STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	R-C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An unannounced Medicare/Medicaid a first revisit which following an abbreviated survey which was conducted on 1/10/18 through 1/16/18 was conducted 3/14/18 through 3/15/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B. The census in this 190 certified bed facility was 179 at the time of the survey. The survey sample consisted of 18 current resident reviews, Residents #101 through #118.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted on 1/10/18 through 1/16/18 was conducted 3/14/18 through 3/15/18. A complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B. The census in this 190 certified bed facility was 179 at the time of the survey. The survey sample consisted of 18 current resident reviews, Residents #101 through #118.	{F 000}		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would	F 558	**F558: Reasonable Accommodation of Needs/Preferences** 1. Resident #114's call bell was placed within reach 3/15/18 and continues to remain within the residents reach. 2. A quality review of current resident rooms completed by the Executive Director (ED)/ Director of Nursing (DON)/Interdisciplinary Team (IDT) to ensure call bells are within the residents reach. Follow up based on findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ERMCe — TITLE: Executive Director — (X6) DATE: 4/6/18

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 558	Continued From page 1 endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a call bell was within reach for one of 18 residents in the survey sample, Resident #114. The facility staff failed to place Resident #114's call bell within her reach, it was observed on several occasions on the floor mat by the bed. The findings include: Resident #114 was admitted to the facility on 11/20/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, dementia, deep vein thrombosis (blood clot) and schizophrenia (any group of mental disorders characterized by gross distortions of reality, withdrawal from social contacts, and disturbances of thought, language, perception and emotional response) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/11/17, coded the resident as having both short and long-term memory difficulties and as being severely impaired to make cognitive daily decisions. Resident #114 was coded as having impaired vision. Resident #114 was coded as requiring extensive assistance of one staff member for moving in the bed and transfers. Observation was made on 3/14/18 at 11:00 a.m. of Resident #114 in her bed; the bed was in low	F 558	3. Current facility staff re-educated by the ED/DON/designee regarding ensuring call bells are within the residents reach. 4. ED/DON/IDT/designee to conduct random quality monitoring through mock survey rounds ensuring call bells are within the residents reach daily x 4weeks, 5 times weekly x 2 weeks, 4 times weekly x 2 weeks then twice weekly then PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 4-15-18.	

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F 558	Continued From page 2	F 558		

the position. There were fall mats on each side of the bed. The call bell was on the floor, out of Resident #114's reach.

A second observation was made on 3/15/18 at 9:16 a.m. of Resident #114 in her bed with fall mats on each side of the bed. The call bell was on the floor out of Resident #114's reach.

The comprehensive care plan dated, 1/9/18, documented in part, "Focus: (Resident #114) has the potential for injury r/t (related to) confusion, diabetes, gait/balance problems." The "Interventions" documented in part, "Be sure the resident's call light is within reach and encourage the resident to use it."

An interview was conducted with CNA (certified nursing assistant) #1 on 3/15/18 at 1:25 p.m. When asked where a resident's call bell should be placed, CNA #1 stated, "It should be on the bed, attached to the covers." When asked if a call light on the floor, is a problem, CNA #1 stated, "They couldn't reach it and they could fall trying to reach it."

An interview was conducted with LPN (licensed practical nurse) #5 on 3/15/18 at 1:50 p.m. When asked why the residents have call bells, LPN #5 stated, "So they can call for assistance." When asked where the call bell should be placed, LPN #5 stated, "Where it can be reached by the resident." When asked if a call bell on the fall mat is reachable, LPN #5 stated, "No."

The facility policy, "Call Bell Systems - Inoperable" documented in part, "Policy: Resident must have, at all times, a system to notify staff when assistance is needed." the policy did not

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F 558	Continued From page 3 address where the call bell should be placed. ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the divisional director of clinical services were made aware of the above concern on 3/15/18 at 6:15 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.	F 558		
{F 607} SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the abuse policies for one of 18 residents in the survey sample, Resident #117. The facility staff failed to implement their policies to investigate/report a bruise of unknown origin	{F 607}	**F607:** **Develop/Implement/Abuse/Neglect Policies** 1. Bruise to resident #117's left eye investigated using Root Cause Analysis (RCA) by the ED/DON on 3/15/18 and determined not to be a result of Abuse. Follow up completed as indicated based on findings. 2. A quality review of current residents most recent skin evaluation completed by the ED/DON/designee to ensure an investigation using RCA is conducted for residents who sustained a bruise or bruising. Follow up based on findings.	

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{F 607}	Continued From page 4 on Resident #117's left eye, to rule out abuse. The findings include: Resident #117 was admitted to the facility on 2/9/18 with a recent readmission on 3/13/18 with diagnoses that included but were not limited to: vascular dementia, abnormal gait and balance, stroke, diabetes, depression, and high blood pressure. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/16/18 coded the resident rarely understanding others and rarely making herself understood. The resident was coded as having both short and long-term memory difficulties. Resident #117 was coded as having the following behaviors during the look back period; physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards other, and other behavioral symptoms not directed towards others such as hitting, scratching pacing, rummaging or verbal/vocal symptoms like screaming and disruptive sounds. Resident #117 was coded as requiring limited assistance of one staff member for most of her activities of daily living. Observation was made of Resident #117 on 3/14/18 at 2:15 p.m. sitting in a wheelchair in the hall. The resident's left eye was noted to be bruised and swollen. When asked how it happened, the resident stated, "Don't know." The resident was observed on 3/15/18 at 9:43 a.m. sitting on the side of her bed. The bruise to the left eye was observed and swelling under the	{F 607}	3. ED/DON re-educated by the Regional Director of Clinical Services (RDCS)/designee regarding ensuring an investigation using RCA is conducted for residents who sustain a bruise or bruising with follow up as indicated based on findings and per regulation. Licensed nurses re-educated by the DON/designee to ensure residents who sustain a bruise are documented on the 24 Hour Report. Licensed nurse re-educated by the ED/designee to ensure the ED/DON are called with residents who sustain a bruise or bruising of unknown origin at the time of the occurrence. CNAs re-educated to report bruising upon identification to supervisor. DON re-educated by the RDCS/designee regarding notifying the ED with residents who sustain a bruise or bruising of unknown origin at the time of identification.	

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{F 607}	Continued From page 5	{F 607}		

eye was noted.

The nurse's notes dated, 3/11/18 at 11:30 a.m. documented in part, "Resident sitting on the floor beside her bed. Asked her if she fell, she stated and the roommate stated that she slid off the bed onto the floor. Resident was also scooting around on the floor in her room. Reddish - purplish bruise observed to left eye. RP (responsible party) and MD (medical doctor) made aware."

A late entry nurse's note dated, 3/12/18 for 3/11/18 at 7:30 a.m. documented in part, "Resident's left eye was red and swollen at 7:30 a.m. when writer did arrive at start of shift. Writer was informed (by the nurse of the off going shift) that the resident was on the floor several times on 11-7 shift (11:00 p.m. to 7:00 a.m.) MD (medical doctor) and RP (responsible party) notified." Review of the clinical record failed to evidence any documentation for the 11-7 shift.

An interview was conducted with LPN (licensed practical nurse) #3, Resident #117's regular nurse, on 3/15/18 at 1:13 p.m. regarding Resident #117's bruise to her eye. LPN #3 stated, "I was told that she got it on Sunday when she fell."

On 3/15/18 at 2:02 p.m., an interview was conducted with LPN #8, who cared for Resident #117 on 3/11/18, regrading the bruise on Resident #117's eye. LPN #8 stated, "I saw it for the first time when I entered the room at 7:30 a.m. on 3/11/18. It started to change colors to red and purple on 3/11/18 at 11:30 a.m. When asked if she notified anyone about the bruise, LPN #8 stated she had notified the acting supervisor of all of the occurrences of the day with Resident #117.

4. ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of residents who sustain a bruise or bruising to ensure an investigation using RCA is conducted with follow as indicated based on findings and per regulation 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, weekly x 4 weeks and PRN as indicated.
ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of the 24 Hour report to ensure residents who sustain a bruise or bruising are investigated using RCA is conducted with follow as indicated based on findings and per regulation 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, weekly x 4 weeks and PRN as indicated.
ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of residents who sustain a bruise or bruising of unknown origin to ensure the ED/DON are called

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{F 607}	Continued From page 6	{F 607}		

When asked if she was asked to provide a statement related to the bruise, LPN #8 stated, "No, Ma'am."

An interview was conducted with ASM (administrative staff member) #1, the executive director, on 3/15/18 at 2:58 p.m. When asked for the bruise investigation for Resident #117's left eye, ASM #1 stated, "I know that it was noted in the clinical meeting on Monday and that she had fallen on Sunday." When asked if there was, an investigation initiated for the bruise, ASM #1 stated, "I will have to get back with you." When asked if anyone obtained statements from staff regarding the bruise, ASM #1 stated, "I'll have to check."

Review of the clinical record did not reveal any falls on 3/11/18. All documentation documented the resident had "Slid from the bed to the floor." The note of 3/12/18 at 1:56 p.m. documented the resident had fallen in the hallway and was assessed for a right swollen hand.

On 3/15/18 at 5:40 p.m. ASM #2, the director of nursing, informed this writer she had started the investigation for the bruise. When asked about the process followed for investigation of bruises of unknown origin, ASM #2 stated, "When the bruise is discovered." When asked if the investigation was just starting for Resident #117's bruise of unknown origin noted by staff on 3/11/18, ASM #2 stated, "Yes, Ma'am."

The facility policy documented in oart the following: "The Administration of the Company recognizes that resident abuse can be committed by other residents, visitors or volunteers...Identification: All reported events

at the time of the occurrence 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, weekly x 4 weeks and PRN as indicated.
DON and or Unit Managers to review Weekly Skin Checks for residents with a bruise or bruising to ensure investigation and reporting occur as per regulation. Mock survey rounds to be reviewed by the ED/DON to ensure investigation and reporting occur as per regulation r/t Abuse.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of compliance 4-15-18.

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{F 607}	Continued From page 7 (bruises, skin tears, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services - director of nursing...Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation resident of the allegation. The nurse or Director of Clinical Services shall perform and document a thorough nursing evaluation, and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the abuse coordinator. Investigation: The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...Reporting/Response: Any employee or contracted service provide who witness or has knowledge of an act of abuse or an allegation of abuse, neglect or exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the	{F 607}		

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allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the Administrator and to other officials in accordance with State law. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting in completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement in a reason able suspicion of crime has occurred."

ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the divisional director of clinical services were made aware of the above concern on 3/15/18 at 6:15 p.m.

No further information regarding the above was provided prior to exit.

{F 607}

{F 609} SS=D Reporting of Alleged Violations
CFR(s): 483.12(c)(1)(4)

{F 609}

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve

F609: Reporting of Alleged Violations

1. Bruise to resident #117's left eye investigated using Root Cause Analysis (RCA) by the ED/DON on 3/15/18 and determined not to be a result of Abuse.

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{F 609}	Continued From page 9 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to report, to the state agency, an bruise of unknown origin for one of 18 residents in the survey sample, Resident #117. The facility failed to report a bruise of unknown origin for Resident #117. Resident #117 was observed with a red swollen bruised left eye. The facility staff did not witness the occurrence of the bruise and failed to report the bruise of unknown origin to the state agency and other officials through established procedures. The findings include: Resident #117 was admitted to the facility on 2/9/18 with a recent readmission on 3/13/18 with diagnoses that included but were not limited to: vascular dementia, abnormal gait and balance, stroke, diabetes, depression, and high blood	{F 609}	2. Quality review of current residents most recent skin evaluations by the ED/DON completed to ensure residents with a bruise or bruising of unknown origin are reported timely to the appropriate state agency per regulation. Follow up based on findings. Quality review of event reports in the last 30 days by the ED/DON completed to ensure residents with an injury of unknown origin are reported timely to the appropriate state agency per regulation. Follow up based on findings. 3. ED and DON re-educated by the RDCS/designee regarding ensuring residents with a bruise or bruising of unknown origin are reported timely to the appropriate state agency per regulation. ED and DON re-educated by the RDCS/designee regarding ensuring residents with an injury of unknown origin are reported 1	

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{F 609}	Continued From page 10	{F 609}		

pressure.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/16/18 coded the resident rarely understanding others and rarely making herself understood. The resident was coded as having both short and long-term memory difficulties. Resident #117 was coded as having the following behaviors during the look back period; physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards other, and other behavioral symptoms not directed towards others such as hitting, scratching pacing, rummaging or verbal/vocal symptoms like screaming and disruptive sounds. Resident #117 was coded as requiring limited assistance of one staff member for most of her activities of daily living.

Observation was made of Resident #117 on 3/14/18 at 2:15 p.m. sitting in a wheelchair in the hall. The resident's left eye was noted to be bruised and swollen. When asked how it happened, the resident stated, "Don't know."

The resident was observed on 3/15/18 at 9:43 a.m. sitting on the side of her bed. The bruise to the left eye was observed and swelling under the eye was noted.

The nurse's notes dated, 3/11/18 at 11:30 a.m. documented in part, "Resident sitting on the floor beside her bed. Asked her if she fell, she stated and the roommate stated that she slid off the bed onto the floor. Resident was also scooting around on the floor in her room. Reddish - purplish bruise observed to left eye. RP

timely to the appropriate state agency per regulation.
CNAs re-educated by the DON/designee to report bruising upon identification to supervisor.

4. ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of event reports to ensure residents with a bruise or bruising of unknown origin are reported to the appropriate state agency timely per regulation 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated.
ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of the 24 Hour Report to ensure residents with a bruise or bruising of unknown origin are reported to the appropriate state agency timely per regulation 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated.

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{F 609}	Continued From page 11 (responsible party) and MD (medical doctor) made aware." A late entry nurse's note dated, 3/12/18 for 3/11/18 at 7:30 a.m. documented in part, "Resident's left eye was red and swollen at 7:30 a.m. when writer did arrive at start of shift. Writer was informed (by the nurse of the off going shift) that the resident was on the floor several times on 11-7 shift (11:00 p.m. to 7:00 a.m.) MD (medical doctor) and RP (responsible party) notified." Review of the clinical record failed to evidence any documentation for the 11-7 shift. An interview was conducted with LPN (licensed practical nurse) #3, Resident #117's regular nurse, on 3/15/18 at 1:13 p.m. regarding Resident #117's bruise to her eye. LPN #3 stated, "I was told that she got it on Sunday when she fell." On 3/15/18 at 2:02 p.m., an interview was conducted with LPN #8, who cared for Resident #117 on 3/11/18, regarding the bruise on Resident #117's eye. LPN #8 stated, "I saw it for the first time when I entered the room at 7:30 a.m. on 3/11/18. It started to change colors to red and purple on 3/11/18 at 11:30 a.m. When asked if she notified anyone about the bruise, LPN #8 stated she had notified the acting supervisor of all of the occurrences of the day with Resident #117. When asked if she was asked to provide a statement related to the bruise, LPN #8 stated, "No, Ma'am." An interview was conducted with ASM (administrative staff member) #1, the executive director, on 3/15/18 at 2:58 p.m. When asked for the bruise investigation for Resident #117's left eye, ASM #1 stated, "I know that it was noted in	{F 609}	ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of event reports to ensure residents with an injury of unknown origin are reported to the appropriate state agency timely per regulation 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated. ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of the 24 Hour Report to ensure residents with an injury of unknown origin are reported to the appropriate state agency timely per regulation 3 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated. DON and or Unit Managers to review Weekly Skin Checks for residents with a bruise or bruising to ensure investigation and reporting occur as per regulation. Mock survey rounds to be reviewed by the ED/DON to ensure investigation and reporting occur as per regulation r/t Abuse.	

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{F 609}	Continued From page 12	{F 609}		

the clinical meeting on Monday and that she had fallen on Sunday." When asked if there was, an investigation initiated for the bruise, ASM #1 stated, "I will have to get back with you." When asked if anyone obtained statements from staff regarding the bruise, ASM #1 stated, "I'll have to check."

Review of the clinical record did not reveal any falls on 3/11/18. All documentation documented the resident had "Slid from the bed to the floor." The note of 3/12/18 at 1:56 p.m. documented the resident had fallen in the hallway and was assessed for a right swollen hand.

On 3/15/18 at 5:40 p.m. ASM #2, the director of nursing, informed this writer she had started the investigation for the bruise. When asked about the process followed for investigation of bruises of unknown origin, ASM #2 stated, "When the bruise is discovered." When asked if the investigation was just starting for Resident #117's bruise of unknown origin noted by staff on 3/11/18, ASM #2 stated, "Yes, Ma'am."

The facility policy documented in part the following: "The Administration of the Company recognizes that resident abuse can be committed by other residents, visitors or volunteers...Identification: All reported events (bruises, skin tears, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services - director of nursing...Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of

Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 4-15-18.

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residents. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation resident of the allegation. The nurse or Director of Clinical Services shall perform and document a thorough nursing evaluation, and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the abuse coordinator. Investigation: The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...Reporting/Response: Any employee or contracted service provide who witness or has knowledge of an act of abuse or an allegation of abuse, neglect or exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the Administrator and to other officials in accordance with State law. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting in completed timely and appropriately to

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appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement in a reason able suspicion of crime has occurred."

ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the divisional director of clinical services were made aware of the above concern on 3/15/18 at 6:15 p.m.

No further information regarding the above was provided prior to exit.

F 610 SS=D Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and clinical

{F 609}

F 610

F610:
Investigate/Prevent/Correct/Alleged Violation

1. Bruise to resident #117's left eye investigated using Root Cause Analysis (RCA) by the ED/DON on 3/15/18 and determined not to be a result of Abuse. Follow up completed as indicated based on findings.

2. A quality review of current residents most recent skin evaluation completed by the ED/DON/designee to ensure an investigation using RCA is conducted for residents who sustained a bruise or bruising. Follow up based on findings.
3. ED/DON re-educated by the Regional Director of Clinical Services (RDCS)/designee regarding ensuring an investigation using RCA is conducted for residents who sustained a bruise or bruising with follow up as indicated based on findings and per regulation.

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record review, it was determined the facility staff failed to investigate an bruise of unknown origin for one of 18 residents in the survey sample, Resident #117.

The facility staff failed to investigate a bruise on Resident #117's left eye.

The findings include:

Resident #117 was admitted to the facility on 2/9/18 with a recent readmission on 3/13/18 with diagnoses that included but were not limited to: vascular dementia, abnormal gait and balance, stroke, diabetes, depression, and high blood pressure.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/16/18 coded the resident rarely understanding others and rarely making herself understood. The resident was coded as having both short and long-term memory difficulties. Resident #117 was coded as having the following behaviors during the look back period; physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards other, and other behavioral symptoms not directed towards others such as hitting, scratching pacing, rummaging or verbal/vocal symptoms like screaming and disruptive sounds. Resident #117 was coded as requiring limited assistance of one staff member for most of her activities of daily living.

Observation was made of Resident #117 on 3/14/18 at 2:15 p.m. sitting in a wheelchair in the

Licensed nurses re-educated by the DON/designee to ensure residents who sustained a bruise are documented on the 24 Hour Report.
Licensed nurse re-educated by the ED to ensure the ED/DON/designee are called with residents who sustain a bruise or bruising of unknown origin at the time of the occurrence.

4. ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of residents who sustain a bruise to ensure an investigation using RCA is conducted with follow up as indicated based on findings and per regulation 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, weekly x 4 weeks and PRN as indicated.

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hall. The resident's left eye was noted to be bruised and swollen. When asked how it happened, the resident stated, "Don't know."

The resident was observed on 3/15/18 at 9:43 a.m. sitting on the side of her bed. The bruise to the left eye was observed and swelling under the eye was noted.

The nurse's notes dated, 3/11/18 at 11:30 a.m. documented in part, "Resident sitting on the floor beside her bed. Asked her if she fell, she stated and the roommate stated that she slid off the bed onto the floor. Resident was also scooting around on the floor in her room. Reddish - purplish bruise observed to left eye. RP (responsible party) and MD (medical doctor) made aware."

A late entry nurse's note dated, 3/12/18 for 3/11/18 at 7:30 a.m. documented in part, "Resident's left eye was red and swollen at 7:30 a.m. when writer did arrive at start of shift. Writer was informed (by the nurse of the off going shift) that the resident was on the floor several times on 11-7 shift (11:00 p.m. to 7:00 a.m.) MD (medical doctor) and RP (responsible party) notified." Review of the clinical record failed to evidence any documentation for the 11-7 shift.

An interview was conducted with LPN (licensed practical nurse) #3, Resident #117's regular nurse, on 3/15/18 at 1:13 p.m. regarding Resident #117's bruise to her eye. LPN #3 stated, "I was told that she got it on Sunday when she fell."

On 3/15/18 at 2:02 p.m., an interview was conducted with LPN #8, who cared for Resident #117 on 3/11/18, regarding the bruise on

ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of the 24 Hour Report to ensure residents who sustain a bruise of unknown origin are investigated using RCA is conducted with follow up as indicated based on findings and per regulation 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, weekly x 4 weeks and PRN as indicated.
DON and or Unit Managers to review Weekly Skin Checks for residents with a bruise or bruising to ensure investigation and reporting occur as per regulation.
Mock survey rounds to be reviewed by the ED/DON to ensure investigation and reporting occur as per regulation r/t Abuse.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of compliance 4-15-18.

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Resident #117's eye. LPN #8 stated, "I saw it for the first time when I entered the room at 7:30 a.m. on 3/11/18. It started to change colors to red and purple on 3/11/18 at 11:30 a.m. When asked if she notified anyone about the bruise, LPN #8 stated she had notified the acting supervisor of all of the occurrences of the day with Resident #117. When asked if she was asked to provide a statement related to the bruise, LPN #8 stated, "No, Ma'am."

An interview was conducted with ASM (administrative staff member) #1, the executive director, on 3/15/18 at 2:58 p.m. When asked for the bruise investigation for Resident #117's left eye, ASM #1 stated, "I know that it was noted in the clinical meeting on Monday and that she had fallen on Sunday." When asked if there was, an investigation initiated for the bruise, ASM #1 stated, "I will have to get back with you." When asked if anyone obtained statements from staff regarding the bruise, ASM #1 stated, "I'll have to check."

Review of the clinical record did not reveal any falls on 3/11/18. All documentation documented the resident had "Slid from the bed to the floor." The note of 3/12/18 at 1:56 p.m. documented the resident had fallen in the hallway and was assessed for a right swollen hand.

On 3/15/18 at 5:40 p.m. ASM #2, the director of nursing, informed this writer she had started the investigation for the bruise. When asked about the process followed for investigation of bruises of unknown origin, ASM #2 stated, "When the bruise is discovered." When asked if the investigation was just starting for Resident #117's bruise of unknown origin noted by staff on

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3/11/18, ASM #2 stated, "Yes, Ma'am."

The facility policy documented in part the following: "The Administration of the Company recognizes that resident abuse can be committed by other residents, visitors or volunteers...Identification: All reported events (bruises, skin tears, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services - director of nursing...Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation resident of the allegation. The nurse or Director of Clinical Services shall perform and document a thorough nursing evaluation, and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the abuse coordinator. Investigation: The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...Reporting/Response: Any employee or contracted service provide who witness or has

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knowledge of an act of abuse or an allegation of abuse, neglect or exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the Administrator and to other officials in accordance with State law. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting in completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement in a reason able suspicion of crime has occurred.

ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the divisional director of clinical services were made aware of the above concern on 3/15/18 at 6:15 p.m.

No further information regarding the above was provided prior to exit.

{F 656} SS=E Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) {F 656}

§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

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

F656: Development/Implement Comprehensive Care Plan

1. Resident #111 received laboratory services per physician order on 03/08/2018.
Resident #116 oral status evaluation completed 3/22/18.
Resident #116 received dental services per the plan of care on 3/28/18.
Care plan updated to reflect the care needs of resident #110's Peripherally Inserted Central Catheter (PICC) on 3/24/18.
Resident #116 heels floated per the plan of care.
Resident #114's call bell was placed within reach 3/15/18 per the plan of care and continues to remain within the residents reach.

2. Quality review of current resident's care plan completed by the DON/Unit Manager (UM)/designee to ensure laboratory services are provided per physician order. Follow up based on findings.

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failed to develop and or implement the comprehensive care plan for five of 18 residents in the survey sample, Residents # 111, 116, 110, 104 and 114.

1. The facility staff failed to implement/follow the comprehensive care plan to obtain laboratory specimens as ordered for Resident #111.

2. The facility staff failed to implement/follow the comprehensive care plan to notify the doctor if the resident's teeth were missing, cracked or decayed for Resident #116.

3. The facility staff failed to develop a comprehensive care plan to address the care needs of Resident #110's peripherally inserted central catheter (PICC).

4. The facility staff failed to float Resident #116's heels per the comprehensive care plan.

5. The facility staff failed to follow the comprehensive care plan to ensure Resident #114's call bell was within reach.

The findings include:

1. Resident #111 was admitted to the facility on 7/10/15 with diagnoses that included but were not limited to: diabetes, heart failure, chronic lung disease, irregular heartbeat, high blood pressure and falls.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 12/14/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident

Quality review of current resident's care plan completed by the DON/UM/designee to ensure residents receive routine dental services annually and/or upon change in condition. Follow up based on findings.
Quality review of current resident's care plan completed by the DON/UM/designee to ensure oral status evaluations are completed per policy. Follow up based on findings.
Quality review completed by the DON/UM/designee to ensure the care plan reflects the care needs of resident's with a PICC. Follow up based on findings.
Quality review of current resident's care plan completed by the DON/UM/designee ensuring resident's call bells are within reach. Follow up based on findings.
Quality review of current resident's care plan completed by the DON/UM/designee ensuring residents heels are floated per the plan of care.

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was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living with the exception of eating which the resident could perform after the tray was set up.

Review of the care plan initiated on 1/30/17 and revised on 1/9/18 documented, "Focus. The resident is at risk for bleeding and decreased cardiac output...Interventions. Monitor labs (laboratory specimens) as ordered and notify the physician of results."

Review of the clinical record documented the resident had a complete metabolic panel (CMP) (1) on 3/8/18.

Review of the physician's orders did not evidence a physician's order for a CMP on that date.

An interview was conducted on 3/15/18 at 10:45 a.m. with LPN, (licensed practical nurse) #7, the MDS coordinator. When asked why residents had care plans, LPN #7 stated, "The care plan drives the resident's care. They're individualized, comprehensive and based off the resident's general diagnoses, behaviors." When asked who used the care plans, LPN #7 stated, "Pretty much the interdisciplinary team plays a role in the care plan." When asked if staff were expected to follow the care plan, LPN #7 stated, "I would say yes."

An interview was conducted on 3/15/18 at 11:00 a.m. with LPN #5, the resident's nurse. When asked about the process staff follow to obtain laboratory specimens, LPN #5 stated, "We get a doctor's order." When asked if they ever obtained a laboratory test without a physician's order LPN

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3. Licensed nurses re-educated by the Division MDS Director/designee to ensure the care plan is followed regarding laboratory services.
Licensed nurses re-educated by Division MDS Director /designee to ensure the care plan is followed regarding dental services.
Licensed nurses re-educated by the Division MDS Director designee to ensure the care plan is followed regarding residents with a PICC.
Licensed nurses re-educated by the Division MDS Director/designee to ensure the care plan is followed regarding call bells within reach.
MDS Coordinator re-educated by the Division MDS Director regarding ensuring the care plan accurately reflects the resident's current status.
Licensed nurses re-educated by the Division MDS Director/designee to ensure the care plan is followed regarding

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#5 stated, "No." A request for the 3/8/18 CMP laboratory specimen order was requested at that time. LPN #5 stated, "The doctor ordered the CMP for 3/19/18 but I got it drawn on 3/8/18." When asked if she had asked the doctor if he wanted the CMP drawn on 3/8/18, LPN #5 stated she had not. When asked why a resident has a care plan, LPN #5 stated, "Basically it's what kind of care we provided for the patient." When asked if staff were expected to follow the care plan, LPN #5 stated, "it should be."

An interview was conducted on 3/15/18 at 11:05 a.m. with ASM #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "it helps to direct their care. It's kind of like a guide for caring for them. It's individualized." When asked who used the care plan, ASM #2 stated, "The whole interdisciplinary team." When asked if staff were expected to follow the care plan, ASM #2 stated, "Yes." ASM #2 was made aware of the findings at that time.

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, divisional director of clinical services were made aware of the findings.

Review of the facility's policy titled, "Plans of Care" documented, "Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are

ensuring residents heels are floated per the plan of care. MDS Coordinator re-educated by the Division MDS Director regarding ensuring licensed nurses and CNA's are aware of and understand their role in development of the resident's care plan.

4. MDS Coordinator/DON/designee to conduct quality monitoring through morning clinical meeting to ensure care plan intervention(s) accurately reflect the resident's current status 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. MDS Coordinator/DON/designee to conduct quality monitoring through morning clinical meeting to ensure the care plan is followed regarding laboratory services 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.

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identified in the comprehensive assessment. Review, update and /or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions...The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being. The individualized Person Centered plan of care may include but is not limited to the following: Resident's strengths and needs. Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required by state and federal regulatory requirements."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

(1) CMP -- The comprehensive metabolic panel

MDS Coordinator/DON/designee to conduct quality monitoring through morning clinical meeting to ensure the care plan is followed regarding dental services 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
MDS Coordinator/DON/designee to conduct quality monitoring through morning clinical meeting to ensure the care plan is followed regarding residents with a PICC 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
MDS Coordinator/DON/designee to conduct quality monitoring through morning clinical meeting to ensure the care plan is followed regarding ensuring residents call bells within reach 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.

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(CMP) is a frequently ordered panel of 14 tests that provides information about the current status of a person's metabolism, including the health of the kidneys and liver, electrolyte and acid/base balance as well as levels of blood glucose and blood proteins. This information was obtained from:
https://labtestsonline.org/tests/comprehensive-metabolic-panel-cmp

2. The facility staff failed to implement/follow the comprehensive care plan to notify the doctor if the resident's teeth were missing, cracked or decayed for Resident #116.

Resident #116 was admitted to the facility on 10/20/15 with diagnoses that included but were not limited to: stroke, Alzheimer's disease, diabetes, depression and difficulty swallowing.

The most recent MDS, a quarterly assessment, with an ARD of 2/5/18 coded the resident as having short-term and long-term memory problems and as severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the annual MDS with an ARD of 10/27/17 in Section L -- Oral/Dental Status documented, "D. Obvious or likely cavity or broken natural teeth."

An observation was made on 3/14/18 at 10:40 a.m. of Resident # 116. The resident was lying in a recliner in the hallway. His eyes were closed and his mouth was open. In the lower jaw, there were two teeth broken to the gum line. There

DON/UM/IDT to conduct quality monitoring through mock survey rounds to ensure residents heels are floated per the plan of care 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 4-15-18.

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were approximately seven teeth, which had food debris, a greenish/gray substance at the base of the teeth and the teeth had black decay above that.

A review of the care plan initiated on 10/27/16 and revised on 11/7/17 documented, "Focus. (Name of resident) has potential for imbalanced nutrition r/t (related to)...Chewing Problem...Resident has poor dentition. Interventions. Monitor/document/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of oral/dental problems needing attention. Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed..."

An interview was conducted on 3/15/18 at 9:30 a.m. with LPN #4, the resident's nurse. When asked about the process staff follows if a resident has dental issues, LPN #4 stated, "If they're vocal they can verbalize if it hurts." When asked how teeth were checked, LPN #4 stated, "Normally when mouth care is done. The CNA (certified nursing assistant) would tell me." When asked what types of issues the CNA would report, LPN #4 stated, "If they're loose or painful." When asked what staff did if the teeth were broken or had obvious cavities, LPN #4 stated, "I'd check the chart for the RP (responsible party) and call the doctor." When asked if there were risks to having decayed and broken teeth, LPN #4 stated, "Decay can cause other health issues." LPN #4 was asked to look in Resident #116's mouth. The resident had no upper teeth, one tooth in the left back lower jaw with a deep black center, two broken teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw.

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When asked if there was decay in the teeth, LPN #4 stated, "Yes."

An interview was conducted on 3/15/18 at 10:45 a.m. with LPN, (licensed practical nurse) #7, the MDS coordinator. When asked why residents had care plans, LPN #7 stated, "The care plan drives the resident's care. They're individualized, comprehensive and based off the resident's general diagnoses, behaviors." When asked was included on the care plan, LPN #7 stated, "Generally we would discuss cognitive function, impaired communication, nutritional status, dental status." When asked who completed Section AL of the annual MDS, LPN #7 stated, "I do." LPN #7 was asked to review Section L of the annual MDS with an ARD of 10/27/17 and the dental care plan. When asked what staff do with the information on the MDS, LPN #7 stated, "The whole IDT (interdisciplinary team) looks at it." When asked about the risks of having decayed and broken teeth, LPN #7 stated, "Infection, cardiac issues." When asked who used the care plans, LPN #7 stated, "Pretty much the interdisciplinary team plays a role in the care plan." When asked if staff were expected to follow the care plan, LPN #7 stated, "I would say yes." When asked if the staff had followed Resident #116's care plan, LPN #7 stated they had not.

An interview was conducted on 3/15/18 at 11:05 a.m. with ASM #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "It helps to direct their care. It's kind of like a guide for caring for them. It's individualized." When asked who used the care plan, ASM #2 stated, "The whole interdisciplinary team." When asked what staff would do if they identified dental issues for a resident, ASM #2 stated, "I would

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expect it to be identified on admission and then every day when assisting the resident with mouth care." When asked if staff were expected to follow the care plan, ASM #2 stated, "Yes." ASM #2 was asked to examine Resident #116's mouth, ASM #2 stated, "Um hmm, I see." ASM #2 was made aware of the findings at that time.

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, divisional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to develop a comprehensive care plan to address the care needs of Resident #110's peripherally inserted central catheter (PICC).

Resident #110 was admitted to the facility on 2/17/18 with diagnoses that included but were not limited to: intraspinal abscess (1), high blood pressure, diabetes, sepsis, difficulty walking and knee surgery.

The most recent MDS, an admission assessment, with an ARD of 2/25/18 coded the resident as having scored 15 out of 15 on the BIMS, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. The resident was coded as receiving intravenously medications.

Review of the physician's orders dated and

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signed on 3/7/18 documented, "Flush Pic (sic) (2) per SASH (saline, antibiotic, saline and heparin (3)). Monitor IV (intravenous) site daily for s/s (signs and symptoms) of infection."

Review of the March 2018 MAR documented, "Flush Per SASH Protocol twice daily 10 cc (cubic centimeters) NS (normal saline) ABT (antibiotic) 10 cc NS 5 cc Heparin." There was no documentation regarding monitoring the site for signs of infection.

Review of the care plan did not evidence documentation regarding the PICC.

An interview was conducted on 3/15/18 at 10:45 a.m. with LPN, (licensed practical nurse) #7, the MDS coordinator. When asked why residents had care plans, LPN #7 stated, "The care plan drives the resident's care. They're individualized, comprehensive and based off the resident's general diagnoses, behaviors." When asked if a resident had a PICC would that be included on the care plan, LPN #7 stated, "Yes I would think that it should probably be care planned." When asked why, LPN #7 stated, "Because it would put them at an increased risk for infection." When asked who used the care plans, LPN #7 stated, "Pretty much the interdisciplinary team plays a role in the care plan."

An interview was conducted on 3/15/18 at 11:00 a.m. with LPN #5, the resident's nurse. When asked why a resident has care plan, LPN #5 stated, "Basically it's what kind of care we provided for the patient." When asked if staff were expected to follow the care plan, LPN #5 stated, "It should be." When asked if a PICC line would be care planned, LPN #5 stated, "Yes

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because we have to keep it clean or they could go septic and die."

An interview was conducted on 3/15/18 at 11:05 a.m. with ASM #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "It helps to direct their care. It's kind of like a guide for caring for them. It's individualized." When asked who used the care plan, ASM #2 stated, "The whole interdisciplinary team."

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, divisional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

1. Intraspinal -- situated within, occurring within, or introduced into the spinal column and especially the vertebral canal. This information was obtained from: https://www.merriam-webster.com/medical/intraspinal Abscess --: a localized collection of pus surrounded by inflamed tissue. This information was obtained from: https://www.merriam-webster.com/dictionary/abscess

2. PICC -- a device used to draw blood and give treatments, including intravenous fluids, drugs, or blood transfusions. A thin, flexible tube is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/picc

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3. Heparin -- heparin injection is an anticoagulant. It is used to decrease the clotting ability of the blood and help prevent harmful clots from developing in blood vessels. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010545/
4. The facility staff failed to float Resident #116's heels per the comprehensive care plan.

Resident #116 was admitted to the facility on 2/21/18 with diagnoses that included but were not limited to multiple sclerosis [1], difficulty walking, left drop foot [2], high blood pressure, pain to left lower leg, BPH (enlarged prostate), paraplegia, and acquired absence of toes. Resident #116 most recent MDS (minimum data set) was a quarterly assessment with ARD (assessment reference date) dated 2/21/18. Resident #116 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #116 was coded as requiring supervision only with most ADLs (activities of daily living). Resident #116 was coded as being independent with walking in his room and on the unit.

Review of Resident #116's clinical record revealed a care plan dated 10/12/16 that documented the following information: "(Name of Resident) has the potential for impaired skin integrity r/t (related to) incontinence, external forces, Medications, allergies, Cardiovascular disease, Hx (history of) Eczema-Psoriasis, Impaired mobility...left foot drop....(Name of Resident #116) will have intact skin, free of redness, blisters or discoloration through next review...interventions: ... Float heels."

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Review of Resident #116's care kardex (care plan for CNAs [certified nursing assistant]) documented the following: "Float heels."

On 3/15/18 at 8:45 a.m. and 9:56 a.m., observations were made of Resident #116. Resident #116 was lying in bed. His heels were not floated.

On 3/15/18 at 9:56 a.m., an interview was conducted with Resident #116. When asked if his heels were elevated on a pillow, Resident #116 stated that staff hadn't been telling him to do that and he could do it himself. Resident #116 stated he didn't think his heels needed it.

Review of Resident #116's Braden Scale for Predicting Pressure Sore Risk [3] revealed that his last assessment was completed on 4/5/17. Resident #116 was coded as being at risk for developing pressure sores.

On 3/15/18 at 10:49 a.m., an interview was conducted with RN (registered nurse) #2, the RN on the unit. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to serve as a guide of care for each resident. RN #2 stated that the care plan was supposed to reflect the resident. RN #2 stated the care plan should be followed or changes should be made to the care plan if interventions cannot be followed. RN #2 stated the care plan is also updated with any change in the resident's conditions. When asked who was responsible for updating the care plan, RN #2 stated that unit managers and the nurses on the unit (floor) nurses can update the care plan. RN #2 stated the care kardex was also updated to

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communicate with the CNAs (certified nursing assistants) any changes. RN #2 stated the nursing aides are also made of changes verbally. RN #2 was not familiar with Resident #116.

On 3/15/18 at 10:55 a.m., an interview was conducted with CNA (certified nursing assistant) #5, Resident #116's aide. When asked how CNAs would know what interventions to put into place for each resident such as skin preventive measures, CNA #5 stated that each resident had a piece of paper or kardex that alerted them on what each resident needed. When asked if Resident #116 needed anything in place to protect his skin, CNA #5 stated that he used to have heel boots but that they were discontinued. When asked the purpose of floating heels, CNA #5 stated, "So the heels don't get red and breakdown." When asked if Resident #116 was supposed to have his heels floated, CNA #5 stated that she didn't think so. When asked if she attempted or offered to float Resident #116's heels that day, CNA #5 sated, "No." When CNA #5, was shown Resident #116's Kardex, CNA #5 confirmed that it instructed to float his heels. When asked if Resident #116's heels were currently floated, CNA #5 stated she was not sure but could go check. This writer accompanied CNA #5 to Resident #116's room. His heels were observed flat on the bed.

On 3/15/18 at 11:00 a.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #116's nurse. When asked the purpose of floating heels, LPN #3 stated the purpose was to prevent skin breakdown and to prevent the skin from getting red. When asked if Resident #116 was supposed to have his heels floated on a pillow while in bed, LPN #3 stated that his heels

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were usually on a pillow if he was in bed. When asked if Resident #116 ever refused to float his heels, LPN #3 stated, "No, his heels are usually floated and I know because I am the treatment nurse." LPN #3 also stated that the resident gets out of bed often by himself. When asked if his heels were floated at that time, LPN #3 stated she was not sure. LPN #3 stated she did not check his heels that day. When asked if Resident #116 should still have an intervention to float heels on his care plan, LPN #3 stated if it was on the care plan than the intervention should be followed.

On 3/15/18 at 11:05 a.m., an observation of Resident #116's heels was conducted with LPN #3. His heels were intact and normal in color.

On 3/15/18 at 3:19 p.m., an interview was conducted with LPN #7, the MDS nurse. When asked if staff were expected to follow the care plan, LPN #7 stated that they were. When asked reasons why staff would not follow the care plan, LPN #7 stated that if an intervention becomes problematic, such as a resident refusing an intervention, then the care plan should be updated to reflect the resident.

No further information was presented prior to exit.

[1] multiple sclerosis- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the National Insitutes of Health.

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https://medlineplus.gov/multiplesclerosis.html.

[2] Left drop foot-Foot drop describes the inability to raise the front part of the foot due to weakness or paralysis of the muscles that lift the foot. As a result, individuals with foot drop scuff their toes along the ground or bend their knees to lift their foot higher than usual to avoid the scuffing, which causes what is called a "steppage" gait. Foot drop can be unilateral (affecting one foot) or bilateral (affecting both feet). This information was obtained from The National Insitutes of Health. https://www.ninds.nih.gov/Disorders/All-Disorders/Foot-Drop-Information-Page.

[3] The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers.
5. The facility staff failed to follow the comprehensive care plan to ensure Resident #114's call bell was within reach.

Resident #114 was admitted to the facility on 11/20/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, dementia, deep vein thrombosis (blood clot) and schizophrenia (any group of mental disorders characterized by gross distortions of reality, withdrawal from social contacts, and disturbances of thought, language, perception and emotional response) (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/11/17, coded the resident as having both short and long-term memory difficulties and as being severely

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impaired to make cognitive daily decisions. Resident #114 was coded as having impaired vision. Resident #114 was coded as requiring extensive assistance of one staff member for moving in the bed and transfers.

The comprehensive care plan dated, 1/9/18, documented in part, "Focus: (Resident #114) has the potential for injury r/t (related to) confusion, diabetes, gait/balance problems." The "Interventions" documented in part, "Be sure the resident's call light is within reach and encourage the resident to use it."

Observation was made on 3/14/18 at 11:00 a.m. of Resident #114 in her bed; the bed was in low the position. There were fall mats on each side of the bed. The call bell was on the floor, out of Resident #114's reach.

A second observation was made on 3/15/18 at 9:16 a.m. of Resident #114 in her bed with fall mats on each side of the bed. The call bell was on the floor out of Resident #114's reach.

An interview was conducted with CNA (certified nursing assistant) #1 on 3/15/18 at 1:25 p.m. When asked where a resident's call bell should be placed, CNA #1 stated, "It should be on the bed, attached to the covers." When asked if a call light on the floor, is a problem, CNA #1 stated, "They couldn't reach it and they could fall trying to reach it." When asked why a resident has a care plan, CNA #1 stated, "It tells us how to give them the proper care." When asked if she has access to the care plan, CNA #1 stated, "Yes." When asked if it should be followed, CNA #1 stated, "Yes."

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{F 656}	Continued From page 37 An interview was conducted with LPN (licensed practical nurse) #5 on 3/15/18 at 1:50 p.m. When asked why the residents have care plans, LPN #5 stated, "It tells us what kind of care we are to provide to the residents." When asked if the care plan should be followed, LPN #5 stated, "Yes." An interview was conducted with LPN #7, the MDS nurse, on 3/15/18 at 3:17 p.m. When asked if the care plan is to be followed, LPN #7 stated, "Yes." When asked if there were any reasons why the care plan should not be followed, LPN #7 stated, "There should not be." ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the divisional director of clinical services were made aware of the above concern on 3/15/18 at 6:15 p.m. No further information was provided prior to exit.	{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, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards for one of 18 residents in the survey sample, Resident #110 and Resident #118.	F 658	**F658: <u>Services to Provide Professional Standards</u>** 1. PICC care and treatment orders obtained 3/15/18 for resident #110. 2. Quality review of current resident's with a PICC completed by the DON/UM/designee to ensure physician orders are obtained and followed regarding residents with a PICC without omission. Follow up based on findings.	

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The facility staff failed to obtain a physician's order for the care and treatment of a peripheral inserted central catheter (PICC) and failed to change the dressing as per professional standard for Resident #110.

The findings include:

Resident #110 was admitted to the facility on 2/17/18 with diagnoses that included but were not limited to: intraspinal abscess (1), high blood pressure, diabetes, sepsis, difficulty walking and knee surgery.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 2/25/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. The resident was coded as receiving intravenously medications.

Review of the physician's orders dated and signed on 3/7/18 documented, "Flush Pic (sic) (2) per SASH (saline, antibiotic, saline and heparin (3). Monitor IV (intravenous) site daily for s/s (signs and symptoms) of infection." There were no other orders for the care and treatment of the PICC.

Review of the March 2018 MAR documented, "Flush Per SASH Protocol twice daily 10 cc (cubic centimeters) NS (normal saline) ABT (antibiotic)

3. Licensed nurses re-educated by the DON/UM/designee to ensure physician orders are obtained and followed regarding residents with a PICC without omission.

4. DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting to ensure physician orders are obtained and followed regarding residents with a PICC without omission 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 4-15-18.

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10 cc NS 5 cc Heparin." There was no documentation regarding monitoring the site for signs of infection. There was no documentation regarding changing the PICC dressing.

Review of the nurses' notes from 3/4/18 through 3/15/18 did not evidence documentation regarding the PICC dressing being changed. Review of the notes did not evidence that the PICC line site was being monitored for signs and symptoms of infections on nine occasions.

An interview was conducted on 3/15/18 at 11:00 a.m. with LPN #5, the resident's nurse. When asked if staff were expected to follow the care plan, LPN #5 stated, "It should be." When asked if a PICC line would be care planned , LPN #5 stated, "Yes, because we have to keep it clean or they could go septic and die."

An observation was made on 3/15/18 at 12:00 of Resident #110. A request was made to check the resident's PICC dressing. The dressing was gauze with an occlusive dressing over it. The edges of the occlusive dressing were partially detached from the skin. The insertion site could not be visualized and there was no date on the dressing. Resident #110 was asked when the dressing had been changed, Resident #110 stated, "Maybe sometime last week. I can't remember." LPN #5 was asked to observe the resident's PICC dressing. When asked if the dressing was dated, LPN #5 stated, "No." When asked when the last time the dressing was changed, LPN #5 stated she didn't know. Resident #110 stated, "I get it wet sometimes, I can't help it. No one will wrap it up for me."

A request was made to ASM (administrative staff

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member) #2 the director of nurses on 3/15/18 at 1:00 p.m.for evidence that the PICC dressing had been changed. ASM #2 stated there was no evidence that the dressing had been changed. ASM #2 was asked what professional standards they used.

An interview was conducted on 3/15/18 at 2:00 p.m. with LPN #4, the resident's nurse that day. When asked when Resident #110's dressing was changed, LPN #4 stated, "I did it once." When asked what day LPN #4 couldn't remember. When asked how often a gauze dressing would be changed, LPN #4 didn't know. When asked why the dressing was changed, LPN #4 stated, "In case it has drainage?" When asked if staff would obtain an order from the physician for care and treatment of a PICC, LPN #4 stated they should. When asked if the dressing change should be noted on the treatment administration record, LPN #4 stated it should be. When asked how staff knew when to change the resident's PICC dressing, LPN #4 did not have a response.

On 3/15/18 at approximately 3:00 p.m. ASM #3, the divisional director of clinical services stated the facility used Lippincott as their professional standard.

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3 the divisional director of clinical services were made aware of the findings.

Review of the facility's policy titled, "Midline Catheter Dressing Change" documented, "Considerations: 1. The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection. 2. A transparent

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dressing is the preferred dressing. Guidance: 2. When a transparent dressing is applied over a sterile gauze dressing it is considered a gauze dressing and is changed: 2.1 24 hours post-insertion or upon admission. 2.2 Every two days. 2.3 If the integrity of the dressing has been compromised (wet, loose or soiled). 5. Assessment of the vascular access site is performed: 5.4 At least once every shift when not in use. 6. Assessment of entire arm with indwelling vascular access device (VAD) for infusion related complications is to include, but is not limited to, the absence or presence of: 6.1 Erythema (redness). 6.2 Drainage. 6.3 Swelling or induration, 6.4 Change in skin temperature at site. 6. 5 Tenderness at the site or along vein tract. 6.6 Integrity of transparent dressing. 6.7 Numbness or tingling during insertion or dwell... Procedure: 1. Verify physician/license independent practitioner (LIP) order."

No further information was obtained prior to exit.

1. Intraspinal -- situated within, occurring within, or introduced into the spinal column and especially the vertebral canal. This information was obtained from: https://www.merriam-webster.com/medical/intraspinal Abscess -- : a localized collection of pus surrounded by inflamed tissue. This information was obtained from: https://www.merriam-webster.com/dictionary/abscess

2. PICC -- a device used to draw blood and give treatments, including intravenous fluids, drugs, or blood transfusions. A thin, flexible tube is inserted

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F 658	Continued From page 42 into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/picc 3. Heparin -- heparin injection is an anticoagulant. It is used to decrease the clotting ability of the blood and help prevent harmful clots from developing in blood vessels. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010545/	F 658		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide treatments and care in accordance with professional standard of practice and the comprehensive person-centered care plan for one of 18 residents in the survey sample, Resident #117. The facility staff failed to have the Resident #17	{F 684}	**F684: Quality of Care** 1. Resident #117 1:1 discontinued per physician order on 3/15/18. Resident #117 room changed per physician order on 3/15/18. 2. Quality review of current residents completed by the DON/UM/designee to ensure physician orders are followed for residents requiring 1:1 supervision. Follow up based on findings. Quality review of current residents completed by the DON/UM/designee to ensure physician orders are followed for residents requiring a room change. Follow up based on findings.	

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on one to one supervision per the physician order and failed to have Resident #17 in a physician prescribed room.

The findings include:

Resident #117 was admitted to the facility on 2/9/18 with a recent readmission on 3/13/18 with diagnoses that included but were not limited to: vascular dementia, abnormal gait and balance, stroke, diabetes, depression, and high blood pressure.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/16/18 coded the resident rarely understanding others and rarely making herself understood. The resident was coded as having both short and long-term memory difficulties. Resident #117 was coded as having the following behaviors during the look back period; physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards other, and other behavioral symptoms not directed towards others such as hitting, scratching pacing, rummaging or verbal/vocal symptoms like screaming and disruptive sounds. Resident #117 was coded as requiring limited assistance of one staff member for most of her activities of daily living.

The physician order dated, 3/11/18 documented, "Place resident on 1:1 (one to one). Resident moved to (room #) B."

There were no further orders to discontinue the one to one and no order to move Resident #117 back to (room #) A.

3. Licensed nurses re-educated by the DON/UM/designee regarding ensuring physician orders are followed regarding residents requiring 1:1 supervision.
Licensed nurses re-educated by the DON/UM/designee regarding ensuring physician orders are followed regarding residents requiring a room change.

4. DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting to ensure physician orders are followed regarding residents requiring 1:1 supervision 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting to ensure physician orders are followed regarding residents requiring a room change 5 x weekly x 2 weeks, 3x weekly x 4

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Resident #117 was observed at the following dates and times. At no time during the survey process was Resident #117 observed to be on one to one supervision. All observations were made of the resident being in (room #) A.
- 3/14/18 at 2:15 p.m. Resident #117 was observed in the hall in a wheelchair.
- 3/14/18 at 4:30 p.m. Resident #117 was observed in the hall in a wheelchair being pushed by a friend.
- 3/15/18 at 8:08 a.m. Resident #117 was observed walking in the hall, very unsteady and wearing a shirt and briefs. (staff member intervened).
- 3/15/18 at 9:43 a.m. Resident #117 was observed sitting on the side of her bed.
- 3/15/18 at 10:00 a.m. Resident #117 was in a wheelchair being pushed by another resident. An activities staff member pushed Resident #117 in her wheelchair to outside the door to her room (room #A).
- 3/15/18 at 10:20 a.m. Resident #117 was in her bed. LPN (licensed practical nurse) #7 was observed talking to the resident from the doorway cautioning her to not get up because her floor was wet (floor had just been cleaned by housekeeping).
- 3/15/18 at 12:58 p.m. Resident #117 was observed in her room with two visitors. Resident #117 was in a wheelchair.

The nurse's note dated, 3/11/18 at 3:15 p.m. documented in part, "Resident starts yelling at her roommate racial remarks at her roommate. Resident and roommate had a verbal altercation. Residents were immediately separated. Resident was placed on 1:1 and moved to another (room). Resident became aggressive pushing writer, hitting writer and pulling clothes of writer. MD

weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated.
Quality monitoring schedule modified based on findings.
5. Date of Compliance 4-15-18.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 45	{F 684}		

(medical doctor) and RP (responsible party) made (aware) of this."

The nurse's note dated, 3/11/18 at 4:00 p.m. documented in part, "Resident continues on 1:1."

The nurse's note dated, 3/11/18 at 10:00 p.m. documented in part, "Continue 1:1."

On 3/12/18 (11-7) (11:00 p.m. to 7:00 a.m.) Resident resting quietly. No c/o (complaints of) pain noted. 1:1 continues."

There was no further documentation in the nurse's notes of the 1:1 supervision.

The Medication administration record and the treatment administration record for March 2018 did not reveal any documentation of the 1:1 supervision.

The comprehensive care plan dated, 2/21/18 and revised on 3/15/18, documented in part, "Focus: Potential for impaired or inappropriate behaviors r/t (related to) diagnosis anxiety and depression AEB (as exhibited by): yelling, screaming, crying, wandering, throwing self backward on bed, sliding to floor, and combative at times punching, yelling, exit seeking, asking for rides so she can meet her parents, noncompliant with use of assistive devices, resident desired to leave facility without needed supervision." The "Interventions" documented in part, "Assess behaviors for underlying medical causes. Assess for changes in psychosocial status and/or environment. Encourage resident to express feelings in appropriate manner. If resident, is violent, remove others and give resident time to calm down. Do not approach until resident is calmer.

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Monitor for increase in behaviors or unsafe behavior and report to physician prn (as needed). Provide calm, quiet environment during periods of agitation or violent behavior. Redirect inappropriate behaviors as needed. Remove sources of agitation as possible. Remove the resident from the area."

An interview was conducted with LPN (licensed practical nurse) #3 on 3/15/18 at 1:13 p.m. When asked if Resident #117 was on one to one supervision, LPN #3 stated, "Right now, no." LPN #3 was shown the physician order dated 3/11/18. When asked why she was not on one to one, LPN #3 stated, "I was off the weekend and when I came in on Monday, the aide assigned to the one to one asked me who was relieving her. I told her I would have to check. The night nurse told me she was on one to one because she got into it with her roommate." When asked which room she was in on Monday morning when she came on duty, LPN #3 stated, "She was in (room #) A. I was told by administration that she didn't need the one to one any longer." When asked if there was an order to discontinue the one to one or a nurse's note that explains why and when she was able to come off one to one supervision, LPN #3 stated, "I don't see one." When asked if there was a physician order to let Resident #117, go back to her original room (room #) A, LPN #3 stated, "No, I haven't seen one."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/15/18 at 2:35 p.m. When asked if there is an order for one to one supervision and no order to discontinue it, should the resident still be on one to one supervision, ASM #2 stated, "Yes." When asked if there is an order for a resident to be

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{F 684} Continued From page 47

moved to another room and no further orders to change rooms, which room should the resident be in, ASM #2 stated, "In the room the order was written for." When you came in on Monday, which room was Resident #117 in, ASM #2 stated, "(Room #) A." When asked when she came in on Monday, was Resident #117 on one to one supervision, ASM #2 stated, "Not that I'm aware of."

During an interview with ASM #1, the executive director, on 2:58 p.m. ASM #1 informed this surveyor Resident #117 was not on one to one when she entered the building on 3/12/18 at approximately 7:30 a.m.

The facility policy, "Physician Orders" did not document how to follow the physician orders.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

The executive director, director of nursing and the divisional director of clinical services were made aware of the above finding on 3/15/18 at 6:15 p.m.

No further information was provided prior to exit.

{F 684}

{F 689} SS=D Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -

{F 689}

F689: Free From Accidents and Hazards/Supervision/Devices

1. Identified non-medical grade power strips removed from the patient vicinity defined as 7 feet above and 6 feet around the resident bed on 3-14-18
Objects and plastic bags removed from on top of and/or around identified power strips on 3-14-18

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{F 689}	Continued From page 48 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation, it was determined the facility staff failed to ensure power strips were safely installed and maintained for 11 of 179 occupied beds. The facility staff failed to maintain non-medical grade power strips outside the patient vicinity, which is defined as seven feet above the bed and six feet around the bed. The findings include: An observation was made on 3/14/18 at 2:30 p.m. of room 129 A (the bed next to the door). There was a power strip plugged into the electrical plug behind the bed. The resident's television and refrigerator were connected to the power strip. The power strip was approximately a foot from the side of the bed. All available resident's rooms were then observed and power strips were seen in several rooms. In room 107 B (the bed next to the window); a partially filled plastic bag was lying on top of the power strip. In room 117 A a gift bag filled with clothes was lying on top of the power strip. In room 112 A an extension cord was plugged into the electrical outlet behind the bed and the resident's telephone charger and phone were connected to it.	{F 689}	2. Quality review completed by the ED/DON/IDT/Maintenance Director/designee to ensure non-medical grade power strips are not used within the patient vicinity defined as 7 feet above and 6 feet around the resident bed. Follow up based on findings. M& M Solutions Instillation of Electrical Receptacles in current residents' rooms initiated 3-15-18. Quality review completed by the ED/DON/IDT/Maintenance Director/designee to ensure objects and plastic bags are not on top of and/or around power strips. Follow up based on findings.	

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{F 689}	Continued From page 49 An interview was conducted on 3/14/18 at 4:00 p.m. with OSM (other staff member) #2, the director of maintenance. When asked could residents have power strips, OSM #2 stated, "We can't, we can only use the hospital grade ones. There's only two types we can use within six feet of a patient area." When asked where he obtained that information, OSM #2 stated, "The fire Marshall." OSM #2 stated, "We're working on getting more outlet space because when this building was built we had the crank beds." A facility tour was conducted on 3/14/18 at 4:05 p.m. with OSM #2 and two surveyors. Each available room was entered. When asked if the power strip in room 129 A, was medical grade, OSM #2 stated it was not. OSM #2 stated, "It's a struggle because we have families bring them in." When asked what process they had to check to see if power strips were brought in, OSM #2 stated, "We have a program that we do (a unit) weekly so the whole building is done each month." When asked how they were tracking power strips, OSM #2 stated, "We're supposed to inventory them but they don't." When asked when he became aware that the non-medical grade power strips had to be six feet from the resident's bed, OSM #2 stated, "I just found out about it not too long ago after the fire marshal came back." When asked when the fire marshal came back, OSM #2 stated, "December." When asked if they did not pass the first inspection, OSM #2 stated, "No." When asked what could be plugged into non-medical grade power strips, OSM #2 stated, "Only resident devices. TVs, refrigerators." When asked if medical devices could be plugged into non-medical grade power strips, OSM #2 stated, "No." When asked what was considered a medical device, OSM #2 stated, "The bed,	{F 689}	3. ED and Maintenance re-educated by the DDCS regarding ensuring non-medical grade power strips are not utilized in the patient vicinity defined as 7 feet above and 6 feet around the resident bed. Current staff re-educated by the ED/DDCS/Maintenance Director/designee to ensure non-medical grade power strips are not utilized in the patient vicinity defined as 7 feet above and 6 feet around the resident bed with notification to the ED/Maintenance Director at the time observed. Current staff re-educated by the ED/DDCS/Maintenance Director/designee to ensure objects and plastic bags are not on top of and around power strips.	

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oxygen concentrators, tube feeding machines." When asked if there was any hazard to having trash bags or clothes on top of a power strip, OSM #2 stated, "Moisture." When asked if there were any other hazards, OSM #2 didn't have a response.

The following rooms were observed by OSM #2 and the two surveyors to have non-medical grade power strips within the patient care vicinity and medical devices plugged in to some of them:

103 A -- non-medical grade power strip with bed plugged into it. Next to the bed.
107 B -- non-medical grade power strip with a clear trash bag partially filled with white objects was laying on top of it. Next to the bed.
109 A -- a non-medical grade power strip was plugged into another non-medical grade power strip with the bed plugged into it. Next to the bed.
112 A -- a white short extension cord with the television and phone charger plugged into it. Next to the bed.
117 A -- a bag of clothes was lying on top of a medical grade power strip. Next to the bed.
118 B -- a non-medical grade power strip with the bed plugged into it. Next to the bed.
123 A -- non-medical grade power strip next to bed.
127 A -- non-medical grade power strip with the bed plugged into it, behind the bed.
127 B -- tube feeding pump plugged into bed A's non-medical power strip.
129 A -- non -medical grade power strip next to the bed.
214 A -- non-medical grade power strip with the tube-feeding pump connected to it. Next to the bed.

4. ED/DON/IDT/designee to conduct random quality monitoring through mock survey rounds ensuring non-medical grade power strips are not used within the patient vicinity defined as 7 feet above and 6 feet around the resident bed daily x 4weeks, 5 times weekly x 2 weeks, 4 times weekly x 2 weeks then twice weekly then PRN as indicated.
ED/DON/IDT/designee to conduct random quality monitoring through mock survey rounds ensuring objects and plastic bags are not on top of and/or around power strips daily x 4weeks, 5 times weekly x 2 weeks, 4 times weekly x 2 weeks then twice weekly then PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of compliance 4-15-18.

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None of the non-medical grade power strips were more than two feet away from the bed.

An interview was conducted on 3/14/18 at 4:20 p.m. with LPN (licensed practical nurse) #5. When asked what could be plugged into a power strip, LPN #5 stated, "It has to be medical grade." When asked what process staff followed if a resident had a non-medical grade power strip in their room, LPN #5 stated, "I'd let (OSM #2) know." They can't be in there. That's not allowed only medical things." When asked why the power strip could not be used, LPN #5 stated, "Because it hasn't been tested." When asked if there was any hazard to leaving trash bags or clothes on a power strip, LPN #5 stated, "Yes ma'am. It's a fire hazard."

An interview was conducted on 3/15/18 at 8:50 a.m. with ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the divisional director of clinical services and OSM #2, the director of maintenance. ASM #1 stated, "The fire marshal came in October and we didn't clear on the power strips." ASM #1 stated the fire marshal had accepted the plan of correction, which would be completed in October of 2018. OSM #2 showed this surveyor an email dated February 2018 from the corporate director of maintenance. The email stated that non-medical grade power strips could be used in the resident's room for resident devices as long as they were not in the patient care vicinity that was defined as seven feet six inches above the bed and six feet around the bed. A request for a copy of the email was made at that time but was not received. OSM #2 stated, "Families bring them in all the time. So we don't have enough plugs in the rooms for all of the

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resident's devices so we use power strips." When asked since he was aware that families brought in power strips what plan did he develop and implement to prevent power strips from being within six feet of the bed, OSM #2 did not have a response. When asked what plan he had developed and implemented to ensure medical devices were plugged into medical grade power strips, OSM #2 had no response. When asked if there was any hazard in having trash bags and clothes on the power strips, ASM #1 stated, "Fire."

Review of the life safety code initial comments dated 12/20/17 documented, "An unannounced Life Safety Code revisit to the standard survey conducted on 10/30/17 was conducted on 12/20/17...The facility was in compliance with the Requirements for Participation Medicare and Medicaid.

No further information was provided prior to exit.

In its Standard for Health Care Facilities (NFPA 99), (1) NFPA defines a patient care area as "any portion of a health care facility wherein patients are intended to be examined or treated." For equipment intended to be used within these areas-which include patient, examining, and treatment rooms, as well as any similar areas in which the patient is likely to come into contact with electrical devices-NFPA specifies that chassis leakage currents should not exceed 300 microamperes. (Note that this limit was increased from the pre-1993 limit of 100 microamperes.) However, NFPA does permit exceptions under certain conditions; for example, leakage currents up to 500 microamperes are permitted if the leakage current does not represent a hazard to

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{F 689}	Continued From page 53 the patient and if the grounding connection remains intact. Also, when chassis leakage from equipment that will be used in the area exceeds 500 microamperes, NFPA permits the use of leakage current reduction methods, such as adding an isolation transformer or redundant ground. Within the patient care area, NFPA further requires that any equipment intended for placement near the patient meet additional requirements. NFPA refers to the area near the patient as the patient care vicinity, which it defines as "a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, . . . or other device that supports the patient . . . [and] vertically to 7 ft 6 in (2.3 m) above the floor." For equipment to be used in this space, NFPA requires that the resistance between conductive chassis surfaces and a reference grounding point not exceed 0.50 W. (NFPA established the concept of a patient care vicinity so that the entire room would not need to meet the stricter requirement.) This information was obtained from: http://www.mdsr.ecri.org/summary/detail.aspx?doc_id=8286	{F 689}		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable	F 770	**F770: Laboratory Services** 1. Resident #113 CMP obtained per physician order on 3/15/18. 2. Quality review of current residents over the last 30 days completed by the DON/UM/designee to ensure laboratory tests are obtained per physician order. Follow up based on findings.	

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F 770	Continued From page 54	F 770		

requirements for laboratories specified in part 493 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to obtain a laboratory test per the physician orders for one of 18 residents in the survey sample, Resident #113.

The facility staff failed to obtain a CMP (comprehensive metabolic panel) ordered by the physician for Resident #113.

The findings include:

Resident #113 was admitted to the facility on 2/2/18 with a readmission on 2/26/18, with diagnoses that included but were not limited to: stroke, contractures, diabetes, high blood pressure, elevated fats in the blood, and vascular dementia with behavioral issues.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/13/18, coded the resident as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was totally dependent on one or more staff members for all of his activities of daily living.

The physician order dated, 3/11/18, documented, "CMP."

A Comprehensive Metabolic Panel (CMP) is used as a broad screening tool to evaluate organ function and check for conditions such as diabetes, liver disease, and kidney disease. The

3. Licensed nurses re-educated by the DON/UM/designee ensuring laboratory tests are obtained per physician order. Licensed nurses re-educated by the DON/UM/designee ensuring residents with orders for laboratory tests are documented on the 24 Hour Report.

4. DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting ensuring laboratory tests are obtained per physician order 5 x weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.

DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting ensuring residents with orders for laboratory tests are documented on the 24 Hour Report 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated.

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CMP may also be ordered to monitor known conditions, such as hypertension, and to monitor people taking specific medications for any kidney- or liver-related side effects. If a doctor is interested in following two or more individual CMP components, she may order the entire CMP because it offers more information. (1)

Review of the clinical record failed to evidence the test results for the CMP.

The comprehensive care plan dated, 2/6/18, failed to evidence documentation related to laboratory testing.

An interview was conducted with LPN (licensed practical nurse) #3 on 3/15/18 at 11:30 a.m. LPN #3 was shown the physician order for the CMP and asked to locate the results. LPN #3 stated, she would get back with this writer. At 11:40 a.m., LPN #3 was asked if she had found anything, LPN #3 stated, "I'm calling the lab (laboratory) now." At 1:07 p.m., LPN #3 returned to this writer and stated that she had contacted the lab. They had lab results for 3/10/18 but the name and date of birth didn't match the name and date of birth for Resident #113. LPN #3 stated, "We just ordered the lab to be completed STAT (Immediate)." When asked if the test was performed per the physician order, LPN #3 stated, "No, Ma'am."

The executive director, director of nursing and the divisional director of clinical services were made aware of the above concern on 3/15/18 at 6:15 p.m.

No further information was provided prior to exit.

Quality monitoring schedule modified based on findings.

5. Date of Compliance 4-15-18.

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F 773 SS=D	Continued From page 56 Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii)	F 773		

§483.50(a)(2) The facility must-
(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.
(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to obtain a physician's order prior to obtaining a laboratory specimen for one of 18 residents in the survey sample, Resident #111.

The facility staff failed to obtain a physician's order for a comprehensive metabolic panel (CMP) obtained on 3/8/18 for Resident #111.

The findings include:

Resident #111 was admitted to the facility on 7/10/15 with diagnoses that included but were not limited to: diabetes, heart failure, chronic lung disease, irregular heartbeat, high blood pressure and falls.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 12/14/17 coded the resident as

F773: Lab Services/Physician/Notify of Results

1. Resident #111 CMP obtained per physician order 3/08/18.
2. Quality review of current residents over the last 30 days completed by the DON/UM/designee to ensure laboratory tests are obtained per physician order. Follow up based on findings.
3. Licensed nurses re-educated by the DON/UM/designee ensuring laboratory tests are obtained per physician order. Licensed nurses re-educated by the DON/UM/designee ensuring residents with orders for laboratory tests are documented on the 24 Hour Report.

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having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living with the exception of eating which the resident could perform after the tray was set up.

Review of the care plan initiated on 1/30/17 and revised on 1/9/18 documented, "Focus. The resident is at risk for bleeding and decreased cardiac output...Interventions. Monitor labs (laboratory specimens) as ordered and notify the physician of results."

Review of the clinical record documented the resident had a complete metabolic panel (CMP) (1) on 3/8/18.

Review of the physician's orders did not evidence a physician's order for a CMP for that date.

An interview was conducted on 3/15/18 at 11:00 a.m. with LPN #5, the resident's nurse. When asked about the process staff follows to obtain laboratory specimens, LPN #5 stated, "We get a doctor's order." When asked if they ever obtained a laboratory test without a physician's order LPN #5 stated, "No." A request for the 3/8/18 CMP laboratory specimen order was requested at that time. LPN #5 stated, "The doctor ordered the CMP for 3/19/18 but I got it drawn on 3/8/18." When asked if she had asked the doctor if he wanted the CMP drawn on 3/8/18, LPN #5 stated she had not.

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, divisional director of clinical services were

4. DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting ensuring laboratory tests are obtained per physician order 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting ensuring residents with orders for laboratory tests are documented on the 24 Hour Report 5 x weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated.
Quality monitoring schedule modified based on findings.
5. Date of Compliance 4-15-18.

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made aware of the findings.

Review of the facility's policy titled, "Laboratory, Diagnostic and X-Ray" documented, "Policy: To provide guidance on ordering, obtaining, documenting and reporting laboratory, diagnostic and x-ray results. Procedure: Obtain a physician's order for laboratory work, diagnostic testing, and x-ray."

No further information was provided prior to exit.

F 790 SS=D Routine/Emergency Dental Srvcs in SNFs
CFR(s): 483.55(a)(1)-(5)

§483.55 Dental services.
The facility must assist residents in obtaining routine and 24-hour emergency dental care.

§483.55(a) Skilled Nursing Facilities
A facility-

§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;

§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;

F 773

F 790

F790: Routine/Emergency Dental Srvcs/SNF

1. Resident #116 dental consult obtained per physician order on 3/15/18. Dental visit scheduled 3/28/18.
2. Quality review of current residents completed by the DON/UM/designee to ensure residents receives a dental consult per physician order. Follow up based on findings.
   Quality review of current residents completed by the DON/UM/designee to ensure residents oral status evaluation is current per policy. Follow up based on findings.
3. Licensed nurses re-educated by the DON/UM/designee ensuring residents receive a dental consult per physician order.
   Licensed nurses re-educated by the DON/UM/designee ensuring residents oral status evaluation is current per policy. Follow up based on findings.

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F 790	Continued From page 59 §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document and clinical record review, it was determined that the facility staff failed to provide dental services for one of 18 residents in the survey sample. Facility staff failed to obtain a consult for dental services for Resident #116. The findings include: Resident #116 was admitted to the facility on 10/20/15 with diagnoses that included but were not limited to: stroke, Alzheimer's disease, diabetes, depression and difficulty swallowing. The most recent MDS, a quarterly assessment, with an ARD of 2/5/18 coded the resident as having short-term and long-term memory problems and severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.	F 790	4. DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting to ensure residents receive a dental consult per physician order 5 x weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. DON/UM/designee to conduct quality monitoring through Morning Clinical Meeting to ensure residents oral status evaluation is current per policy 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 4-15-18.	

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Review of the annual MDS with an ARD of 10/27/17 in Section L -- Oral/Dental Status documented, "D. Obvious or likely cavity or broken natural teeth."

An observation was made on 3/14/18 at 10:40 a.m. of Resident # 116. The resident was lying in a recliner in the hallway. His eyes were closed and his mouth was open. In the lower jaw, there were two teeth broken to the gum line and the gums were reddened and slightly swollen around the area. There were approximately seven teeth, which had food debris, a greenish/gray substance at the base of the teeth, and the teeth had black decay above that.

A review of the care plan initiated on 10/27/16 and revised on 11/7/17 documented, "Focus. (Name of resident) has potential for imbalanced nutrition r/t (related to)...Chewing Problem...Resident has poor dentition. Interventions. Monitor/document/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of oral/dental problems needing attention. Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed..."

An interview was conducted on 3/15/18 at 9:30 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked the process staff follow if a resident has dental issues, LPN #4 stated, "If they're vocal they can verbalize if it hurts." When asked how teeth were checked, LPN #4 stated, "Normally when mouth care is done. The CNA (certified nursing assistant) would tell me." When asked what types of issues the CNA would report, LPN #4 stated, "If they're loose

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or painful." When asked what staff did if the teeth were broken or had obvious cavities, LPN #4 stated, "I'd check the chart for the RP (responsible party) and call the doctor." When asked if there were risks to having decayed and broken teeth, LPN #4 stated, "Decay can cause other health issues." LPN #4 was asked to look in Resident #116's mouth. The resident had no upper teeth, one tooth in the left back lower jaw with a deep black center, two broken teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw. When asked if there was decay in the teeth, LPN #4 stated, "Yes."

An interview was conducted on 3/15/18 at 10:45 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked how oral care was conducted, CNA #8 stated, "First of all you have to make sure they're not NPO (nothing by mouth). I try to wet his mouth first and brush his teeth." When asked what staff look for while doing mouth care, CNA #8 stated, "If the teeth are broken, if the teeth are rotting." When asked if Resident #116 had broken and rotting teeth, CNA #8 stated, "Yes. I told them. They told me they were aware and to make sure to still perform oral care on him."

An interview was conducted on 3/15/18 at 11:05 a.m. with ASM #2, the director of nursing. When asked what was expected of staff regarding dental issues, ASM #2 stated, "What I would expect is it to be identified on admission and then everyday when assisting the resident with mouth care." When asked how residents obtained dental services, ASM #2 stated, "This would an all depends situation. We would ask the family if they had a dentist. If not we would work with them to find a dentist." ASM #2 was asked to examine

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Resident #116's mouth, ASM #2 stated, "Um hmm, I see." ASM #2 was asked if there was ever a consult or a conversation with the family or physician about the care of Resident #116's teeth. ASM #2 stated, "Let me look into that."

On 3/15/18 at 1:05 p.m. ASM #2 stated, "There's no consult." When asked if there was any documentation about the resident's teeth, ASM #2 stated, "No."

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, divisional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

F 812 SS=E Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional

F 790

F 812

F812: Food Procurement/Store Prepare/Serve

1. Identified OSM #1 re-educated by the ED regarding how to properly wear a hair net when serving food form the steam table.
Identified CNA#10 re-educated by the ED regarding serving food to residents in a sanitary manner.
Resident identified in the 2567 did not suffer any adverse effects r/t food served in the dining room on 3/15/18.

2. Quality review of the kitchen/steam table during meal service completed by the ED/Dietary Manger (DM)/ designee to ensure hair nets are worn properly when serving food from the steam table. Follow up as indicated.
Quality review of meal service completed by the ED/DON/IDT/designee ensuring food is served to residents in a sanitary manner. Follow up as indicated.

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standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and in the course of a complaint investigation, the facility staff failed to serve food in a sanitary manner for one of two dining rooms (the main dining room).

1. The facility staff failed to wear hair restraints properly while serving food from the steam table.

2. The facility staff failed to serve food to the residents in a sanitary manner in the main dining room.

The findings include:

1. On 3/15/18 at 11:55 a.m., an observation of the main dining room was conducted. OSM (other staff member) #1, the dietary aide was observed at the steam table dishing out food and placing them on resident plates. OSM #1 had a one-inch piece of hair coming out of the front of her hair net. Her strand of hair was covering an eyebrow piercing.

On 3/15/18 at 12:20 p.m., the regional dietary manager (OSM #3) was observed walking by OSM #1. When asked how his staff should be wearing hairnets, OSM #3 stated that dietary staff should have all of their hair tucked underneath the net. When asked the purpose of the hairnet, OSM #3 stated that it was an infection control issue if hair were to get into the food. When asked if OSM #1 was wearing her hair net properly, OSM # 3 stated that she wasn't. OSM #3 then instructed OSM #1 to fix her hairnet.

3. Dietary staff re-educated by the DM/ED/designee regarding ensuring hair nets are worn properly while in the kitchen when serving food from the steam table. CNAs re-educated by the ED/DON/IDT/designee regarding ensuring food is served to residents in a sanitary manner.

4. ED/DM/designee to conduct random quality monitoring of the kitchen to ensure hair nets are worn properly when serving food from the steam table 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
DON/UM/IDT/designee to conduct random quality monitoring of meal service to ensuring food is served to residents in a sanitary manner 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.

5. Date of Compliance 4-15-18.

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On 3/15/18 at 6:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the DON (Director of Nursing) was made aware of the above concerns.

The facility policy titled, "Staff Attire;" documents in part, the following: "All staff members will have their hair off their shoulders, confined in a hair net or cap, and facial hair properly restrained."

No further information was presented prior to exit.

2. The facility staff failed to serve food to the residents in a sanitary manner in the main dining room.

On 3/15/18 at 11:55 a.m., an observation of the main dining room was conducted. At 11:55 p.m., CNA (certified nursing assistant) 10 was observed taking a plate from the steam table and serving it to a resident. CNA #10 was not wearing gloves, and her fingers were on the edge of the plate. CNA #10 had very long, fake nails. On 11:56 p.m., CNA #10 was observed sanitizing her hands and then grabbing another plate with her bare fingers on the edge of the plate. This plate was then served to a resident.

On 3/15/18 at 12:06 p.m., CNA #1, was observed holding a plate close to her body. The plate was not touching her clothes but a long strand of her hair was resting on top of the breaded okra. CNA #1 then proceeded to serve this plate, also with her bare fingers touching the edge of the plate, to the resident.

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On 3/15/18 at 12:20 p.m., the resident who received the plate from CNA #1 had eaten 100 percent of the breaded okra.

On 3/15/18 at 1:18 p.m., an interview was conducted with CNA #1. When asked how to maintain infection control while serving food to residents in the dining room, CNA #1 stated that she should hold the food a few inches away from her body. When asked why she should hold the food a few inches away from her body, CNA #1 stated, "So hair couldn't get into it, that's nasty." When asked how she should hold a plate while transporting a resident's meal from the steam table to the resident, CNA #1 demonstrated holding a plate by using a clipboard. CNA #1 demonstrated that her thumbs would be on the edge of the plate. When asked if she should have her thumbs on the edge of the plate, CNA #1 quickly removed her thumps from the clipboard and stated, "Oh no." When asked why bare thumbs should not be on the edge of the plate, CNA #1 stated that something on her hands could touch the food. When asked if she had fake nails, CNA #1 stated that she did. When asked if they were allowed to be worn while serving food, CNA #1 stated, "I don't know, everybody has fake nails." CNA #1 stated she was not aware of the observations made while she was in dining.

On 3/15/18 at 6:15 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the DON (Director of Nursing) was made aware of the above concerns.

The facility policy titled, "Staff attire" documents in part, the following: "Fingernails will be kept clean and neat. Nail polish and/or acrylic nails are not

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F 812	Continued From page 66 permitted." Another facility policy titled, "Meal Distribution," documents in part, the following: "Meals are transported to the dining locations in a manner that ensure proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner..." No further information was presented prior to exit.	F 812		
F 813 SS=E	Complaint deficiency Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to store residents' food in a sanitary manner for two of three nourishment rooms (Unit 2 and Unit 3). The facility staff failed to label and date food that was brought in by family/visitors for resident use in two of three nourishment rooms. (Unit 2 and Unit 3). The findings include: On 3/15/18 at approximately 8:30 a.m., an observation was conducted of the Unit 3 nourishment room. Four bowls were found covered with aluminum foil in the refrigerator.	F 813	**F813: Personal Food Policy** 1. Identified food items Unit 2 nourishment room refrigerator discarded 3/16/18. Identified food items Unit 3 nourishment room refrigerator discarded 3/16/18. Unit 2 refrigerator cleaned 3/16/18. 2. Quality review of nourishment room refrigerators completed by the DM/DON/UM/designee to ensure resident personal food items are labeled dated and discarded per policy. Follow up based on findings. Quality review of nourishment room refrigerators completed by DM/DON/UM/designee to ensure nourishment room refrigerators are free from spillage and/or soiling. Follow up based on findings.	

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The bowls had the resident's name and room number. There were no dates on the bowls indicating when it was brought into the facility. Three of the bowls contained rice and the other bowl contained Okra.

On 3/15/18 at approximately 8:35 a.m., an interview was conducted with CNA (certified nursing assistant) #2, a CNA on unit 3. When asked the process if family were to bring in food from an outside source, CNA #2 stated that the food should be dated and thrown out two days later. When asked the process staff follows if she were to find the bowls in the refrigerator with no dates on them, CNA #2 stated that she would ask the nurse for further directions. CNA #2 stated that the family actually has to bring the food to the nurse so that the nurse can approve the food items. CNA #2 stated the nurses were responsible for dating the food. When asked who was responsible for cleaning out the refrigerator, CNA #2 stated a dietary aide comes in and cleans out the refrigerator. CNA #2 could not determine how often this happened. When asked if she knew how long the bowls were in the refrigerator, CNA #2 stated she normally works on unit 2 and could not determine that.

On 3/15/18 at 9:45 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked about the process staff follows when family brings in food for a resident. RN #1 stated she would first have to find out what is in the food and if it matches with their dietary restrictions. RN #1 stated she would have to find out when the food was prepared and label it with that date. RN #1 stated she would also label the food items with the resident's name and/or room number. RN #1 did not have a key to the nourishment room. RN

3. Current staff re-educated by the DON/UM/designee ensuring resident personal food items are labeled dated and discarded per policy. Current staff re-educated by the DON/UM/designee ensuring staff personal food items are not refrigerated in nourishment refrigerators. Current staff re-educated by the DON/UM/designee ensuring nourishment room refrigerators are free from spillage and/or soiling.

4. ED/DON/UM/DM/designee to conduct random quality monitoring of nourishment room refrigerators to ensure resident personal food items are labeled dated and discarded per policy 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.

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#1 called LPN (licensed practical nurse) #1 over to open the nourishment room. LPN #1 confirmed the food items were not dated and should be discarded. LPN #1 stated the 11-7 shift nurses are supposed to clean out the refrigerator. LPN #1 stated the family for Resident #116 were always bringing in food. LPN #1 confirmed that the food contained in the bowls were rice and okra.

On 3/15/18 at 10:00 a.m., observation of the Unit 2 nourishment room was conducted. A take out box containing a bacon cheeseburger, a plastic bag of grapes, a box of pizza, and a Tupperware container full of what appeared to be egg salad was found in the refrigerator. All food items belonged to one resident in room 224. The resident's name and room number were the only things labeled on the food items. A red sticky substance was also observed stuck on refrigerator shelf.

On 3/15/18 at 10:03 a.m., RN (registered nurse) #2 confirmed the above food items in the refrigerator were not dated. RN #2 stated she would throw out all items because she was not sure when the food was brought into the facility. RN #2 could not determine what the red substance on the refrigerator's shelf was and stated that she would clean it. RN #2 stated that dietary usually cleans the refrigerators in the nourishment rooms.

On 3/15/18 at approximately 4:45 p.m., an interview was conducted with OSM (other staff member) #4, the dietary manager. OSM #4 stated a dietary aide will clean out the refrigerators every morning at 6:30 a.m. OSM #4 stated it is not the same aide every time. OSM

ED/DON/UM/DM/designee to conduct random quality monitoring of nourishment room refrigerators to ensure staff personal food items are not stored in nourishment room refrigerators 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
ED/DON/UM/DM/designee to conduct random quality monitoring of nourishment room refrigerators to ensure nourishment room refrigerators are free from spillage and/or soiling 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
5. Date of Compliance 4-15-18.

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#4 stated other staff are responsible to help if they notice a spill. When OSM #4 was informed of the red sticky substance on the refrigerator shelf, OSM #4 stated it was probably cranberry juice. The cleaning schedule of the nourishment room refrigerator's was requested.

On 3/15/18 at 6:15 p.m., ASM #1 (administrative staff member) #1, the executive director and ASM (administrative staff member) #2, the DON (Director of Nursing) were made aware of the above concerns. The cleaning schedule could not be presented.

The facility policy titled, "Food: Safe Handling for Foods from Visitors" documents in part, the following: "Residents will be assisted in properly storing and safely consuming food brought into the facility for residents by visitors. Procedures: The facility staff will request that visitors bringing in food, and/or residents that receive food, must notify a member of the nursing or activities departments. 2. The responsible facility staff member will determine whether the food item is for immediate consumption or to be stored for later use... 4. When food items are intended for later consumption, the responsible facility staff member will: -Ensure that the food is stored separate or easily distinguishable from the facility food. - Ensure that foods are in a sealed container to prevent cross contamination. Label foods with the resident's name and the current date...5. Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and: ...-daily monitoring for refrigerated storage duration and discard of any food items that have been stored for greater or equal to 7 days. -Cleaned weekly."

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No further information was presented prior to exit.

{F 840} Use of Outside Resources
SS=D CFR(s): 483.70(g)(1)(2) {F 840}

§483.70(g) Use of outside resources.
§483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section.

§483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-
(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and
(ii) The timeliness of the services.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a contract for dental services for one of 18 residents in the survey sample.

The facility staff failed to maintain a contract for dental services for Resident #116. Resident #116 had broken and decaying teeth.

The findings include:

F840: Use of Outside Resources

1. Dental contract obtained 3/26/18.
2. Quality review completed by the ED/designee to ensure outside vendors requiring a contract is current and accessible. Follow up based on findings.
3. ED re-educated by the Divisional Director of Clinical Services (DDCS)/designee regarding ensuring vendors requiring a contract is current and accessible.
4. ED/DDCS/designee to conduct random quality monitoring of outside vendors requiring a contract to ensuring contracts are current and accessible 2 x

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Resident #116 was admitted to the facility on 10/20/15 with diagnoses that included but were not limited to: stroke, Alzheimer's disease, diabetes, depression and difficulty swallowing.

The most recent MDS, a quarterly assessment, with an ARD of 2/5/18 coded the resident as having short-term and long-term memory problems and severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the annual MDS with an ARD of 10/27/17 in Section L -- Oral/Dental Status documented, "D. Obvious or likely cavity or broken natural teeth."

An observation was made on 3/14/18 at 10:40 a.m. of Resident # 116. The resident was lying in a recliner in the hallway. His eyes were closed and his mouth was open. In the lower jaw, there were two teeth broken to the gum line and the gums were reddened and slightly swollen around the area. There were approximately seven teeth, which had food debris, a greenish/gray substance at the base of the teeth, and the teeth had black decay above that.

A review of the care plan initiated on 10/27/16 and revised on 11/7/17 documented, "Focus. (Name of resident) has potential for imbalanced nutrition r/t (related to)...Chewing Problem...Resident has poor dentition. Interventions. Monitor/document/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of oral/dental problems needing attention. Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded,

weekly x 2 weeks, weekly x 2 weeks, and then monthly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 4-15-18.

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decayed..."

An interview was conducted on 3/15/18 at 9:30 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked the process staff follow if a resident has dental issues, LPN #4 stated, "If they're vocal they can verbalize if it hurts." When asked how teeth were checked, LPN #4 stated, "Normally when mouth care is done. The CNA (certified nursing assistant) would tell me." When asked what types of issues the CNA would report, LPN #4 stated, "If they're loose or painful." When asked what staff did if the teeth were broken or had obvious cavities, LPN #4 stated, "I'd check the chart for the RP (responsible party) and call the doctor." When asked if there were risks to having decayed and broken teeth, LPN #4 stated, "Decay can cause other health issues." LPN #4 was asked to look in Resident #116's mouth. The resident had no upper teeth, one tooth in the left back lower jaw with a deep black center, two broken teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw. When asked if there was decay in the teeth, LPN #4 stated, "Yes."

An interview was conducted on 3/15/18 at 10:45 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked how oral care was conducted, CNA #8 stated, "First of all you have to make sure they're not NPO (nothing by mouth). I try to wet his mouth first and brush his teeth." When asked what staff look for while doing mouth care, CNA #8 stated, "If the teeth are broken, if the teeth are rotting." When asked if Resident #116 had broken and rotting teeth, CNA #8 stated, "Yes. I told them. They told me they were aware and to make sure to still perform oral care on him."

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An interview was conducted on 3/15/18 at 11:05 a.m. with ASM #2, the director of nursing. When asked what was expected of staff regarding dental issues, ASM #2 stated, "What I would expect is it to be identified on admission and then everyday when assisting the resident with mouth care." When asked how residents obtained dental services, ASM #2 stated, "This would an all depends situation. We would ask the family if they had a dentist. If not we would work with them to find a dentist." ASM #2 was asked to examine Resident #116's mouth, ASM #2 stated, "Um hmm, I see." ASM #2 was asked if there was ever a consult or a conversation with the family or physician about the care of Resident #116's teeth. ASM #2 stated, "Let me look into that."

On 3/15/18 at 1:05 p.m. ASM #2 stated, "There's no consult." When asked if there was any documentation about the resident's teeth, ASM #2 stated, "No."

A request for the facility's dental contract was made on 3/15/18 at 1:10 p.m. of ASM #1, the executive director. ASM #1 stated, "We have a verbal contract with (name of dentist). He takes everyone on Medicare and Medicaid. I just got a copy of a contract from a mobile dental unit and it's in corporate now getting approved."

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, divisional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

F 908 Essential Equipment, Safe Operating Condition

F 908

F908: Essential Equipment/Safe Operating Condition

1. Identified areas of standing water drained/cleaned/dried 3/14/18.

Identified missing tiles/grout replaced by 4/15/18.

Garbage disposal replaced by 4/15/18.

Identified leaking pipe(s) fixed by 4/15/18.

Identified food items, wet towels and debris removed/areas identified cleaned 3/16/18.

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F 908 SS=C	Continued From page 74 CFR(s): 483.90(d)(2)	F 908	2. Quality review completed by the ED/designee to ensure the kitchen is free from standing water. Follow up based on findings. Quality review completed by the ED/designee to ensure the kitchen is free from missing tile/grout. Follow up based on findings. Quality review completed by the ED/designee to ensure the kitchen is free from leaking pipe(s). Follow up based on findings. Quality review completed by the ED/designee to ensure food items, wet towels and debris in the kitchen are removed/cleansed timely per policy. Follow up based on findings. Quality review completed by the ED/designee to ensure the kitchen garbage disposal is in good working order. Follow up based on findings. Quality review completed by the ED/designee to ensure kitchen equipment is in good working order. Follow up based on findings.	

§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, and in the course of a complaint investigation it was determined that facility staff failed to maintain equipment in safe operating condition in the facility kitchen.

The kitchen floor was covered in half an inch of standing water from a leaking pipe that was connected to a broken garbage disposal, sink and dishwasher. OSM #2, the maintenance director, stated that the garbage disposal had been acting up in the beginning of January and that the pipe was leaking.

The findings include:

On 3/14/18 at 10:30 a.m., observation of the facility's kitchen was conducted with OSM (other staff member) #3, the regional dietary manager. At 10:35 a.m., approximately half an inch of water was observed on the floor underneath the kitchen's sink and garbage disposal. The pipe underneath this sink was leaking. The facility's dishwasher was also connected to this pipe. A saturated cardboard box was observed on the floor folded up flat with food debris in the center of it. The box remained covered in water. When asked OSM #3 what was going on, OSM #3 stated that there appeared to be a lot of standing water. When asked why the box was on the ground, OSM #3 removed the box and revealed 6 missing tiles underneath the box. The area where

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F 908	Continued From page 75	F 908		

the tiles were missing were full of water. Soggy food debris was also observed on the floor underneath the garbage disposal. Rolled up saturated towels were observed on the floor underneath the dishwasher. When asked OSM #3 where the leak was coming from, OSM #3 stated that he would ask the dietary manager because he had just started on Monday.

On 3/14/18 at 10:36 a.m., an interview was conducted with OSM #4, the dietary manager. When asked where the leak was coming from, OSM #4 stated that the leak was coming from the garbage disposal. When asked how long the garbage disposal/sink had been leaking, OSM #4 stated that it had been leaking for "about two months." OSM #4 stated that she was told the leak was "In the works" from maintenance. When asked where all the food debris came from, OSM #4 stated that it was from breakfast. OSM #4 stated that staff still used the area to clean off the trays. This writer then observed food debris inside the garbage disposal. When asked if the garbage disposal was still functioning, OSM #4 stated that it didn't work. When asked how long food debris was inside the garbage disposal, OSM #4 stated that the food debris inside the garbage disposal was also from breakfast. OSM #4 stated that her staff still rinse off the trays and then take a glove and sweep out the garbage disposal with their hands. When asked the clean up time after breakfast, OSM #4 stated that breakfast clean up was usually started at about 9 a.m.

On 3/14/18 at approximately 5 p.m., a second observation was made of the kitchen. The standing water had been drained. The floor underneath the garbage disposal/sink was still

3. Maintenance Director/DM re-educated by the ED/designee regarding ensuring the kitchen is free from standing water, the kitchen is free from missing tile/grout, the kitchen is free from leaking pipe(s), food items, wet towels and debris in the kitchen are removed/cleansed timely per policy, the kitchen garbage disposal is in good working order, kitchen equipment is in good working order and reporting items needing repair to the ED at the time observed.

ED re-educated by the DDCS/designee regarding ensuring the kitchen is free from standing water, the kitchen is free from missing tile/grout, the kitchen is free from leaking pipe(s), food items, wet towels and debris in the kitchen are removed/cleansed timely per policy, the kitchen garbage disposal is in good working order, kitchen equipment is in good working order and

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wet. The food debris had been cleaned up, and the wet towels on the floor had been removed.

On 3/15/18 at 9:25 a.m., an interview was conducted with OSM #3. When asked why there was that much standing water underneath the garbage disposal/sink on 3/14/18, OSM #3 stated that the dishwasher was connected to the same pipe as the sink and garbage disposal. OSM #3 stated that every time the dishwasher runs, there is a large amount of water that leaks onto the floor. OSM #3 stated that he assumed that the standing water drained slowly over a period of a few hours. OSM #3 stated that staff had just finished using the dishwasher for breakfast clean-up, before this writer made the above observation. When asked if there should ever be standing water on the floor in the kitchen, OSM #3 stated, "No." When asked why there should never be standing water on the floor of the kitchen, OSM #3 stated that is was an infection control issue, especially in the area with the missing grout and tiles. OSM #3 stated that the pipe and garbage disposal had been broken for some time. When asked why it was taking 2 months to fix this problem, OSM #3 stated that he was not sure, but thought OSM #4 may have had some documentation regarding repair requests. OSM #3 was asked to provide this information.

On 3/15/18 at approximately 11:00 a.m., OSM #3 stated that OSM #4 was not in the building that morning but would be back in the evening. OSM #3 stated that he could not access her emails. OSM #3 stated that the maintenance director may have additional information.

On 3/15/18 at 3:30 p.m., an interview was conducted with OSM #2, the maintenance

reporting items needing repair to the Regional Vice President of Operations at the time observed. Dietary staff re-educated by the DM regarding ensuring the kitchen is free from standing water, the kitchen is free from missing tile/grout, the kitchen is free from leaking pipe(s), food items, wet towels and debris in the kitchen are removed/cleansed timely per policy, the kitchen garbage

disposal is in good working order, kitchen equipment is in good working order and reporting items needing repair to the DM/Maintenance Director at the time observed. Maintenance work orders to be discussed in Morning Stand Up meeting.

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F 908	Continued From page 77 director. When asked what he could tell me about the garbage disposal in the kitchen, OSM #2 stated that the garbage disposal had been acting up in the beginning of January and that the pipe was leaking. OSM #2 stated that he had to research the part because the garbage disposal was so old, the serial numbers were worn off on the part that he needed. OSM #2 stated, "Now I guess it doesn't work at all. OSM #2 stated, "They told me today." When asked who told him today, OSM #2 stated, "Well you are saying it isn't working." When asked if he had ever fixed the garbage disposal and pipe after having knowledge of the initial leak in January, OSM #2 stated that it was fixed before. OSM #2 stated that he was going to have someone come out and look at the leak tomorrow. OSM #2 stated that the kitchen staff should not have been using the area if it was leaking water. OSM #2 was asked to provide all maintenance requests sheets or evidence that he had fixed the initial leak back in January. OSM #2 then presented a proposal from to fix the garbage disposal. The proposal form was dated 3/15/18. OSM #2 could not provide any additional information. On 3/15/18 at 5:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. Complaint Deficiency	F 908	4. ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure the kitchen is free from standing water 5 x weekly x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated. ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure the kitchen is free from missing tile/grout 5 x weekly x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated. ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure the kitchen is free from leaking pipe(s) 5 x weekly x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated. ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure food items, wet towels and debris in the kitchen are removed/cleaned timely per policy 5 x weekly	

x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated.
ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure the kitchen garbage disposal is in good working order 5 x weekly x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated.
ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure kitchen equipment is in good working order 5 x weekly x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated.
Quality monitoring schedule modified based on findings.

5. Compliance Date 4-15-18