STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355122	A. BUILDING _____ B. WING _____	01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	8885 HIGHWAY 10 RICHARDTON, ND 58652

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 01/08/18 and concluded 01/11/18.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		2/15/18

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

Electronically Signed | 02/05/2018

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the medical record for 1 of 12 sampled residents (Resident #19), 1 supplemental resident (Resident #6) and 1 closed resident record (Resident #27) accurately reflected the resident's Advance Directive requesting CPR (cardio pulmonary resuscitation). Failure to ensure the resident's medical record accurately reflected their wishes limited emergency personnel from knowing the residents' wants in the event of a medical emergency. Findings include: Review of the facility policy titled "Advanced Directives" occurred on 01/11/18. This policy dated 10/01/17, stated, " . . . If a resident experiences a cardiac arrest, facility staff will provide care per advanced directive, prior to the arrival of emergency medical services: In accordance with the resident's advance directives. Advanced Directive form will be addressed during each admission process. Resident/representative will choose according to resident wishes the advanced directive healthcare personnel are to follow in the event advanced directives are needed. Advance	F 578	F Tag 578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives #1. Resident #6's physician order related to Advance Directive will accurately reflect the wishes of resident/resident representative throughout the entire medical record. Resident #19's medical record related to Advance Directive will accurately reflect the POA's wishes. Resident #27: No corrective action will be taken related to resident no longer resides in this facility. #2. All residents have the potential to be affected if Advance Directives orders or resident/resident representative wishes are not reflected in the medical record. #3. Advance Directive policy and procedure will be reviewed and updated as necessary for attaining and maintaining substantial regulatory compliance. Education for Social Services Designee, Business Office Manager, Charge Nurses, Clinical Coordinator,	

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F 578	Continued From page 2 Directive can be verbal or written. Advanced Directive can be revised/changed at any time." - Review of Resident #6's medical record occurred on January 9-10, 2018. Diagnoses included, heart failure, seizures, schizophrenia, dementia, pain, chronic atrial fibrillation (irregular heart rhythm). A "Code Status" form signed and dated on 01/05/17 by Resident #6, indicated, "Full Code; call 911, start CPR (cardio pulmonary resuscitation) transfer to the nearest hospital." A physician's order, dated 01/05/17, indicated Full Code status. The eMAR (electronic medication administration record), eTAR (electronic treatment administration record) and care plan all indicated DNR (Do Not Resuscitate). During an interview on 01/10/18, when asked why the code status in Resident #6's eMAR, eTAR and care plan did not match the physician's order, an administrative staff member (#1) stated the resident had a hospital transfer on 08/10/17 due to a decline in health condition. The primary care provider spoke with Resident #6's Resident Representative and a decision was made to change to code status Do Not Resuscitate. The facility failed to obtain or change the current physician's order to accurately reflect the wishes of Resident #6/Resident Representative, throughout the entire medical record. - Review of Resident #19's medical record occurred on January 9-10, 2018. Diagnoses included dementia. A "Code Status" form signed and dated on 08/15/17 by Resident #19's POA (Power of Attorney), indicated DNR/DNI (Do Not	F 578	MDS Coordinator and DON related to Advance Directives being accurately reflected in our residents medical records will be completed on or before February 15th 2018. #4. Social Services Designee is responsible and accountable for auditing residents' medical records to ensure all current resident/resident representative wishes are accurately reflected on physician order, Advance Directive document, care plan and face sheet. SSD will continue compliance with each new admission x 12months, then perform a random audit at four(4)quarterly QAPI meetings. DON or designee is responsible and accountable for randomly auditing residents' Advance Directives to ensure resident/resident representative wishes are accurately reflected x 12months. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. Social Services designee is responsible and accountable for reporting audits to the QA committee at weekly meetings. Social Services is responsible and accountable for reporting audits to the QAPI committee at monthly meetings. DON or designee is responsible and accountable for reporting audits to the QAPI committee at monthly meetings. #5. Corrective action will be complete on or before February 15, 2018.	

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F 578	Continued From page 3	F 578		

Resuscitate, Do Not intubate); Do NOT call 911, Do NOT start CPR, Do NOT transfer." A physician's order, dated 01/27/17, indicated Full Code status. The eMAR, eTAR, and care plan all indicated DNR/DNI.

The facility failed to ensure Resident's #19's medical record accurately reflected the POA's wishes.

- Review of Resident #27's record occurred on 01/11/18 and identified Resident #27 as a full code. At the time of admission, 08/14/17, Resident #27 completed the facility "Resident/Family Statement" which stated "As a resident on [sic] the Richardton Health Center, I choose to have the following care provided in the event that my heart or breathing stops," Resident #27 chose "Code Status: Full code; call 911, start CPR, transfer to the nearest hospital." A physician's order and baseline care plan, both dated 08/14/17, identified Resident #27 as a DNR/DNI.

The record showed the Resident #27's health declined and he was admitted to the hospital on 11/19/17 and returned on 11/29/17. Documentation identified the following:
* Nurse progress note: 11/30/17 11:52 a.m., "Called to residents room by aide, resident laying on R [right] side in bed, speech garbled, right eye opens, L [left] eye closed, L sided facial drooping noted, grips uneven to L side, B/P [blood pressure] 98/62, T. [temperature]96.7, HR [heart rate] -112, R-14, SPO2 [saturation of partial oxygen] @ [at] 97% on RA [room air], contacted daughter, [daughter's name], informed of residents condition and that resident's paperwork

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F 578	Continued From page 4 from readmit listed him as a DNR she stated that is correct, instructed this nurse to contact PCP [primary care provider] and ask for opinion on how to proceed, telephone call to [PCP], she advised that we monitor resident and keep comfortable, relayed this message to [resident's daughter], she agrees, asked that we make sure he is comfortable and that she will be in this afternoon as soon as she is able." A physician's order, dated 11/30/17, stated "begin comfort measures only Every Shift CNA Day, CNA Day." The facility failed to resolve the discrepancy between Resident #27's choice of full code status with the physician at time of admission, resulting in the baseline care plan to be incorrect. The facility failed to change the medical record to match the orders for comfort cares when Resident #27 returned from the hospital on 11/29/17. Resident #27 had the potential to receive CPR and hospitalization when no longer wanted.	F 578		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		2/15/18

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F 655	Continued From page 5 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy, the facility failed to develop a baseline care plan for 1 of 2 new admissions (Resident #13) and 1 closed resident record (Resident #27). Failure to develop and	F 655	F Tag 655 - 483.21 (a)(1)-(3) Baseline Care Plan #1. No corrective action will be made to Resident #13's Baseline Care Plan, as	

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F 655	Continued From page 6 implement a baseline care plan limits staff's ability to provide effective and person-centered care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 01/11/18. This policy, dated 10/11/17, stated, ". . . The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. . . . The baseline care plan will: be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary: Initial goals based on admission orders. Physician orders. Dietary orders. Therapy services. Social services. PASARR (preadmission screening and resident review) recommendation, if applicable . . . The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. Interventions shall be initiated that address the resident's current needs . . ." Review of Resident #13's medical record occurred on all days of survey. Diagnoses included, Chronic obstructive pulmonary disease, pneumonia, chronic pain, paroxysmal atrial fibrillation (irregular heart rhythm), and weakness. Admission physician's orders dated, 12/15/17, indicated Rehab-Occupational Therapy	F 655	the resident no longer resides in our facility. No corrective action will be made to Resident #27's Baseline Care Plan, as the resident no longer resides in our facility. #2. All residents have the potential to be affected if the facility failed to develop a baseline care plan. #3. Baseline Care Plan policy and procedure will be reviewed and updated as appropriate for development of a baseline care plan to address the residents' minimum health care needs and include instructions needed for staff to provide effective, person centered care within 48 hours after admission. Education related to developing a Baseline Care Plan to address the residents' minimum health care needs and instructions needed to provide person centered care will be completed by all nursing staff and clinical interdisciplinary team, to include, but not limited to: Administrator, DON, SSD, Dietary Manager, MDS Coordinator, Clinical Coordinator and all charge nurses, on or before February 15, 2018. #4. All disciplines writing care plans is responsible and accountable for initiating a person centered baseline care plan within 48 hours after admission. An audit of Baseline Care Plans will be completed by the Administrator or	

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F 655	Continued From page 7 and Physical Therapy to evaluate and treat. Eliquis (anticoagulant) 5 milligrams twice a day, Norco (hydrocodone-acetaminophen) 5/325 milligrams three times a day, prednisone 10 milligrams once a day, arthritis aid cream to neck twice a day as needed, and acetaminophen 650 milligrams every 4 hours as needed. Review of Resident #13's care plan occurred on 01/09/18. The current care plan stated, "Goal: My immediate needs will be met and care needed will be provided based on admission physician orders and professional standards of quality care through my next review date: 03/15/17. Approach: Physician orders as per eMAR (electronic medication administration record) and eTAR (electronic treatment administration record), check my vital signs as ordered, offer my diet as ordered, provide me with therapy as ordered, provide me with social services as ordered/indicated. Provide PASRR recommendation for me, if applicable. Anticipate and meet my needs as per professional standards." During an interview on 01/10/18 at 1:55 p.m., an administrative staff member (#1), verified the care plan, consisting of the one problem, goal and approach's was Resident #13's current care plan. The facility failed to develop a baseline care plan to address the residents' minimum health care needs and include instructions needed for staff to provide effective, person-centered care within 48 hours after admission. - Review of Resident #27's record occurred on	F 655	DON within 48 hours of each admission for the next ten (10) admissions. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. Administrator or DON is responsible and accountable for reporting audit findings to the QA committee and QAPI committee at the next scheduled weekly and/or monthly meeting after each admission. #5. Corrective action will be completed on or before February 15, 2018.	

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F 655	Continued From page 8 01/11/18. At the time of admission, 08/14/17, Resident #27 completed the facility "Resident/Family Statement" which stated "As a resident on [sic] the Richardton Health Center, I choose to have the following care provided in the event that my heart or breathing stops," Resident #27 chose "Code Status: Full code; call 911, start CPR (cardio pulmonary resuscitation), transfer to the nearest hospital." The baseline care plan, dated 08/14/17, stated, "Category: Psychosocial Well-Being PROBLEM: DNR [do not resuscitate]/DNI [do not intubate] Code Status. GOAL: [Resident #27's] wishes to be honored. APPROACH: Call family before hospitalizing." The baseline care plan failed to reflect Resident #27's choice of full code status at admission.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		2/15/18

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F 656	Continued From page 9 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 record review, staff and resident interview, and review of facility policy, the facility failed to develop a comprehensive care plan for 4 of 12 sampled residents (Resident #3, #13, #23, and #175). Care planning drives the type of care and services that a resident receives and failure to develop a care plan that includes the care and services to be provided to the resident may negatively impact the resident's quality of life. Findings include:	F 656	F Tag 656 - 483.21(b)(1) Develop/Implement Comprehensive Care Plan #1. Comprehensive care plans for Resident #3 will be reviewed/revised/updated to reflect problems, goals and approaches for activity limitations related to right sided weakness, physical therapy order relating to transfers, use of oxygen, anticoagulant medication, skin care and treatment.	

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F 656	Continued From page 10 Review of the facility policy titled "Care Plan" occurred on 01/11/18. This policy, dated 10/11/17, stated, ". . . The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. . . ." - Review of Resident #175's medical record occurred on all days of survey. Diagnoses included dementia, mood disorder, and head injury. A quarterly Minimum Data Set (MDS), dated 11/09/17 identified wandering and verbal behaviors. Current physician's orders stated risperidone (an antipsychotic medication) 0.25 milligrams (mg) once in the morning and 0.5 mg once at bedtime. Review of Resident #175's progress notes identified the following: * 08/31/17, 7:41 p.m., "This afternoon visitors brought a dog into facility . . . was very upset and tearful. Resident then became combative and attempted to tip an occupied wheelchair over and swung at staff and another resident. Resident was redirected and did not hit another person . . ." * 10/01/17 6:22 p.m., ". . . was very upset with another resident that he is usually very pleasant around. He said she was following him and anytime he saw the resident he would put his fists up. Residents were kept apart for the remainder of the day. . . ." * 10/21/17 11:36 a.m., "LATE ENTRY: At 1115 resident open handedly smacked another resident in the face; incident was witnessed by CNA [certified nurse aide] and residents were	F 656	Comprehensive care plans for Resident #13 will not be reviewed/revised/updated related to the resident no longer residing in the facility. Comprehensive care plans for Resident #23 will be reviewed/revised/updated to reflect problems, goals and approaches for turning, repositioning, mobility for range of motion, interventions for preventing and/or healing pressure sores and Activities of Daily Living. Comprehensive care plans for Resident #175 will be reviewed/revised/updated related to addressing behaviors toward other residents and interventions for those behaviors and the use of an antipsychotic medication. #2. All residents have the potential to be affected by deficient comprehensive care plans. #3. Comprehensive care plan policy and procedure will be reviewed/revised/updated to ensure substantial regulatory compliance. Education related to comprehensive care plans will be completed for the clinical interdisciplinary care plan team, including, but not limited to: Administrator, DON, MDS Coordinator, SSD, Activity Director, Food and Nutrition Services Manager, Clinical Coordinator and all charge nurses on or before February 15, 2018. Comprehensive care plans will be	

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F 656	Continued From page 11 separated immediately; residents will be placed at separate tables for mealtimes and monitored closely. . ." * 12/27/17 3:15 p.m., ". . . was very upset with another resident this afternoon. He went up to other resident and hit [sic] table in front of him . . . " Review of Resident #175's care plan occurred on 01/09/18. This care plan stated, ". . . Behavioral Symptoms . . . I enter other resident's rooms, follow residents and staff around facility, argue with staff, refuse medication. . . ." The care plan failed to address Resident #175's behaviors toward other residents and the use of an antipsychotic medication, and lacked interventions to address those issues. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included alcoholic cirrhosis of liver with ascites (fluid in the abdomen), cerebral infarction (stroke) with hemiplegia (paralysis) affecting right side, chronic kidney disease, stage 3, chronic obstructive pulmonary disease, anxiety disorder, weakness and edema. Physician's orders dated, 11/14/17, stated, Rehab OT (Occupational Therapy), PT (Physical Therapy) Speech, evaluate and treat. Plavix (anticoagulant) 75 milligrams once a day. A physician's order dated, 11/15/17, stated, Oxygen at 2 liters at bedtime and as needed. A physician's order dated, 12/15/17, stated, cleanse area under breasts pat dry, apply nystatin cream and monitor for signs and symptoms of infection twice a day until resolved and then discontinue. A nursing order, dated, 11/15/17 stated, Weekly skin assessment. A Physical Therapy order, dated, 11/30/17,	F 656	updated as resident care changes. #4. Each team member representing each discipline will be responsible and accountable for updating care plans as resident care changes and for reporting reviewed/revised/updated comprehensive care plan to the QA committee at each weekly meeting . MDS Coordinator or designee will be responsible and accountable for reporting compliance in reviewing/revising/updating comprehensive care plans at monthly QAPI meetings. Random weekly audits of comprehensive care plans will be completed by the Administrator/DON for six months or until the QAPI committee determines substantial compliance has been achieved. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. #5. Corrective action will be completed on or before February 15, 2018.	

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F 656	Continued From page 12	F 656		

stated, "Pivot from bed to/from bedside commode, assist x 2 with FWW (front-wheeled walker). Commode should be placed at foot of bed, facing dresser on window side of bed to allow for safe transfer."

Review of Resident #3's care plan occurred on 01/09/18. The care plan lacked problems, goals, and approaches for Resident #3's activity limitations related to right sided weakness, physical therapy order relating to transfers, use of oxygen, anticoagulant medication, skin care and treatment.

- Review of Resident #13's medical record occurred on all days of survey. Diagnoses included, chronic obstructive pulmonary disease, pneumonia, chronic pain, paroxysmal atrial fibrillation (irregular heart rhythm), and weakness. Physician's orders dated, 12/15/17, identified, Rehab Occupational Therapy, and Physical Therapy to evaluate and treat. Eliquis (anticoagulant) 5 milligrams (mg) twice a day, Norco (opioid pain medication) 5/325 mg three times a day, prednisone 10 mg once a day, fast arthritis aid cream to neck twice a day as needed, and acetaminophen 650 mg every 4 hours as needed.

Review of Resident #13's care plan occurred on 01/09/18. The care plan lacked problems, goals, and approaches for Resident #13's activities of daily living relating to ambulation, transfers, toileting, dressing, grooming, anticoagulant medication, pain and respiratory care.

During an interview on 01/10/18 at 1:55 p.m., an administrative staff member (#1), verified the

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F 656	Continued From page 13 care plan, consisting of the one problem, goal and approach's was Resident #13's current care plan. - Review of Resident #23's medical record occurred on all days of survey. Diagnoses included history of pain, cramps and spasms, back pain, muscle weakness and restless leg syndrome. An admission Minimum Data Set (MDS), dated 11/10/2017 identified intact cognition, extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS also identified the resident at risk for pressure ulcer. A progress note dated, 12/05/17 at 03:30 p.m., stated, "Skin: has small pin point open area to right buttock." During an interview on 01/08/18 at 5:23 p.m., Resident #23 stated, "I cannot move my lower legs due to complications with back surgery that I had, I also have limited feeling in my lower legs." Resident #23's care plan lacked problems, goals and approaches for turning, repositioning, mobility for Range of Motion, interventions for preventing and/or healing pressure sores, as well as Activities of Daily Living (ADL).	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and review of professional	F 658	F Tag 658 - 483.21(b)(3)(I)Services	2/15/18

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F 658	Continued From page 14 reference, the facility failed to follow professional standards of practice during 1 of 2 observations of insulin administration (Resident #9). Failure to ensure staff offered food within the recommended time frame after rapid-acting insulin administration may result in hypoglycemia (low blood sugar). Findings include: "The Nursing 2017 Drug Handbook," 37th edition, Wolters Kluwer, Philadelphia, page 790, stated regarding Rapid-Acting insulin,". . . give subcutaneous [by injection] immediately (5 to 10 minutes) before a meal. . . ." Observation on 01/09/18 at 7:21 a.m. showed a licensed nurse (#5) administered 38 units of NovoLog insulin to Resident #9. Observation showed Resident #9 received his meal tray at 7:43 a.m. (22 minutes later). During an interview on 01/11/18 at 10:40 a.m., administrative staff members (#1 and #2) stated rapid- acting insulin should be administered 15 minutes before meals.	F 658	Provided Meet Professional Standards #1. Corrective action for Resident #9 cannot be completed due to opportunity to correct was on January 9, 2018 at the breakfast meal. #2. All residents requiring rapid-acting insulin administration has the potential to be affected. #3. Rapid-acting insulin administration policy and procedure will be reviewed/revised/updated to reflect professional standards of practice related to recommended time frame of offering food after administration. Education related to offering food within the recommended time frame after rapid-acting insulin administration will be completed for all nurses on or before February 15, 2018. #4. Clinical Coordinator will be responsible and accountable for audits on adherence of recommended time frame between administration of rapid-acting insulin and offering of food. Clinical Coordinator or designee will complete audit on each resident receiving rapid-acting insulin, each time they receive it, for five (5) consecutive days, then every other day for fourteen (14)days, then two (2) times per week for two (2) weeks, then weekly for one month, then monthly for three months, then 3x randomly for 2 quarters. Administrator/DON or designee will	

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F 658	Continued From page 15	F 658	complete random audits to determine compliance related to recommended time frame for ninety (90) days to ensure substantial compliance. If any discrepancies are noted, corrective action will be immediate. Clinical Coordinator will be responsible and accountable for reporting to the QA committee during weekly meetings. DON or designee will be responsible and accountable for reporting audit findings to the QAPI committee at monthly meetings. #5. Corrective action will be completed on or before February 15, 2018.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident interview, the facility	F 686	F Tag 686 483.25 (b)(1)(I) (ii)Treatment/Services to Prevent	2/15/18

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F 686	Continued From page 16 failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #23) with current pressure ulcers. Failure to routinely assess, monitor, and measure pressure ulcers and ensure consistent implementation of interventions and treatment may result in delayed healing of the pressure ulcers. Findings include: Review of the facility policy titled "Skin Assessment" occurred on 01/11/2018. This policy, revised September 2017 stated, " . . . perform a full body skin assessment as part of our systematic approach for pressure ulcer prevention and for the promotion of healing of various skin conditions . . ." The administrative staff member (#1) stated the facility does not have a specific policy on pressure ulcers. Review of Resident #23's medical record occurred on all days of survey. Diagnoses include history of pain, cramps and spasms, back pain, muscle weakness and restless leg syndrome. The admission Minimum Data Set (MDS), dated 11/10/17, identified intact cognition, extensive assistance of two staff members with bed mobility, transfers, dressing, and toileting. The MDS also identified a risk for development of pressure ulcers. The care plan lacked problems, goals and approaches for turning, and repositioning for preventing and/or healing Resident #23's pressure ulcers. During an interview on 01/08/18 at 05:23 p.m. Resident #23 stated, " I cannot move my lower legs due to complications with back surgery that I had, I also have limited feeling in my lower legs."	F 686	Heal/Pressure Ulcer #1 Resident #23 was seen by Wound Specialist on January 17, 2018 resulting in new diagnosis..."...friction burns to right buttock...left heel deep tissue pressure injury...resolved." Resident #23 comprehensive care plan will be reviewed/revised/updated to include problems, goals and approaches/interventions, turning and repositioning to prevent/heal pressure ulcer(s). #2. All residents with pressure ulcer(s) have the potential to be affected. #3. Skin/wound policy and procedure will be reviewed/revised/updated as appropriate to include routinely assess, stage, monitor and measure pressure ulcers and ensure consistent implementation of interventions and treatments as ordered. Education for all nurses and CNAs related to skin/wound policy and procedure and care plan goals and approaches, turning/repositioning for prevention of pressure ulcers will be completed on or before February 15, 2018. #4. Charge nurse will be accountable for skin observations/assessments to be completed once weekly according to bathing schedule. Charge nurse will be responsible and accountable for identified pressure ulcers	

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F 686	Continued From page 17 She also stated, she has a wound on her left heel. Observation showed Resident #23's left heel with a dark discolored area, open to air and resting directly on the bed. Observation on 01/09/18 at 8:00 a.m., showed Resident #23 in bed, with socks on and her heels resting directly on the bed. Observation on 01/09/18 at 9:05 a.m., showed Resident #23 in a wheelchair with socks on her feet and her heels resting directly on the foot rest. The progress notes identified the following regarding Resident #23's buttock pressure ulcer: *12/05/17 3:30 p.m. " . . . has small pin point open area to right buttock . . ." *12/10/17 4:27 p.m. ". . . has pea sized opening to right buttock . . ." *12/11/17 11:09 a.m. ". . . Open pea sized area to right buttock . . ." *12/18/17 9:08 p.m. "Did skin assessment on buttocks as not done earlier. Has area to right buttocks that is open with first layer of skin gone. Measures .7 cm x .7 cm [centimeters] . . ." *12/21/2017 10:31 a.m. " . . . small open area to L [left] buttock 5 mm x 5 mm, [millimeter] no warmth or drainage present to site, Nurse Practitioner [name] in facility, assessed resident gave the following orders; . . . Barrier cream (Calmeseptine) to buttock and coccyx BID [twice a day] and PRN [as needed]" *12/27/2017 2:29 p.m. " . . . Sheering to buttocks. Small open slit to bottom of coccyx. Barrier cream applied. . . ." *12/27/2017 6:55 p.m. " . . . Calmoseptic ointment applied to left buttock and other red	F 686	being assessed, staged, measured, monitored and results documented weekly/PRN. Charge nurse will be responsible and accountable for implementation of interventions and treatment of pressure ulcers per nursing/physicians orders. Charge nurse will be accountable and CNAs responsible for turning/repositioning to be routine to prevent pressure ulcers. Clinical Coordinator will audit completion of weekly skin observations/assessments according to bath schedule x 12 weeks then randomly for 12 weeks, then 3 times randomly for the next quarter and completion of identified pressure ulcers being assessed, staged, measured and documented x 12 weeks then randomly x 12 weeks and completion of interventions and treatment of pressure ulcers being implemented per orders x 12 weeks then randomly for 12 weeks and turning/repositioning is routine to prevent pressure ulcers daily x 2 weeks, then 3 times per week for 2 weeks, 2 times monthly for three months. DON or designee will perform random audits of skin observations, identified pressure ulcers assessments, staging, measuring, monitoring, interventions and treatments, and turning/repositioning routinely for twenty-four (24) weeks. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. Clinical Coordinator will be responsible	

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F 686	Continued From page 18 areas. Areas are blanchable and she denies any pain at site. There is pinpoint open area with sloughing skin around area." *12/29/2017 3:31 p.m. " . . . Applied barrier cream to buttock. Area is small open with red center and dark red/purple area surrounding. . . ." *12/30/2017 6:50 p.m. " . . . Right inner buttocks has a small open area present; area cleansed with normal saline and barrier cream applied." *01/02/2018 2:53 p.m. "Skin: Small pea sized open area to coccyx, appears to have first layer of skin sloughed off, dark purple area surrounding open area. Spoke to Nurse Practitioner [name] regarding area and received TORB: [Treatment Order Reply Back] "Apply Mepilex BID [twice a day] and PRN to open area." Orders implemented. . . ." *01/05/2018 6:54 p.m. " . . . She also has open area to her coccyx. New open area noted above the previous area, which is approximately an inch long. Mepilex applied to both areas. Areas are blanchable." *01/09/2018 2:24 p.m. "Fax notification received from Nurse Practitioner [name] stating the following: . . . Pressure ulcer to left heel and abrasion to rt [right] buttock, refer to Nurse Practitioner [name] for evaluation and treatment recommendations . . ." *01/09/18 3:59 p.m. . . . "applied mepilex to two spots on R [right] coccyx area . . ." *01/10/18 6:59 p.m. "Applied Mepilex to two open areas on right buttock. . . . she has been up in her wheelchair this afternoon . . ." The progress notes identified the following regarding Resident #23's heel pressure ulcer: *12/21/2017 10:31 a.m. ". . . resident has large blister to L [left] heel, intact no drainage, no	F 686	and accountable to report information related to the audits to the QA committee at weekly meetings and to the QAPI committee at monthly meeting. DON or designee will be responsible and accountable to report information related to audits to QA committee at weekly meeting and to the QAPI committee at monthly meeting. #5. Corrective action will be completed on or before February 15, 2018.	

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F 686	Continued From page 19 warmth or redness present to site . . . Nurse Practitioner [name] in facility, assessed resident gave the following orders; Duoderm to L heel change Q 72 [Every 72 hours]. *12/27/2017 6:55 p.m. "Applied new Duoderm to left heel blister as ordered. No open areas, area is soft to touch and she denies pain to site. . . ." *12/29/2017 3:31 p.m. " . . . Changed dressing to left heel as well. Blister covers entire heel and is soft and spongy feeling. She denies pain to either site." *12/30/2017 6:50 p.m. "Left heel cleansed with normal saline and patted dry; new Duoderm applied; heel has a fluid filled blister present; resident denies pain to the area. . . ." *01/02/2018 2:53 p.m. " . . . Changed dressing to left heel as well, cleansed area with normal saline, padded dry and applied new Duoderm. Area appears spongy with loose white skin. She states area is not painful and she has very little sensation to lower extremities." *01/05/2018 6:54 p.m. "... left heel has blister like appearance. Writer removed old duoderm dressing to heel. Blister was noted to have dark coloring under it, where as previous days blister had white appearance. ... leg had a spasm and part of the skin covering became loose. Under loose skin the heel is dark brown in appearance. The area covers her entire heel. Left heel open to air as the skin is unattached. Bilateral [both] heels are elevated on pillow in bed. Right heel is red and spongy in appearance. Both heels are blanchable. . . ." *01/09/2018 2:24 p.m. "Fax notification received from Nurse Practitioner [name] stating the following: . . . Pressure ulcer to left heel . . . refer to Nurse Practitioner [name] for evaluation and treatment recommendations . . ."	F 686		

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F 686	Continued From page 20 *01/09/18 3:59 p.m. ". . . L heel covered with duoderm continues with blistered area and discoloration." The facility failed to provide consistent monitoring of Resident #23's pressure ulcers, including staging and measuring of the areas which limited the facility's ability to identify improvement or worsening of the pressure ulcers. The facility also failed to care plan and implement goals and interventions for prevention and healing of Resident #23's pressure ulcers.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692		2/15/18

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F 692	Continued From page 21 Based on record review, and staff interview, the facility failed to provide monitoring for 1 of 1 sampled residents (Resident #17) who experienced significant weight loss. Failure to monitor weights as ordered has the potential for further decline in weight. Findings included: Review of Resident #17's medical record occurred on all days of survey. Diagnoses included dementia, edema, and abnormal weight loss. A quarterly Minimum Data Set (MDS), dated 11/28/17 identified a significant weight loss. Current physician orders stated, "10/02/2017 weekly weight once a day . . ." Review of Resident #17's weights from July 2017 to January 2018 showed the following: 07/08/17 - 206.00 lbs (pounds) 08/08/17 - 196.80 lbs 09/09/17 - 192.60 lbs 10/02/17 - 187.40 lbs. 10/16/17 - 190.20 lbs two weeks later 11/06/17 - 186.80 lbs three weeks later 12/05/17 - 180.00 lbs four weeks later 12/14/17 - 186.20 lbs 01/02/18 - 179.20 lbs three weeks later 01/09/18 - 179.00 lbs Review of Resident #17's medical record showed dietary documented the significant weight change and continued to adjust interventions. During an interview on 01/11/18 at 10:55 a.m. the dietary manager (#3) reported the resident has been on a pureed diet after she was in the hospital in November, but refused to eat it.	F 692	F Tag 692 - 483.25 (g)(1)-(3) Nutrition/Hydration Status Maintenance #1. Resident #17 will be weighed weekly per physician's orders. #2. All residents who have physician orders to be weighed weekly have the potential to be affected. #3. Weekly weight policy and procedure will be reviewed/revised/updated as appropriate. Education will be completed for all nurses and CNAs related to weekly weight policy and procedure to include the potential for further decline in weight if monitoring of weight is not completed as ordered on or before February 15, 2018. #4. CNAs will be responsible for completing weekly weights. Charge nurses will be accountable for ensuring weekly weights are completed. Clinical Coordinator will be accountable and responsible for auditing completion of weekly weights x 12 weeks, then every other week for 12 weeks, then monthly for two quarters. DON or designee will be accountable for randomly auditing weekly weight completion for 24 weeks. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. Clinical Coordinator will be accountable for reporting audit results to the QA committee weekly and to the	

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F 692	Continued From page 22 During an interview on 01/11/18 at 11:18 a.m. a staff nurse (#4) confirmed Resident #17's physician's orders stated to weigh weekly.	F 692	QAPI committee monthly. DON or designee will be responsible and accountable for reporting audit results to the QAPI committee monthly. #5. Corrective action will be completed on or before February 15, 2018.	
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to obtain admission orders for 1 of 1 sampled resident (Resident #23) discharged and readmitted to the facility. Failure to obtain admission orders may result in the resident not receiving needed services. Findings include:	F 710	F Tag 710 - 483.30(a)(1)(2) Resident's Care Supervised by a Physician #1. Corrective action to obtain written admission orders for Resident #23 upon admission on 11.3.2017 cannot not accomplished as the date has passed.	2/15/18

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	355122	A. BUILDING _____ B. WING _____	01/11/2018

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F 710	Continued From page 23 Review of Resident #23's record occurred on all days of survey. The record showed Resident #23 resided at the facility until discharged on 10/31/17. Review of the MDS, dated 10/31/17, showed the resident discharged - return not anticipated. The medical record showed a current admission date of 11/03/17, but lacked physician's orders for the readmission. An interview with an administrative staff member (#1), occurred on 01/10/18. The staff member stated, Resident #23 contacted the facility on 11/02/17, requesting to be re-admitted as she was not doing well at home. The administrative staff member (#1) stated a Physician Notification was sent to the nurse practitioner stating, " resident is requesting to be admitted [after] being D/C (discharged) to home on 10/31/17 plan to admit 11/03/17." Written response from the nurse practitioner stated, "11/02/17 noted". When asked about the 11/03/17 admission orders, the administrative staff member (#1) provided a copy of admission orders dated 08/21/17. The facility failed to obtain written admission orders for Resident #23's admission on 11/03/17.	F 710	#2. All residents, upon admission, have the potential to be affected if admission orders for the resident's immediate care and needs are not obtained. #3. Admission orders policy and procedure will be reviewed/revised/updated as appropriate to include obtaining admission orders for the resident's immediate care and needs. Education for all nurses will be completed related to resident's care must be supervised by a physician, including obtaining admission orders for the resident's immediate care and needs on or before February 15, 2018. #4. Charge nurses will be responsible and accountable for obtaining admission orders for the resident's care and needs for every admission. Clinical Coordinator will responsible and accountable for auditing every admission to ensure admission orders have been obtained x ten (10) admissions. DON or designee will randomly audit next ten (10) admissions to ensure admission orders have been obtained. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. Clinical Coordinator will be responsible for reporting audit findings to the QA committee at the next weekly meeting following the admission(s). Clinical Coordinator will be responsible for reporting audit findings to the QAPI	

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F 710	Continued From page 24	F 710	committee at each monthly meeting until at which time ten admissions have been audited and the QAPI committee concludes substantial compliance has been met. DON or designee will be responsible for reporting audit findings to the QAPI committee at each monthly meeting until at which time ten admissions have been audited and the QAPI committee concludes substantial compliance has been met. #5. Corrective action will be completed on or before February 15, 2018.	
F 761 SS=C	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. §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	F 761		2/15/18

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F 761	Continued From page 25 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, and staff interview, the facility failed to properly store medications, and laboratory supplies for 2 of 2 storage areas (medication room and medication cart). Failure to discard expired medications, culture swabs and vacutainers (blood specimen collection tubes) increases the risk of residents receiving outdated medications with reduced efficacy and/or staff utilizing outdated laboratory supplies. Findings include: Observation of the medication room and medication cart occurred on the morning of 01/11/18 with a licensed staff member (#4). Observation identified the following expired medications and laboratory supplies: Medication Cart: * Dryl Diphenhydramine (antihistamine) - May 2017 * Major Deep Sea Nasal Spray - April 2017 Medication Room: * Glycosamine Chondroitin (dietary supplement) - May 2017 * Major Deep Sea Nasal Spray - October 2017 * Four culture swaps - October 2017 * Four purple top vacutainers - September 2017 * One blue top vacutainer - September 2016 During the observation, the licensed staff member (#4) agreed the above items needed to	F 761	F Tag 761 - 483.45(g)(h)(1)(2)Label/Store Drugs and Biological #1. On Friday, January 12, 2018, the medication room and medication cart were inspected for expired medications and laboratory supplies. The inspection results were the medication room and medication cart were free of any expired medications and/or laboratory supplies. #2. All residents have the potential to be affected by expired medications and laboratory supplies. #3. Expired medication/supply policy and procedure will be reviewed/revised/updated as appropriate to ensure substantial regulatory compliance. Education will be completed for all nurses related to expired medication and laboratory supplies in the medication room and medication cart on or before February 15, 2018. #4. All nurses will be responsible and accountable for inspecting for/removing of/discarding of expired medications and laboratory supplies in medication room and medication cart each shift/daily.	

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F 761	Continued From page 26 be discarded.	F 761	Clinical Coordinator will be responsible and accountable for auditing medication room and medication cart to be free from expired medications or laboratory supplies every day for two (2) weeks, then every day for five (5) days for two weeks, then three (3) times per week for four (4) weeks, then one (1) time per week for (4) weeks, then six times randomly each quarter for 2 quarters. DON or designee will be responsible and accountable for randomly auditing the medication room and medication cart for expired medications and laboratory supplies for twenty-four (24) weeks. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. Clinical Coordinator will be responsible and accountable for reporting audit findings to the QA committee at weekly meetings. Clinical Coordinator will be responsible and accountable for reporting audit findings to the QAPI committee at monthly meetings. DON or designee will be responsible and accountable for reporting audit findings to the QAPI committee at monthly meetings. #5. Corrective action will be completed on or before February 15, 2018.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating	F 908		2/15/18

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F 908	Continued From page 27 condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency equipment remained in safe/clean operating condition for 1 of 1 suction machine. Failure to ensure the suction machine was readily available for use in an emergency situation placed all residents at risk for choking and aspiration. Findings include: Observation on the morning of 01/11/18 showed the facility suction machine not located on the cart in the nurses station. The licensed nurse (#4) stated staff used the suction machine earlier in the week for a resident who is in the hospital, and the suction machine remained in the resident's room. During an interview on 01/11/18 at 10:40 a.m., administrative staff members (#1 and #2) confirmed the facility had only one suction machine and had not made provisions for cleaning it and returning it to the proper location.	F 908	F Tag 908 - 483.90(d)(2) Essential Equipment, Safe Operating Condition #1. On Friday, January 12, 2018 the suction machine was cleaned, in safe operating condition and readily available for use in an emergency situation. #2. All residents have the potential to be affected by suction machines not cleaned and readily available for use. #3. Equipment cleaning/safe operating condition policy and procedure will be reviewed/revised/updated as appropriate to include ensuring suction machine is cleaned, safe and readily available for use in an emergency situation. Education will be completed for all nurses related to cleaning the suction machine after every resident use on or before February 15, 2018. #4. All nurses are responsible and accountable for cleaning of the suction machine after use for each resident. Clinical Coordinator will be responsible and accountable for auditing cleanliness and readiness of the suction machine after every resident use for twenty-four (24) weeks, then six random checks over the next quarter. DON or designee will be responsible and accountable for randomly auditing cleanliness and readiness of the suction	

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F 908	Continued From page 28	F 908	machine after every resident use for twenty-four (24) weeks. If any discrepancies are noted, corrective action will be immediate to ensure substantial compliance. Clinical Coordinator will be responsible and accountable for reporting audit findings to the QA committee at each weekly meeting. Clinical Coordinator will be responsible and accountable for reporting audit findings to the QAPI committee at each monthly meeting. DON or designee will be responsible and accountable for reporting audit findings to the QAPI committee at each monthly meeting. #5. Corrective action will be completed on or before February 15, 2018.	