

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2019
NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD ELLISVILLE, MS 39437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health from 02/25/2019 to 02/28/2019. The facility was found not to be in substantial compliance the Medicare and Medicaid Requirements for Participation. Deficiencies were cited at F550, F554, F567, F582, F604, F656, F684, F756, F758, F761, and F880. Survey Census: 115. The facility held a license for 122 beds.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550			4/29/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/09/2019

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, record reviews, and interviews the facility failed to ensure two (2) of 29 sampled residents, Resident (R) 42 and R56, were treated with respect and dignity. Specifically, staff failed to knock before entering the room as requested by R42; and R56 was observed with a soiled brief, and staff failed to provide timely continence care. Findings include: Record review of the facility's policy dated 07/18/17, titled "South Central Regional Medical Center", revealed "Resident Respect and Dignity"; the purpose of the policy was to promote resident rights and treat each resident with respect and dignity, and care for each resident in a manner that maintained or enhanced the resident's quality of life. The policy further defined dignity as activities that maintained and enhanced	F 550	Statements contained herein are intended for purposes of compliance with Federal and State laws regarding responses to Statements of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for purposes of compliance with participation requirements of Medicare and Medicaid. F550 1) Social Worker met with Resident (R) 42 and R56 on April 15, 2019, to assess the residents for psychosocial harm relating to their residents rights. No psychosocial harm was found to have occurred. 2) All residents have the potential to be affected. 3) Nursing Staff responsible for the care		

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F 550	Continued From page 2 the resident's self esteem and self-worth. Record review of the procedure part of the policy revealed the staff would respond to a resident's need for assistance in a timely manner. The procedure further specified the staff would respect the resident's space by knocking on doors and waiting for permission to enter. Resident #42 Observation of R42 on 02/25/19 at 11:00 AM, revealed the resident lying in bed, in her room. The closets in the resident's rooms were by the door, and this resident had small bells dangling from the door handle. R42 stated she put the bells on the door handle to alert her when someone was opening the door. Observation on 02/25/19 at 9:41 AM, by another surveyor, revealed a Certified Nursing Assistant (CNA) entered room 104 to provide the resident with a snack and did not knock before entering. Observation on 02/25/19 at 9:43 AM, by another surveyor, revealed a CNA opened the door to room 109, knocked, and entered the room without waiting for a response. Observation on 02/25/19 at 2:43 PM, during an interview by another surveyor, revealed a CNA entered room 109 to give the resident a snack and did not knock before entering. Observation on 02/27/19 at 12:01 PM, revealed Licensed Practical Nurse (LPN) #4 entered R56's room to do a skin assessment and did not knock on the door before she entered. The roommate, whose bed was by the door was also present in the room.	F 550	of R42 and R56 were in-serviced by Medical Records Nurse on April 8, 2019, regarding proper procedures for maintaining resident rights for respect and dignity by knocking on doors before entering room for R42, and for providing timely continence care for R56. The Quality Assessment and Assurance (QAA) Committee updated the Resident Respect and Dignity policy on April 8, 2019, to include respecting and maintaining resident dignity by providing care and personal hygiene in a timely manner. All staff are being in-serviced by the Director of Nurses on the policy, specifically knocking on doors and waiting for permission before entering a resident's room. The in-services began on April 12, 2019, and will continue until all staff have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. Licensed and non-licensed nursing staff are being in-serviced by Director of Nurses, regarding maintaining resident's respect and dignity by providing care and personal hygiene in a timely manner. In-servicing began on April 12, 2019, and will continue until all nursing staff have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. To ensure timely care is provided, nurses were also educated during this in-service regarding their responsibility to provide for resident care needs, including continence care, during meal times when the certified nursing assistants are providing meal		

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F 550	Continued From page 3 Observation on 02/25/19 at 9:41 AM, by another surveyor, revealed a CNA entered rooms 103 and 107 to provide the residents with a snack and did not knock on the door before entering. Record review of the "Face Sheet" in the electronic record for R42 revealed the facility admitted the resident on 02/02/17, with diagnoses of contractures, Rheumatoid Arthritis, chronic pain, long term opiate use, Anxiety Disorder, Depressive Disorder, and Bipolar Disorder. Record review of the yearly "Minimum Data Set (MDS)," dated 01/04/19 revealed R42 had a "Brief Interview of Mental Status (BIMS)," score of 15 out of 15, which indicated the resident was cognitively intact, and able to make decisions about her care. Record review of the "Care Plan" for R42, with an onset date of 10/15/18, and a goal date of 04/08/19, revealed a problem for choices, and one (1) of the interventions was to allow R42 to make her own decisions. Interview with R42 on 02/25/19 at 11:05 AM, revealed staff did not always knock on the door when they came into the room. While R42 and this surveyor were conversing, the door to her room was opened abruptly, and a staff member brought her roommate, who was in a geri-chair, into the room. Observation revealed the staff member did not knock on the door before entering. R42 stated, "See". R42 revealed she has had her toes hit by the door before because the staff did not knock and just came right on in and she couldn't get out of the way. R42 also stated she has asked the staff to knock on the door before entering, but some staff continued to	F 550	assistance to residents. 4) Medical Record Nurse and/or Charge Nurse will conduct three random observations of staff weekly over the next three months to ensure staff are promoting and maintaining resident dignity by knocking on doors and providing timely care and hygiene in accordance with facility's policy and regulatory requirements. These observations will begin on April 15, 2019, and the Medical Record Nurse will present these observation reports to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

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F 550	Continued From page 4 enter without knocking. Interview with LPN #4 on 02/27/19 at 12:15 PM, revealed staff were supposed to knock on the door before entering because it was the resident's room and staff should be respectful of that. Interview with CNA #1 on 02/28/19 at 12:51 PM, revealed staff should knock on the resident's door before entering because anything could be going on. CNA #1 further revealed resident's families could be visiting and staff could be performing personal care. CNA #1 stated privacy was a big deal and knocking on the door showed respect for the resident. CNA #1 revealed everyone knew R42 and that you needed to knock on the door before your entered. Interview on 02/28/19 at 11:57 AM, with the Director of Nursing (DON), revealed staff should knock on the resident's doors before they entered the room. The DON stated it was just like home, in that you knock on the door before going into someone else's room. The DON revealed there had been concerns voiced from the "Resident Council" in the past about staff not knocking on doors before they entered. The DON revealed they had done in-services related to privacy and knocking on doors. Resident #56 Record review of the "Face Sheet" in the electronic chart revealed the facility admitted R56 on 09/28/07, with diagnoses of Cerebral Palsy, Hypertension, Hemiplegia, and Depression. Record review of the quarterly "MDS", dated 01/01/19, revealed a "BIMS" score of 15 out of 15, which indicated the resident was cognitively	F 550			

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F 550	Continued From page 5 intact. The MDS indicated that R56 was totally dependent on staff for hygiene. The MDS indicated in "Section H: Bladder and Bowel" that R56 was always incontinent of bowel and bladder. Record review in the electronic chart revealed a "Care Plan (CP)" for R56 dated 10/18/18. A problem was listed for staff to honor the wishes of R56. A goal was to provide dignity and support to R56 and the family. Review of the interventions revealed staff were to provide emotional support to the resident. Another problem identified on the CP was the resident required total assist with her daily care needs. Observation of R56 on 02/27/19 at 11:39 AM, revealed the resident was lying in bed with the head of the bed in up position and staff were assisting with her meal. The Resident consented to an observation of her skin assessment by staff. Observation on 02/27/19 at 12:01 PM, of the skin assessment with LPN #4 and another nurse, revealed the resident did not have any pressure areas. However, R56 had a wet brief on and LPN #4 verified it was urine. Continued observation revealed LPN #4 reapplied the urine-soaked brief to R56 and told the resident she would get someone in there to clean the resident up. Observation revealed both nurses walked out of the room leaving a wet brief on R56. Continued observation on 02/27/19 at 12:18 PM, revealed a CNA delivered a tray to R56's room-mate and did not assist R56. At 12:33 PM, a CNA brought a water pitcher into the room and did not assist R56.	F 550			

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F 550	Continued From page 6 Observations of LPN #4, after leaving R56's room, revealed the LPN had returned to her medication cart multiple times without following up to see if R56 had been changed. The medication cart was right outside R56's room. Observation on 02/27/19 at 12:38 PM, revealed a CNA removed the tray from the other resident in the room and did not assist R56. Interview with LPN #4 on 02/27/19 at 12:45 PM, revealed 45 minutes would be too long for a resident to wait to have their soiled brief changed. LPN #4 stated skin breakdown can occur when a resident laid in urine. LPN #4 asked CNA #2 to help R56. Interview with CNA #2 on 02/27/19 at 12:45 PM, revealed the other nurse in the room with LPN #4 had asked her to change R56, but she had forgotten. The interview further revealed when the food trays were being passed, they (CNAs) were to keep passing trays and not provide hands on care to the residents. CNA #2 revealed the trays had to be passed immediately, so no one received cold food. Interview on 02/27/19 at 12:50 PM, with Registered Nurse (RN) #2, who was the charge nurse that day, revealed she would have changed R56 herself unless there was something more pressing had occurred. RN #2 stated if a nurse was just passing medications, they should go ahead and change the resident themselves. RN #2 stated 45 minutes was not an acceptable time range for a resident to have to wait to be changed. RN #2 further revealed when the CNA's were passing trays the nurses on the unit answered the call lights and helped with the	F 550			

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F 550	Continued From page 7 resident's care. CNA's were not supposed to answer call lights or do rounds while they passed trays. Interview with the DON on 02/27/19 at 2:52 PM, revealed a resident should be changed when soiled, and at a maximum within 15 minutes. The DON revealed 45 minutes was not acceptable. The DON stated, "I would not want to sit in a soiled brief for that long and the nurses who were aware of the soiled brief should have changed it right then, unless they had something else going on and, in that case, they should have made sure someone assisted R56." The DON confirmed it was a dignity issue for R56, and it also increased the resident's risk for skin breakdown and a urinary tract infection. The DON stated the CNA's were to check on the residents before passing trays and the nurses were to answer the call lights and provide care while the CNA's passed trays. Interview on 02/28/19 at 4:51 PM, with the Administrator, revealed she would expect a resident to be changed when soiled, and within 15 minutes of staff being aware of it. The Administrator stated she would have expected the nurses to change R56 when they saw she was soiled.	F 550			
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554			4/29/19

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F 554	Continued From page 8 Based on review of the facility's policy, observations, interviews, and record reviews, the facility failed to ensure the Interdisciplinary Team (IDT) determined it was clinically appropriate and safe for a resident to self-administer medications for one (1) of one (1) unsampled residents, Resident (R) #9. Specifically, R #9 was allowed to have medication at her bedside, without a facility assessment to indicate the resident could safely self-administer medications. Findings include: Review of the facility's policy titled, "Resident Rights-Self Administration of Medication," revised 05/09/17, revealed the purpose of the policy was to ensure the resident's right to self-administer medications when determined to be clinically appropriate. Continued review of the policy revealed if a resident requested to self-administer medications, it was the responsibility of the Interdisciplinary Team (IDT) to determine that it is safe for the resident to do so, before the resident could exercise that right. Further review of the policy revealed if the resident requested to self-administer any or all of their medications, the IDT would complete the "Self-Administration of Medication Evaluation" to determine if this practice was safe and clinically appropriate. The policy also revealed if the resident was deemed safe to self-administer medications, a physician's order would be obtained indicating which medications the resident could self-administer and it was the nurse's responsibility to monitor the use of bedside medications and document the use on the Electronic Medication Administration Record (EMAR). Observation and interview, on 02/25/19 at 10:18	F 554	F554 1) For Resident (R) 9, a Self-Administration of Medication Evaluation was completed by Minimum Data Set (MDS) Nurse #1 on February 27, 2019. This resident was determined to be unable to self-administer medications as prescribed. The medication was removed from the resident's room. 2) All cognitive residents have the potential to be affected. On February 27, 2019, a 100% resident room audit was performed by the Director of Nurses, Assistant Director of Nurse, Infection Preventionist and Medical Records Nurse to ensure no medications were at bedside without a physician's order and an evaluation to determine clinical appropriateness. There were no other residents found to be self-administering medications that were not properly assessed or care planned. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Self-Administration of Medication policy on April 8, 2019, with no revisions made at that time. All nurses will be in-serviced by the Director of Nurses on the policy by April 29, 2019. The in-services began on April 12, 2019, and will continue until all nurses have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. Nurse education regarding self-administration of medication will be reviewed annually, and will be included for all newly hired nurses. 4) This corrective action will be monitored		

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F 554	Continued From page 9 AM, in R #9's room, revealed one (1) bottle of nasal spray on the resident's bedside table and one (1) bottle of nasal spray on the resident's night stand. Interview with the resident revealed it was her medication that she paid for herself. Observation and interview, on 02/26/19 at 10:08 AM, with R #9 in her room, revealed two (2) bottles of Flonase Propionate nasal spray at the resident's bedside. R #9 stated she did not know how often she was supposed to take the medication, but she took it every eight (8) hours for her sinuses and allergies. R #9 also stated staff did not always ask her if and when she had taken the nasal medication, but they did occasionally ask. Continued observation revealed the medication at the bedside did not have a label indicating it was prescribed specifically for the resident and it lacked specific instructions for administration. Review of R #9's "Face Sheet," revealed the facility admitted the resident on 12/16/16, with diagnoses which included Vascular Dementia without behavioral disturbance, Hypertension, Heart Failure, and Allergies. Review of the resident's "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 11/28/18, revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15, which indicated R #9 was moderately cognitively impaired. Review of R #9's "Physician Orders," dated February 2019, revealed she was ordered Flonase (nasal spray used to treat allergies) 0.05% nasal spray of two (2) sprays per nostril	F 554	by the Medical Record Nurse who will conduct three random observations of resident's rooms weekly over the next three months to ensure no medications are left at bedside for self-administration without proper assessment and physician's orders in accordance with facility's policy and regulatory requirements. These observations will begin on April 15, 2019, and the Medical Record Nurse will present these observation reports to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

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F 554	Continued From page 10 daily. Continued review of the physician's orders revealed no documented evidence the resident was cleared to self-administer the medication. Review of R #9's medical record revealed no documented evidence the resident had been assessed for safe, self-administration of medications. Observation and interview, on 02/26/19 at 4:35 PM, with Licensed Practical Nurse (LPN) #5, who was R #9's nurse that shift, revealed an empty Flonase prescription box in the medication cart that indicated R #9 was to be administered two (2) sprays in each nostril one (1) time a day. Continued observation revealed written on the prescription box was "Kept in room." The LPN stated R #9 was prescribed Flonase; however, per the medication box, it was kept in the resident's room. The LPN further stated she was not aware the medication was kept by the resident in her room, nor has she ever had to record the medication on the Electronic Medication Administration Record (EMAR) because the resident takes the medication in the morning, and she works evening shift. Interview, on 02/27/19 at 8:20 AM, with the facility's Medical Director, who was also the R #9's attending physician, revealed it was his expectation the facility would have followed his physician orders and their policy about residents being able to self-administer medications. Continued interview revealed even though there was little danger for R #9 taking the medication more than it was prescribed, the facility should have ensured his orders were followed. Interview, on 02/28/19 at 12:49 PM, with	F 554			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2019
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F 554	Continued From page 11 Registered Nurse (RN) #4 who was the charge nurse on duty, revealed prior to the surveyors making the observations of the medication being at R #9's bedside, there was not an assessment to ensure the resident was able to self-administer medications. Continued interview revealed there was not a physician's order for the resident to self-administer medications and no order for the resident to be able to keep the medications at her bedside. The RN stated he did not know what happened, or why the resident was not assessed to safely self-administer medication, but it must have slipped through the cracks. RN #4 further stated it was important an assessment should have been completed. Interview on 02/28/19 at 1:20 PM, with the MDS Coordinator, revealed she was the person responsible for completing assessments for residents to self-administer medications. The MDS Coordinator stated she was not aware R #9 was keeping medications at her bedside and self-administering it; however, the resident should have been assessed first. The MDS Coordinator stated the resident was not assessed to self-administer medication prior to the survey agency identifying it. The MDS Coordinator stated the resident should have been assessed to ensure she knew how to administer it correctly. Interview, on 02/28/19 at 3:35 PM, with the Director of Nursing (DON), revealed R #9 did not have an assessment completed for self-administration of medication. The DON confirmed the resident should have been assessed to ensure the resident could use the medication correctly and therapeutically. During an interview, on 02/28/19 at 4:06 PM, the	F 554			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 554	Continued From page 12 facility's Administrator stated it was her expectation the resident would have been assessed to self-administer medication to ensure she could safely do so. The facility staff had not followed their policy related to self-administration of medication.	F 554			
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10)(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of \$100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal	F 567			4/29/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 567	Continued From page 13 funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the resident's personal funds were available on the weekends for three (3) of the 29 sampled residents. Residents (R) 42, R56, and R95 did not have access to their personal funds on the weekends. Findings include: Review of the facility's policy dated 08/30/18, titled, "South Central Regional Medical Center," under the "Resident Rights - Personal Funds," section, revealed the purpose of the policy was to ensure the residents had the right to manage their own funds. Review of the policy revealed there was no indication that the facility had to provide availability for personal funds on the weekends. Resident #42 Record review of the "Face Sheet" in the electronic chart revealed R42 was admitted by the facility on 02/02/17, with diagnoses of Rheumatoid Arthritis, Chronic Pain, Anxiety Disorder, Depressive Disorder, Bipolar Disorder and Deep Vein Thrombosis.	F 567	F567 1) Residents (R) 42 and R56 were provided information on the new procedure for obtaining funds after business hours and on weekends and holidays. Information was provided by Administration Assistant Clerical Level #1 on April 15, 2019. R95 is no longer a resident of the facility. 2) All residents with a personal funds account have the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee modified the Resident Rights Personal Funds policy and the petty cash fund system on April 8, 2019. The resident petty cash fund will be managed by the Charge Nurse during non-office hours to ensure residents have access to their personal funds after business hours, on weekends and holidays. All staff will begin being in-serviced by Director of Nurses on April 12, 2019, until all staff is in-serviced regarding the new procedures allowing resident access to his/her funds after business hours. The in-services began on April 12, 2019, and will continue until all staff have received		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 567	Continued From page 14 Record review of the yearly "Minimum Data Set (MDS)," dated 01/14/19, revealed a Brief Interview of Mental Status (BIMS) (a cognitive evaluation) score of 15 out of 15, which indicated R42 was cognitively intact, and could be interviewed about her care. Observation and interview with R42 on 02/26/19 at 9:08 AM, revealed she was in her room and agreeable to an individual resident interview. R42 revealed she had personal funds held by the facility for her, however she was not able to access it on the weekends. She stated there was no one in the office to dispense money to her on the weekends. R42 stated there had been occasions when she wanted some money on the weekend but was unable to access it. R42 revealed she could get money on Fridays, but she may not always know in advance that she wants/needs money for the weekend. Resident #56 Record review of the "Face Sheet" in the electronic chart revealed R56 was admitted by the facility on 09/28/07, with diagnoses of Cerebral Palsy, Hypertension, Scoliosis, Hemiplegia, Dysphagia, Anxiety, and Depression. Record review of the quarterly "MDS" dated 01/01/19, revealed in "Section C: Cognitive Patterns" R56 had a "BIMS" score of 15 out of 15, which indicated R56 was cognitively intact. Record review of the MDS in "Section G: Functional Status" revealed R56 needed extensive assistance with mobility and two-person support. Observation of R56 on 02/26/19 at 12:36 PM, revealed she was in her room in bed. Interview	F 567	the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. All residents and/or resident representatives were provided notice of the new procedures to allow access to available resident funds by letter on April 12, 2019, by Administrator. Information regarding access to available resident funds will be included during new admission process and acknowledged through the Availability of Personal Funds Notice. 4) The Business Office staff will randomly conduct three resident interviews weekly over the next three months to determine if they were able to obtain personal funds after business hours or during the weekend or holidays, or if no funds were desired, was the resident aware of how to access available funds. These observations will begin on April 15, 2019, and the Administrator will present these observation reports to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 567	Continued From page 15 with R56, at the time of the observation, revealed she had a personal fund account in the office. However, the office was closed on the weekends and she could not access her funds. R56 revealed if she needed something on the weekends she would call home. Resident #95 Record review of the "Face Sheet" for R95, revealed he was admitted by the facility on 01/04/19, with diagnoses of Weakness, Atrial Fibrillation, Congestive Heart Failure, and Hypertension. Record review of the admission "MDS", dated 01/31/19, revealed under "Section C: Cognitive Patterns" a "BIMS" score of 15 out of 15, which indicated R95 was cognitively intact, and a reliable interview about his care. Observation and interview with R95 on 02/25/19 at 3:38 PM, revealed he was sitting on the side of his bed and his wife was visiting at bedside. R95 stated he had money in the office, but the office was not open on weekends. R95 stated when the office wasn't opened, he would have to call his wife if he needed any money. Interview on 02/27/19 at 11:47 AM, with Certified Nursing Assistant (CNA) #1, revealed she would have to talk to the charge nurse and see what to do if a resident asked for money on the weekends because the office was closed, and that was where the residents kept their money. CNA #1 revealed there weren't many residents that have asked for their money on weekends, but that may be because they knew the office was closed. Interview with Registered Nurse (RN) #2, who was the Charge Nurse, on 02/27/19 at 12:15 PM,	F 567			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 567	Continued From page 16 revealed she was not sure how the residents could get their money on the weekends because the office was closed, and the personal funds were locked in the office. RN #2 further revealed there were staff on call on weekends and the nurses could maybe call them. Interview with Licensed Practical Nurse (LPN) #3 on 02/27/19 at 12:58 PM, revealed the nurses do not have access to the funds and she did not know who did have access on the weekends. LPN #3 revealed she would have to ask the Charge Nurse what to do. Interview with the Administration Assistant Clerical Level (CL) #1 on 02/27/19 at 1:02 PM, revealed many of the residents do have a personal fund set up, and they usually will come to the office on Friday to get any money for the weekend. CL #1 revealed the office was not opened on weekends and the weekend nursing staff do not have access to the funds. CL #1 stated if a resident needed money on the weekend they would have to ask the staff to call her, and if she wasn't available, they would have to call another "on call" staff member until they got someone that could come in and dispense the money. In an interview with the Administrator on 02/27/19 at 01:05 PM, she stated she was also on call and could come in if a resident needed access to their funds.	F 567			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in	F 582			4/29/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 582	Continued From page 17 writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the	F 582			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 582	Continued From page 18 facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure each resident whose Medicare therapy services were terminated received a notice including the reason the services were ending, and what options were available to the residents prior to the discontinuation of services. This failure effected two (2) of three (3) residents, Residents (R) 71, and R265, reviewed for SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review. Findings include: Resident #71 Review of the medical record for R71 revealed she was admitted to the facility on 08/03/18. R71 had Medicare benefits and when she was discontinued from skilled therapy services on 08/31/18, she had not exhausted her Medicare benefit days. However, there was no documented evidence the facility provided her with the appropriate notices upon discontinuation of services. They did not provide her with the Skilled Nursing Facility Beneficiary Notice (SNFABN) Centers for Medicare and Medicaid Services (CMS) form 10055 or one (1) of the five (5)	F 582	F582 1) For Resident (R) 71, Medicare Minimum Data Set (MDS) Coordinator notified the resident's representative via telephone of the resident's last covered day on April 8, 2019, and witness verification was documented. R265 was discharged to the hospital on February 7, 2019, and subsequently expired. 2) All residents receiving Medicare benefits have the potential to be affected. An audit was conducted by the Medicare MDS Coordinator on April 8, 2019, for current residents who were admitted in the past six (6) months, and notification provided when required per regulatory requirements. This audit affected 13 current residents. 3) The Quality Assessment and Assurance (QAA) Committee developed a policy regarding Advance Beneficiary Notice on April 8, 2019. The Administrator educated the following personnel on the facility's Advance Beneficiary Notices policy on April 12, 2019: Business Office Staff, Social Services Staff, Director and Assistant Director of Nurses, and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 582	Continued From page 19 uniform Denial Letters found in §358 of the Skilled Nursing Facility Manual. There was no record of the Notice of Medicare Non-Coverage (CMS 10123) being provided to the resident or their representative. Resident #265 Review of the medical record for R265 revealed he was admitted to the facility on 09/10/18. R265 had Medicare benefits and when he was discontinued from skilled therapy services on 10/18/18, he had exhausted his Medicare benefit days. However, there was no documented evidence the facility provided him with the appropriate notices upon discontinuation of services. They did not provide him with the Skilled Nursing Facility Beneficiary Notice (SNFABN) Centers for Medicare and Medicaid Services (CMS) form 10055 or one (1) of the five (5) uniform Denial Letters found in §358 of the Skilled Nursing Facility Manual. There was no record of the Notice of Medicare Non-Coverage (CMS 10123) being provided to the resident or their representative. On 02/27/19 at 11:00 AM, an interview with the Administrator was conducted. The Administrator stated the letters are just mailed and there are no records to confirm when or if they were sent. There were no signed forms available for review. On 02/28/19 at 10:00 AM, an interview with the Administrator was conducted. The Administrator stated the facility does not have a policy or procedure for the issuing or handling of the Skilled Nursing Facility Beneficiary Notice to residents or their representative's. On 02/28/19 at 3:13 PM, an interview with	F 582	Medicare MDS Coordinator. 4) The Business Office staff will conduct an audit of all Medicare discharged residents for three consecutive months to verify that notices were issued timely and appropriately. These audits will begin on April 15, 2019, and the Administrator will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 582	Continued From page 20 Registered Nurse (RN) #1 was conducted. RN #1 stated she fills out the SNFABN forms at least 10 days before the resident's discharge date. She then takes the forms to the front office for mailing. The signed forms are maintained in the resident's financial folder. On 02/28/19 at 3:20 PM, an interview with Clerical Level (CL) #1 was conducted. CL #1 stated she placed the letters in the regular mail and there was no tracking of the letters to confirm their receipt. She also stated they did not regularly make copies of the forms before mailing them. The forms that are signed and returned are maintained in the resident's financial folder. The CL confirmed there were no forms/documents to review for R71 and R265.	F 582			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604		4/29/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 604	Continued From page 21 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, observations, interviews, and record reviews, the facility failed to ensure residents had the right to be free from any physical restraints for one (1) of 29 sampled residents, Resident (R) 31. Specifically, R31 had a device in place which she could not remove easily, and limited her freedom of movement. There was no documented evidence the facility assessed the resident for an appropriate medical diagnosis to warrant the use of a restraint. Findings include: Review the facility's policy titled, "Resident Rights-Restraint Free Environment," revised on 12/27/16, revealed the purpose of the facility's policy was to ensure the resident's right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The facility's policy defined a physical restraint as: any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that	F 604	F604 1) Resident (R) 31 was transferred to a geri-chair on April 12, 2019, by the Director of Nurses to ensure that resident is free from physical restraint. 2) R31 is the only resident with the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Resident Rights Restraint Free Environment policy on April 8, 2019, with no revisions at that time. All therapy staff, licensed and non-licensed nursing staff will be in-serviced by Director of Nurses starting on April 12, 2019, regarding the facility policy, and included definitions of a restraint, proper assessment, and possible alternative(s) to restraint usage until all staff are in-serviced. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. 4) The Director of Nurses will conduct		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2019
FORM APPROVED
OMB NO. 0938-0391

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F 604	Continued From page 22 the individual cannot remove easily which restricts freedom of movement or normal access to ones' body; and any device in conjunction with a chair (such as bars or belts) that the resident could not remove easily, that prevent a resident from rising. The facility's policy also revealed the facility could not use restraints solely based on a legal surrogate or representatives request, and a physician's order alone was not enough to warrant the use of a restraint. Continued review of the facility's policy revealed restraints would not be used at the facility and when the resident required the use of an orthotic body device such as specialty chairs, an assessment would be conducted to ensure the use of the device did not restrain or restrict freedom of movement or normal access to the resident's own body. The facility's policy indicated residents who are restrained may face a loss of autonomy, dignity, and self-respect, and may show symptoms of withdrawal, depression, or reduced social contact. Review of R31's "face sheet" revealed the facility admitted the resident on 06/13/18, with diagnoses which included Nontraumatic Intracerebral Hemorrhage, Weakness, and Hemiplegia following Intracerebral Hemorrhage affecting left nondominated side. Observation, on 02/25/19 at 9:12 AM, in the lounge area on the east wing, revealed R31 sitting in her wheelchair in front of the television. Continued observations revealed the resident had a seat belt on while in her wheel chair. Review of R31's "Physician Orders," dated February 2019, revealed no documented evidence of a current order for the restraint, and	F 604	three random audits weekly over the next three months to ensure devices used by the resident do not act as a restraint, and that the reason(s) for device use are properly identified, evaluated, documented and care planned in accordance with facility policy and regulatory guidance. These audits will begin on April 15, 2019, and the Director of Nurses will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 604	Continued From page 23 no documentation that a restraint was medically necessary. Review of the resident's "Minimum Data Set (MDS)," dated 12/18/18, revealed a cognitive evaluation could not be completed because the resident was rarely/never understood however; the facility assessed the resident's cognitive skills for daily decision making was severely impaired. Continued review of the MDS under "Section G: Functional Status," the facility assessed the resident to have "Functional Limitation in Range of Motion" to only one (1) side of her upper and lower extremity. Further review of the MDS under "Section P: Restraints," the facility assessed the resident as not using any physical restraints including equipment attached or adjacent to the resident's body that the individual could not remove easily which restricts freedom of movement or normal access to one's body. Review of R31's "Care Plan," reviewed and updated 12/19/18, revealed the problem of the resident's wheelchair has a lap and leg strap related to poor trunk control. The intervention was "personal wheelchair with lap and leg strap for security due to poor trunk control." Continued review of the resident's care plan revealed the goal: the resident would not have further loss of mobility or contracture development. Interview on 02/27/19 at 8:30 AM, with the Therapy Coordinator revealed he was aware the resident's wheelchair had the seat belt and the leg straps; however, the therapy department did not recommend them. Continued interview revealed the facility had a no restraints policy, and the wheelchair straps were restraints. The Therapy Coordinator stated there was no	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 604	Continued From page 24 assessment or a physician's order. The Therapy Coordinator further stated the facility did not utilize restraints because residents' had the right to be restraint free. Interview, on 02/27/19 at 9:00 AM, with the facility's Medical Director revealed it was his expectation the facility would have followed their policy related to the known restraints. The Medical Director stated to the best of his knowledge, there was no physician's order for the use of the seat belt, and no matter who brought the chair in, it did not make it ok for the seat belt to be used. Interview, on 02/27/19 at 9:35 AM, with Certified Nursing Assistant (CNA) #3, who was providing care for R31, revealed she was familiar with the resident. Continued interview revealed the resident did not have much movement in her left arm, but she could move her right arm well. CNA #3 stated she did put the seat belt on the resident when the resident was in her wheel chair. The CNA stated the purpose of the seat belt was for the resident's safety, so the resident did not fall out of her wheelchair. Interview, on 02/28/19 at 12:18 PM, with Registered Nurse (RN) #4, revealed R31's wheelchair was brought into the facility by the resident's spouse. Continued interview revealed the use of the seat belt was technically a restraint, so it was care planned. Interview, on 02/28/19 at 1:20 PM, with the MDS Coordinator revealed R31 was not assessed on the MDS to have a restraint, because she did not consider the seat belt a restraint. Continued interview revealed if the seat belt prevented the	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 604	Continued From page 25 resident from getting up from her wheelchair, then she should consider the seat belt a restraint. Interview, on 02/28/19 at 3:16 PM, with CNA #4, who was assigned to R31's care, revealed CNA #4 was not buckling the resident's seat belt when the resident's spouse first brought the wheelchair to the facility; however, the spouse requested she start buckling it. When asked if she could ask the resident to unbuckle the seat belt, the CNA stated she knew the resident could not, and did not want to ask her to do something she could not do. Interview, on 02/28/29 at 3:30 PM, with the Director of Nursing (DON), revealed she was aware the seat belt was being used on R31; however, she did not view the seat belt as a restraint. The DON confirmed there was not an assessment to indicate whether it was or was not a restraint, and there was no physician's order for the seatbelt. Interview on 02/28/19 at 4:06 PM, with the Administrator, revealed even though she was not aware the resident was being buckled in the chair, she did not consider the seat belt a restraint.	F 604			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656			4/29/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 26 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, record reviews, and interviews, the facility failed to ensure services were implemented in accordance with each resident's comprehensive person-centered care plan for one (1) of 29	F 656	F656 1) Resident (R) 68 was administered oral laxative as ordered and identified on the resident's person centered care plan on February 27, 2019, by Charge Nurse with		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 27 sampled residents, Resident (R) 68. R68's comprehensive care plan revealed the facility's nurse(s) was to check the resident's bowel movement (bm) record periodically for the need of PRN (as needed) laxative; however, there was no documented evidence the nursing staff was implementing the care plan. Findings include: Review of the facility's policy titled, "Comprehensive Person Centered-Care Plan Policy," dated 11/08/18, revealed the facility was to develop and implement a comprehensive person-centered plan of care for each resident, consistent with resident rights. The care plan should include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. Continued review of the policy revealed the services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, would be provided by qualified persons in accordance with each resident's written plan of care. Review of the facility's policy titled, "Bowel and Bladder Function Evaluation," dated 02/08/18, revealed the facility was to provide care and services for the resident to achieve or maintain as much normal bowel and bladder function as possible. Continued review of the policy revealed routine monitoring of bowel movements was to be conducted by the nursing staff which included frequency of bowel movements and monitoring for signs and symptoms of constipation. Further review of the policy revealed the nurse would administer laxatives or stool softeners as	F 656	resulting bowel movement on February 28, 2019. 2) All residents have the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Comprehensive Person-Centered Care Plan policy on April 8, 2019, with no revisions at that time. All licensed and non-licensed nursing staff will begin being in-serviced by Director of Nurses on April 12, 2019, until all nursing staff is in-serviced regarding the facility policy, and included guidance on monitoring the No Bowel Movement Report, following the person-centered care plan, and routine medication orders available to promote bowel movement. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. The No Bowel Movement Report is available to all nurses in the resident electronic medical record and has been incorporated into the change of shift workflow for each shift. All nurses were educated during the in-service on how to access the report and routine orders to follow when residents with no bowel movement are identified, as well as following the resident's person centered care plan interventions. 4) To ensure services are implemented in accordance with each resident's comprehensive person-centered care plan, the Assistant Director of Nurses will conduct three random bowel care plan		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 28 indicated. Review of R68's "Care Plan," revised 01/21/19, revealed the resident had the problems of being continent of bowel with constipation and a history (hx) of constipation, with an onset date of 10/24/18. Continued review of the care plan revealed the resident had the goal of establishing regular bowel movements with a target date of 04/21/19. Further review of R68's care plan revealed the approach of nursing being responsible for checking the BM record periodically for the need of PRN laxative. Review of R68's "Face Sheet," revealed the facility admitted the resident on 02/17/17 with diagnoses which included other Cerebral Infarction, Hemiplegia affection left non-dominate side, Essential Tremor, Hyperlipidemia, Insomnia, Gastro-Esophageal Reflux Disease, and Dysphagia. Review of R68's "Physician Orders," dated February 2019, revealed the resident was ordered one (1) Colace (a laxative used to treat constipation) capsule PO BID (twice daily) for constipation. Continued review of the physician's orders revealed the resident had standing orders which included milk of magnesia (used to treat constipation) 30 cubic centimeters (cc) po daily PRN for constipation; Dulcolax (used to treat constipation) 5 mg tablet 1 or 2 tablet(s) po daily PRN (as needed) for constipation; Dulcolax 10 milligram (mg) suppository; and fleets enema (used to treat constipation) 133 milliliter (ml) per rectum daily PRN for constipation. Review of R68's "Bowel Movement Roster," dated February 2019, revealed on 01/29/19 at	F 656	audits weekly over the next three months. These audits will begin on April 15, 2019, and the Assistant Director of Nurses will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 29 6:18 AM, the resident had a documented bowel movement (bm). Continued review of the bowel movement roster revealed the resident did not have another documented bowel movement until 02/07/19 at 10:53 PM, indicating the resident did not have a documented bowel movement for nine (9) days. Review of the Electronic Medication Administration Record (EMAR) revealed no documented evidence the resident received any PRN medication for constipation between the dates of 01/29/19 and 02/07/19. Continued review of the bowel movement roster revealed on 02/19/19 at 4:25 PM, it was documented R68 had a bowel movement. The bowel movement roster revealed as of 02/27/19 at 3:14 PM, the resident had not had a bowel movement, indicating the resident had gone eight (8) days without a bowel movement. Review of the EMAR revealed no documented evidence the resident was administered a PRN laxative medication for constipation during the eight (8)-day timeframe. Review of the resident's "Minimum Data Set (MDS)," dated 01/18/19, revealed the facility assessed R68 to have a "Brief Interview for Mental Status (BIMS)" (a cognitive evaluation) score of 15 out of 15, which indicated the resident was cognitively intact. Continued review of the MDS revealed the resident was assessed to have experienced constipation during the assessment period. Interview, on 02/27/19 at 1:10 PM, with R68 revealed the resident did have a problem with	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 30 constipation. Continued interview revealed she has gone five (5) and six (6) days without having a bowel movement, with the most recent being current. R68 stated after three (3) or four (4) days the nurses will give her milk of magnesia each day until she has a bowel movement. R68 further stated when she does go longer than three (3) or four (4) days without having a bowel movement, she has some pains in her stomach; however, they are not real painful, but they are uncomfortable. Interview, on 02/27/19 at 1:17 PM, with Licensed Practical Nurse (LPN) #3, who was R'68's regular nurse, revealed the resident has been on the facility's "No BM (bowel movement) Report" before. Continued interview revealed when a resident is on the "No BM Report," nurses are to investigate to see if the resident has had a BM that day and if not, the resident would be administered a standing order of milk of magnesia. The LPN stated she never works more than three (3) consecutive days in a row; however, there has been days/shifts she has not been given the "No BM Report", and the only way she knows if the resident hasn't had bowel movement is if the list is given to her. The LPN stated this is how they monitor bowel movements. Interview, on 02/27/19 at 2:05 PM, with Certified Nursing Assistant (CNA) #4, who was responsible for providing care to R68, revealed she was the CNA who usually worked regularly with the resident when she was on duty. The interview revealed she has only known the resident going two (2) days without a bowel movement; however, she is never on duty for more than three (3) consecutive days in a row. Further interview with the CNA revealed R68 requires assistance to	F 656			

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F 656	Continued From page 31 the bathroom and if the resident has a bowel movement, it was her responsibility to document the bowel movement in the Kiosk. The CNA stated CNAs could only enter data in the Kiosk, they could not go back and look to see how long a resident has went without a bowel movement. Interview, on 02/28/19 at 12:55 PM, with Registered Nurse #4, who is a Charge Nurse, revealed it was his expectation that the nurses follow the resident's care plan. He confirmed it was important that residents' care plans were followed, and interventions implemented. Interview, on 02/28/19 at 1:20 PM, with the MDS Coordinator, revealed the resident was assessed to have constipation during the assessment period, which triggered the need for a care plan. The interview revealed it was her expectation for all staff to follow R68's care plan and monitor the resident's bowel movements. The MDS Coordinator stated it was important the resident's bowel patterns to be monitored because of possible adverse consequences due to constipation. Interview, on 02/28/19 at 3:35 PM, with the Director of Nursing (DON) revealed it was her expectation that staff follow the residents' care plans at all times, to ensure they are getting the care they are supposed to. Interview, on 02/28/19 at 4:06 PM, with the Administrator, revealed it was her expectation staff follow residents' care plans. The Administrator stated it was important to ensure the residents were appropriately taken care of per their person-center care plan.	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684 F 684 SS=D	Continued From page 32 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, record reviews, and interviews, the facility failed to ensure services were implemented in accordance with each resident's comprehensive person-centered care plan for one (1) of 29 sampled residents, Resident (R) 68. R68's comprehensive care plan revealed the facility's nurse(s) was to check the resident's bowel movement (bm) record periodically for the need of PRN (as needed) laxatives; however, there was no documented evidence the nursing staff was implementing the care plan, and providing the interventions as ordered. Findings include: Review of the facility's policy titled, "Comprehensive Person Centered-Care Plan Policy," dated 11/08/18, revealed the facility was to develop and implement a comprehensive person-centered plan of care for each resident, consistent with resident rights. The care plan should include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in	F 684 F 684	F684 1) The care plan for Resident (R) 68 was followed on February 27, 2019, by the Charge Nurse with the administration of an oral laxative as ordered, and as identified on the resident's person centered care plan. This intervention resulted in a bowel movement on February 28, 2019, with no negative outcomes identified. 2) All residents have the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Comprehensive Person-Centered Care Plan policy on April 8, 2019, and approved the policy with no revisions at that time. The Bowel and Bladder Function Evaluation policy was also reviewed at that time and was revised to provide guidance to nursing staff regarding monitoring and documenting resident bowel movements. All licensed and non-licensed nursing staff will begin being in-serviced by Director of		4/29/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2019
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F 684	Continued From page 33 the resident's comprehensive assessment. Continued review of the policy revealed the services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, would be provided by qualified persons in accordance with each resident's written plan of care. Review of the facility's policy titled, "Bowel and Bladder Function Evaluation," dated 02/08/18, revealed the facility was to provide care and services for the resident to achieve or maintain as much normal bowel and bladder function as possible. Continued review of the policy revealed routine monitoring of bowel movements was to be conducted by the nursing staff which included frequency of bowel movements and monitoring for signs and symptoms of constipation. Further review of the policy revealed the nurse would administer laxatives or stool softeners as indicated. Review of R68's "Face Sheet," revealed the facility admitted the resident on 02/17/17, with diagnoses which included other Cerebral Infarction, Hemiplegia affection left non-dominate side, Essential Tremor, Hyperlipidemia, Insomnia, Gastro-Esophageal Reflux Disease, and Dysphagia. Review of R68's "Physician Orders," dated February 2019, revealed the resident was ordered one (1) Colace (a laxative used to treat constipation) capsule orally twice daily for constipation. The physician's orders further revealed the resident had standing orders which included milk of magnesia (used to treat constipation) 30 cubic centimeter (cc) po daily as needed (PRN) for constipation; Dulcolax (used to	F 684	Nurses on April 12, 2019, until all nursing staff is in-serviced regarding the facility Comprehensive Person-Centered Care Plan and Bowel and Bladder Function Evaluation policies. The in-service also included: " guidance on monitoring the No Bowel Movement Report " following the person-centered care plan " routine medication orders available to promote bowel movement " providing treatment and care in accordance with professional standards of practice by ensuring proper documentation of all as needed (PRN) medications administered and proper follow-up The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. The No Bowel Movement Report was made available to all nurses in the resident electronic medical record and has been incorporated into the nurses change of shift workflow for each shift change. All nurses were educated during the in-service on how to access the No Bowel Movement Report and routine orders to follow when residents with no bowel movement are identified, as well as following the resident's person-centered care plan interventions. 4) The Assistant Director of Nurses will conduct three random bowel care plan audits weekly over the next three months to ensure services are implemented in		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 34 treat constipation) 5 milligram (mg) one (1) or two (2) tablet(s) po daily PRN for constipation; Dulcolax 10 mg suppository; and fleets enema (used to treat constipation) 133 milliliter (ml) per rectum daily PRN for constipation. Review of R68's "Care Plan," revised 01/21/19, revealed the resident had the problems of being continent of bowel with constipation and a history (hx) of constipation, with an onset date of 10/24/18. Continued review of the care plan revealed the resident had the goal of establishing regular bowel movements with a target date of 04/21/19. Further review of R68's care plan revealed the approach of: nursing would be responsible for checking the BM record periodically for the need of PRN laxative. Review of R68's "Bowel Movement Roster," dated February 2019, revealed on 01/29/19 at 6:18 AM, the resident had a documented bowel movement (bm). Continued review of the bowel movement roster revealed the resident did not have another documented bowel movement until 02/07/19 at 10:53 PM, indicating the resident did not have a documented bowel movement for nine (9) days. Review of the Electronic Medication Administration Record (EMAR) revealed no documented evidence the resident received any PRN medication for constipation between the dates of 01/29/19 and 02/07/19. Continued review of the bowel movement roster revealed on 02/19/19 at 4:25 PM, it was documented R68 had a bowel movement. The bowel movement roster revealed as of 02/27/19 at 3:14 PM, the resident had not had a bowel	F 684	accordance with each resident's comprehensive person-centered care plan, and any PRN medications administered to promote bowel movements were properly documented. These audits will begin on April 15, 2019, and the Assistant Director of Nurses will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 35 movement, indicating the resident had gone eight (8) days without a bowel movement. Review of the EMAR revealed no documented evidence the resident was administered a PRN laxative medication for constipation during the eight (8)-day timeframe. Review of the resident's "Minimum Data Set (MDS)," dated 01/18/19, revealed the facility assessed R68 to have a "Brief Interview for Mental Status (BIMS)" (a cognitive evaluation) score of 15 out of 15, which indicated the resident was cognitively intact. Continued review of the MDS revealed the resident had experienced constipation during the seven (7) day assessment period. Interview, on 02/27/19 at 1:10 PM, with R68, revealed the resident did have a problem with constipation. Continued interview revealed she has gone five and six days without having a bowel movement, with the most recent being current. R68 stated after three (3) or four (4) days the nurses will give her milk of magnesia each day until she has a bowel movement. R68 further stated "when she does go longer than three (3) or four (4) days without having a bowel movement, she has some pains in her stomach, they are not real painful, but they are uncomfortable." Interview, on 02/27/19 at 1:17 PM, with Licensed Practical Nurse (LPN) # 3, who was R'68's regular nurse, revealed the resident has been on the facility's "No BM (bowel movement) Report" before. Continued interview revealed when a resident is on the "No BM Report," nurses are to investigate to see if the resident has had a BM that day and if not, the resident would be	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 36 administered a standing order of milk of magnesia. The LPN stated she never works more than three (3) consecutive days in a row; however, there has been days/shifts she has not been given the "No BM Report" and the only way she knows if the resident hasn't had bowel movement is if the list is given to her. The LPN stated this is how they monitor bowel movements. Interview, on 02/27/19 at 2:05 PM, with Certified Nursing Assistant (CNA) #4, who was responsible for providing care to R68, revealed she was the CNA who usually worked regularly with the resident when she was on duty. The interview revealed she has only known the resident going two (2) days without a bowel movement; however, she is never on duty for more than three (3) consecutive days in a row. Further interview with CNA #4 revealed R68 required assistance to the bathroom and if the resident had a bowel movement it was her responsibility to document the bowel movement in the Kiosk. The CNA stated CNAs could only enter data in the Kiosk, they could not go back and look to see how long a resident has went without a bowel movement. Interview, on 02/28/19 at 12:55 PM, with Registered Nurse #4, who is a charge nurse, revealed it was his expectation that the nurses follow the residents care plan. He confirmed it was important that residents' care plans were followed, and interventions implemented. Interview, on 02/28/19 at 1:20 PM, with the MDS Coordinator revealed the resident was assessed to have constipation during the assessment period which triggered the need for a care plan. The interview revealed it was her expectation for all staff to follow R68's care plan and monitor the	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 37 resident's bowel movements. The MDS Coordinator stated it was important the resident's bowel patterns to be monitored because of possible adverse consequences due to constipation. Interview, on 02/28/19 at 3:35 PM, with the Director of Nursing (DON), revealed it was her expectation that staff follow the residents' care plans at all times, to ensure they are getting the care they are supposed to. Interview, on 02/28/19 at 4:06 PM, with the Administrator, revealed it was her expectation staff follow residents' care plans. The Administrator stated it was important to ensure the residents were appropriately taken care of per their person-center care plan.	F 684			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		4/29/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 756	Continued From page 38 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, interviews, and record reviews, the facility failed to ensure the Consultant Pharmacist identified and acted upon an irregularity related to an antipsychotic medication that was in use without adequate clinical indication. This failure effected one (1) of 29 sampled residents, Resident (R) 68. Findings include: Review of the facility's policy titled, "Medication Regimen Review and Psychotropic Medication Use," dated 01/08/18, revealed the purpose of the policy was each resident's medication regimen will be monitored and managed to promote highest resident function and well-being and is free from unnecessary drugs. The facility's policy	F 756	F756 1) On April 11, 2019, the Geodon for Resident (R) 68 was decreased by the attending physician and the resident will be monitored and documented for any changes. 2) All residents receiving an antipsychotic medication have the potential to be affected. The Consultant Pharmacist reviewed the drug regimen of each resident receiving an antipsychotic medication on March 29, 2019, and all irregularities were reported to the Director of Nurses on March 30, 2019, and to the Medical Director on March 30, 2019. The Medical Director acted upon all irregularities identified on March 30, 2019.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 756	Continued From page 39 revealed unnecessary drugs were defined by CMS (Center for Medicare/Medicaid Services) as any drug in any of the following ways: in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for use and in the presence of adverse consequences. Further review of the policy revealed a psychotropic medication was defined by CMS as any drug that affects brain activities associated with mental processes and behavior including antipsychotics. The policy also specified the medication regimen of each resident would be reviewed by a licensed pharmacist, at least once a month; and the "Medication Regimen Review" (MRR) would include a review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The policy revealed the pharmacist did not need to document a continuing irregularity in the report each month if the physician had documented a valid clinical rationale for rejecting the pharmacist's recommendation with the MRR communication form being provided to the physician and the Director of Nursing (DON) within 10 working days of the pharmacy review. The facility's policy indicated the physician would document the irregularity, or recommendation was reviewed and what action would be taken to address it; if there was no change to the medication, or the physician declined the recommendation, it would require a documented clinical rationale describing the reason a GDR was clinically contraindicated. Review of R68's "Face Sheet," revealed the facility admitted the resident on 02/17/17, with diagnoses which included other recurrent Depressive Disorders, other Cerebral Infarction, Hemiplegia affection left non-dominate side,	F 756	No other residents were affected. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Medication Regimen Review and Psychotropic Medication Use policy on April 8, 2019, and approved the policy with no revisions. This policy includes the following guidance: Residents who use psychotropic medications will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue use of these drugs: a. Within the first year in which a resident is admitted on a psychotropic drug or after the prescribing practitioner has initiated a psychotropic drug, the facility will attempt a gradual dose reduction (GDR) in two separate quarters (with at least one month between attempts). b. After the first year, a GDR will be attempted annually. All nurses and the Consultant Pharmacist will begin being in-serviced by Director of Nurses on April 12, 2019, until all nurses and the Consultant Pharmacist is in-serviced regarding the facility Medication Regimen Review and Psychotropic Medication Use policy. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. 4) The Director of Nursing will conduct three random audits weekly over the next three months for residents receiving an		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 756	Continued From page 40 Essential Tremor, Hyperlipidemia, Insomnia, Gastro-Esophageal Reflux Disease, and Dysphagia. Review of R68's "Physician Orders," dated February 2019, revealed the resident was ordered one (1) Geodon (an antipsychotic used to treat Schizophrenia and Bipolar disorder) 40 Milligram (MG) capsule to be administered PO (by mouth) at HS (hour of sleep) for agitation. The date of the original order was upon admission on 02/17/17. Review of R68's "Electronic Medication Administration Records (EMAR's)," dated January 2019 and February 2019, revealed the resident received the medication Geodon 40 MG every day. Review of the "Medication Review Nurse-Physician Communication Form," dated 09/14/17, revealed the Consultant Pharmacist requested R68's Geodon 40 MG be reduced or D/C (discontinued) with the rationale being no Gradual Dose Reductions (GDR's) had been attempted with the antipsychotic medication since admission. The communication form revealed the Psychiatric Physician initially responded to the GDR by reducing the dose to 20 MG; however, the medical director, who is the resident's attending physician increased the dose back to 40 MG the same day, documenting the clinical rationale as: "The resident's family insists no medication changes and no visits from the psychiatric physician." Review of the "Physician's Order Sheet," dated 09/14/17, revealed a verbal order from the Psychiatric Physician to decrease R68's Geodon	F 756	antipsychotic medication to ensure the Consultant Pharmacist conducted a medication regimen review to identify any irregularity related to antipsychotic medication use per facility policy. These audits will begin on April 15, 2019, and the Director of Nurses will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 756	Continued From page 41 40 MG PO at HS to Geodon 20 MG po at HS. Continued review of the "Physician's Order Sheet," dated 09/14/17, revealed a verbal order from the Medical Director, who is R68's attending physician, to D/C (discontinue) the above change for R68's Geodon. The physician also documented the resident's family requested no psychiatrist visits and no medications be changed r/t (related to) past psychotic episodes. Review of R68's medical record revealed the resident's medication regimen was being reviewed monthly by a licensed Pharmacist; however, there was no documented evidence a licensed Pharmacist had identified the irregularity of the use of Geodon without adequate indication since 09/14/17, and had not communicated the irregularity to the physician and the Director of Nursing (DON) after the 2017 GDR was declined. In an interview, on 02/28/19 at 9:15 AM, the Medical Director, who is R68's attending physician, stated he thought all anti-psychotics should be eliminated in nursing homes. Continued interview revealed the reason the R68 was ordered Geodon was because of behavioral issues. In an interview, on 02/28/29 at 12:25 PM, the facility's Consulting Pharmacist stated he was the pharmacist who requested the GDR on 09/14/17, of R68's Geodon. The Pharmacist made the GDR recommendation related to regulatory requirements. The Pharmacist stated he normally recommends a GDR of an antipsychotic every 90 days. The pharmacist further stated he had not recommended another GDR because of the physician's response that the resident's family did not want the resident's medication of Geodon	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 756	Continued From page 42 changed. Interview, on 02/18/19 at 3:35 PM, with the DON, revealed she was aware no GDR had been completed and she was aware no further recommendations had been made by the Pharmacist since 09/14/17. The DON confirmed the reason that no further recommendations had been made was because R68's family did not want any of the resident's medications changed. During a subsequent interview on 02/28/19 at 3:55 PM, the Medical Director stated the dose of Geodon was increased back to the original dose in 2017, because an attempted GDR was met with great resistance from R68's family, due to recurrent behaviors in the past. The Medical Director further stated it would have been reasonable for the Pharmacist to have flagged it for him to evaluate it again. Interview, on 02/28/19 at 4:06 PM, with the Administrator, revealed it was her expectation the facility would have assessed the resident and her medication regimen. The Administrator stated per the regulation, the Pharmacist should have reviewed the medication regimen and requested a GDR, even though the Medical Director had previously declined the dose reduction.	F 756			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758			4/29/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER JONES CO REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 683 COUNTY HOME ROAD ELLISVILLE, MS 39437		
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F 758	Continued From page 43 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 44 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, interviews, and record reviews, the facility failed to ensure the residents' medication regimens were free from unnecessary drugs for one (1) of 29 sampled residents, Resident (R) 68. Specifically, R68 was prescribed an antipsychotic medication without attempted Gradual Dose Reductions (GDRs) to reduce unnecessary medications. The resident's physician declined a dose reduction recommended by R68's Psychiatrist without a clinical contraindication. Findings include: Review of the facility's policy titled, "Medication Regimen Review and Psychotropic Medication Use," dated 01/08/18, revealed the purpose of the policy was: each resident's medication regimen will be monitored and managed to promote highest resident function and well-being and is free from unnecessary drugs. The policy indicated unnecessary drugs were defined by CMS (Center for Medicare and Medicaid Services) as any drug in any of the following ways: in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for use and in the presence of adverse consequences. The policy specified that residents who have not used a psychotropic drug were not given these drugs unless psychotropic drug therapy was necessary to treat a specific condition, and the indications for use would be documented in the resident's medical record. The policy specified that residents who used psychotropic drugs were regularly evaluated for	F 758	F758 1) On April 11, 2019, the Geodon for Resident (R) 68 was decreased by the attending physician and the resident will be monitored and documented for any changes. 2) All residents receiving an antipsychotic medication have the potential to be affected. The Consultant Pharmacist reviewed the drug regimen of each resident receiving an antipsychotic medication on March 29, 2019, and all irregularities were reported to the Director of Nurses on March 30, 2019, and to the Medical Director on March 30, 2019. The Medical Director acted upon all irregularities identified on March 30, 2019. No other residents were affected. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Medication Regimen Review and Psychotropic Medication Use policy on April 8, 2019, and approved the policy with no revisions. This policy includes the following guidance: Residents who use psychotropic medications will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue use of these drugs: a. Within the first year in which a resident is admitted on a psychotropic drug or after the prescribing practitioner has initiated a psychotropic drug, the facility will attempt a gradual dose		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 45 GDR's, unless clinically contraindicated, in an effort to discontinue these drugs. Review of R68's "Face Sheet," revealed the facility admitted the resident on 02/17/17 ,with diagnoses which included other recurrent Depressive Disorders, other Cerebral Infarction, Hemiplegia affection left non-dominate side, Essential Tremor, Hyperlipidemia, Insomnia, Gastro-Esophageal Reflux Disease, and Dysphagia. Review of "Physician Orders," dated February 2019, revealed R68 was ordered Geodon 40 Milligram (MG) PO (by mouth) at HS (hour of sleep) for agitation. The physician's order for the antipsychotic was written during the resident's admission on 02/17/19. Review of the "Medication Review Nurse-Physician Communication Form," dated 09/14/17, revealed the Consultant Pharmacist requested R68's Geodon 40 MG be reduced or D/C (discontinued) with the rationale being no Gradual Dose Reductions (GDR's) had been attempted since admission with the medication. Continued review of the communication form revealed an initial response from the Consulting Psychiatrist. The Psychiatrist recommended reducing the dose to 20 MG; however, the Medical Director, who is the resident's attending physician increased the dose back to 40 MG the same day, documenting the clinical rationale as: The resident's family insists no medication changes and no visits from the psychiatric physician. Review of the "Physician's Order Sheet," dated 09/14/17, revealed a verbal order from the	F 758	reduction (GDR) in two separate quarters (with at least one month between attempts). b. After the first year, a GDR will be attempted annually. All nurses and the Consultant Pharmacist will begin being in-serviced by Director of Nurses on April 12, 2019, until all nurses and Consultant Pharmacist is in-serviced regarding the facility Medication Regimen Review and Psychotropic Medication use policy. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. 4) The Director of Nurses will conduct three random audits weekly over the next three months for residents receiving an antipsychotic medication to ensure the Consultant Pharmacist conducted a medication regimen review to identify any irregularity related to antipsychotic medication use per facility policy. These audits will begin on April 15, 2019, and the Director of Nurses will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 46 Psychiatric Physician to decrease R68's Geodon 40 MG PO at HS to Geodon 20 MG po at HS. Continued review of the "Physician's Order Sheet," dated 09/14/17, revealed a verbal order from R68's attending physician, to D/C (discontinue) the above change for R68's Geodon and resident's family request no psychiatrist visits and no medications be changed r/t (related to) past psychotic episodes. Review of R68's medical record revealed even though the resident's medication regimen was being reviewed monthly by a licensed Pharmacist, there was no documented evidence a licensed Pharmacist had communicated to the Medical Director and the DON the irregularity of an unnecessary medication. Interview, on 02/28/19 at 9:15 AM, with the Medical Director, who is also R68's attending physician, revealed the reason the resident was ordered Geodon was because of behavioral issues. The Medical Director stated, as Medical Director, he was responsible for all medications ordered, and he thought all anti-psychotics should be eliminated in nursing homes. Interview, on 02/28/29 at 12:25 PM, with the facility's Consulting Pharmacist, revealed he was the Pharmacist who requested the GDR on 09/14/17, of R68's Geodon. Continued interview revealed he requested the GDR to stay within the regulation; however, agitation is an appropriate reason for Geodon to be given to a resident. The pharmacist stated due to the physician's rationale that R68's family insisted the resident's medication dose not be changed, he had not recommended another GDR since 09/14/17.	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 47 Interview, on 02/18/19 at 3:35 PM, with the DON, revealed she was aware no GDR had been completed and she was aware no further recommendations had been made by the Pharmacist since 09/14/17 because R'68s family did not want any of the resident's medication changed. The DON stated the facility did attempt a GDR; however, the resident's family would not allow it. During a subsequent interview on 02/28/19 at 3:55 PM, the Medical Director stated he increased the dose of Geodon back to the original dose because the attempted GDR was met with great resistance from R68's family, due to affecting her behavior in the past. The Medical Director further stated it would have been reasonable for the pharmacist to have flagged it for him to evaluate it again. Interview, on 02/28/19 at 4:06 PM, with the Administrator, revealed it was her expectation the facility would have assessed the resident and her medication regimen. The Administrator stated per the regulation, the Pharmacist should have reviewed the medication regimen and requested a GDR, even though the Medical Director did not agree with it before.	F 758			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		4/29/19	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 48 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to remove expired medications from two (2) of the four (4) medication carts audited during the survey. Findings include: Review of the facility's policy dated 07/04/2018, titled, "South Central Regional Medical Center Disposal of Non-Controlled Medication," revealed the purpose of the policy was to provide guidelines for the disposal of non-controlled medications. The procedure was: medications would be properly disposed of when discontinued by the physician, and/or when the resident was discharged or deceased. The policy review revealed expired medications were not addressed in the policy provided.	F 761	F761 1) On February 27, 2019, the expired medications were removed from the medication/treatment cart by the Treatment Nurse. 2) All residents have the potential to be affected. The Treatment Nurse conducted a 100% medication audit of all treatments in the treatment cart on February 27, 2019, to ensure no expired medications were present. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Administration and Charting of Medications policy on April 8, 2019, and revised to indicate the nurses responsibility for proper removal and disposal of expired medications. The nursing staff will begin being		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 49 Observation on 02/27/19 at 10:01 AM, with Licensed Practical Nurse (LPN) #1 present, at the East Unit treatment cart, revealed 23 prescription Baza Cream Sensicare, with expired dates, were available for use by the residents. The expiration dates were written on the top of the containers and ranged from 06/18/18 to 01/19/19 (all expired at the time of the survey). Continued observation revealed a Nutraderm patch that expired on 01/13/19. Observation on 02/27/19 at 10:35 AM, with LPN #1 present, at the West Unit treatment cart, revealed 12 expired Baza Cream Sensicare containers with expiration dates that ranged from 01/21/18 to 02/21/19. Interview with LPN #1 on 02/27/19 at 10:05 AM, revealed one (1) container of the Baza Cream Sensicare was in the East Unit treatment cart and belonged to a resident that passed away. LPN #1 revealed a container of Ammonia Nitrate was no longer being utilized, but remained on the cart. Continued interview with LPN #1, revealed she was not sure what the dates on top of the Baza Cream Sensicare indicated, but after she talked to the Pharmacist, she realized the dates were indeed the expiration dates of the medication. LPN #1 confirmed the Baza Cream Sensicare that was expired should be removed from the cart. LPN #1 stated that, ultimately, it was her responsibility to make sure medications that were expired or no longer in use were removed from the treatment carts. Interview with LPN #2 on 02/27/19 at 10:54 AM, revealed she was not aware that Baza Cream Sensicare expired in 30 days after being made as a compound mixture. She revealed it was new for	F 761	in-serviced by Director of Nurses on April 12, 2019, until all nursing staff is in-serviced regarding the Administration and Charting of Medications policy, specifically proper removal and destruction of expired medications. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. 4) The Treatment Nurse will conduct three random audits weekly over the next three months of the medication/treatment cart to monitor for expired medications. These audits will begin on April 15, 2019, and the Treatment Nurse will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 50 the Pharmacy to write the expiration date on top of the Baza Cream Sensicare containers. LPN #2 stated she did the audits on the medication rooms and medication carts, and LPN #1 did the audits on the treatment carts. Interview with the Director of Nursing (DON) on 02/27/19 at 10:44 AM, revealed if medications were expired they should be removed from the treatment carts. The DON revealed it was the responsibility of LPN #1 to ensure expired and discontinued medications were removed from the carts.	F 761			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		4/29/19	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 51 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 52 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, observations, and interviews, the facility failed to ensure proper cleaning of the ice machine in accordance with professional standards for service safety and prevention of infection. The deficient practice effected all of the residents on the east wing, who were served ice and water that was being dispensed from an unsanitary machine. Findings include: Review of the manufacturer's recommendations titled, "Maintenance and Cleaning Instruction-GEMD270A," undated, revealed the ice machine should have maintenance completed at least two (2) times per year which included taking the ice spout off the machine, washing and sanitizing it. Continued review revealed the water system should be thoroughly cleaned during the regular maintenance by running a manufacture recommended cleaning solution through the water system. Further review of the recommendations revealed the times and the procedures for maintenance and cleaning were given as guidelines but were not to be construed as absolute or invariable. Review of the facility's policy titled, "Infection Control Policy for Food Services Department," dated 06/14/18, revealed all iced used would be free from visible trash and sediment. The policy further specified the ice storage bin would be cleaned on a regular basis following the	F 880	F880 1) The ice machine was taken out of service on February 25, 2019. A new ice machine was installed and put into service on April 8, 2019. 2) All residents have the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee revised the policy for Ice Making and Dispensing on April 8, 2019. The Maintenance staff was in-serviced on April 15, 2019, by the Administrator regarding the policy, specifically maintaining proper infection control practices by following manufacturer's recommendations to remove the ice spout from the machine and to wash and sanitize it at least two (2) times per year. 4) The Infection Preventionist will inspect the ice machines monthly to ensure the machine is clean and free of obvious buildup of substances. These inspections will begin on April 15, 2019, and the Infection Preventionist will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.		

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F 880	Continued From page 53 manufacturer's recommendation. Observation on the east wing, near the nurses' station, on 02/25/19 at 11:40 AM, revealed an ice and water dispenser used by the facility staff to deliver ice and water to the residents of the 100, 200, and 300 halls. Continued observation revealed a white and gray, crusty substance on and around the dispensing mechanism (where the ice and water come out of). Observation and interview, on 02/25/19 at 2:02 PM, with the facility's Registered Dietitian, confirmed there was white and gray, crusty sediment on and around the dispensing mechanism. The dietitian stated the ice machine was dirty, and the area where the water and ice were actually dispensed "was gray, white, and slimy." Observation and interview, on 02/25/19 at 2:12 PM, with the facility's Maintenance Employee revealed he was responsible for cleaning the ice and water machine. Continued observation revealed the Maintenance Employee took a white wash cloth and wiped the inside of the dispensing mechanism where the ice and water come out; when he removed the wash cloth, there was a black substance on the wash cloth. The maintenance employee stated he had never cleaned that part of the machine and did not realize it was dirty. Observation and interview on 02/25/19 at 2:22 PM, with the Infection Control Nurse, revealed the nurse stated the ice machine needed to be cleaned. She stated it was important the ice/water machine was cleaned due to infection control concerns such as mold. She further stated	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 54 maintenance was to schedule cleaning and maintenance of the ice machine. Interview, on 02/28/19 at 4:25 PM, with the Administrator revealed it was her expectation maintenance would have cleaned the ice machine per manufacturers recommendations. The Administrator confirmed the importance of cleaning the ice machine to reduce infection control and food borne illness concerns.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000			
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222		4/29/19	

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TITLE

(X6) DATE

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K 222	Continued From page 1 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain patient sleeping room doors as directed by NFPA 101 section 19.2.2.2.5. This deficiency affected 59 of the 119 residents in the facility on the day of survey. Findings include:	K 222	Statements contained herein are intended for purposes of compliance with Federal and State laws regarding responses to Statements of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for purposes of		

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K 222	Continued From page 2 On February 28, 2019 at 11:25 AM, observations revealed locked, blocked, and obstructed exit doors on the 400, 500 and 600 Halls of the facility. These three (3) exit doors did not release upon activation of the fire alarm system and created a dead end corridor on the 400, 500 and 600 Halls of the facility. Staff members were immediately placed and trained the door code on the three (3) exit doors of the facility.	K 222	compliance with participation requirements of Medicare and Medicaid. K222 1) Once identified on February 28, 2019 at 11:25 a.m., a staff member was immediately placed at each set of exit doors on the 400, 500 and 600 halls of the facility. The staff members were trained regarding the door code and when to release the doors. These staff members also kept monitoring logs until exit doors were completely repaired at 2:04 p.m. that same day by third party contractors. 2) All residents have the potential to be affected by locked exit doors. 3) The Fire Drill Form was updated by the Administrator on March 6, 2019 with QAA approval on April 8, 2019, to include Did all exit doors work properly. The Fire Alarm or Sprinkler Systems Out of Service policy and procedure was also reviewed and updated on March 6, 2019, by the Administrator with QAA approval on April 8, 2019, to include guidance when any component of the fire alarm or sprinkler systems are out of service. All staff were in-serviced regarding fire drills and the addition of verifying that all exit doors work properly. The in-service will begin on April 12, 2019, and will continue until all staff have received the in-service training. All current staff will be in-serviced by April 29, 2019, and all new employees during the initial orientation process. 4) This corrective action will be monitored by the Maintenance Director or Maintenance Assistant, in the absence of the Director, who will provide fire drills quarterly on each shift per Life Safety		

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K 222	Continued From page 3	K 222	Code K-712. Any issues identified will be immediately addressed by the Maintenance Director or Maintenance Assistant, in the absence of the Director, and the Fire Alarm or Sprinkler Systems Out of Service policy will be initiated. The deficiency and the corrective action was presented to the QAA Committee on April 8, 2019. The plan was reviewed and accepted by the QAA Committee.		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly maintain smoke barrier walls for the purpose of providing one (1) half hour fire resistance as directed by NFPA 101 section 8.5.6. This deficiency affected all nine (9) compartments and all 119 residents in the facility on day of survey. Findings Include:	K 372	K372 1) An audit of the facility was completed on March 1, 2019, by the Maintenance Director and Maintenance Assistant verifying the unsealed penetrations. The audit revealed penetrations throughout the building from the installation of the call light system. Fire barrier sealant was obtained and the Maintenance	4/29/19	

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K 372	Continued From page 4 On February 28, 2019 at 11:10 AM, observations revealed unsealed penetrations in the smoke barrier ceiling throughout the facility. The open penetrations were primarily around wires and conduit. The solid smoke ceiling is located above the lay in tiles and serves as the smoke barrier for the entire facility. The nine (9) smoke barrier walls do not extend above the solid smoke barrier ceiling in the facility.	K 372	department began the process of sealing the penetrations in the smoke barrier on March 4, 2019. 2) All residents have the potential to be affected by an improperly maintained smoke barrier. 3) The Maintenance Assistant will fully complete sealing all penetrations in the smoke barrier ceiling throughout the facility by April 12, 2019 with fire barrier sealant. 4) This corrective action will be monitored by the Maintenance Director or Maintenance Assistant, in the absence of the Director, by bi-annual above ceiling observations and upon any maintenance, repairs or new installations above the ceiling of the facility. The deficiency and the corrective action was presented to the QAA Committee on April 8, 2019. The plan was reviewed and accepted by the QAA Committee.		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000			

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 2/28/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.			E 000			

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