 8/4/14, Provide half PBJ (peanut butter and jelly) for HS (bedtime snack) that was above a sliding scale insulin order. On 9/12/14 at 8:17 A.M., the current Director of Nursing (CDON) reviewed Resident 80's physician order for [REDACTED]. A copy of the Medication Administration Record [REDACTED]. On 9/12/14 at 8:34 A.M., the CDON stated she reviewed the MAR's and a PBJ was on the MAR but was not implemented. the CDON stated that it was a nursing standards of practice to clarify a physician's order, and the nurse should have clarified the PBJ order when it was initially ordered.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain records for the Bioethics committee meetings for 2 of 24 sampled residents (95, 96) and 4 unsampled residents (99, 113, 114, 121). In addition, the facility failed to ensure a plan of care was updated for 1 of 24 sampled residents (56). As a result, discussions by the Bioethics committee, which may have included discharge plans, and treatment were not found in the records, and there was a potential for inaccurate care plan for a resident with multiple falls. Findings: 1 a. Resident 95 was admitted to the facility on [DATE], per the Face Sheet. Resident 95 was discharged to a Board and Care facility on [DATE] according to the Discharge order sheet. Resident 95 did not have capacity to make decisions per the Face Sheet and her Responsible Party listed was Bio Ethics. Clinical records were reviewed on [DATE]. 1 b. Resident 96 was admitted to the facility on [DATE], per the Face Sheet. Resident 96 was discharged from the facility [DATE]. Clinical records were reviewed on [DATE]. Resident 96 did not have capacity to make decisions per the Face Sheet and her Responsible Party listed was Bio Ethics. 1 c. Resident 99 was admitted to the facility on [DATE], per the Face Sheet. Resident 99 was discharged on [DATE] according to Interdisciplinary Team notes. Clinical records were reviewed on [DATE]. Resident 99 did not have capacity to make decisions per the Face Sheet and her Responsible Party listed was Bio Ethics. In the records a Bioethics meeting was found, it did not have any attendees listed, and was dated [DATE]. Concerns to be Discussed .Resident cannot participate in decision making and does not have a personal representative to participate in medical decisions. Bioethics committee met & discussed res. (resident) needs the Bioethics .After Bioethics committee gather relevant information & considered different options & opinion they (Bioethics) came to a conclusion that the Facility will provide tx (treatment) & make decisions in the best interest of the resident since res. (resident) has no responsible party & has a COC (change of condition). 1 d. Resident 113 was admitted to the facility on [DATE], per the Face Sheet. Clinical records were reviewed on [DATE]. Resident 113 was transferred to the hospital on [DATE], per the Physician order [REDACTED]. The Second Contact was listed as Bioethics.

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F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) 1 e. Resident 114 was admitted to the facility on [DATE], per the Face Sheet. Resident 114 was discharged as expired on [DATE]. Clinical records were reviewed on [DATE]. Resident 114's Face Sheet listed Resident 114 as her own Responsible Party with a second contact. 1 f. Resident 121 was admitted to the facility on [DATE], per the Face sheet. Resident 121 was transferred to the hospital on [DATE], per the Physician order [REDACTED]. There was no Responsible Party listed on the Face Sheet. According to the PDON, on [DATE] at 2 P.M., Bioethics meetings were conducted monthly and recorded. When the Bioethics records were requested from the Administrator, on [DATE] at 1:30 P.M., the Administrator said, We are still looking for the records, we have a new Director of Nurses and we moved the new Director of Nurses to a different office. According to the Bioethics committee policy, Policy No. SS-16, page 1, undated .III. The Bioethics Committee will document its considerations and determination on the Bioethics Committee Minutes. 2. Resident 56 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 56 was identified as a high risk for falls due to a history of falls prior to admission to the facility. On [DATE] at 2:40 P.M., Resident 56 was observed in his room. The resident's bed was in a low position, with a landing pad on the floor to the left side of his bed. On [DATE] at 9:42 A.M., CNA 5 was interviewed. He stated Resident 56 is a 2 person assist for transfers out of bed and transfers out of wheelchair. When asked why the resident's bed was in a low position, CNA 5 stated, so he won't roll out of bed. On [DATE] at 2:15 P.M., Resident 56 was observed in the main dining room participating in activities. The resident was able to answer questions and was slow in his speech. In addition, Resident 56 had a black helmet on the table. When asked why he owned a helmet, the resident tapped the right side of his temple. On [DATE] a record review was conducted. According to the nurse's note dated [DATE], Resident 56 had fallen and had a swollen cheek as a result of the fall. On [DATE], the LN documented Resident 56 had a fall with no injury. On [DATE] the LN documented Resident 56 had a fall with no injury. Resident 56 sustained 3 falls during the period of [DATE] through [DATE] with no major injury. A review of Resident 56's care plan entitled Risk for Injury/Fall was reviewed. The care plan was dated [DATE] and included the helmet for protection due to Resident 56's history for falls. During a concurrent review of Resident 56's care plan on [DATE] at 4:15 P.M., was conducted with the CDON. She confirmed the Resident 56's care plan did not address the 3 falls. The CDON stated the facility had a falls committee that reviewed resident falls and notes would be taken by the Interdisciplinary Team. On [DATE] the CDON acknowledged there was no Interdisciplinary Team Meeting notes regarding the resident's falls. According to the facility's undated policy and procedure entitled, Charting Guidelines - Documentation, B. Care Plans are to be updated at the time of the weekly summary .Problems/goals on the care Plan will be documented. The CDON confirmed the facility did not follow the policy and procedure.
F 0283 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide proper discharge planning and communication, of the resident's health status and summary of the resident's stay.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Patient Transfer Form, (a document with medical condition information, which was to include allergies [REDACTED]. As a result, the emergency room physicians and staff may have had a delay in treatment, while they took extra time to obtain information to diagnose, inform the Responsible Party and formulate a treatment plan. Findings: 1. Resident 55 was admitted to the facility on [DATE] per the Face Sheet. Resident 55 was transferred to the hospital from the facility on 6/21/14 according to the Patient Transfer Form dated 6/21/14. Clinical records were reviewed on 9/3/14. According to the transfer form, Resident 55 was delusional and restless but there was no documentation of records sent to the hospital with Resident 55, and the section for diagnosis, drug allergy information, or contact information for Resident 55's Responsible Party were all blank. 2. Resident 80 was admitted to the facility on [DATE], per the Face Sheet. Resident 80 was transferred to the hospital from the facility on 6/4/14, per the Patient Transfer form, for evaluation. Clinical records were reviewed on 9/3/14. There was no documentation of records sent to the hospital with Resident 80, and there was no diagnosis, drug allergy information, or contact information for Resident 80's Responsible Party. 3. Resident 112 was admitted to the facility on [DATE] per the Face Sheet. Resident 112 was transferred to the hospital from the facility on 6/21/14, per the Patient Transfer Form. Clinical records were reviewed on 9/3/14. According to the Patient Transfer form, Resident 112 had purple feet. There was no documentation of records sent to the hospital with Resident 112, and there was no diagnosis, drug allergy information, or contact information for Resident 112's Responsible Party. On 9/3/14 at 10:30 A.M., the Medical Records Director was interviewed and records were jointly reviewed. The Medical Records Director said there should be a check off list of documents which the nursing staff copies and sends to the hospital, Our other facility uses a check off list of the documents sent with the patient to the hospital. On 9/4/14 at 2 P.M., the Administrator reviewed the transfer record for Resident 55. She said there was no indication of which if any records were sent by the facility to the hospital with Resident 55. The Administrator said there was no system in place to determine which if any records accompanied a resident to the hospital, or audit process to determine if the transfer form was completed. According to the facility policy entitled, Emergency Transfer and Discharge, undated, Policy No. AD-12, a transfer form was to be sent with the resident. The facility policy did not address completion of the form.
F 0284 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a post-discharge plan with the resident and family for the resident's care after leaving the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop a discharge plan of care, to assist residents with adjustment in their change of living environment for 2 unsampled residents (120,99). As a result, residents may not have had adequate information for follow up physician appointments, emergency medical contacts, medication schedule and instructions. Findings: 1. Resident 120 was admitted to the facility on [DATE], per the Face Sheet. Resident 120 was discharged to a Board and Care Facility on 5/19/14 per the Physician Order. Clinical records were reviewed on 8/13/14. Per the Medication Transfer Sheet, Resident 120 was to receive a medication, [MEDICATION NAME] (a blood thinner tablet) by mouth for 13 days for [MEDICAL CONDITION] ([MEDICAL CONDITION] (blood clot)) [MEDICATION NAME] until 5/19/14. Per the record a PTT/INR (an anticoagulant lab test which determined the level of medication) was to be drawn on 5/19/14. No lab results were located in the records to determine if the physician had increased, decreased or discontinued the medication. The transfer sheet did not reflect any precautions which were to be utilized if Resident 120 had bleeding or bruising due to his medication. Additionally [MEDICATION NAME] (an inhaled breathing medication) was to be used for shortness of breath and oxygen at 2LPM (liters per minute/a measurement of oxygen delivery) per nasal cannula (tube to the nose to deliver oxygen), if Resident 120's oxygen level dropped below 92% saturation. There was no indication to determine how the Board and Care facility was

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F 0284 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 13) to determine the oxygen saturation level (measured by electronic machine) was to be completed Resident 99 was admitted to the facility on [DATE], per the Face Sheet. Resident 99 was discharged to a Board and Care facility on 6/17/14, per the Physician order [REDACTED]. According to the Medication Transfer Sheet, Resident 99 was to have finger stick blood sugar (a needle stick with testing for blood sugar level) for diabetics before breakfast. The physician was to be called if the blood sugar was above 300 or below 70. Per Resident 99's Interdisciplinary Discharge Summary dated, 6/17/14, the Reason for discharge/discharge diagnosis (es): B.E. The Facility Consultant 1 said on 8/13/14 at 4 P.M., B.E. was an abbreviation for Benefits Exhausted, or Medicare payment days exhausted. The FC 1 said it was not ok to discharge a resident for B.E. The Facility Consultant (FC) said on 8/13/14 at 4 P.M. that there was no documentation that the Board and Care facilities understood how to assist the residents with specialized care, medications, treatments, emergencies and appointments. According to the facility policy entitled, Transfer of Residents, undated Policy No.-AD-xx .The Facility may transfer a resident for the following reasons: i. the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the Facility.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and clinical record and document review, the facility failed to provide the necessary care and services to ensure the highest practicable level of physical well-being related to pain management for four of 29 sampled residents (38, 48, 63, and 80) and one non-sampled resident (39). For Resident 48, the facility did not assess the pattern and frequency of as-needed pain medication administrations, to request for routine pain medication coverage in order to avoid unnecessary pain for the resident. For Residents 38, 39, 48, 63, and 80, the facility staff failed to conduct and document pain assessment and interventions every time pain medication was administered (see F431 for more details of the deficient practice). The failure had the potential to expose residents to unsafe and ineffective pain management. Findings: 1. On 9/12/14, a review of Resident 48's medical record revealed he was admitted to the facility with [DIAGNOSES REDACTED]. He had a physician order [REDACTED]. During an interview with Resident 48 on 9/12/14 at 3:40 P.M., he said had pain all over the place as he pointed to his left shoulder, arms, and legs, and said he asked for pain medication all the time. The Controlled Drug Record (an inventory sheet), from 8/17/14 to 9/17/14, showed the nursing staff signed out 2 tablets of [MEDICATION NAME] 5/325 mg each time, averaging 3 times (6 tablets) per day; there were days 10 tablets (5 times per day) were signed out each day for patient administration. The August and September 2014 Pain Assessment Flowsheets (PAF, a form which documented the pain assessment, the pre-[MEDICATION NAME] pain rating, etc.) revealed the resident had pain levels of 7 to 8 (moderate to severe) from the 0 - 10 pain rating scale (0 = no pain, 10 = worst pain possible) each time a dose of [MEDICATION NAME] was administered. Review of Resident 48's physician monthly orders for September 2014 showed no routine pain medications were ordered. During an interview with the CDON, ADON, and VPCS on 9/18/14 at 9:20 A.M., the VPCS acknowledged the facility had not evaluated the effectiveness of pain interventions for Resident 48. When asked if the facility had requested for routine medication coverage to avoid unnecessary pain for the resident, VPCS said, Not yet. 2a. Resident 80 had a physician order, dated 7/23/14, for [MEDICATION NAME] 5/325 mg to take 1 tablet every 4 hours as needed for moderate pain and 2 tablets every 4 hours as needed for severe pain. On 9/11/14 at 2:25 P.M., an inspection of the controlled substance (CS) medication accountability records with LN2, revealed 2 tablets were signed out of the controlled drug record (CDR) at 3 A.M. on 9/11/14, but the nursing staff did not document the administration on the medication administration record (MAR; front or back) or on the pain assessment flow sheet (PAF). Therefore, 2 tablets of [MEDICATION NAME] were unaccounted for. During an interview on 9/15/14 at 1:50 P.M., the CDON confirmed CS medications signed out of the CDR must be documented on the MAR after given, then on the PAF to document the pain assessment and interventions. On 9/16/14 at 10:30 A.M., a review of the CS records for Resident 80's [MEDICATION NAME], from 8/19/14 to 9/7/14, revealed additional 16 tablets of [MEDICATION NAME] unaccounted for, meaning they were signed out of the CDR as being given but not recorded on the PAF or on the back of MAR. 2b. For resident 48, review of the CS records on 9/12/14, 9/15/14, and 9/17/14 revealed a total of 65 tablets of [MEDICATION NAME] 5/325 mg were not accounted for from 8/17/14 to 9/17/14. They were signed out of the CDRs as being given without subsequent documentation of pain assessment and interventions on the PAF or on the back of the MAR. 2c. For Resident 38, a review of the CS records on 9/12/14 and 9/16/14 revealed a total of 24 tablets of [MEDICATION NAME] 5/325 mg were unaccounted for from 8/1/14 to 9/10/14. They were signed out of the CDRs as being given to the resident without subsequent documentation of pain assessment and interventions on the PAF or on the back of the MAR. 2d. For Resident 39, a review of the CS records on 9/12/14 and 9/16/14 revealed a total of 8 tablets of [MEDICATION NAME] 5/325 mg were unaccounted for from 8/1/14 to 9/12/14. They were signed out of the CDRs as being given to the resident without subsequent documentation of pain assessment and interventions on the PAF or on the back of the MAR. 2e. For Resident 63, a review of the CS records on 9/17/14 revealed a total of 11 tablets of [MEDICATION NAME] 10 mg were unaccounted for from 8/1/14 to 9/17/14. They were signed out of the CDRs as being given to the resident without subsequent documentation of pain assessment and interventions on the PAF or on the back of the MAR. For each missing documentation, it was undeterminable what pain level and location of pain had been, if the medication was effective, if there had been any side effects, and if non-drug interventions were taken. During an interview with CDON, ADON, and VPCS on 9/18/14 at 9:20 A.M., they acknowledged the nursing staff failed to conduct and document pain assessment and interventions every time pain medication was administered, for Residents 38, 39, 48, 63, and 80. The facility's procedures, undated, entitled Medication - Administration Nursing Manual - General, indicated: PRN (as needed) Medication Documentation A. When a PRN medication is given, it will be charted on the Medication Administration Record. The Nurse will document the reason given, reason for the drug, route of administration, date, and time. B. The result of the PRN medication will be charted by the responsible Nurse on the back of the MAR. C. If the PRN is for complaint of pain, the Nurse will document the pain score prior to given the medication and after the administration of the pain medication.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on observation and interview, the facility failed to identify and address safety hazards in, 1 of 2 shower rooms, 1 of 48 (16) resident room flooring, and 1 television was unsecure. As a result, the facility did not identify and address safety hazards that potentially could have caused great harm to residents. Findings: 1. On 9/8/14 at 3 P.M., during the initial tour, shower room 1 was observed. A solid metal plate covered the bottom third of the door, had sharp metal sticking out at the top of the plate and one at the bottom of the plate. Also, there was a box by the door hanging on the wall for disposable razors and other sharp materials. The box for the sharps was full and there were 13 stacked used razors on top of the box. Beside the box was another container that had liquid fluid. LN 1 said the container contained hair and body shampoo. The container was barely hanging on the wall, it had pulled away from the wall approximately 2 inches. Inside the shower stall, on the floor, were four 3 x 3 inch tiles that were shattered and very sharp. Janitor 1 stated, Yes, the metal sticking out of the door is dangerous. He also said the container for used sharp supplies

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F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 14) should had been replaced. He further said he was supposed to write the repairs needed in the maintenance log and said he did not write them in the log or notify MS. 2. On 9/8/14 at 3 P.M. during the initial tour, room 16 & 17's shared bathroom was observed. Wood flooring from the resident ' s room going into the bathroom was not flush with the bathroom flooring. Uneven cut pieces of boards were sharp. 3. On 9/8/14 at 3 P.M., during the initial tour, a 20 inch television was observed sitting on a wall mount that was not secured. MS stated, Yes, it could fall if bumped. MS also said, he was not aware of the repairs needed and that the issues were not written in the maintenance log for repairs. On 9/11/14 the facility's policy, Maintenance Work Log, undate, To protect the health and safety of residents, visitors, and Facility Staff. Maintenance work orders shall be completed in an effort to sustain maintenance services as a priority.
F 0325 **Level of harm** - Actual harm **Residents Affected** - Some	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive systematic approach to ensure effective monitoring and systems to maintain acceptable parameters of nutritional status for 5 of 20 sampled residents (80, 45, 30, 82, 20) and 2 of 4 extended sampled residents (42, 35). The facility failed to ensure two residents identified as nutritionally high risk at the time of admission was assessed by and/or Registered Dietitian recommendations were communicated to the physician timely to meet the assessed nutritional needs (Resident 80, 42). The facility failed to identify and address unplanned, gradual, progressive weight loss prior to becoming an unplanned significant weight loss. In addition, the facility failed to notify the physician of the unplanned, significant weight loss which had the potential for delayed nutrition intervention to address the weight loss by the practitioner responsible for the care of the resident (Resident 45). The facility failed to ensure an effective monitoring system of parameters of nutritional status in order for facility staff, the Registered Dietitian, and/or the Interdisciplinary team to identify and determine underlying causes of a slow progressive weight loss (Resident 30). The facility failed to ensure care staff was knowledgeable on how to implement a physician's order for nourishment (Resident 82, Resident 35). Lacked an effective system to ensure timely Registered Dietitian (RD) assessments and/or follow up, a system to ensure RD recommendations were communicated to the physician in a consistent and timely manner. In addition, the facility failed to have a system to document the percentage consumed of a planned nutrition intervention for an identified concern as related to evaluating and nutrition assessment and compared to assessed needs. (Resident 82, 20, 35) The above cited systems failures had the potential to negatively impact and compromise the medical status of all residents residing in the facility. Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. (American Family Physician, February 15, 2002/Volume 65, Number 4) Findings: 1. On 9/11/14 at 8:05 A.M., Resident 80's medical record was reviewed. Resident 80 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 7/23/14 Resident 80's physician prescribed fibersource HN (a liquid nutrition formula) at 50 cc (cubic centimeter)/HR (hour) x 20 hrs to provide 1000cc/1200 kcal (calories) via Peg tube (a tube inserted through the wall of the abdomen directly into the stomach) and enteral pump (a device that controls the amount of nutrition delivered). Start at 9 PM off at 5 pm until dose completed. Flush (infuse water) GT w/165 ml (milliliters) H20 (water) q (every) 4 h (hour). On 7/30/14, 7 days after admission, a registered dietitian (RD) completed a Eneral Feeding Assessment, dated 7/30/14 for Resident 80. The RD noted Resident 80 was 56 (inches) tall and weighed 71 pounds (lbs). Per the RD, Resident 80's ideal body weight was 81 lbs - 90 lbs - 99 lbs. The RD noted the current formula prescription had not met Resident 80's estimated caloric needs. The RD noted the formula prescription provided 1,200 calories, and 54 grams of protein. The RD had assessed Resident 80's calorie needs at 1,307-1,745 calories a day, 39-47 grams of protein a day. The RD recommended changing the formula to [MEDICATION NAME] 1.5 at 50 ml x 20 hr to provide 1,500 calories a day. On 8/4/14 there was a physician's order to carry out the RDs recommendations of [MEDICATION NAME] 1.5 at 50 ml x 20 hours to provide 1,500 calories a day, 4 days after the RD identified Resident 30 had not been receiving sufficient calories for 7 days, compared to assessed needs. According to the August Medication Administration Record [REDACTED]. On 8/19/14, the physician order changed back to the original admission tube feeding order that provided 1,200 calories and 54 grams of protein a day. The RD had not followed up from 7/30/14, until almost a month later, on 8/28/14. On 8/28/14, RD 2 noted that the formula changed back to 1200 calories a day since 8/19/14, 9 days earlier. Per the Weekly/Monthly Weight Trend Assessment (initiated on 7/24/14), Resident 80 who was under her ideal body weight dropped two pounds from 71 lbs to 69 lbs, as of 8/11/14. On 8/28/14, RD 2 noted, goal gradual wt (weight) gain to at least 90# (pounds; lbs)/ 1-2 #/week and heal pressure sore. Increase Fibersource HN = 70 ml x 20 hr to provide 1, 680 calories a day, and 74.2 grams of protein a day. The RD noted the recommendation in the dietary/nursing communication log book on 8/28/14. On 9/9/14, eleven days later, after the RD was aware that Resident 80 had not been receiving sufficient caloric intake, compared to assessed needs per RD 2, and lost two pounds, RD 3 conducted a follow up nutrition assessment. RD 3's 9/9/14 note indicated, Recommend Prostat (a protein supplement) 30 ml q day . RD 3 logged the Prostat recommendation in the dietary/nursing communication log. On 9/11/14 at 11:03 A.M, RD 3 stated, I recommended the Prostat because the resident has multiple wounds and the Prostat will help with wound healing. On 9/11/14 at 11:15 A.M., the Assistant Director of Nurses (ADON) reviewed the dietary/nursing communication log. ADON observed nurses' initials and date of 8/4/14 next to the RD recommendation, and stated, That means that is the day the nurse communicated the recommendation to the doctor. Concurrently, ADON reviewed the RD recommendations located in the communication log dated 8/28/14 (a recommendation to modify the formula again for further increase in calories), and on 9/9/14 (for Prostat to increase protein), and stated, These were not communicated to the physician because there is not a nursing initial. ADON stated it was a charge nurse's responsibility to ensure the RD recommendations were communicated to the physician. On 9/12/14 at 7:40 A.M, the current Director of Nursing (CDON) reviewed the RD recommendations which were logged in the dietary/nursing communication log on 8/28/14, and 9/9/14, and acknowledged that there was no documentation to indicate they were communicated to the physician. The CDON verified that the RD recommendation made on 7/30/14, and communicated to the physician on 8/4/14 to address insufficient calories from the formula was not timely. The CDON stated she was employed at the facility since mid-august 2014 and was not aware of the facility's expectations in terms of timeliness for communicating RD recommendations to the physician. The CDON stated it would be her expectation as a nurse to have the recommendations communicated immediately, at least by the end of every shift. Resident 80 had worsening pressure sores since her re-admission to the facility on [DATE]. A record review of the wound care physician's documentation, from 7/30/14 through 9/2/14, indicated the progress of the following pressure ulcers: 1. Left big toe UTD (unable to determine the depth/stage of the wound), which measured 1.5 x 1 cm (centimeter; 2.54 cm equals 1 inch) 2. Right plantar (sole of the foot) healing scab, which measured 1 x 1.5 cm 3. Right ankle lateral (sides), which measure 1 x 1 x 0.1 x 0.2 cm , slough 20% and debrided (surgical removal of dead tissue) 4. Left hip/trochanter (area for attachment of muscles to the thigh bone) stage 4, which measured 0.5 x 0.5 x 0.3 x 0.5 cm and debrided; 5. Sacrum (triangular bone in the lower back) Stage 4, which measured 0.8 x 0.8 x 0.1 x 0.2 cm, not healed, but improving

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F 0325 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 15) 6. Right Buttock/trochanter Stage 4, which measured 3.5 x 4.0 x 1.0 x 1.2 cm, not healed, but improving. On 8/5/14 the wound care physician re-assessed Resident 80 ' s pressure ulcers: 1. Right ankle lateral, 0.5 x 1 x 0.1 x 0.2cm , 20% slough 2. Right lateral trochanter 2 x 2.5 x 1 x 1.2 cm, 30% slough 3. Right trochanter foot healing 1.5 x 1.5 cm 4. UTD sacrum stage 4/5 5. Left ankle healing; 6. Right hip lateral 0.7 x 1 x 0.2 x 0.3 cm, 30% ; On 8/25/14: 1. Sacrum Stage 4, measured 3 x 0.5 x 0.1 x 0.2 cm, not healed 2. Right trochanter Stage 4 2.5 x 1.5 x 0.8 x 1.0 cm (increased in size and stage) 3. Right big toe 1 x 0.5 [MEDICAL CONDITION] x 0.2 cm 4. Right ankle 1 x 1 x 0.1 x 0.2 cm 5. Left big toe 0.5 x 0.5 x 0.1 cm, healing 6. Right 2nd toe 0.5 x 0.5 x 0.1 cm scab, healing (new) 9/2/14 1. Right ankle 0.3 x 0.3 cm 2. Right foot plantar 1 x 1 x 0.1 cm 3. Right trochanter stage 4, 2 x 3 x 1 x 1.5 cm 4. Sacrum Stage 4 measured at 3 x 4 x 0.1 x 0.2 cm On 9/15/14 at 8:32 A.M., Resident 80's medical record was reviewed from a re-admission to the facility which occurred on 6/26/14. According to the nutrition care plan which was developed on 6/26/14, and was effective through 9/26/14, Resident 80's goal was for a weight gain of 1- 2 pounds a week to reach 100 pounds. In a physician's order, dated 6/26/14, Fibersource HN @ 40 cc/ x 20 hr till RD eval (evaluates) . On 9/15/14 at 8:48 A.M., RD 2 reviewed the above order, and Resident 80's medical record, and stated that the physician consult order was not addressed by a RD. According to physician orders, dated 7/14/14, the physician repeated the order for an RD consult, Dietary Consult. On 9/15/14 at 8:48 A.M., RD 2 reviewed the above order and stated that the physician consult order was not addressed by an RD. RD 2 stated that the RD was not informed that there was a physicians order for a dietary consult. The following note was observed in the Licensed Personnel Weekly Progress Notes, dated 7/14/14, Dietary consult ordered & carried out; low protein and [MEDICATION NAME]. RD 2 verified that the dietary consult was not completed and addressed by a registered dietitian. A Licensed Personnel Weekly Progress Notes, dated 7/18/14 at 1100, indicated Resident 80 was transferred to a hospital due to vomiting and temperature for further evaluation. Resident 80 was re-admitted to the facility on [DATE]. Per physician progress notes [REDACTED].readmit from (name of hospital) .recent bacteremia (bacteria in the blood), and [MEDICAL CONDITION] (infection is caused by a strain of staph bacteria that's become resistant to the antibiotics commonly used) wound infection . The facility's policy and procedure entitled, Nutritional Screening/Assessments/Resident Care Planning, (undated) indicated, Policy: The resident's nutritional status and his nutritional needs will be assessed. A nutritional program specific to his needs will be planned and implemented, and then reassessed periodically for progress . 2. On 9/9/14 at 9:33 A.M., Resident 45's medical record was reviewed. Resident 45 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 5/10/13 the physician ordered a mechanical soft, chopped meat diet. According to the weights documented on Resident 45's Weekly/Monthly Weight Trend Assessment; 1/1/14 - 149.2 lbs 2/2/14 - 151 lbs 3/2/14 - 151 lbs 4/1/14 - 146.6 lbs 5/1/14 - 143 lbs 6/1/14 - 142 lbs 7/1/14 - 139 lbs 8/1/14 - 135 lbs 8/11/14 - 136 lbs 8/18/14 - 135 lbs 9/1/14 - 136 lbs 9/8/14 - 135 lbs An interdisciplinary meeting (IDT) note indicated, dated 8/4/14, IDT met today to discuss weight loss .weight loss of 16 lbs -10.6% x 6 months . The same IDT note documented an intervention to add fortified (adding calories to food) to the diet order, and to change the monitoring of weight from monthly to weekly. RD 1 verified that the IDT had not documented possible underlying causes for the weight loss. On 9/9/14 at 10:53 A.M., the facility's consultant registered dietitian (RD 1) stated that Resident 45 was not on a physician -prescribed weight-loss regimen. RD 1 verified that the kitchen was providing Resident 45 a fortified diet since 8/4/14 as a result of the IDT meeting. RD 1 verified that 8/4/14 was the first intervention by the facility in regard to weight loss since January 2014. RD 1 stated that it was the facility's process to obtain a physician's order for a fortified diet, but was unable to find a physician's order. Concurrently, RD 1 reviewed Resident 45's nutrition care plan and verified that it had not been updated and revised to reflect the status of significant weight loss, the intervention of a fortified diet, and had not included a root cause analysis for the significant change in condition, and should have. On 9/9/14 at 1:43 P.M., a licensed nurse (LN 2) verified that there was no physician's order for the fortified diet, and stated, There should be a physician order (for fortified diet). On 9/10/14 at 8:34 A.M., LN 11 reviewed Resident 45's medical record which included the IDT note from 8/4/14, and a quarterly nutrition assessment dated [DATE] which noted a 11.8 % significant weight loss in 6 months. LN 11 verified there was no documentation that the physician had been notified of the significant weight loss. On 9/15/14 at 9:26 A.M., RD 2 reviewed Resident 45's Weekly/Monthly Weight Trend Assessment (beginning on 1/1/14), and stated, An RD should have seen the resident at the beginning of June because she had three consecutive months of slow weight loss. On 9/8/14 at 5:31 P.M., the Administrator stated that the facility had not had Registered Dietitian services available at the facility from 6/1/14 to 6/25/14. The facility failed to identify and address an unplanned slow weight loss prior to becoming a significant weight loss. The facility failed to notify the physician once there was significant weight loss. The facility failed to update and revise the nutrition care plan to include an analysis of the underlying cause of the change in condition (significant weight loss), and failed to document a planned nutrition intervention of the addition of fortified to the diet with measurable time frames to monitor for effectiveness of the nutrition plan of care. The facility's policy and procedure (P & P) entitled, Nutrition Care; Subject: Weight Variance Policy and Procedure, (undated) indicated, 6. Charge nurses will notify the physicians .of significant weight changes via fax/phone .with responses documented in the resident's/patient's medical record/computer and necessary disciplines notified of any new changes, 7.Discussion of possible causes for the weight changes .will be documented in the medical record with the heading of Weight Variance Committee ., recommendations requiring a physician order will be initiated by the responsible discipline, followed up by nursing, and the care plan updated to reflect interventions . The facility's P & P entitled, Diet Orders (undated) indicated, Policy: Diet orders as prescribed by the Physician will be provided by the dietary department .

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F 0325 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 16) The facility's P & P entitled, Diet Record Maintenance (undated) indicated, Purpose: To ensure that the Facility provides residents with meals that meet the nutritional and consistency requirements per physician orders ., Policy; The dietary department will maintain a system to record dietary information necessary to use on the resident's tray care ., Procedure; I. The diet record system will contain the following information to be reflected on the resident's tray card: F. Physician ordered supplemental feeding or extra nourishments provided to the resident beyond those listed on the therapeutic diet extension sheet . 3. On 9/9/14 at 3:15 P.M., Resident 30's medical record was reviewed. Resident 30 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to Resident 45's Weekly/Monthly Weight Trend Assessment the following were the documented weights; 1/1/14 - 122.4 lbs 2/2/14 - 123.2 lbs 3/2/14 - 118.6 lbs 4/1/14 - 118.4 lbs 5/1/14 - 115 lbs 6/3/14 - 114 lbs 7/1/14 - 113 lbs 8/1/14 - 112 lbs 9/2/14 - 113 lbs On 9/10/14 at 8:30 A.M., a licensed nurse (LN 11) reviewed the above weights and stated that as of 5/1/14 the weight was a concern because it met one of the facility's criteria which was a three month consecutive slow weight loss, and should have been identified and referred to a weight variance committee by the interdisciplinary team (IDT). LN 11 reviewed the medical record and verified that there had not been an IDT meeting to determine, and address underlying causes for the slow progressive weight loss. On 9/10/14 at 9:18 A.M., the facility's registered dietitian (RD 2) reviewed the above weights and stated that the facility should have identified and referred the slow progressive weight loss to a RD or the IDT beginning 5/1/14. RD 2 reviewed the dietary notes and stated that there had not been a dietary follow up by either an RD, or dietary services supervisor (DSS), since 12/31/13. RD 2 verified that per the annual nutrition assessment, dated 12/17/13, the resident was noted as receiving a puree fortified diet, and the goal was to maintain weight at 121 pounds. Concurrently, RD 2 stated that it would have been the facility's expectations for a DSS to have conducted a dietary quarterly follow up during March 2014, and June 2014, which were not done. RD 2 acknowledged that the purpose of the dietary quarterly reviews were to monitor for changes which could impact nutrition such as a decrease in diet intake and/or weight loss which would have resulted in a referral to the RD. RD 2 confirmed that a RD was unaware of Resident 30's unplanned, slow, progressive weight loss. RD 2 was asked to review a label which was located on the front of Resident 30's medical record which indicated an allergy to nuts. RD 2 was then asked to review the dietary meal tray card for Resident 30, which was observed to not have indicated a nut allergy. RD 2 reviewed the meal tray card and stated, The food allergy to nuts should be listed on the meal ticket. RD 2 reviewed the nutritional screening form completed by a DSS on 12/11/13 under the pre-printed category of Food allergies [REDACTED]. Concurrently, RD 2 reviewed the nutrition care plan which had an initial date of 3/6/12, with a date of 9/14 under the last re-evaluated date of the nutrition care plan. The nutrition care plan which was currently in effect as of 9/9/14 at 3:15 P.M., noted under the approach column that Resident 30 was receiving a 2 cal med pass (oral nourishment for calories/protein) 60 cc BID (two times a day), as of 12/19/12. RD 2 acknowledged the nutrition care plan had not reflected the current nutritional status for Resident 30 as it had not reflected the resident's slow, progressive weight loss, and failed to note that the 2 cal med pass 60 cc BID was not a current intervention. RD 2 stated, Last evening I reviewed Resident 30's medical record and revised the nutrition care plan. A review of the revised nutrition care plan indicated, Resident goal; Maintenance Weight 108 - 118 # (pounds). There was no indication on the nutrition care plan that there was physician involvement, and/or conservator involvement in determining a weight maintenance goal of 108 - 118 #, which would have been a potential 5 pound additional weight loss. A review of the physician's progress notes indicated the following, 6/23/14 .weight loss of 8.4 pounds since 1/14 ., 7/26/14 .the nursing staff have not reported any acute problems. She is losing weight ., 8/19/14 .the nursing staff are not aware of any new problems. She is not eating very well and since 01/01/14 she has had a weight loss of 10.4 pounds .plan: .monitor weight . The facility failed to implement policies and procedures (P & P) that would have involved a monitoring mechanism for facility staff to have identified the slow weight loss, and would have resulted in a referral to the RD and/or IDT meeting to determine potential underlying causes for the change in nutritional parameters, prior to becoming an unplanned significant weight loss. In addition, the facility failed to ensure the kitchen staff was aware of Resident 30's nut allergy. According to the facility's P & P entitled, Nutritional Screening/Assessment/Resident Care Planning, (undated), Policy: The resident's nutritional status and his nutritional needs will be assessed. A nutrition program specific to his needs will be planned and implemented, and then reassess periodically for progress. Procedure: .All residents will be reviewed quarterly. The Dietary Services Supervisor (DSS) will also chart on any resident with changes in weight, eating habits .as these problems arise. Change in eating habits ., weight and other problems will be recorded in the dietary progress notes and resident care plan. The (DSS) will complete the Dietitian Assessment & Monitoring Sheet on a daily basis and give this sheet to the Dietitian on each visit. This way the Dietitian will be aware of all dietary changes, . weight changes ., .The Dietary Service Supervisor and/or Dietitian will participate in resident care planning to contribute pertinent nutritional information to the medical and nursing team . The facility's P & P entitled, Diet Record Maintenance, (undated) indicated, Policy: The dietary department will maintain a system to record dietary information necessary to use on the resident's tray cart. Procedure; 1. The diet record system will contain the following information to be reflected on the resident's tray card:G. allergies [REDACTED]. The facility's P & P entitled, Tray Card System, (undated) indicated, Policy: Each meal tray at breakfast, lunch and dinner will have a tray card which designates the resident's name, diet, food dislikes, food requests, allergies [REDACTED]. 4. On 9/12/14 at 9:33 A.M., Resident 82's medical record was reviewed. Resident 82 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Physician orders, dated 7/6/14, included an order for [REDACTED].>On 9/16/14 at 11:00 A.M., RD 2 was asked what the physician's order for nourishment meant and she stated, I don't know what that means. Means nothing. On 9/16/14 at 1:47 P.M., LN 11 was asked how the physician order for [REDACTED]. The kitchen will be implementing as snacks. LN 11 was asked to show the documentation to show a physician's order was implemented related to the nourishment, and was unable to provide the documentation. RD 2 stated that an order for [REDACTED]. On 7/11/14, an RD completed a nutritional assessment for Resident 82. The RD noted that Resident 82's admission weight was 175 pounds, and the ideal body weight was 112-125-138 pounds. The RD assessed daily caloric needs based on a weight of 138 pounds for this [AGE] year old resident who weighed 175 pounds. On 9/12/14 at 3:27 P.M., RD 2 (who had the contract with the facility) stated, I teach them not to use ABW (adjusted body weight). On 9/15/14 at 2:44 P.M., RD 2 stated that healthshakes was started on 9/11/14 due to weight loss for Resident 82. RD 2 was asked how the facility monitored percentage consumed of a planned nutrition intervention which was provided for a specific identified problem (weight loss). RD 2 stated, I usually just ask the resident and/or staff, but let me go check. On 9/15/14 at 2:53 P.M., the resident's certified nursing assistant (CNA 10) stated that she documents the overall cc consumption of fluid from the tray, and enters it on a column under cc on a CNA form . CNA 10 reviewed the form under 9/15/15, for Resident 82, which indicated 360 cc for lunch. CNA 10 stated, That could be any fluid on the tray including water or the healthshake. A review of the form utilized by the CNA had an area for % (percent), Sup (supplement), and cc (cubic centimeter). The column under sup was blank. On 9/15/14 at 2:57 P.M., the current Director of Nursing (CDON) stated that the healthshake was also located on the Medication Administration Record [REDACTED]. RD 2 acknowledged the facility lacked a system to monitor the effectiveness of a planned nutrition intervention provided for

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F 0325 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 17) an identified concern. RD 2 acnowledged that lack of accurate monitoring would impair the accuracy of a nutrition assessment, compared to assessed needs. RD 2 stated, I would expect a referral if intake of food, fluids and supplements is below 75%. RD 2 verified that the facility had not had a system to monitor percent consumption of the supplement, therefore would impede an appropriate referral to the RD in a timely manner. The facility's policy and procedure entitled Food Inake - Recording Percentage & Nutritional Assessment (undated) indicated, Purpose; To ensure the optimal nutritional status, an assessment of nutritional intake will be performed for each resident. Policy; In order to assess the nutritional status of the resident, the percentage of food taken will be recorded by the Certified Nursing Assistant (CNA). Procedure; .IV. The amount of supplement or nourishment taken as a meal replacement will be recorded on the resident's food intake record after each meal. 5. On 9/15/14 at 9:42 A.M., Resident 20's medical record was reviewed. Resident 20 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident 20's food preferences and nutrition assessment was not conducted until 7/10/14, one month after admission, as indicated on the admission nutiritonal screening and assessment form completed on 7/10/14. On 9/15/14 a 9:50 A.M., RD 2 stated that the nutrition screening and nutrition assessment was not done in a timely manner, and should have been completed no later than seven days after admission. The facility's policy and procedure entitled, Nutritional Screening/Assessments/Resident Care Planning, (undated) indicated, Policy: The resident's nutritional status and his nutritional needs will be assessed. A nutritional program specific to his needs will be planned and implemented, and then reassessed periodically for progress, Procedure: The Dietary Services Supervisor will complete the Nutrition Screening form on all new residents within seven days ., The Consultant Dietitian is to complete the Registered Dietitian Nutrition Assessment . 6. On 9/16/14 at 2:35 P.M., Resident 42's medical record was reviewed. Resident 42 was re-admitted to the facility on [DATE]. A nutrition assessment was completed by a Registered Dietitian (RD) on 7/30/14. The RD noted the current formula prescription was providing 1,440 calories and 65 grams of protein. The RD assessed the current formula prescription was not meeting Resident 42's assessed nutritional needs of 1, 809 calories and 74-83 grams of protein. The RD recommended a change in the tube feeding to increase the calories to 1,800 calories and 81 grams of protein, which was not communicated to the physician until 4 days later. On 9/16/14 at 3:00 P.M., RD 2 acknowledged that communicating RD recommendations to a physician 4 days later, after it was identified that assessed calorie needs were not being met in a nutritionally high risk resident, was not timely. RD 2 would have expected the recommendations to have been communicated to the physician by the end of the nursing shift. On 9/12/14 at 7:40 A.M, the CDON stated she was employed at the facility since mid-august 2014 and was not aware of the facility's expectations in terms of timeliness on communicating RD recommendations to the physician. The CDON stated it would be her expectation as a nurse to have the recommendations communicated immediately, at least by the end of every shift. The facility's policy and procedure (P & P) entitled, Nutritional Screening/Assessments/Resident Care Planning, (undated) indicated, Policy: The resident's nutritional status and his nutritional needs will be assessed. A nutritional program specific to his needs will be planned and implemented, and then reassessed periodically for progress . On 9/17/14 at 10:30 A.M., Resident 42's medical record was reviewed from a 6/10/14 admission to the facility per the face sheet. Physician orders, dated 6/10/14, included Diabetic Resource 60 (a formula to provide nutrition) ml (milliliters) via PEG tube (a tube inserted through the wall of the abdomen directly into the stomach) (7 am - 7 pm) til further order of dietitian. A diet order, dated 6/10/14, was NPO (nothing by mouth). Per physician order, dated 6/10/14, Stage I to Lt Heel . (a stage 1 pressure ulcer to the left heel. A pressure ulcer is a lesion that results in damage to the underlying tissue. Stage 1 is an observable, pressure-related alteration of intact skin) Per physician order, dated 6/10/14, Stage II to Lt (left) buttock . (A stage II pressure ulcer is a partial thickness loss of skin) Per physician order, dated 6/12/14, Diabetic Resource 60 ml via peg tube till RD eval (on 7 PM - Off 7 AM) or till dose completed total dose 720 cc (cubic centimeter). On 6/26/14 per the interdisciplinary progress notes, IDT met today to discuss weight loss of 2.0 lbs 1.5% in one week , POC (plan of care) RD to evaluate resident. A Nutritional Assessment was completed on 7/11/14, 30 days after the physician originally ordered a dietary evaluation. Per the nutrition assessment, Resident 42 had been receiving 864 calories a day, 38.16 grams of protein, since admission, as compared to assessed needs per the RD to be 1,745-1800 calories a day, and 75 - 90 grams of protein a day. The RD recommendations were not communicated to the physician until 7/15/14, which made a total of 34 days with insufficient caloric and protein intake. (At that time, the RD noted there was a 3 day ST (speech therapist) Po trial diets) On 9/17/14 at 11:00 A.M., RD 2 stated that there were no RD services available at the facility when the physician ordered an RD consult on 6/10/14, and 6/12/14. The RD 2 noted the 6/26/14 IDT note above that indicated RD to evaluate, and stated that she received a call from the facility that day to re-establish RD contracted services. RD 2 stated RD contracted services that occurred on-site was re-initiated on 6/28/14. On 9/8/14 at 5:29 P.M., the Administrator acknowledged that administration had not ensured there were RD services available to meet the nutritional needs of the residents from 6/1/14 to 6/25/14. Record review indicated from admission of 6/10/14 to 7/14/14, Resident 42 primary means of nutrition was via a [DEVICE] in which insufficient caloric and protein intake had been infused since admission, and had a six pound unplanned weight loss at which time he had a stage I and stage II pressure ulcer. According to the Weekly/Monthly Weight Trend Assessment, Resident 42 weighed 132 pounds on 6/12/14, and weighed 126 pounds on 7/14/14. The facility's P & P entitled, Nutritional Screening/Assessments/Resident Care Planning,
F 0327 **Level of harm** - Actual harm **Residents Affected** - Few	**Give each resident enough fluids to keep them healthy and prevent dehydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility dietician, nursing staff, and physician failed to monitor the fluid intake and act upon abnormal laboratory values, to prevent dehydration in 1 of 24 sampled residents (Resident 77). As a result the resident was transferred to the general acute care hospital due to a dehydrated state. Findings: Resident 77 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 7/10/17, Resident 77 was transferred to an general acute care hospital emergency room . Per the MDS (Minimum Data Set) dated 3/31/14, Resident 77's BIMS (Brief Interview for Mental Status) was scored at 7, meaning the Resident had severe impairment of cognitive functioning (related to memory and ability to process thoughts). On 9/16/14 at 12:00 PM, Resident 77 was observed in the dining room sitting in a chair being assisted with lunch. Resident was quiet and non-talkative while being fed. Per the Certified Nursing Assistant on 9/16/14 at 12:00 PM, the Resident only speaks Tagalog, and only a few English words on occasion. Resident 77 was eating chicken, potatoes and corn bread with assistance from the CNA. Per the admission orders [REDACTED]. In addition NP 1 ordered the resident to have Fibersource HN (liquid nutrition) at 55 cc's every 24 hours with a flush of 150 cc's of water every 8 hours through his gastrostomy tube. Per the Nursing Dehydration Assessment Score dated 3/15/14, the resident's score was assessed at 70. According to the Dehydration Assessment sheet, High Risk-50+. Per the Nutrition Nursing Care Plan dated 3/15/14, the resident was at risk for weight loss and dehydration due to difficulty swallowing. The care plan included interventions which included: Offer assistance as needed; Dietary Consult; Monitor of signs and symptoms of dehydration and notify MD as indicated; Dietician to assess nutrition and hydration as needed. Per the Nutritional Screening assessment dated , 3/17/14, the Dietary Services Supervisor (DSS) documented Residents 77's weight as 137.2 lbs, and a Body Mass Index (a number calculated from a person's weight and height that provides a reliable indicator of body fat) of 25.1. Based on the Nutritional Screening Assessment, the residents enteral nutrition (the delivery of nutrients in liquid form directly into the stomach) was to provide 1320 cc's of fluid, 1584 calories and 71

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	055698	A. BUILDING _____ B. WING _____	09/19/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIREMONT HEALTHCARE & WELLNESS CENTRE, LLC	8060 FROST STREET SAN DIEGO, CA 92123

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F 0327 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 18) gm's of protein. In addition the DSS documented the following TF (tube feeding trial), Res (Resident) tolerating TF well, spoke to ST (Speech Therapist) who stated the trial for po (by mouth) tolerance is going well and has been consuming 100% of B (breakfast), could not get a hold of family to find out UBW (usual body weight). On 3/17/14, NP 1 documented, H & P (History and Physical) dictated. Meds and chart reviewed. CBC (Complete Blood Count) BMP (Basic Metabolic Panel) 1 week. RD (Registered Dietician Consult). On 3/18/14, NP 1 ordered for Speech and Language services 5 times a week for 4 weeks due to Resident 77's difficulty swallowing. Per the RD (Registered Dietician) 1 notes dated 3/20/14, meds/labs/skin noted, rec'd to change TF to Fibersource HN @ 70 ml x (times) 18 hours to provide 1260 ml/1512 kcal (kilocalories)/1020 ml of water to begin a 9 am until finished. Goals (1) Will tolerate TF (2) No sig (significant) wt change (3) BM (bowel movement q (every) 1-3 d (days) (4) No s/s (signs and symptoms of dehydration, continue to monitor F/U (Follow Up) PRN (as needed). There was no further documentation by RD 1 until 5/7/14, a total of 37 days. On 5/7/14, RD 1 documented, RD TF note, Spoke with ST who stated that he is doing well with meals. 4/21/14-133 # (lbs), 4/14/14-133#, 3/2414-134.6 #. No new meds, labs 4/21 BUN 30 ¿ (elevated), no new skin issues. ST adding extra meal and will be getting L (lunch) and D (dinner) Mechanical Soft with thin liquids. Received change TF to Fibersource HN @ 75 ml/900 kcal/41 gm protein/ 607 ml water, change fluid flush to 200 ml TID, continue to monitor, F/U PRN. In addition the RD documented the following on 5/7/14. Nutritional Update: Res (resident) seen/screened by ST noted L (lunch) D (dinner) meals. OK mechanical soft diet will monitor tolerance. ST to F/U progress. On 9/17/14 at 1:35 PM, RD 2 acknowledged the clinical record contained no documented visits by the RD from 5/7/14 until Resident 77's transfer to the general acute care hospital on [DATE]. Per RD 2, Resident 77 should have been assessed by the RD at least every 30 days. Per the Intake and Output Record dated 4/1/14, Resident 77's Intake and Output was monitored between 3/25/14 and 3/31/14 (I & O (I & O documents how much liquid was consumed and how much was eliminated as urine) . There was no I & O documented for the days between 3/17/14 and 3/25/14, nor any I & O documented after 3/25/14. Per the Laboratory Report dated 3/26/14, Resident 77's BUN (Blood Urea Nitrogen-A common blood test, the blood urea nitrogen (BUN) test reveals important information about how well your kidneys and liver are working) was 28 H (high). Normal BUN reference levels are 7-25 mg\dl (milligrams per deciliter). Per the physicians order sheet dated 3/26/14, NP 1 ordered, CBC, BMP next Monday. Per Resident 77's Laboratory Report dated 3/31/14, Glucose 112 H (High-Normal Range 70-99); BUN 29 H High BUN Normal 7-25 mg\dl (milligrams per deciliter); WBC (White Blood Count) 12.7 High-Normal Range 4.8-10.8; Hgb (Hemoglobin- the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues) 11.7 L Low Normal Range 12.0-16.0; Hct (Hematocrit-is the proportion, by volume, of the blood that consists of red blood cells) 35.6 % (percent) L Low-Normal range 37.0-47.0 % Per the NP 1's Monthly Visit note dated 4/10/14 at 0900, S (Subjective):No complaints, no reports of acute events, tolerating tub feeding. No CP (chest pain), no SOB (Shortness of Breath). O (Objective): VSS (Vital signs stable) afebrile (no fever), Wt 133 lbs. There was no documentation by NP 1 related to Resident 77's elevated BUN level or other elevated laboratory values. On 4/19/14, NP 1 verbally ordered, CBC and BMP for Monday. Per the Laboratory Report dated 4/21/14, Resident 77's BUN was 30 H High Normal 7-25 mg\dl (milligrams per deciliter); and his Chloride (is a type of electrolyte. It works with other electrolytes such as potassium, sodium, and carbon [MEDICATION NAME] (CO2). These substances help keep the proper balance of body fluids and maintain the body's acid-base balance) 110 H High Normal Range 98-107. There was no visit documented by an attending physician and or NP for the month of May 2014. During Resident 77's stay at the facility between 3/15/14 and until his transfer to the general acute care hospital on [DATE], there is no documentation the resident was seen by his attending physician in person after admission, as required by the regulations. Per the Monthly Visit note dated 6/20/14 by NP 1, S (Subjective): No complaints, No SOB (shortness of breath) No Chest Pain. There was no documentation by the NP to acknowledge the residents abnormal laboratory values on 3/26/14, 3/31/14, or 4/21/14. There was no documentation by the NP to suggest Resident 77 was discussed in a Interdisciplinary Team meeting or Case Conference. There were no further NP or Attending Physician notes dated past 6/20/14, yet between 3/15/14 to 7/9/14, there were 18 separate Speech Therapy and/or Diet Clarification orders written for Resident 77. Per review of the Physician order [REDACTED]. In addition NP 1 ordered, ST eval, CBC, BMP, UA (urinalysis) and C & S (Culture and Sensitivity in AM. Per the laboratory results dated [DATE] at 12:55 PM, Resident 77's BUN was 31 H High (Normal Values 7-25 mg\dl (milligrams per deciliter); Creatinine (the kidneys maintain the blood creatinine in a normal range. Creatinine (has been found to be a fairly reliable indicator of kidney function. Elevated creatinine level signifies impaired kidney function or kidney disease) 1.45 H High; Sodium (The sodium blood test measures the amount of sodium in the blood) 151 H High Normal 136-145; Chloride (Chloride is a type of electrolyte. It works with other electrolytes such as potassium, sodium, and carbon [MEDICATION NAME] to help keep the proper balance of body fluids and maintain the body's acid-base balance) 110 H High Normal Values 98-107. Per the Licensed Personnel Weekly Progress Notes dated 7/10/14 at 7 PM, Notified (name of attending physician) regarding labs abnormalities 151 NA (Sodium)-then faxed labs to MD office. T.O. (Telephone order) 1/2 N. S. ((Normal Saline-Normal saline is the name for the 0.9% strength of sodium chloride (salt) solution in water) @ 100 cc's/hour x 2 liters then BMP noted. Per the Licensed Personnel Weekly Progress Notes dated 7/10/14 at 8:45 PM, T.O. (Telephone Order) Transfer pt to (name of general acute care hospital) Dx. (Diagnosis) Dehydration (pt. had a hard stick for IV) noted. Per the Patient Transfer Form dated 7/10/14, per Section 4 Physicians Orders On Transfer, Transfer pt. to (name of general acute care hospital), dehydration, hard stick IV. Per Section 20 Nursing Assessment and Recommendations, Pt. hard stick. Order was 1/2 NS 100 cc/hour, but unable to insert IV. Per (Name of attending physician) transfer pt. out to hospital (see lab). On 9/17/14 at 10:00 AM, ST (Speech Therapist) 1 stated she coordinated care with the dietician and nursing as such, I talk to them on a daily basis. They changed the RD. But I always text them. I always talk to nursing and dietary. On 9/17/14 at 10:00 AM, the ST was asked if it would be important to maintain an I & O on a patient with a tube feeding and with so many changes in Resident 77's Speech Therapy orders. The ST stated, It depends, yes, but if the patient was a recreational feeder, no. The ST was asked if she documented evidence of care coordination between herself, the physician, dietary, nursing related to the resident's goals regarding food and water intake. The ST stated, I would document in the notes, kitchen notified. I always reported to his medication nurse. When asked if the different disciplines in the facility conducted care conferences for Resident 77, the ST stated, Not in a formal setting. The ST was asked if Resident 77's case was considered complicated, and the ST stated, Yes. Based on her yes answer, the ST was asked if it would be important to discuss Resident 77's care with all disciplines. The ST stated, I wouldn't say it was done in a formal meeting. But I did discuss his care with the ADON (Assistant Director of Nursing). The ST went on to state she was never asked to participate in case conferences regarding the patients she cared for in the facility. On 9/17/14 at 1:35 PM, RD 2 stated (name of RD 1) was the dietician in March. RD 2 acknowledged Resident 77 was only seen by a Registered Dietician twice between his admission to the facility on [DATE] and his subsequent transfer to the general acute care hospital on [DATE]. RD 2 stated the resident should have been seen by an RD at least every 30 days. When asked how a RD would be evaluate Resident 77's fluid intake, the RD 2 stated, We would have seen how much he was drinking and we would request more information such as an I & O. According to RD 2, the RDs' would be following up monthly with the tube feeders, but stated, We did not have the time allotment to meet the needs of the residents.

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F 0327 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 19) RD 2 was asked if she was ever asked to participate in a care conference for Resident 77, and RD 2 stated, No. The RD was asked based on her education and experience what her opinion was regarding Resident 77's laboratory report dated 7/10/14. The RD stated the resident's laboratory values were indicative of dehydration. On 9/17/14 at 8:00 AM, LN 10 stated residents with tube feedings should be on I & O if they come in with a Tube Feeding. LN 10 could not comment why Resident 77 id not have his I & O documented upon admission or afterward. Resident 77's clinical record did not contain any Interdisciplinary Team notes or Care Conference notes to indicate the Physician, Nurse Practitioner, Nursing Department, Speech Therapist, or Dietician met to discuss Resident 77's on-going care, multiple changes in his Speech Therapy orders or his hydration needs. On 9/18/14 at 2:30 PM, the Director of Nursing (DON) stated the facility should be doing care conferences. A joint clinical record review with the DON failed to produce any documented Interdisciplinary Team meeting notes, or Case Conference notes for Resident 77. Per the DON, Case Conferences were to be done upon admission, quarterly or as needed if the patient's situation changed. MD 2 was not available on site at the facility during the survey for interview. In addition, the NP was not available during the survey for interview. On 9/17/14 at 8: 45 AM and on 9/18/14 9:12 AM, messages were left on the voice mail of the NP. There were no return calls to the survey team. On 9/18/14 at 8:47 AM, MD 2 stated in a telephone interview she could not comment on Resident 77's care since she was not currently on site at the facility. MD 2 was asked if she was aware of Resident 77's ongoing elevated BUN levels, MD 2 declined to answer. MD 2 asked if she could call the survey team back for interview, but never returned the call. Per the undated facility policy entitled Interdisciplinary Team Meetings, 1. Meetings will be held as follows: 2. Social Services will schedule the meetings. 3. Social Services will notify appropriate families and residents of the schedule for the upcoming week. 4. All disciplines will complete their MDS Sections, RAPS, and Update their care plan entries prior to the meetings. 5. The Charge Nurse will notify the Nursing Assistant's responsible for the resident of the impending meeting in order to assure the resident will be brought to the meeting. 6. All departments will attend meetings . Per the undated facility policy entitled Care Planning, IV. IDT Meetings A. The facility will invite the resident and/or his/her family or legal representative to care planning meetings and use its best effort to schedule care planning meetings at times convenient for the resident, family, and/or legal representative. B. The care conference will be documented on NP-04-Form A-IDT Conference Record.:
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure each of the resident's drug regimen was free from unnecessary drugs for three of 24 sampled residents (Residents 26,38, and 55), when: - The facility did not monitor the black box warning (BBW, strongest warning put in the labeling of a prescription drug by the Food and Drug Administration (FDA) to indicate the drug carries a significant risk of serious or life-threatening adverse effects) and potential serious and significant side effects (undesirable harmful effects) associated with antipsychotic medications for Residents 26, 38, and 55; - Additionally for Resident 55, the facility did not accurately monitor the side effects associated with [MEDICATION NAME] (a medication to treat mood disorder); and did not carry out in a timely manner the [MEDICAL CONDITION] Behavior Committee's recommendation to discontinue [MEDICATION NAME] (an anti-[MEDICAL CONDITION] medication) when it did not have an adequate indication for use, and may be contributing to the behaviors the resident was experiencing; - Additionally for Resident 26, the facility did not have an adequate indication for the use of [MEDICATION NAME] (an antipsychotic medication), as the documented behavioral symptom did not present a danger to the resident or to others. The failure to monitor the BBW and side effects related to drug therapy had the potential to expose residents to unnecessary and unsafe use of medications, such as when staff would not recognize the side effects the residents may be experiencing, and as a result, would not to report to the physician. Findings: 1. Resident 55's medical record was reviewed on 9/11/14 at 10:30 A.M. She was admitted to the facility with [DIAGNOSES REDACTED]. The 8/13/14 Patient Transfer Form indicated the resident had behaviors of screaming, yelling, increased confusion, agitation, and visual hallucinations. Resident 55's physician orders [REDACTED].> - [MEDICATION NAME] 1,000 milligrams (mg) twice daily (a high dose) for [MEDICAL CONDITION] disorder AEB (as evidenced by) mood swings, dated 8/17/14; - [MEDICATION NAME] 15 mg every evening (a high dose) for [MEDICAL CONDITION] disorder, dated 8/17/14; - [MEDICATION NAME] 1 mg twice daily for EPS [MEDICATION NAME] (prevention of extrapyramidal syndrome; EPS are various movement disorders induced by antipsychotic and other medications), dated 6/24/14; - Monitor side effects of [MEDICATION NAME] every shift . see care plan, dated 6/24/14; and - Monitor side effects of [MEDICATION NAME] every shift (Black Box Warning - See CPLAN (care plan)), dated 6/24/14. Review of the Medication Administration Record [REDACTED]. The MARs indicated to see care plan for side effects. Review of the Antipsychotic Care Plan, dated 6/24/14, revealed it addressed the behaviors and side effects to be monitored every shift. However, it did not include the BBW related to the use of [MEDICATION NAME]. Also, it did not include potential significant and harmful side effects such as: cardiac arrhythmias (irregular heart rhythms), falls, lethargy, increase in cholesterol and triglycerides, weight changes, blood sugar elevation, stroke, and sedation. [MEDICATION NAME] has the following BBW: Increase in mortality in Elderly Patients with Dementia-Related [MEDICAL CONDITION].([MEDICATION NAME] Prescribing Information, 2009) For [MEDICATION NAME], the 6/24/14 Care Plan did not include the side effects consistent with its use. It listed side effects associated with antipsychotic medication such as dry mouth, movement disorders, etc. when Depakoke had a BBW related to liver failure and liver toxicity. [MEDICATION NAME] also had other potential side effects such as anorexia, vomiting, weakness, lethargy, inflammation of the pancreas, and [MEDICAL CONDITION] (low platelet count). Further review of Resident 55's medical record revealed a recommendation from the [MEDICAL CONDITION] Behavior Committee (PBC, which comprised of multiple disciplines), dated 8/11/14, to discontinue [MEDICATION NAME]. [MEDICATION NAME] is a medication prescribed for treating the symptoms of drug-induced side effects known as extrapyramidal syndrome (involuntary movement disorders such as hand tremors, abnormal tongue movement). Current literatures indicate [MEDICATION NAME] is for the treatment of [REDACTED].who.int/mental_health/mhgap/evidence/resource/[MEDICAL CONDITION].pdf) Potential side effects of [MEDICATION NAME] includes sedation, dry mouth, [MEDICAL CONDITION], increased confusion, visual hallucinations, depression, etc. Resident 55 was observed on 9/12/14 at 8:40 A.M. She looked calm, pleasant, and did not exhibit any symptoms of EPS (i.e. no hand shaking, tremors, etc.) During an interview on 9/12/14 at 9:50 A.M., when asked if the PBC's recommendation was communicated to the physician, ADON said, Not yet. She said it was not placed in the communication binder (when it was supposed to) for the physician to see. She agreed it was not carried out timely. During an interview on 9/17/14 at 2:30 P.M., the consultant pharmacist (CP) said he recognized Resident 55's behaviors as possible side effects from [MEDICATION NAME]; and its wrong indication, therefore he recommended to discontinue it during the PBC meeting on 8/11/14. During an interview on 9/17/14 at 4:05 P.M., the CP agreed the side effect monitoring for [MEDICATION NAME] was not consistent with the medication; and one for [MEDICATION NAME] did not include the BBW and other potential harmful side effects as indicated above. 2. Resident 38's medical record was reviewed on 9/15/14 at 5:20 P.M. She was admitted to the facility with [DIAGNOSES REDACTED]. (BLACK BOX WARNING-SEE CPLAN). Review of Resident 38's Antipsychotic Care Plan, dated 6/2/14, revealed it did not include the BBW and other potential harmful side effects related to [MEDICATION NAME] such as: cardiac arrhythmias (irregular heart rhythms), falls, lethargy, increase in cholesterol and triglycerides, weight changes, blood sugar elevation, stroke, and sedation.

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 20) 3. Resident 26's medical record was reviewed on 9/18/14 at 8:45 A.M. The record showed the resident had an order for [REDACTED]. There was also an order [REDACTED]. The Antipsychotic Care Plan, dated 8/7/14, indicated the resident had episodes of [MEDICAL CONDITION] exhibited by resistive to care. The Antipsychotic Care Plan also did not include the BBW and other potential harmful side effects associated with [MEDICATION NAME] such as: cardiac arrhythmias (irregular heart rhythms), falls, lethargy, increase in cholesterol and triglycerides, weight changes, blood sugar elevation, stroke, and sedation. An interview with the CDON, ADON, and the VPCS was conducted on 9/18/14 at 9:20 A.M. They agreed the indication for [MEDICATION NAME] for Resident 26 was not adequate. The facility did not specify how the behavior of being resistive to care would present a danger to the resident or to others, to necessitate the use of an antipsychotic medication. During this interview, they confirmed the facility did not accurately monitor the side effects associated with [MEDICATION NAME] for Resident 55; and the care plans, which addressed the behaviors and side effects to be monitored every shift for Resident 26, 38, and 55, did not include specific harmful side effects relative to the drug. The facility's policy and procedure entitled Psychotherapeutic Medication Use (not dated), provided by ADON on 9/18/14, indicated to monitor for side effects but did not specify types of medication (i.e. antipsychotic, anti-anxiety, etc.) and did not specify what types of side effects to monitor.
F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility had a 6.4% medication error rate when two medication errors out of 31 opportunities were observed during the medication passes. Findings During the 9 A.M. medication pass observations on 9/9/14 and 9/10/14, the following errors were observed: 1. On 9/9/14 at 10:30 A.M., LN2 was observed giving 9 medications to Resident 40. A review of Resident 40's medical record revealed his medications included a physician order, dated 5/2/14, for cranberry (to treat and prevent urinary tract infection) 450 milligrams (mg) 1 tablet twice daily, scheduled to be given at 9 A.M. and 5 P.M. daily. The cranberry tablet was not included in the morning medication pass observed. On 9/9/14 at 2:40 P.M., LN2 confirmed she did not give the cranberry tablet to Resident 40 during the morning medication pass. 2. On 9/10/14 at 8:05 A.M., LN7 was observed giving multiple medications to Resident 52. The medications included an inhaler [MEDICATION NAME] Respimat 20 micrograms (mcg)/100 mcg (a combination of two inhalation medications to treat [MEDICAL CONDITIONS]). As LN7 was about to give a dose from the [MEDICATION NAME] canister, she discovered it was empty. The resident did not receive his morning dose of [MEDICATION NAME]. A review of Resident 52's medical record on 9/10/14 at 10:05 A.M. revealed a physician order, dated 7/13/14, for [MEDICATION NAME], to give 1 inhalation three times daily for [MEDICAL CONDITION], scheduled at 8 A.M., 12 P.M., and 4 P.M. On 9/10/14 at 12:30 A.M., LN7 said she placed a call to the pharmacy to get a new [MEDICATION NAME] Inhaler for Resident 52 but still had not received it yet. She confirmed the resident missed his morning dose.
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 non-sampled resident (Resident 43), observed during a medication pass, was free from a significant medication error when more than 1 [MEDICATION NAME] (medication applied to the skin to treat dementia) was applied at a time. This had the potential to cause drug overdose for the resident. Findings: On 2/7/15 at 8:45 A.M., LN 19 was observed giving 7 medications, including an [MEDICATION NAME] 9.5 mg/24 hours patch, to Resident 43. [MEDICATION NAME] is designed to release the drug in a slow, steady manner over 24 hours. It is available in 4.6 mg/24 hours, 9.5 mg/24hours, and 13.3 mg/24 hours patches. Each patch is to be worn every 24 hours, and replaced with a new one after 24 hours. During this medication pass observation at the resident's bedside, LN 19 was observed searching for the old [MEDICATION NAME] on the resident's chest, upper back and shoulders by looking down the neck hole of the resident's sweatshirt. After a brief search, LN 19 said she could not find the old patch, and then placed a new patch on the resident's right chest. On 2/7/15 at 10:16 A.M., LN 19 was asked to recheck the resident's body for the old patch to ensure there were not two [MEDICATION NAME]es on the resident's body. When LN 19 lifted resident's sweatshirt to conduct a thorough check of the resident's back, a patch was identified, affixed to the skin on the resident left shoulder, near the armpit. The date on that patch indicated: 1/30/15 (the date it was applied). LN 19 removed this patch, and acknowledged there were two [MEDICATION NAME]es on the resident's body before this discovery. A review of Resident 43's medical record revealed a physician's orders [REDACTED]. On 2/7/15, a review of the January 2015 Medication Administration Record [REDACTED]. The manufacturer's prescribing information for the [MEDICATION NAME] Patch indicates the following under Important Administration Instructions: (b) Apply the [MEDICATION NAME] PATCH once a day . (d) Replace the [MEDICATION NAME] PATCH with a new patch every 24 hours. Instruct patients to only wear 1 patch at a time (remove the previous day's patch before applying a new patch) (see Warnings and Precautions (5.1) and Overdosage (10)) . The prescribing information further indicates that, over a 24-hour dermal application, approximately 50% of the drug content of the patch is released from the system. This means 50% of the drug remains in the system after 24 hours' use. Under Overdosage, it indicates overdoses have occurred from application of more than one patch at one time and not removing the previous day's patch before applying a new patch. The overdose symptoms include severe nausea, vomiting, salivation, sweating, [MEDICAL CONDITION] (slow heart beats), [MEDICAL CONDITION] (low blood pressure), respiratory depression, and convulsions. On 2/7/15 at 12:50 P.M., LN 19 acknowledged there had been two [MEDICATION NAME]es on Resident 43 since 1/30/15. The January and February 2015 MARs showed one patch was applied every day since 1/30/15. She stated she had notified the physician earlier regarding this discovery and was told to monitor for [MEDICATION NAME] side effects. The nursing notes, made on 2/7/15 at 10:40 A.M., indicated, Rt (resident) has old patch on lt (left) lateral shoulder that was put on 1/30/15. Called Dr. (name) and notify . Monitor rt for 72 hours .
F 0361 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Hire a qualified dietician.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient dietary services supervisor (director of food service/DSS) and registered dietitian (RD) services on a consistent basis to meet the nutritional needs of the residents that had the potential to negatively affect all residents residing at the facility. As a result of the lack of, and/or insufficient availability of the RD or DSS, there were missed physician dietary consult orders for residents being fed via a tube, missed dietary quarterly reviews that should have been completed by a DSS to monitor and identify slow progressive weight loss to refer to the RD, untimely RD assessments, and untimely follow up of RD recommendations that impeded meeting the nutritional needs of residents in a timely manner resulting in harm and a systemic failure for maintaining acceptable parameters of nutritional status during that time (Cross Reference F325) Findings: On 7/3/14 at 4:26 P.M., via a telephone interview, the former DSS (DSS 2) that had worked at the facility said, I was full-time to the facility until the Admin told me that I had to split my time to her other facility which began on 2/28/14 until I left on 6/9/14. DSS 2 had reported the above statement to the Department as related to a sister facility that had the same Administrator (ADM).

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F 0361 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 21) On 9/9/14 at 2:37 P.M., a facility staff member (FS 11) verified that DSS 2 was not here full-time. On 9/9/14 at 2:45 P.M., the Accounts Payable employee provided an Employee Pay Information form to reflect that DSS 2 was employed at the facility from 3/1/14 to 6/26/14 as a salaried employee defined as 40 hours per week per the form. Accounts Payable was asked how the facility would know if DSS 2 fulfilled her salaried position of working at the facility for at least 40 hours a week, and the Accounts Payable stated, It's a salaried position, there is not a time card or sign-in in any form. On 9/9/14 at 2:54 P.M., the ADM verified that she directed DSS 2 to be the DSS for two different licensed skilled nursing facilities that she Administered, at the same time. The ADM stated that she believed DSS 2 was continuing to work full-time at the facility by working hours very early in the morning, late in the evening, and on weekends. The ADM verified there was no mechanism for an ADM to provide oversight of obligated time spent, 40 hours a week per the ADM, at the facility by DSS 2. On 9/25/14 at 10:05 A.M., via an interview with DSS 2, she stated that her last day being employed at this licensed skilled nursing facility was on 6/6/14, and not 6/26/14 as indicated on the Employee Pay Information form. On 9/9/14 at 2:54 P.M., per the ADM, the facility had recently had four different dietary service supervisors in the past 1 1/2 years. The ADM provided the Employee Pay Information for the four DSS's and they were as follows; DSS 1 : Date Employed: 3/21/13 to Date Terminated: 02/28/2014, DSS 2 : Date Employed 3/1/2014 to Date Terminated: 06/26/2014 (Per DSS 2 her last day of employment was at the facility on 6/6/14). Based on DSS 2 interview, there would have been no DSS available at the facility fron 6/6/14 through 6/26/14. DSS 3: Date Employed 06/27/2014 to 07/13/2014 DSS 4: Date Employed 07/14/2014 to current. On 9/10/14 at 9:18 A.M., during a medical record review for Resident 30, RD 2 stated that it would have been the facility's expectations for a DSS to have conducted a dietary quarterly follow up during March 2014, and June 2014, which were not done. RD 2 acknowledged that the purpose of the dietary quarterly reviews were to monitor for changes that could impact nutrition such as a decrease in diet intake, and/or weight loss which would have resulted in a referral to the RD. RD 2 confirmed that an RD was unaware of Resident 30's unplanned, slow progressive weight loss. (Cross Reference F 325) On 9/8/14 at 5:29 P.M., the ADM stated that she had not ensured there were RD services available to meet the nutritional needs of the residents from 6/1/14 to 6/25/14. The ADM was asked why the administration had not ensured RD services were available during that time, and she stated, The dietary supervisor (DSS 2) said she did not like (name of RD 2) so I listened to her. During the course of the survey that had begun on 9/8/14, there were multiple nutrition related care issues that had negatively impacted the nutritional status, and health of residents (cross-reference F 325), that included an RD not being available to meet physician orders [REDACTED]. On 9/15/14 at 11:07 A.M., RD 2 stated that the contracted registered dietitian services was in place between her and the facility since January 2013. RD 2 stated that the usual amount of hours spent at the facility by an RD on a weekly basis was 12 hours a week at this facility, which was already challenging. RD 2 stated that starting approximately 3/1/14, the ADM informed the RD she would need to limit her time to 4 hours a week. RD 2 stated that she ended her contractual services to the facility starting 6/1/14 because she knew that she was not keeping up with addressing the resident's nutritional needs within 4 hours a week. RD 2 stated that she had not documented the concern of insufficient RD hours available at the facility in a written consultant Dietitian report, but had discussed the concern with the ADM. The RD stated the residents at the facility had higher nutrition related acuity needs and the limit in hours was not based upon the needs of the residents. A review of the previous contract between RD 2 and the facility was dated 8/1/13, and was in place until the RD left at the end of May 29, 2014, per RD 2. Per the contract, .the average number of hours to be spent in the facility per week is a minimum of 8 hours . RD 2 verified that the ADM informed her to limit RD services to 4 hours per week starting approximately March 2014. RD 2 provided copies of Consultant Dietitian Report forms that were provided to the ADM verifying RD time spent at the facility, and items that were addressed by the RD. A review of the Consultant Dietitian Report indicated the following time spent at the facility; 39 hours for the month of January 2014,29.25 hours for the month of February 2014, 16 hours for the month of March 2014, 21 hours for the month of April 2014, 16 hours for the month of May 2014, and there were no RD services from 6/1/14 to 6/25/14. RD time at the facility resumed on June 28, 2014 to total 9.25 hours for the month of June 2014. RD 2 stated the ADM called her to ask for her services to be resumed on June 26, 2014 (but first day back on-site by an RD was on 6/28/14), and the ADM then told the RD that she may have as much time as needed to meet the needs of the residents. RD time spent at the facility were 74.25 hours for July 2014, and 50 hours for August 2014. A review of the current contract between RD 2 and the facility was signed by the facility and RD 2 on 6/26/14. According to RD 2, and the written consultant dietitian report, since initiation of the new contract the first day of on-site RD services was conducted on 6/28/14. The facilities job description for Dietary Services Supervisor, and Responsibilities of the Consultant Dietitian (Revised 2/10) indicated, Policy: A qualified Dietary Service Supervisor, chosen by the Administrator, is responsible for the total operation of the Dietary Department. All dietetic service is performed under their direction ., Responsibilities of the Dietary Service Supervisor; Dietetic service orientation, staffing, supervision, staff training and in-servicing, food purchasing, receiving, storage and preparation, .conferring regularly with the Administrator, DON (Director of Nursing), Activity Director, residents and other facility staff as necessary, .complete resident dietary profile, nutritional screening, quarterly note, annual review and MDS (minimum data assessment), visit all new residents to record food preferences and allergies [REDACTED].is a staff member who provides regularly schedules on-premises consultation, to the Administrator, the Dietetic Service Supervisor, the residents, and other facility personnel and staff. The Dietitian will sign a consultation agreement with the Administrator, specifying hours of consultation per month, responsibilities of the Registered Dietitian, length of time agreement is valid, terms of termination, and remuneration. The Dietitian will provide staff development programs, (in-servicing) for dietary and nursing staff and consultations that assure the professional dietetic service needs of the facility are met. This will include, but is not limited to sanitation inspections, meal service accuracy and enforcement/education of Title 22 and F-Tag 371 & 325 requirements. A written report after each visit with recommendations will be given to the Administrator, DON and Dietary Supervisor. The facility's job description for Administrator (initialed by the Administrator on 1/2/14) indicated, Principal Responsibilities: Serves as liaison between governing body and Center personnel, Ensures Center compliance with all Federal, State and company regulations and policies, Ensures that all practices and policies are carried out in the highest ethical manner, Ensures that all Standard of Care and service provided is of the highest quality, Ensures recruitment and retention of quality, professional, service-oriented personnel .
F 0363 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure menus meet the resident's nutritional needs and that there is a prepared menu by which nutritious meals have been planned for the resident and followed.** Based on observation, interview and record review, the facility failed to 1) Maintain adequate food supply in order to ensure the planned menus could be implemented as posted in advance for residents review. 2.) The facility failed to ensure planned scoop sizes were utilized to ensure the menu was implemented as planned. Findings: 1. On 7/3/14 at 2 P.M., due to a complaint received to the Department, an observation of the Kitchen was made with the dietary services supervisor (DSS 3) who explained she made an order last Friday (6/30/14), in which she substituted the Monday delivery date for Tuesday. The order on Wednesday was made for delivery today, Thursday. The DSS continued to say the coleslaw that was to be served for dinner on (7/3/14) had been served for the previous

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F 0363 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 22) evening's meal. In a more detailed explanation, DSS 3 confirmed the entire dinner menu for 7/3/14 had been served on 7/2/14. Instead of the posted Hot Turkey Sandwich with mashed potatoes & gravy, peas and custard that was on the posted planned menu for 7/2/14, all residents received Fish Sticks, coleslaw, oven fried potatoes, green beans, bread and canned plums for dinner on 7/2/14. DSS 3 stated there was a problem with the facility method of ordering food, therefore the necessary food was not at the facility to implement the menu as planned, as posted in advance for residents to review. Residents are notified of the planned menus in advance to provide the opportunity to discuss any desire for changes with the dietary staff, and/or to anticipate what to expect for any given meal. On 9/9/14 at 9:10 A.M., a dietary aide (DA 13) stated that every Friday she provides 8 - 9 menus to the resident council president because he stated those residents expressed it was important to them to know ahead of time what the planned meals were. On 9/9/14 at 2:06 P.M., RD 2 verified that she was present during the 7/3/14 observation and confirmed that the planned menu was not being implemented as posted in advance for residents. RD 2 confirmed that the DSS had to be re-trained on how to order food supply in order to ensure the menu could be implemented as posted in advance for residents to review. On 7/29/14, as continued investigation into a complaint that was made to the Department, an observation of lunch tray line was conducted. The planned lunch per the pre-planned menu for 7/29/14 was meatloaf with Piquant Sauce, mashed potatoes with gravy, broccoli au Gratin, bread/margarine, peach crumble and a beverage. However, that was not the lunch being served, instead the dinner that was planned for 7/29/14 was being served for lunch. DSS 3 no longer worked at the facility at that time. DSS 4 was now employed at the facility, and DSS 4 stated, The delivery truck was late. DSS 4 verified the pre-planned menu could not be implemented as planned because the necessary food supply was unavailable at the facility at that time. On 9/9/14 at 2:06 P.M., RD 1 verified that she was aware of the above occurrence and confirmed that the problem was due to how the food supply was being ordered, at that time. According to the facility's policy and procedure entitled Purchasing Food And Supplies (2/10), Policy: .Proper procedures are to be followed in purchasing food and seeing that food is delivered ., The Dietary Service Supervisor will observe the following: 1. Food purchasing begins with a planned menu. Supplies shall be appropriate to meet the requirements of the menu and therapeutic diets ordered ., 4. At least one week's supply of staple foods and at least three days of perishable items shall be maintained . The facility's policy and procedure entitled Menu Planning (undated) indicated, 2. Menus are to be dated and posted in the kitchen and on the consumer bulletin board in the entrance of the facility by the Dietary Service Supervisor two weeks in advance . 2. On 9/10/14 during observation of lunch tray line, a slotted spoon was observed being used by Cook 11 to serve the broccoli for the regular diet. According to the cook's spreadsheet, ½ a cup should be served for the regular diet. RD 2 observed the slotted spoon and acknowledged that it was not measured to provide a standardized portion of a ½ cup each time, but was eyeball a ½ cup. Cook 11 was observed using a #12 scoop and estimating to fill the #12 scoop half way to serve brown rice pilaf to a resident who had small portion specified on the meal tray card (Resident 63). Cook 11 was observed using a #8 scoop and eyeballing to fill the # 8 scoop half way of pureed Tahitian chicken with sauce for a small portion, puree diet, that was specified on Resident 63's meal tray card. According to the directions on the spreadsheet that provided guidance to dietary staff on how to implement the planned menu in accordance with the nutrient analysis, a #16 scoop should have been used for a small portion for the rice, and a #12 scoop to serve a small portion for the Tahitian chicken with sauce for Resident 63, diet order was puree. The spreadsheet indicated that a small portions diet would provide between 1600-1900 calories if serve as planned, which differed from a regular portion diet would have been 2100 -2400 calories. RD 2 and DSS 4 acknowledged that the directions on the spreadsheet in regard to portions for a small portion diet were not followed. RD 2 acknowledged that over or under estimating portion sizes had the potential to impede an accurate calorie count as compared to assessed needs, and accuracy of nutrition assessment. The facility's policy and procedure entitled Portion Sizes (undated) indicated, Policy: Various portion sizes of the food served will be available to better meet the needs of the residents. Procedure: The small and large portion servings will be served as printed on the cook's spreadsheets for every meal .
F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.** Based on observation, interview and record review, three of six residents from the confidential resident council meeting indicated the food intended to be served hot was cold. Based on a test tray, the facility failed to ensure vegetables were served at a palatable temperature as discerned by residents, and per facility expectations. Findings: On 9/9/14 at 10:00 A.M., during a confidential resident council meeting three of six residents complained the food intended to be served hot was served cold. On 9/10/14 at 11:43 A.M., a cook took temperatures of the food items for lunch from the steam table, and/or bin with ice, with a calibrated thermometer. The temperatures from the steam table were as follows: Tahitian Chicken - 169 degrees F, broccoli - 160 degrees F, brown rice pilaf - 168 degrees F, milk - 34.2 degrees F. F. On 9/10/14 at 12:57 P,M., after the last lunch meal was served to the resident's, temperatures of a test tray were obtained. The food temperatures were as follow from the test tray: Hamburger patty (facility ran out of the main entree for the test tray, but had not ran out of the main entree for residents) - 126.5 degrees F, broccoli - 112 degrees F, mashed potato (facility ran out of rice for the test tray only) - 129.4 degrees F, milk -40.8 degrees F. On 9/11/14 at 9:42 A.M., the registered dietitian (RD 2) stated the facility had not had a policy and procedures on acceptable food temperatures at point of service to the residents. RD 2 stated, I would expect 120 degrees F. Vegetables are a challenge to maintain temperature. The facility's policy and procedure entitled Meal Service (undated) indicated, Policy: Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner, and served at the appropriate temperatures ., 3. The food temperatures will be served at the recommended temperatures as below and recorded on the daily therapeutic menu in the temperature column . Food item: Casseroles, potatoes and vegetables - 160 - 180 degrees F .
F 0387 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that doctors visit residents regularly, as required.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident 77 was readmitted to the agency on 3/15/14, with [DIAGNOSES REDACTED]. Per the MDS (Minimum Data Set) dated 3/31/14, Resident 77's BIMS (Brief Interview for Mental Status) was scored at 7, meaning the Resident had severe impairment of cognitive functioning. On 9/16/14 at 12:00 PM, Resident 77 was observed in the dining room sitting in a chair being assisted with lunch. Resident was quiet and non-talkative while being fed. Per the Certified Nursing Assistant, the Resident only speaks Tagalog, and only a few English words on occasion. Resident 77 was eating chicken, potatoes and corn bread with assistance. Per the admission orders [REDACTED]. In addition NP 1 ordered the resident to have Fibersource HN (liquid nutrition) @ 55 cc's every 24 hours with a flush of 150 cc's of water q 8 hours through his gastrostomy tube. There was no documentation to indicate Resident 77's attending physician saw the resident upon readmission to the facility. On 3/17/14, NP 1 documented, H & P (History and Physical) dictated. Meds and chart reviewed. CBC (Complete Blood Count) BMP (Basic Metabolic Panel) 1 week. RD (Registered Dietician Consult). On 3/18/14, NP 1 ordered for Speech and Language services 5 times a week for 4 weeks due to Resident 77's difficulty swallowing. Per the physicians order sheet dated 3/26/14, NP 1 ordered, CBC, BMP next Monday. Per the NP 1's Monthly Visit note dated 4/10/14 at 0900, S (Subjective):No complaints, no reports of acute events, tolerating tub feeding. No CP (chest pain), no SOB (Shortness of Breath). O (Objective): VSS (Vital signs stable) afebrile

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F 0387 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 23) (no fever), Wt 133 lbs. There was no documentation by NP 1 related to Resident 77's elevated BUN level or other elevated laboratory values. On 4/19/14, NP 1 verbally ordered, CBC and BMP for Monday. There was no visit documented by an attending physician and or NP for the month of May 2014. During Resident 77's stay at the facility between 3/15/14 and until his transfer to the general acute care hospital on [DATE], there is no documentation the resident was seen by his attending physician in person. There were no further NP or Attending Physician notes dated past 6/20/14, yet between 3/15/14 to 7/9/14, there were 18 separate Speech Therapy and/or Diet Clarification orders written for Resident 77. MD 2 was not available during the survey for interview. In addition, the NP was not available during the survey for interview. On 9/18/14 at 8:47 AM, MD 2 stated she did not see the Resident at admission because, I saw him at the hospital. MD 2 continued to state she could not comment on Resident 77's care since she was not on site at the facility. MD 2 asked if she could call the survey team back for interview, but never returned the call.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the provision of pharmaceutical services that met the needs of one of 24 sampled residents (55) when an antidepressant (Celexa) for Resident 55 was not given timely after ordered. The failure resulted in a delay in treatment for [REDACTED]. Findings: Resident 55 was admitted to the facility with [DIAGNOSES REDACTED]. On 9/11/14 at 10:30 A.M., a review of Resident 55's medical record revealed she had a physician order, dated 9/3/14, for Celexa 10 milligrams (mg) every morning for depression as evidenced by passive suicidal statements. On 9/12/14 at 8:30 A.M., a review of the Medication Administration Record [REDACTED]. LN13 agreed the medication was not carried out timely for Resident 55.
F 0428 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the consultant pharmacist failed to identify irregularities related to drug therapy for 1 of 6 sampled residents (15) and 1 non-sampled resident (43). The failure had the potential to result in unsafe medication use for the residents. Findings: 1. On 2/7/15 at 8:45 A.M., LN 19 was observed giving 7 medications, including an Exelon 9.5 mg/24 hour patch, to Resident 43. The manufacturer's prescribing information for the Exelon Patch indicates the following under Important Administration Instructions: (b) Apply the EXELON PATCH once a day . (d) Replace the EXELON PATCH with a new patch every 24 hours. Instruct patients to only wear 1 patch at a time (remove the previous day's patch before applying a new patch) (see Warnings and Precautions (5.1) and Overdosage (10)) . (e) Change the site of patch application daily to minimize potential irritation . Do not apply a new patch to the same location for at least 14 days. During this medication pass observation at the resident's bedside, after a quick search on the resident's chest, upper back, and shoulders, LN 19 said she could not find the old patch, and proceeded to place a new patch on the resident's right chest. Shortly after the application, LN 19 documented on the MAR the application site was RC (right chest). On 2/7/15 at 12:50 P.M., LN 19 said she did not know that Exelon could not be re-applied to the same location within 14 days. On 2/7/15, a review of Resident 43's medical record revealed a physician's orders [REDACTED]. A review of Resident 43's January 2015 MAR showed the staff applied the daily Exelon patch to the right chest 9 times, and left chest 7 times. A review of Resident 43's February 2015 MAR revealed, in the first 7 days of February, the staff applied the daily Exelon patch to the right chest 3 times, left chest 2 times, right abdomen once, and right shoulder once. During an interview on 2/7/15 at 1:25 P.M., the director of nursing (DON) said she was not aware that Exelon could not be re-applied to the same location within 14 days. She stated that without a diagram (site map on the body where Exelon Patch may be applied), the facility did not meet the manufacturer's specification for the administration of Exelon patches. As of 2/7/15, the facility had 4 residents who were receiving Exelon patches. 2. On 2/8/15, a review of Resident 15's medical record revealed the resident was admitted with [DIAGNOSES REDACTED]. The record showed the Ativan order remained on the December 2014 and January 2015 monthly physician order [REDACTED]. Similarly, the record showed the Ativan order remained on the November 2014, December 2014, and January 2015 MARs. During an interview with the ADON on 2/8/15 at 9:45 A.M., she said the Ativan should have been taken off the November physician's orders [REDACTED]. She acknowledged failure to do so posed a potential for it to be given by mistake. On 2/8/15 at 10:50 A.M., the MRD, who generated the monthly physician orders [REDACTED]. [REDACTED]. She agreed it should have been taken off in November. During an interview on 2/8/15 at 10:30 A.M., the CP said he did not identify the untimely removal of the Ativan order from the monthly physician's orders [REDACTED]. He stated, I should have. When asked if he had identified the lack of a diagram for the use of Exelon patch as potentially unsafe medication use, CP stated he had made that recommendation for other facilities, but not here. At 10:45 A.M., after looking up his computer records, the CP verified he had not made or reported to the facility any findings related to these. The RPS Consultants - Service Job Description, dated 6/2012, indicated the consultant pharmacist coordinates, supervises and assists in the development of pharmaceutical services within the facility. The CP's responsibilities included reviewing risks and potential for errors in medication administration.
F 0431 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record and document review, the facility failed to ensure controlled substance (CS) medications (drug tightly regulated by the Federal government for its abuse or risk potential) were accurately accounted for as evidenced by: 1. A review of controlled substance records for 8 residents (sampled and non-sampled) reflected 126 tablets of CS medications were not accurately accounted for five residents (Residents 38, 48, 63, and 80, and one non-sampled resident, 39) since August 1, 2014, as follows: - 65 tablets of Percocet (a combination of oxycodone 5 milligrams (mg) & Tylenol 325 mg; is a Schedule II (high potential for abuse) narcotic for pain) for Resident 48 from 8/17/14 to 9/17/14 (a one-month period); - 11 tablets of oxycodone 10 mg (a Schedule II narcotic for severe pain) for Resident 63; - 24 tablets of Norco (hydrocodone 5 mg & acetaminophen 325 mg, a potent narcotic for moderate to severe pain) for Resident 38,

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F 0431 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 24) - 18 tablets of Norco 5/325 mg for Resident 80; and - 8 tablets of Norco 5/325 mg for Resident 39; were signed of the Controlled Drug Record (CDR) without subsequent documentation on the medication administration record (MAR) and/or pain assessment flow sheet (PAF) as given in accordance with the facility procedures. It was undeterminable what happened to these medications. Also, for 2 of 5 residents (Residents 48 and 80) with identified CS drug unaccountability, the facility could not provide controlled drug records prior to 8/17/14 for Resident 48, and prior to 8/19/14 for Resident 80. The frequent and repeated failures to document CS medication administration on the MAR and/or on the PAF, and the failure to account for all CS medications, had the potential to result in CS medication overdose (such as when the medication is given too soon before due time) for a universe of 32 residents who were receiving CS medications; and misuse/diversion of controlled substances in the facility. Overdosing of CS narcotic medication could lead to adverse effects such as respiratory depression (a condition of having a breathing rate that becomes too low to ventilate the lung), extreme sedation, muscle weakness, slow heart rhythms, low blood pressure, loss of consciousness, and death. 2. The facility could not provide controlled drug disposition records to account for all discontinued/discharged controlled drugs from 5/5/14 to 8/11/14. Federal regulations require that the facility have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medications. CDR (a.k.a. count sheet) is an inventory sheet that includes the resident's name, medication, and direction for use. The form contains entries for staff to enter date, time, doses present, and the signature of staff signing out the number of doses. The PAF is a form used by the facility to evaluate the safety and effectiveness of pain medications. It is individually filled out for each resident, to document the date, time, location of pain, pre-analgesia pain rating, medication and dose given, date and time of re-assessment, post-analgesia pain rating, sedation level, the non-drug interventions taken, and the signature of the licensed staff who gave the medication and performed the pain assessment. As a result, an Immediate Jeopardy was declared on 9/17/14 at 12:05 P.M. with the Administrator and the Vice President of Clinical Service. As of survey exit on 9/19/14 at 3:30 P.M., the Immediate Jeopardy had not been abated. On 10/3/14 at 4:20 PM, the survey team accepted the Allegation of Removal of Immediate Jeopardy (POC) and informed the ADM the Immediate Jeopardy was abated. Findings: 1. On 9/11/14 at 2:25 P.M., an inspection of the CS medication accountability records at the North Station Medication Cart #2 was conducted with LN2 revealed Resident 80 had a physician order, dated 7/23/14, for Norco 5/325 mg to take 1 tablet every 4 hours as needed for moderate pain and 2 tablets every 4 hours as needed for severe pain. The record showed 2 tablets were signed out of the controlled drug record (CDR) at 3 A.M. on 9/11/14, but the nursing staff did not document the administration on the MAR or on the pain assessment flow sheet (PAF). LN2 said every time a CS medication was signed out, the nurse had to document on the MAR after the medication was administered, and document on the PAF the pain assessment and the interventions taken. LN2 acknowledged 2 tablets of Norco for Resident 80 were not accounted for. On 9/12/14 at 3:05 P.M. an inspection the CS medication accountability for 3 residents at the South Station Medication Cart #2 with LN3 revealed the following: - 16 tablets of Percocet 5/325 mg for Resident 48 were unaccounted for in a 7-day period from 9/5/14 to 9/12/14. They were signed out the CDR at various times as given but not documented on the MAR (front or back) or on the PAF. For example, on 9/6/14, 10 tablets of Percocet were signed out on the CDR as given, 2 tablets each, at 1 A.M., 8:55 A.M., 3 P.M., 4 P.M., and 9 P.M. None of these were documented on the MAR under 9/6/14 entry. The PAF only had one entry, dated and timed 9/6/14 at 9 A.M., that accounted for the 8:55 A.M. dose. The other 4 doses (8 tablets) were not documented anywhere else on the MAR (such as the back of the MAR where staff occasionally entered PRN medication administration) to account for them. Again, on 9/7/14 at 6 P.M., 2 tablets were signed out on the CDR as given. This administration was not documented anywhere on the MAR or the PAF. This happened again on 9/9/14, 9/10/14, and 9/11/14. - 2 tablets of Norco 5/325 mg for Resident 38 were unaccounted for. They were signed out of the CDR on 9/5/14 and 9/8/14 as administered without subsequently documented on the MAR (front or back) or on the PAF as given. - 1 tablet of Norco 5/325 mg for Resident 39 was not accounted for on 9/12/14, when it was signed out the CDR but not subsequently documented on the MAR (front or back) or on the PAF as being given. During this inspection, LN3 acknowledged CS medications for three of three residents (Residents 38, 39, and 48) were not accurately accounted for, and staff were not consistently documenting CS medication administration on the MAR and/or on the PAF. When asked to explain what happened to the unaccounted medications, LN3 shrugged and said, I don't know. She stated CS medications signed out of the CDR must be documented on the MAR after given to the resident and then on the PAF to document nursing assessment and interventions. During an interview with Resident 48 on 9/12/14 at 3:40 P.M., he said had pain all over the place as he pointed to his left shoulder, arms, and legs, and said he asked for pain medication all the time. He stated he received medication every time he asked and often got pain relief after the medication given. On 9/12/14, a review of Resident 48's medical record revealed he was admitted to the facility with [DIAGNOSES REDACTED]. He had a physician order, dated 5/25/13, for Percocet 5/325 mg 1 tablet every 4 hours as needed for moderate pain, and 2 tablets every 4 hours as needed for severe pain. During an interview on 9/15/14 at 1:50 P.M., the director of nursing (DON) confirmed CS medications signed out of the CDR must be documented on the MAR after given, then on the PAF to document the pain assessment and interventions. She was presented with documents showing CS medications for 4 residents (38, 39, 48, and 80) not accurately accounted for. The DON agreed that without documentation on the MAR or on the PAF (or on the back of the MAR), there was no telling of what happened to the medications. The DON said she could not provide an explanation, and said that there was a failure of staff to document. During this interview, a review of Patient 48's Percocet CDR with the DON showed on 9/6/14 at 3 P.M., a nursing staff signed out 2 tablets of Percocet 5/325 mg but did not document on the MAR (front or back) or on the PAF. One hour later, at 4 P.M. (after shift change, which took place at 3 P.M.), another nursing staff (LN4) signed out 2 tablets for the resident, and again this administration was not documented. Thus, within 1 hour period, the resident was reportedly given 4 tablets of Percocet 5/325 mg. The DON acknowledged the lack of documentation on the MAR and on the PAF could potentially lead to nursing staff administering the medication too close together or too soon before due time (due to the lack of documentation of the medication given from the previous shift), which would lead to overdose for residents. LN4 was interviewed on 9/15/14 at 2:50 P.M. She said she could not recall what happened on 9/6/14 when she signed out 2 tablets of Percocet at 4 P.M. for Resident 48. She acknowledged she did not document that Percocet administration on the MAR and on the PAF. She stated she did not realize 4 tablets were signed out just one hour apart. On 9/15/14 at 2 P.M., the Percocet CDRs from 8/1/14 to 9/5/14 for Resident 48 were requested from the medical record director (MRD). At 2:50 P.M., the MRD said she could only find CDRs for Resident 48 dating back to 8/17/14; she could not find CDRs from 8/1/14 to 8/17/14. A review of the provided CDRs for Resident 48, from 8/17/14 to 9/5/14, revealed 120 tablets of Percocet were signed out on the CDR, but the medication administration recorded on the MAR, PAF, and the back of the MAR, only accounted for 79 tablets, leaving 41 tablets unaccounted for. Thus, in a period of 27-day period from 8/17/14 to 9/12/14, a total of 57 tablets (16+ 41) of Percocet for Resident 48 were unaccounted for. On 9/15/14 at 4 P.M., the DON was informed of the additional finding related to Resident 48's unaccounted Percocet. Again, DON stated she could not provide an explanation but insisted it was a documentation problem, and that staff failed to document CS medication administration on the MAR and on the PAF to account for medications given. On 9/16/14 at 8:40 A.M., the CDRs for Resident 48's Percocet and Resident 80's Norco were requested from the MRD. At 9:30 A.M., the MDSN said the facility could only find CDRs dating back to 8/19/14 for Resident 80. She said the facility was still looking for the missing CDRs for Resident 48 (they were not provided by the end of the survey). On 9/16/14 at 10:30 A.M., the MRD confirmed she could not find CDRs for Resident 80 prior to 8/19/14. A review of the provided CDR (from 8/19/14 to 9/7/14) revealed additional 16 tablets of Norco unaccounted for. Thus, adding the data from 9/11/14, a total of 18 tablets (16+2) of Norco for Resident 80 were unaccounted for, in a period of 23 days. She had

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F 0431 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 25) [DIAGNOSES REDACTED]. Resident 80 was not available for interview. On 9/16/14 at 11:15 A.M., Residents 38's CDRs for Norco from 8/1/14 to 9/10/14 was reviewed. It reflected a total of 24 tablets of unaccounted Norco, as they were signed out from the CDRs but not subsequently documented on the MAR (front or back) or on the PAF. Resident 38 had a physician order, dated 7/3/14, for Norco 5/325 mg 1 tablet every 4 hours as needed for moderate pain or 2 tablets as needed for severe pain. She had [DIAGNOSES REDACTED]. Resident 38 was not available for interview. Similarly, on 9/16/14 at 11:40 A.M., a review of Resident 39's CDRs for Norco from 8/1/14 to 9/12/14 reflected 8 tablets were unaccounted for. Resident 39 had physician order, dated 7/7/14, for Norco 5/325 mg 1 tablet every 6 hours as needed for moderate pain. He had [DIAGNOSES REDACTED]. The above findings were verified with the DON on 9/16/14 at 2 P.M. She acknowledged the unaccounted for CS medications for 4 residents (38, 39, 48, and 80) and that staff were not consistently documenting on the MAR and on the PAF as required, in accordance with the facility procedures. On 9/16/14 at 3:40 P.M., an interview was conducted with LN5, who signed out 2 tablets of Percocet for Resident 48 on 9/10/14 without documenting on the MAR. She acknowledged and said, I missed it. On 9/16/14 at 3:50 P.M., an interview was conducted with LN6. The CDR of Norco for Resident 38 showed LN6 signed out 1 tablet of Norco each day for Resident 38 from 8/1/14 to 8/4/14 (4 tablets) without documenting on the MAR (front or back), or on the PAF. When shown that there was no documentation of Norco administration from 8/1/14 to 8/4/14, LN6 said, I forgot. She said she was supposed to document on the MAR after the medication given to the resident and on the PAF to document pain assessment and interventions. On 9/16/14 at 4:25 P.M., the DON provided the facility's procedure, undated, entitled Medication - Administration Nursing Manual - General. It indicated: PRN (as needed) Medication Documentation A. When a PRN medication is given, it will be charted on the Medication Administration Record. The Nurse will document the reason given, reason for the drug, route of administration, date, and time. B. The result of the PRN medication will be charted by the responsible Nurse on the back of the MAR. C. If the PRN is for complaint of pain, the Nurse will document the pain score prior to given the medication and after the administration of the pain medication. The DON also presented the PAF. She said the nursing staff were to use the PAF to document the pain assessments and interventions (as it was a tool to evaluate the safety and effectiveness of pain medication interventions), instead of on the back of the MAR. On 9/17/14, a review of the facility's policy and procedures, entitled PAIN MANAGEMENT, undated, indicated: I. Pain Assessment: . D. Resident given PRN pain medication, after intervention/medication are implemented, resident (sic) will re-evaluate the resident's level of pain within one hour II. Pain Management: . B. The Licensed Nurse will administer pain medication as ordered and document all medication administered on Medication Administration Record (MAR). On 9/17/14 at 8:45 A.M., further review of the Percocet CDR, the MAR, and PAF for Resident 48 since 9/12/14 (the day CS unaccountability was identified) was conducted at the Medication Cart with LN3. The records showed: - On 9/14/14, 10 tablets of Percocet were signed out of CDR, but the MAR and the PAF only accounted for 6 tablets (4 tablets unaccounted for) - On 9/15/14, 8 tablets of Percocet were signed out of the CDR, but the MAR and the PAF only accounted for 4 tablets (4 tablets unaccounted for) LN3 verified the finding. Thus, the concern of unaccounted CS medications continued even after it was brought up with the licensed staff on 9/12/14. Therefore, in a 31-day period from 8/17/14 to 9/17/14, a total of 65 (57 + 8) tablets of Percocet for Resident 48 were unaccounted for. On 9/17/14 at 9 A.M., a review of Resident 63's medical record reflected she had [DIAGNOSES REDACTED]. She had a physician order, dated 7/7/14, for oxycodone 10 mg 1 tablet every 6 hours as needed for moderate or severe pain. On 9/17/14 at 9:15 A.M., a review of Resident 63's CDRs, MARs, and PAFs from 8/1/14 to 9/17/14 with LN7 revealed a total of 33 tablets were signed out of the CDRs, but the MAR and the PAF (and the back of the MAR) only accounted for 22 tablets, leaving 11 tablets unaccounted for. For example, on 9/15/14, 4 tablets of oxycodone 10 mg were signed out as given, but the MAR only accounted for 2 tablets. LN7 verified the finding. During an interview with Resident 63 on 9/17/14 at 10:15 A.M., she said she usually hurt all the time. She said she received pain medication when she asked for them. When asked if she had sufficient pain relief after pain medication given, she stated, Sometimes it does, sometimes it doesn ' t. Resident 63 also had order, dated 8/9/14, for Tramadol (a pain medication for mild-moderate pain) 25 mg three times daily. On 9/17/14 at 12:05 P.M., a declaration of Immediate Jeopardy was called with the Administrator and the Vice President of Clinical Service due to CS medication unaccountability and potential for CS drug overdose due to the lack of medication administration documentation on the MAR and/or on the PAF. To date, the manufacturer for oxycodone indicates: Acute overdose with oxycodone hydrochloride tablets can be manifested by respiratory depression, somnolence (sleepiness), progressing to stupor or coma, skeletal muscle flaccidity (soft and weak), cold and clammy skin, constricted pupils, bradycardia (slow heart rhythms), hypotension (low blood pressure), and death. (http://dailymed.nlm.nih.gov/dailymed/index.cfm, accessed 9/19/14) For Norco, the manufacturer indicates overdose with hydrocodone (a component of Norco) is characterized by respiratory depression, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. (http://dailymed.nlm.nih.gov/dailymed/index.cfm, accessed 9/19/14) During an interview with the consultant pharmacist (CP) on 9/17/14 at 3:30 P.M., he said he had identified issue with CS unaccountability (uncharted CS medication administration on the MAR) for at least three months. He stated he had conducted an in-service with nursing staff on 8/11/14 to address this issue. He acknowledged despite the in-service, the staff were still not documenting CS medication administration, as required, to account for all control substances. 2. During an interview on 9/17/14 at 3:30 P.M., the CP said discontinued CS medications or those for discharged residents would be given to the DON. He said he and the previous DON destroyed those medications together about once every three months. He stated they last destroyed CS medications on 8/11/14. At 4 P.M., a review of the CS disposition records in the DON's office found disposition records dating up to 5/5/14. In other words, no disposition records for after 5/5/14 were found. On 9/18/14 at 11:25 A.M., the CP said after further looking and inquiring, he could not find the CS disposition records which he conducted with the previous DON (PDON) on 8/11/14. CP acknowledged, without the said disposition records, the facility could not account for discontinued/discharged controlled medications from 5/5/14 to 8/11/14. During the interview, the CP provided a procedure entitled B. DISPOSAL OF CONTROLLED DRUGS, dated 6/2013. It indicated: Controlled Drugs listed in Schedule II, III, or IV of the Controlled Substances Act of 1970 shall be disposed of in the presence of an RN (employed by the facility) and a registered pharmacist. Document must include: Name of Resident Name and Strength of drug . Signature of 2 Witnesses (Pharmacist and RN) Method of Disposal Documentation shall be recorded on the control count sheet. The disposal record must be legally saved for three years.
F 0441 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an Infection Control Program was in place. As a result, staff were not following infection control practices, which placed all residents at risk for acquiring the

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 26) transmission of disease and infection. An Immediate Jeopardy was called on 9/10/14 at 6 P.M., related to the facility's non existent infection control program. The team accepted the Allegation of Removal of Immediate Jeopardy (POC) and informed the ADM on 9/16/14 at 9:10 A.M., that the Immediate Jeopardy was abated. Findings: 1. On 9/8/14 at 3 P.M., during the initial tour, it was observed in room [ROOM NUMBER], non sampled Resident 51 had 3 urinals on his bedside table. One urinal was 1/4 full (approximately 100 cc) of dark yellow fluid. On 9/9/14 at 7:30 A.M., Resident 51 was observed with 3 urinals on his bedside table. One urinal was 1/4 full (approximately 100 cc) of yellow fluid and the other 2 urinals were empty. Resident 51 was asked how often the staff emptied his urinals, he stated, They empty it. On 9/9/14 at 11 A.M., Resident 51 was observed with 3 urinals on his bedside table. All 3 urinals were empty. On 9/9/14 at 12:30 P.M., Resident 51 was observed eating his lunch tray which was placed on his bedside table. The 3 urinals were placed hanging on the top right side rail of his bed. On 9/9/14 at 1:30 P.M., CNA 1 stated, He's not assigned to me, when asked how often the urinals are emptied. On 9/9/14 at 2 P.M., Resident 51 was observed with 3 urinals on his bedside table. One urinal was 1/4 full (approximately 100 cc), of yellow fluid. It was unknown how long the urinal with urine had been sitting on the bedside table. On 9/9/14 at 2:31 P.M., the ICN was interviewed. A request was made to review the infection control binder for policies and procedures. She stated she was newly employed at the facility and acknowledged there was no infection control binder, There's nothing. She further confirmed, she initiated the infection surveillance for the facility on 9/8/14. On 9/10/14 at 8:30 A.M., Resident 51 was observed with 3 urinals on his bedside table. One urinal was approximately 100 cc's filled with dark yellow urine. 2 a. During a medication pass observation, 3 LNs did not sanitize the blood pressure (BP) cuff (inflatable cuff that wraps around the arm, used to measure blood pressure), which was used for multiple residents, before and after use. During a medication pass observation on 9/9/14 at 9:40 A.M., LN 8 was observed taking the BP cuff from the medication cart and did not sanitize the cuff. She proceeded to take Resident 53's BP. After LN 8 finished, she placed the cuff back into the medication cart and did not sanitize the BP cuff. On 9/9/14 at 9:50 A.M., LN 8 confirmed she did not sanitize the BP cuff before and after use for Resident 53. When asked she said, I should have done it. During a medication pass observation on 9/9/14 at 10 A.M., LN 11 was observed taking Resident 24's BP before administering the medications. LN 11 did not clean/sanitize the BP cuff before and after use. At 11:20 A.M., she confirmed she did not clean/sanitize the BP cuff before and after use. During a medication pass observation on 9/9/14 at 10:30 A.M., LN 2 was observed using the BP cuff to measure BP for Resident 40 without sanitizing it before and after use. At 11:10 A.M., LN 2 said she did not know she was suppose to clean it before and after use. On 9/9/14 at 2:45 P.M., the DON said nursing staff are expected to sanitize the BP cuff before and after taking BP for each resident. The facility's policy and procedures entitled Cleaning & Disinfection of Resident Care Equipment, undated, indicated: Reusable items are cleaned and disinfected or sterilized between residents. The reusable items included BP cuffs. 2 b. During a medication pass observation, a nursing staff did not use the appropriate disinfectant to disinfect the glucometer as per manufacturer's recommendation. On 9/9/14 at 2 P.M., LN 12 was observed obtaining a finger stick (blood sample obtained from a finger and placed on a test strip which is inserted in a glucometer, to get a blood sugar reading) from Resident 86. After finished, LN 12 sanitized the glucometer (Assure Platinum Brand) with a Procure Hand Sanitizing wipe. This wipe contained only 65.9% of alcohol and had no disinfecting action against E. Coli bacteria, Salmonella bacteria, HIV, Hepatitis B Virus, Hepatitis C Virus, different types of fungi, etc. On 9/9/14 at 3:40 P.M., the ADON provided the facility's undated policy and procedures entitled CLEANING AND DISINFECTION OF GLUCOMETER. It indicated: Disinfect after cleaning the exterior surfaces following the manufacturer's directions . A review of the manufacturer's recommendation for Assure Platinum glucometers, provided by the DON on 9/10/14, read: Disinfecting can be accomplished with an EPA (Environmental Protection Agency) registered disinfectant detergent or germicide that is approved for healthcare settings or a solution of 1 part to 10 parts concentration of sodium hypochlorite (bleach). On 9/10/14 at 9:30 A.M., the ADON said the Procure Hand Sanitizing wipe was not appropriate for disinfecting the glucometers. She said the facility just brought in a new sanitizing wipe called Clorox Healthcare Bleach Germicidal Wipes, which the facility will use to disinfect all resident care equipments. 2 c. During a medication pass observation, a nursing staff did not appropriately disposed of potentially contaminated IV medication bag and IV tubing to prevent the transmission of disease within the facility. Resident 21 was admitted to the facility with [DIAGNOSES REDACTED]. diff). According to the CDC, symptoms of [DIAGNOSES REDACTED] include: watery diarrhea, fever, loss of appetite, nausea, and abdominal pain. Residents can get sick from [DIAGNOSES REDACTED]icile picked up from contaminated surfaces or spread from a health care provider's hands. (http://www.cdc.gov/hai/organisms/cdiff/Cdiff-patient.html) On 9/10/14 at 11:10 A.M., the ADON said Resident 21 was placed on contact isolation precautions due to [DIAGNOSES REDACTED]icile. Contact precautions are measures put in place to prevent transmission of microorganisms in healthcare setting. The measures include proper hand hygiene, personal protective equipment, isolation of resident care equipment, etc. These measures are designed to protect residents, staff, and visitors from contact with infectious diseases. On 9/10/14 at 11:15 A.M., the ADON was observed hanging a new IV medication ([MEDICATION NAME], an IV antibiotic to treat various infections) bag at Resident 21's bedside. She then removed the empty IV [MEDICATION NAME] bag and its tubing (which had been hanging on the IV pole from the night before) and brought them out of the resident's room. ADON then cut sharp end of the tubing and placed it in the sharps container hung outside of a medication cart. She then threw the rest of the IV tubing and the empty IV medication bag in the trash bin located on the side of that same medication cart. During this observation, when asked if that was a proper disposal of the potentially contaminated IV bag and IV tubing, ADON did not respond but quickly retrieved the IV bag and tubing from the trash bin, and discarded them in a large unlabeled black trash container located in a room adjacent to the nursing station. She said that black trash container was a biohazard bin although it did not have any signs indicating it was a biohazard bin. When asked what was the proper way to handle potentially contaminated materials, ADON said, You are right. We should dispose of those in the room. We should have the designated trash bin and sharps container in the patient's room. ADON acknowledged that bringing potentially contaminated materials outside of the contact isolation room had the potential for spreading infections in the facility. In the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, the CDC recommended: Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set and Equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents. 3. On 9/8/14 at 4:15 P.M., during the initial tour jointly with LN 1, shower room [ROOM NUMBER] was observed. The shower curtain had brown substance spots at the bottom of the curtain, 4 x 4 tiles were coated with black substance. The corners of the shower stall floor had black substance. In addition, on the wall of shower room [ROOM NUMBER], was a sharp disposal container, which was filled to the top with disposal razors and other disposable sharps. At the top of the sharp disposal container was 13 used disposal razors which were stacked on top of the sharp disposal container. On 9/8/14 at 5 P.M., LN 1 was stated, It is overflowed and should have been changed. On 9/18/14 at 8:30 A.M., the DON stated she expected CNAs' or central supply staff for a new container, to replace the filled sharp disposable container. According to the facility's undated and unsigned policy and procedure, entitled Sharps Precautions, B. Such containers shall be easily accessible to personnel needing them .and will not spill their contents if knocked over and will not themselves

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	055698	A. BUILDING _____ B. WING _____	09/19/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIREMONT HEALTHCARE & WELLNESS CENTRE, LLC	8060 FROST STREET SAN DIEGO, CA 92123

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 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 27) allow injuries when handled. 4. On 9/9/14 at 7:30 A.M., it was observed that an isolation cart in the hallway at the entrance of the door for room [ROOM NUMBER]. Resident 21 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 9/9/14 at 3:12 P.M., CNA 2 was observed. CNA 2 put on a yellow gown, gloves and a mask that was obtained from Resident 21's isolation cart. CNA 2 entered Resident 21's room, and greeted the resident. CNA 2 raised Resident 21's head of bed higher and assisted the resident in comfort. CNA 2 disposed of the yellow gown, gloves and mask in the garbage can located inside room [ROOM NUMBER] then, walked out of the room without washing her hands and proceeded to walk down the hallway. CNA 2, after leaving Resident 21's room, was about to enter another resident's room. CNA 2 was stopped for an interview before entering another resident's room. CNA 2 was asked, the process when a resident is on isolation precautions. She hesitated in her response then stated, I should wash my hands, after I take off my gown and gloves. I did not wash my hands after leaving Resident 21's room. CNA 2 stated she was trained on infection control procedures, I think a couple of months ago. On 9/10/14 at 7:25 A.M., during breakfast observation, the CDON was observed sitting and feeding a resident. She stood up and went to a second resident and assisted the resident with her meal tray. The CDON walked over to a third resident. She repositioned his wheelchair and went to a fourth resident, to touch the resident's shoulder. The CDON moved the fourth resident's meal tray to another table and pushed the resident to another table. The CDON picked up the fourth resident's 4 ounce glass of white fluid and proceeded to assist her with her meal. The CDON then leaned against a fifth resident's wheelchair and placed her hand on his wheelchair and began to feed the resident. The CDON went back and forth between 5 residents and assisted them with their meals. The CDON did not wash her hands nor sanitize her hands between each resident contact. On 9/10/14 at 7:51 A.M., CNA 2 was observed feeding a male resident. The CNA stood up and poured coffee for another resident. The CNA left the main dining room to go to the kitchen and entered the kitchen to obtain more coffee and cups. CNA 2 returned with the coffee and cups. She assisted another resident with his meal. The CNA did not wash her hands between residents and did not wash her hands upon her return to the main dining room. CNA 2 sat between 2 different residents and assisted the residents with their meal. A different resident at the same table started to cough and the CNA attended to the resident and wiped her mouth. She returned to the 2 residents and resumed feeding the residents. CNA 2 did not wash her hands after she assisted the resident who had coughed. On 9/10/14 at 12:45 P.M., CNA 3 was observed at the doorway of Resident 21, who was on isolation precautions. CNA 3 put on a yellow isolation gown, and gloves and obtained a lunch tray from the meal cart. She delivered the tray to Resident 21 and assisted the resident with his meal tray. The CNA removed the yellow isolation gown and her gloves at the trash can inside Resident 21's room. She left the room and proceeded to the meal cart and obtained another meal tray. CNA 3 did not wash her hands when she exited Resident 21's room. CNA 3 stated she forgot to wash her hands after leaving his room. On 9/10/14 at 1:25 P.M., CNA 4 was observed standing at Resident 21's doorway. CNA 3 handed Resident 21's consumed meal tray to CNA 4. CNA 4 accepted the meal tray and placed the tray on the meal cart. CNA 4 then entered another resident's room and did not wash her hands after she handled Resident 21's meal tray. CNA 4 stated, she forgot to wash her hands. On 9/10/14 at 2:10 P.M., the team coordinator called a team meeting to discuss the infection control issues observed. The team agreed to obtain additional interviews. On 9/10/14 at 3:55 P.M., the CDON was interviewed. She stated that was the first time she had assisted in the main dining room for meals. She further stated she did not monitor the staff on handwashing. She further stated, she had not conducted inservices for hand washing to the staff. On 9/10/14 at 4:10 P.M., the ICN was interviewed. She acknowledged there was no infection control program throughout the facility, No program yet. Due to the facility's failure to: 1. Ensure the staff practiced proper hand washing techniques; 2. Ensure the staff were in-serviced on infection control prevention; and 3. Ensure the facility monitored and tracked infection control issues within the facility. On 9/10/14 at 6 P.M., the survey team called the Immediate Jeopardy and informed the ADM and the VPCS. The team requested the ADM provide the survey team with immediate measures that would be taken to ensure the safety of each resident to prevent the spread of infectious disease and implement an Infection Control Program. On 9/16/14 at 9:10 A.M., the survey team reviewed an Allegation of Removal of Immediate Jeopardy (POC) presented by the facility. According to the POC: 1. The staff were inserviced on hand washing techniques; 2. The staff were inserviced on contact isolation; 3. The facility installed 11 automatic hand sanitizers which were placed in hallways and common areas throughout the facility; 4. An infection control checklist for rounds was developed; 5. The department heads were inserviced on hand washing and cleaning of medical equipment; 6. An Infection Control Committee was developed, the Infection Control Consultant made rounds throughout the facility; 7. The facility re-instituted the infection control surveillance logs and committed to a monthly monitoring process; 8. An infection control manual was reviewed and accepted by the Infection Control Committee. The team accepted the Allegation of Removal of Immediate Jeopardy (POC) and informed the ADM on 9/16/14 at 9:10 A.M., that the Immediate Jeopardy was abated.
F 0458 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** Based on observation and record review, the facility failed to provide the minimum of 80 square feet (sq. ft.) per resident in 4 of 48 resident rooms (Rooms 23, 25, 29, and 31). As a result, residents of 4 of 48 room were not afforded regulatory requirement of 80 square feet per resident. Findings: On 9/16/14, the facility's Analysis of Accommodations dated 9/9/14 was reviewed with the MS. According to the Analysis of Accommodations, it was listed that 4 rooms did not meet the requirement. On 9/16/14 at 10:25 A.M., the MS measured resident rooms 23, 25, 29, and 31. Each room measured 223.2 sq. ft. The individual rooms accommodated 3 residents, providing only 74.4 sq. ft. of space per resident which did not meet the required square footage of 80 sq. ft. per resident. On 9/17/14 at 11:15 A.M., residents residing in rooms 23, 25, 29 and 31 stated that they liked their room accommodations and spend most of the day in activities. Direct care staff said there were no issues with space in resident's room when proved care. Resident rooms were free of clutter and there was no specialty equipment noted. There were no Quality of Care or Quality of Life issues identified during the survey for the residents that were housed in these rooms. The Department recommends continuance of the room size variance waiver.
F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Deficiency Text Not Available
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards**

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F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 28) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1) Ensure a dietary nutritional screening form had accurate food allergies [REDACTED]. As a result, inaccurate documentation in the clinical record on a nutritional screening form may have contributed to barrier in communicating to kitchen staff. The dietary tray card that was used by kitchen staff to prepare the resident ' s meal had not contained the pertinent food allergy. As a result Resident 80's medical record was incomplete without consents signed by the Responsible Party. Findings: 1. On 9/10/14 at 9:18 A.M., the facility's registered dietitian (RD 2) reviewed a label that was located on the front of Resident 30's medical record that indicated an allergy to nuts. RD 2 reviewed the nutritional screening form completed by a dietary services supervisor (DSS) on 12/11/13 under the pre-printed category of Food allergies [REDACTED]. RD 2 was then asked to review the dietary meal tray card for Resident 30, which was observed to not have indicated a nut allergy. RD 2 reviewed the meal tray card and stated, The food allergy to nuts should be listed on the meal tray card. The facility's P & P entitled Diet Record Maintenance (undated) indicated, Policy: The dietary department will maintain a system to record dietary information necessary to use on the resident's tray cart. Procedure; 1. The diet record system will contain the following information to be reflected on the resident's tray card:G. allergies [REDACTED]. The facility's P & P entitled Tray Card System (undated) indicated, Policy: Each meal tray at breakfast, lunch and dinner will have a tray card which designates the resident's name, diet, food dislikes, food requests, allergies [REDACTED]. 2. Resident 80 was readmitted to the facility on [DATE], per the Face Sheet. According to the same Face Sheet, Resident 80 had a Responsible Party for health decisions, which was a family member. During a clinical record review on 9/2/14 at 1:30 P.M., the Medical Records Director said, all records should be completed and this included the consent for treatment. The Admission consent for treatment was not completed for Resident 80. Per the facility policy, Informed Consent, undated, I. Informed Consent is defined as the voluntary agreement of a resident (or a representative of an incapacitated resident) to accept a treatment or procedure II. The informed consent will be documented and placed in the resident's medical record 2. The resident or representative must sign an informed consent form.
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview and record review, the facility failed to provide evidence of a viable, ongoing, and comprehensive Quality Assurance Program which evaluated the facility's ability to provide continuous assessment of issues, related to quality of care, quality of life and facility practices. As a result, the facility was unable to identify system issues, develop and implement plans to address areas of concern and opportunities for improvement in a timely manner. Due to the facility's failure to: 1. Identify and discuss on going activities within the facility; 2. Identify system issues related to Resident Behavior and Facility Practices, Quality of Care, and Quality of Life, the survey team called an Immediate Jeopardy for QA. On 9/18/14 at 12:35 P.M., the survey team called an Immediate Jeopardy and informed the ADM. The team requested the ADM provide the survey team with immediate measure that would ensure a QAC was implemented. As of survey exit on 9/19/14 at 3:30 P.M., the Immediate Jeopardy had not been abated. On 10/3/14 at 4:20 PM, the survey team accepted the Allegation of Removal of Immediate Jeopardy (POC) and informed the ADM the Immediate Jeopardy was abated. Findings: 1. On 9/10/14 an Immediate Jeopardy was called related to the facility's lack of a comprehensive Infection Control Program. On 9/11/14 at 9:40 A.M., an interview with the ICC was conducted. She confirmed that she had not received any surveillance of infections for Months, from the facility. She further stated, she was not kept, In the loop, regarding infection control in the facility. While the ICC attended the quarterly QAC meetings, she acknowledged that no discussions or decisions were made regarding Infection Control Practices. Due to the facility's lack of surveillance, the facility was unable to identify infection control trends. On 9/15/14 at 9:45 A.M., the Pharmacy Consultant was interviewed. He stated, I have never given them any reports on antibiotic use. I have told them we could, but (they) do not come to us, (regarding QA). 2. On 9/15/14 at 9:30 A.M., the MD was interviewed. He stated his services as Medical Director of the facility would no longer be needed, effective 9/30/14. He further stated, that they (ADM) may have mentioned the Immediate Jeopardy related to Infection Control and stated, he was not aware of the second Immediate Jeopardy related to abuse. According to the MD, he used to be involved in QA with the previous ADM. He stated that when the new ADM started in January 2014, she (ADM) did not include him and further stated he was not involved with QA and that the committee was Passive, just the paperwork. On 9/18/14 at 9:26 A.M., the MD was re-interviewed. The MD stated, he did not participate at all in the meetings. He stated, Just a formality (Quarterly QA meeting), maybe 30 to 40 minutes, it was just, you sign (here); no discussion, superficial and sign here and there. He acknowledged that he attended the quarterly meetings and signed as directed by the ADM. The MD further acknowledged he was not involve in nor informed of any QA related issues since January 2014, when the new Administrator came. 3. On 9/18/14 at 10:31 A.M., the ADM was interviewed. She stated the QAC met on a quarterly basis throughout the calendar year. During the April 2014 QAC meeting, which reflected the QA issues for January through March 2014, the ADM stated the previous nursing department heads presented a report that did not meet her standards. She graded the report as an F. She then met with the previous nursing department heads around April, May-ish to review their revised reports. Again, the ADM stated, there was no data collection by the previous nursing department heads. During the July 2014 QAC meeting, which reflected the QA issues for April through June 2014. The ADM stated, the PDON reported limited information regarding falls, nothing was reported on restraints, weight loss, skin issues, or abuse. The ADM further stated, that the IC surveillance was not accurately reported. Also, the DSD/ICN was not present during the July meeting. The ADM confirmed she accepted the ICC report related to urine cultures and infection rates, but stated the ICC shared she obtained the cultures and infection rates based on the lab results only and did not receive any input related to the cultures and infection rates from the DON or DSD/ICN. The ADM acknowledged, the information form the ICN was not accurate. A review of the July 2014 agenda and sign-in sheet was conducted. Each department head signed the sign-in sheet, but no agenda item was noted for each department head. When asked what decisions were made during the July 2014 QAC meeting, the ADM was unable to locate the minutes in the binder. The ADM acknowledged, that with the inaccurate data from the ICN reports, the absence of data collection of resident care issues from the previous DON, ADON and DSD/ICN, there was no QAC program for the facility. In addition, the ADM stated, there was no Bioethics Committee agenda item on the QAC and was not aware of any bioethics committee until she received a complaint.