Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 11, 2018

Ms. Heather Presch, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Ms. Presch:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 14, 2018.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING _____ B. WING _____	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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E 000	Initial Comments A unannounced on-site evaluation of the facility emergency preparedness program was conducted by the Division of Licensing and Protection between 3/12-14/2018. No regulatory issues were identified at this time.	E 000	**F635** Admission Physician Orders for Immediate Care MD orders were signed by the covering physician for the Immediate Care of resident #70. Resident #70 did not have any negative effects from the alleged deficient practice. The following was completed as corrective action for residents found to be potentially affected by the alleged deficient practice. Admissions for the previous 30 days were reviewed and updated accordingly. Education will be provided to the Medical Director on the requirement for Admission Orders for Immediate Care to be signed by a Physician. Education will be provided to licensed nursing staff and admissions regarding the process for ensuring new admission orders are signed by the MD for the immediate care of each resident. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan.	
F 000	INITIAL COMMENTS An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 3/12-14/2018. The following regulatory concerns were identified and the specifics are detailed below:	F 000		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have signed physician orders for 1 applicable resident from a sample of 24, Resident #70. Findings include: Resident #70 was admitted to the facility 2/16/18 and per review of the medical record, the orders for the resident were taken from the hospital discharge summary that was signed by a Nurse Practitioner and there is no evidence that they were reconciled by a physician. Confirmation was made by the Licensed Practical Nurse, Unit Manager on 3/13/18 at 3:39 PM that the physician had not signed or reconciled the orders.	F 635		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Passeh — TITLE: Center Executive Director — (X6) DATE: 4/5/18

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 645	Continued From page 1 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645	The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F635 PoC accepted 4/9/18 GColemanRN/PMC **F645** PASARR Screening for MD & ID Resident # 59 was rescreened to resolve the concern. Resident #59 had no negative effects from the alleged deficient practice. The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. A chart review was conducted on residents with Mental Disorder and/or Intellectual Disability to ensure timely PASARR screening/rescreening. Education will be provided to Admissions staff, backup admissions staff and Social Services staff regarding the requirements and process for PASARR screening and rescreening. An audit will be completed weekly x4 and monthly x3 the DNS or designee to monitor the effectiveness of the plan.	

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F 645	Continued From page 2 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview, the facility failed to complete a Preadmission Screening for Mental Illness, Mental Retardation or related conditions (PASRR) for 1 applicable resident in a sample of 24. Resident #59 had a length of stay that exceeded the 30-day exemption. The findings include the following: Record review identifies that Resident #59 was	F 645	The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F645 POC accepted 4/9/18 GColemanRN/PMC	

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F 645	Continued From page 3 admitted on 1/22/18. The PASRR form signed by the physician and dated 1/22/18 identifies diagnosis to include, a metal illness of Delusional Disorder and Depression. The physician certified the resident will require less than 30 days of nursing facility services. The PASRR form identifies if the nursing facility stay is 30 days or longer, a new PASRR screen and resident review must be performed within 40 calendar days of admission. Per record review and staff interview, Resident #59 has remained in the nursing facility since admission 1/22/18. Per discussion with Social Services staff on 3/12/18 at approximately 12:08 PM, confirmation was made that the resident review has not been performed within 40 calendar days of admission as the screening form identifies.	F 645		
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 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	**F656** Develop/Implement Comprehensive Care Plan Care plans for residents #279 and #40 were reviewed and revised as needed. Residents #279 and #40 had no negative effects from the alleged deficient practices. The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice.	

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F 656	Continued From page 4 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 observation, staff interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 24 residents in the applicable sample (Residents #40 and #279). Findings include: 1. Per record review, Resident #279 displayed symptoms of depression and was prescribed and administered an antidepressant medication beginning on 3/9/18. During interview on 3/13/18 at 3:13 PM, the Nurse Manager confirmed that to date the written plan of care for Resident #279	F 656	An in house screen was completed for residents with contractures and residents exhibiting signs of depression. Care plans were reviewed and updated accordingly. Education will be provided to nursing staff and Social Services on the care plan process. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F656 POC accepted 4/9/18 GCdemunrad/PMC	

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F 656	Continued From page 5 did not include specific goals and interventions regarding symptoms of depression or the use of an antidepressant medication. 2.) Per observation of Resident #40 on 3/12/18, s/he presented with contractures of both hands and did not have splints on. During morning care, on 3/13/18, the Licensed Nursing Assistant (LNA) attempted to do Range of Motion (ROM) to the resident's hand, but the resident resisted and hollered out. Per interview with the LNA at this time, s/he stated that s/he doesn't know exactly what is supposed to be done for the ROM, but does try to get the resident to move his/her fingers. Review of the medical record for Resident #40 did not have care plans to address the contractures. Further review of the medical record presents the resident is to have heels floated off the bed, per physician orders. There is also a care plan that indicates the resident has potential for skin break down, but there is nothing in the care plan to address the need to position the resident. Per interview with the Licensed Practical Nurse at 9:52 AM on 3/14/18, s/he confirmed that there were no care plans for the ROM and contractures and there was no care plan to address the positioning of the resident.	F 656		
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	F 686	**F686** Treatment/Svcs to Prevent/Heal Pressure Ulcer A skin assessment was conducted on residents #40. Residents #40 had no negative effects from the alleged deficient practices.	

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F 686	Continued From page 6 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 and staff interview, the facility failed to insure that 1 of 24 residents in the applicable sample, Resident #40, received care consistent with professional standards of practice to prevent pressure ulcers. Findings include: Per observation of Resident #40 during the first day of survey, 3/12/18 between the hours of 10:00 AM and 12:00 Noon and then between 12:30 PM and 3:30 PM, the resident was observed in the same position in bed, on her back with his/her bilateral booties on in place. Per record review, Resident #40 is non-ambulatory and per interview on 3/13/18 with the Licensed Practical Nurse and the Licensed Nursing Assistant, Resident # 40 is only out of bed in the mornings and needs to be transferred by mechanical lift. Per care plan s/he is also at risk for skin breakdown secondary to contractures, shear/friction risks, limited mobility and the need for extensive assist. On 3/13/18, the LNA who had been assigned to the care of Resident #40 on 3/12 and 3/13/18, confirmed at 9:15 AM, that s/he had not positioned the resident during an interval of more than 4 hours on 3/12/18. S/he further stated that s/he sometimes gets busy and doesn't get back to the residents to turn them, as directed in care plans. Per review of LNA task bar in electronic records, the LNA had documented that the resident had been turned and repositioned every 2 hours or as	F 686	The following was completed as corrective action for residents found to be potentially affected by the alleged deficient practice. Residents at risk for skin break down were assessed and the care plans reviewed and updated accordingly. Education will be provided to nursing staff on the process for turning and repositioning residents at risk for skin break down as per POC assignments. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance 4/12/18 F686 POC accepted 4/9/18 GColemanRN/PMC	

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F 686	Continued From page 7 specified by the care plan on 3/12/18. Per observation and LNA confirmation, the resident had not been turned and positioned. The LNA confirmed that s/he had inaccurately documented the positioning in the medical record. Also see F842.	F 686		
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 ensure that the medical care of each resident was supervised by a physician, or another physycian supervised the medical care when the attending physician was unavailable for 1 of 24 residents in the sample (Resident #70) Findings include: Resident #70 was admitted to the facility 2/16/18	F 710	**F710** Resident's Care Supervised by a Physician The covering MD assumed responsibility for the care of resident #70 in the absence of the Medical Director. Residents #70 had no negative effects from the alleged deficient practices. The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. Resident orders reviewed and signed as necessary. Education will be provided to the Medical Director on the regulation for a physician personally approving in writing a recommendation that an individual be admitted to a facility and each resident must remain under the care of a physician.	

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F 710	Continued From page 8 following a hospital stay and required medical monitoring and services for diagnosis consisting of Middle Cerebral Artery Infarction and pharmacological management. Per review of the medical record there is no evidence that a physician approved the admission to the facility, the orders from the hospital were signed by the Nurse Practitioner and not a physician. The attending physician at the facility, was notified that the resident was admitted to the facility and as of 3/13/18, the resident had not been seen by the physician. The Physician's Assistant had seen the resident twice, on 2/20/18 and again on 2/27/18, at which time the admission history and physical was completed. During interview with the Licensed Practical Nurse on 3/14/18 at 8:21 AM, confirmation was made that the physician had not made the first visit as stated in the regulation. It was further confirmed that the resident did not have signed physician orders for the month of March. The LPN further stated that the orders had been sent to the physician on March 1st and have not yet been returned as of 3/14/18.	F 710	An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F710 POC accepted 4/9/18 GColemanRN/PMC	
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs	F 712	**F712** Physician Visits-Frequency/Timeliness/Alt NPP Residents #7, #32, #50, #39, #17, and #44 were seen by a physician and their cycles were reset so they will be seen on a regular basis moving forward.	

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F 712	Continued From page 9 (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that Physician visits were made at the required appropriate intervals for 6 of 24 residents sampled (Residents #7, #32, #50, #39, #17, #44). Findings include: 1). Per record review, for Resident #7, there were no progress notes reflecting a Physician visit for January, February, March, May, June, July, October, and December of 2017 and none for 2018. There are documented visits, by the Physician, on 4/25/17 and 11/28/17 and by the Physician's Assistant, on 8/18/17 and 9/26/17. The Unit Manager confirmed, on 3/14/18, that there was no evidence of any additional visits for Resident #7 and that it has been difficult to ensure that Physician visits are being made as required. The difficulty has been reported to the Medical Director. 2). Per record review, for Resident #32, there was a 3 month period, September to December 2017, when no Physician visits were made and no 60 day visit in February, 2018. The Unit Manager confirmed, on 3/14/18, that no other visit documentation was available. 3). Per record review, for Resident #50,	F 712	None of the 6 residents identified experienced negative effects from the alleged deficient practice. The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. A chart review was conducted to ensure residents were scheduled to be seen by the physician in a timely manner according to regulations. Education will be provided to the Medical Director on the regulation for requirements for physician visits. Education will be provided to licensed nurses on the process for tracking MD visits. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F712 POC accepted 4/9/18 GColemanRN/PMC	

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F 712	Continued From page 10 documented Physician visits were made on 1/18/17, 3/4/17, 3/22/17, 4/29/17, 5/17/17, 5/24/17, 8/8/17, and 12/12/17 and Nurse Practitioner or Physician Assistant visits were made on 6/27/17, 8/14/17, and 9/28/17. There is a 3 month period without any evidence of a Physician visit. The Unit Manager confirmed, on 3/14/18, that no other visit documentation was available. 4). Per record review, Resident #39 was admitted in January of 2017. Per review of the Physician progress notes, the resident was seen at the facility per the required intervals by the MD until July of 2017. The MD made the visit on 5/10/17, but on 6/10 and 7/25/17 was seen at the facility by the Physician's Assistant (PA). On 8/22/17, 10/17, and 10/24/17 the resident was again seen by the Physician's Assistant. MD visits were made again on 11/14/17, and then the next progress note by the MD was on 2/13/18. Per the requirement for the MD to alternate resident visits with a Nurse Practitioner or Physician's Assistant designated by the MD, it was found that the requirement was not met as there was a 6 month gap between MD visits to the resident (5/10/17 to 11/14/17). There was also a gap of 90 days between the MD or NP visiting the resident at the facility between 11/14/17 and 2/13/18. Per interview on 3/13/18 at 10:20 AM, the Unit Manager confirmed that these visits were not meeting the requirements for MD visits every 60 days, or with the required alternation between MD and PA visits. 5.) Per record review for Resident #17, there is no evidence that the physician visited at least every 60 days per regulations. Review of the past year (3/1/17 - 3/13/17) the physician visited on 3/1/17, 3/15, 4/12, 4/28, 5/3, 5/17 and	F 712		

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F 712	Continued From page 11 6/13/17. Per interview and confirmation with the Licensed Practical Nurse (LPN), Unit Manager, at 1:05 PM, a call was placed to physician office and s/he did not see the resident until October 2017. The LPN stated that the physician should have seen the resident at least every 60 days and there had only been visits by the Physician Assistant since October 2017. 6.) Per record review for Resident #44 on 03/14/18 at 10:05 AM, there is no evidence of the required physician visits of at least every 60 days during a period from May 2017 to March 2018. The physician visited 5/9/17, 5/24/17, 6/13/17, 7/11/17, 10/10/17, 11/14/17, 2/13/18. Physician Assistant (PA) visited 6/6/17, 6/27/17, 9/28/17, 10/3/17 10/17/17, 10/27/17, 1/16/18, 1/30/18, 2/6/18, 2/27/18, 3/6/18. There is no evidence that the physician visited in September 2017 or January 2018. There is no evidence that the resident was seen by the physician or PA in August 2017. The LPN confirmed at 1:05 PM that having the physician visits done in the required time frame has been an on-going concern and the medical director is aware of the problem.	F 712		
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	F 756	**F756** Drug Regimen Review, Report Irregular, Act On The order for resident #70 was clarified.	

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F 756	Continued From page 12 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take 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 staff interview and record review, the facility pharmacist failed to report an irregularity regarding 1 resident of 6, Resident #70, surrounding the use of prn (as needed) anti-psychotic medication. Findings include: Resident #70 was admitted to the facility on 2/16/18 and per record review on 3/13/18 there is an admission order for Seroquel (an antipsychotic) 25 milligram(mg) one tablet by	F 756	Residents #70 had no negative effects from the alleged deficient practices. The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. Orders for residents on antipsychotic medications were reviewed to ensure a stop date was in place when required. Education will be provided to the pharmacist and licensed nurses on finding, reporting and following up on irregularities related to antipsychotic medications. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F756 POC accepted 4/9/18 GColemanRS/PMC	

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F 756	Continued From page 13 mouth daily at 3 PM and one tablet at bedtime. There was also an order to give one tablet prn (as needed) in a 24 hour period by mouth for anxiety, combative behavior, manic behavior until 04/02/2018. At 10:30 AM on 03/13/18 confirmation was made by the Licensed Practical Nurse, that there is not a 14 day stop order for the prn antipsychotic. There was a pharmacy review completed on 2/19/18 and there was no recommendation from the pharmacist regarding the Seroquel needing to have a 14 day stop order. Per phone interview with the pharmacist on 3/14/18 at 11:03 AM, s/he said that it may have been an oversight on his/her part regarding not making a recommendation for the antipsychotic and not documenting on the consult log in the medical record.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757	**F757** Drug Regimen is Free from Unnecessary Drugs An appropriate diagnosis was obtained for resident #70 to support the use of an anti-psychotic medication. Residents #70 had no negative effects from the alleged deficient practices.	

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F 757	Continued From page 14 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that 1 of 6 residents, Resident #70 had a drug regimen that was free from unnecessary drugs. Findings include: Per record review, Resident #70 was admitted to the facility 2/16/18 with no diagnosis of depression or any diagnoses that support the use of an anti-psychotic medication. His/her medications include: Lexapro (anti-depressant) and Remeron (anti-depressant), and Seroquel (anti-psychotic). Per record review, there is no evidence that the resident has diagnosis of depression, bi-polar disorder, schizophrenia or psychosis (the diagnosis needed for anti-psychotic medications). Per the pharmacist review on 2/19/18, the use of Seroquel, per Federal Nursing facility regulations require a supporting diagnosis. Per interview with the Licensed Practical Nurse on 03/14/18 at 8:21 AM there are no diagnoses to support the reason for the anti-depressants and the anti-psychotic medications. S/he further stated that the resident was admitted from the hospital and these medications were medications that were taken at the hospital.	F 757	The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. Residents on anti-psychotic and anti-depressant medications were reviewed and diagnosis updated as necessary. Education will be provided for the Medical Director and licensed nurses on appropriate supporting diagnosis for anti-psychotic and anti-depressant medications. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F757 POC accepted 4/9/18 GCdemanpd | PMC	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5); 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842	**F842** Resident Records – Identifiable Information Resident #40 had a skin assessment completed on 3/16/18 with no adverse findings.	

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F 842	Continued From page 15 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or	F 842	The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. No additional resident were identified. Education will be provided to LNA's on the process for completing assigned tasks and importance of accurate documentation. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F842a POC accepted 4/9/18 GColemanRN/PMC	

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F 842	Continued From page 16 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to insure accurately documented medical records for 1 of 24 residents, Resident #40, where staff falsely documented that care was completed. Findings include: Per observation of Resident #40 during the first day of survey, 3/12/18 between the hours of 10:00 AM and 12:00 Noon and then between 12:30 PM and 3:30 PM, the resident was observed in the same position in bed, on her back with his/her bilateral booties on in place. Per record review, Resident #40 is non-ambulatory and per interview on 3/13/18 with the Licensed	F 842		

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F 842	Continued From page 17 Practical Nurse and the Licensed Nursing Assistant, Resident # 40 is only out of bed in the mornings and needs to be transferred by mechanical lift. Per care plan s/he is also at risk for skin breakdown secondary to contractures, shear/friction risks, limited mobility and the need for extensive assist. On 3/13/18, the LNA who had been assigned to the care of Resident #40 on 3/12 and 3/13/18, confirmed at 9:15 AM, that s/he had not positioned the resident during an interval of more than 4 hours on 3/12/18. Per review of LNA task bar in electronic records, the LNA had documented that the resident had been turned and repositioned every 2 hours or as specified by the care plan on 3/12/18. Per observation and LNA confirmation, the resident had not been turned and positioned. The LNA confirmed that s/he had inaccurately documented the positioning in the medical record.	F 842		
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	F 880	**F880** Infection Control Nebulizer Equipment for residents #66, #30, #73 and #329 was bagged the day it was observed. The residents identified had no negative effects from the alleged deficient practices.	

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F 880	Continued From page 18 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; §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.	F 880	The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. Nebulizer equipment was observed and bagged as needed. Education will be provided to nursing staff regarding Infection Control Practices. An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 4/12/18 F880 POC accepted 4/9/18 GColemanRN/PM	

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F 880	Continued From page 19 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 observation and confirmed through staff interview, the facility failed to ensure that infection control practices were followed to help prevent the development and transmission of communicable diseases and infections for 4 of 24 residents in the sample (Residents #30, #66, #73, and #329). Findings include: 1. Per observation during the initial tour on 3/12/18 at 10:10 AM, Resident #66 had a nebulizer machine with tubing and mask attached that was sitting uncovered on the bedside table. This observation was confirmed by an LNA (Licensed Nursing Assistant) on the unit at 10:11 AM. 2. Per observation during the initial tour on 3/12/18 at approximately 1:15 AM and a second tour with the Unit Manger on 3/13/18, Residents #30, #73 and #329, were found to have nebulizer machines with tubing attached to the face mask and the medication chamber, resting on the resident's bedside table unprotected. The Unit Manger confirmed during the tour on 3/13/18 at 1:25 PM, that the above equipment should be protected in a plastic bag.	F 880		