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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 06/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(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 standard survey, Complaint Survey and Emergency Preparedness survey was conducted 05/29/18 through 06/04/18. Significant Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Four complaints were investigated during the survey. The census in this 138 certified bed facility was 117 at the time of the survey. The survey sample consisted of 42 current Resident reviews and 3 closed record reviews.	E 000	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirements and the statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey, Complaint Survey and Emergency Preparedness survey was conducted 05/29/18 through 06/04/18. Significant Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Four complaints were investigated during the survey. The census in this 138 certified bed facility was 117 at the time of the survey. The survey sample consisted of 42 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE: Administrator | (X6) DATE: 6/18/2018

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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with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation resident and staff interview and clinical record review it was determined the facility staff failed to respect the dignity of 4 of 45 residents while providing care (Residents #77, 86, 5 and 26).

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Findings:

1. Facility staff (CNAs #VI & II) failed to respect the dignity of Resident #77 while providing care. The resident's clinical record was reviewed on 5/30/18 at 3:00 PM.

Resident #77 was admitted to the facility on 9/2/16. Her active diagnoses included hypertension, anemia, peripheral vascular disease, diabetes, vascular dementia, anxiety, depression, chronic obstructive pulmonary disease, and weight loss.

The latest MDS (minimum data set) assessment dated, 4/25/18, coded the resident with unimpaired communication ability, and intact cognitive ability. She was coded as not having any issues with her memory.

The MDS documented the resident as feeling down, depressed or hopeless, feeling tired and felling bad about herself. The resident was documented as not having any issues with psychosis or delusions.

The latest CCP (comprehensive care plan) reviewed and revised on 5/4/18 documented the resident as nervous and anxious at times. These concerns were addressed with interventions that included, "If I don't like what I am doing, let me do something else" and "If I'm upset, please redirect the conversation or task." The staff were instructed to "avoid things that made the resident more anxious."

The physician's orders signed and dated 1/8/18 documented a prescription for Depakote Sprinkles 125 mg two times daily for behavior.

F 550 1. CNA VI, CNA II, CNA I, CNA IV, LPN III, LPN I, received disciplinary action regarding F550 failure to provide the dignity of resident #77, #86, #5 and #26. Social Services Director followed up with residents #77, #86, #5 and #26 to evaluate for any psychosocial distress. Social Services to follow up with residents as needed.
Resident #86 CCP updated to reflect intervention of supportive listening and providing reassurance.
Resident #26 notified in regards to receiving a new roommate. Staff member identified and received disciplinary action due to failure to provide dignity to resident #26.
2. Residents that reside in the facility have the potential to be effected by this deficient practice.
3. Group re-education by Director Of Nursing and Human Resources in regards to customer service completed on 6/12/2018 and 6/13/2018. Staff required to complete Relias Training Courses for Resident's Rights, Customer Service, and Customer Service Essentials. Ombudsman to re-educate facility staff regarding respecting the dignity of residents in the facility. Patient Interview & Observation (Dignity/Resident Rights) Audit to be completed by Social Service Director or Designee 5 times a week x 8 weeks to ensure facility staff respects the dignity of residents in the facility.
4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated. 7/4/2018

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Lexapro 10 mg every day was ordered on 9/2/16. A review of the MAR (medication administration record) documented the medications were provided as ordered.

On 5/30/18 at 12:15 PM Resident #77 was in the dining room and seated at the table with peers. When the food trays start coming out of the kitchen a staff member grabbed the resident's wheelchair and wheeled her back to south unit and dropped her off at a table with two CNAs (CNA VI & II) on either side.

The surveyor asked why the staff had moved her out of the dining room and CNAs VI & II both said she eats second lunch and just likes to sit in the dining room and watch everybody else eat. They both started laughing at this point and saying "why would resident she want to do that?"

Resident #77 looked at surveyor and said she wanted to eat her lunch in her room. Before the surveyor could reply, the CNAs laughed again CNA VI stated, "You don't want to go to your room--you wanna stay out here with us."

Both CNAs were laughing and talking over top of her everytime she tried to respond. The resident dipped head looking at the floor, pursed her lips and looked defeated. The surveyor asked the resident again if she wanted to eat lunch in room and resident looked up and said, "Tearfully, yes--I want to eat in my room."

The two CNAs continued to chortle and laugh and CNA VI stated, "I'll see if your nurse will let you eat in your room--but you're supposed to go to dining room." The surveyor asked the staff members if the resident could feed herself. They

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said, yes.

The surveyor then asked the CNAs why the resident needed the nurse's permission to eat in her room. They replied, "She don't."

When second lunch came the resident was observed to be back in the dining room and left to eat there--unassisted.

At 1:45 PM resident observed to be laying in bed. She was asked how it made her feel when we had the meeting at the unit table. She stated, "I didn't like it much--you could see I just got quiet and wouldn't speak to them anymore." Resident #77 said the CNAs hurt her feelings when they laughed at her.

On 5/30/18 at 11:06 AM the facility resident council was interviewed about the staff's care and attitudes. Resident #124 spoke up and told the surveyor "Some of the CNAs are horrible to us....I think it's because they're short of help and they're irritable."

Resident #33 stated, "The staff are nasty to us. We'll go to get a wash cloth from the linen cart because they won't bring us any. If they see you they holler at you, 'don't touch those rags' we need them!"

The resident council members refused to give any names of the offending staff members. One resident #124 stated, "We've complained about them before. They never respond to anything we complain about. We feel like we're wasting our breath.

On 6/3/18 at 7:45 PM LPN II was interviewed

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about the staff's attitudes towards resident. She said she never had any trouble with the residents and noted that it was all how staff approached them that made a difference. If they're not in the mood to be bothered, I come back at another time. "It's all how you treat somebody."

LPN II said CNA I was a "cold fish" and could really cop an attitude at times. She stated, "She acts like everything is a chore."

ON 6/3/18 at 7:30 PM CNA VII told the surveyor she had not had any problems with some of the residents--but knew some aides had problems with them (Residents #5, & 86). If I go in and they're in a mood, I just leave and come back later when they don't mind having care done. "Anybody can get in a mood and want to be left alone--I don't mind."

On 5/30/18 at 4:00 PM the DON was informed of the findings. She said if the resident wanted to eat in her room, she should be allowed to.

No additional information was provided prior to exit.

2. The facility failed to provide to respect the dignity of Resident #86 while providing care.

Resident #86 was admitted to the facility on 8/17/18. His admission diagnoses included: Dabetes II, Anxiety. Complete amputation at knee level, bilateral, and anemia.

The resident's latest MDS (minimum data set) dated 5/3/18 coded the resident with unimpaired communications skills. His cognitive ability showed slight memory impairment during testing.

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The same interview taesting indicated the resident indicated the resident felt "down, depressed or hopeless", had trouble sleeping, and had little energy.

The MDS captured the resident's behaviors duirng the look back period. The resident had no indicators for psychosis and no indicators for physical, verbal or other behavior sysmptoms documented. The resident was documented as rejecting staff care every one to three days.

The MDS coded the resident as requiring the inervention of at least one staff member for all the ADLs (activities of daily living.) Resident #86 was documented as able to feed himself with set-up help only. The resident was incontinent of both bowel and bladder and required staff intervention to provide care.

The MDS coded the staff with administering antianxiety medication for this resident seven days a week.

The physician's order, signed and dated 11/12/17, documents the medication Depakote tab, delayed release, 125 mg every day for behaviors related to his anxiety disorder. The physician's order for Klonopin 0.5 mg at nite and 0.25 mg three times a day for anxiety was igned and dated 2/21/18. A review of the MAR (medication administration sheets) indicated the staff documented the meds administered as ordered.

The clinical record contained two psychiatric evaluations for Resident #86 (4/9/18 & 5/24/18.) Both dates contained consistent information concerning the resident's treatmen for depression and anxiety. The examiner documented the

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resident to be alert and oriented to person, place and time. He judged his cognition skills to be adequate and intact.

The visiting mental health examiner agreed with the medication therapy as consistent with his diagnosis for generalized anxiety. His recommened behavioral interventions to staff were documented as "supportive listening" and "provide reassurance."

The resident's CCP (comprehensive care plan) documented the resident with behaviors (refusing medicine, arguing with staff, calling 911, refusing care, cursing staff, name-calling staff and yelling). Interventions including providing doctor-ordered meds, attempting interventions before behavior begins, speaking in calm voice, diversion, check for pain, etc. The interventions suggested by the psychiatric therapist "supportive listening" and "provide reassurance" were NOT in the resident's CCP under any focus.

The CCP also documented the resident was grieving for his mother and brother who both died in December 2017 (12/4/17 & 12/14/17 respectively.) Interventions were included to help the resident cope with his grief and to sensitive to his feelings at this time.

The surveyor interviewed every staff member found to working with Resident #86 uring the time of the survey and several administrative staff members as well about his allegations and concerns. No one mentioned or acknowleged this resident has lost two significant family members only five months before and just prior to Christmas.

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On 5/30/18 at 3:00 PM the facility administrator provided the surveyor with a log of 911 calls made by Resident #86 to the local police department. The calls included the situation--but were not dated:
1. He needs to get back to his bed, he don't have any legs.
2. Says nurses are not taking care of him, he called for them and they won't come....
3. He is being threatened and insulted by a nurse named Kelly.....she was all up in his face and he told her to go and she refused to leave room....
4. He needs his insulin.
5. He needs his meds.
6. Nobody has checked blood sugar levels since shifts changed.
7. Upset because he's been laying there for four hours without water....
8. No one will put him in his bed.....
9. He hasn't been cleaned all day and no one will help him or his roomate...
10. No one has washed him up and he is just laying there...
11. Nurse came and gave his diabetic medicine but did not give anxiety and sinus med/ said she left it on the cart and doesn't know what happened to it.
12. Supposed to get diabetic medicine and hasn't gotten it...
13. CNAs won't put him back in his bed, he's asked and they just keep walking by his room....
14. Laying in his feces, when he asks for help they say they're short-handed/he is tired of being nasty.....
*** This was a sample of the calls made from the nursing home. More were logged, but are basically the same thing over and over. The log does indicate, that with 4 exceptions, all the 911 calls were made on or after December 15, 2017,

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after the resident's mother and brother expired.

On 5/29/18 at 5:50 PM the resident was visited in his room. He complained about the way he was treated by the CNAs in the facility and that they were rude and laughed at him when he requested help. Resident #86 stated, "(Name of CNA I) has a nasty attitude. I told the supervisor (name not provided) about her being no nasty. She won't come in and clean me up. (Name of CNA I) left me in my own waste and laughed at me. She said you can keep ringing that bell--I'll come when I get ready. (name of CNA IV) got so ugly one nite she told me she "hoped to see me dead in that bed with no legs!"

Resident #86 began weeping at this point with his head in his hands. He said (Name of CNA I) is still working on my hall. He stated, "I makes you feel like nothing--sitting here sick and can't get clean and can't get water. I never thought I'd have to beg for water. If they make me mad--I tell them to leave me alone. They treat me like a kid all the time like something's always funny to them. They come in in the early morning hours and be laughing like fools."

On 5/30/18 at 11:06 AM the facility resident council was interviewed about the staff's care and attitudes. Resident #124 spoke up and told the surveyor "Some of the CNAs are horrible to us....I think it's because they're short of help and they're irritable."

Resident #33 stated, "The staff are nasty to us. We'll go to get a wash cloth from the linen cart because they won't bring us any. If they see you they holler, 'don't touch those rags' we need them!"

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The resident council members refused to give any names of the offending staff members. One resident #124 stated, "We've complained about them before. They never respond to anything we complain about. We feel like we're wasting our breath.

On 6/30/18 at 7:45 PM LPN II was interviewed about the staff's attitudes towards resident. She said she never had any trouble with the residents and noted that it was all how staff approached them that made a difference. If they're not in the mood to be bothered, I come back at another time. "It's all how you treat somebody."

LPN II said CNA I was a "cold fish" and could really cop an attitude at times. She stated, "She acts like everything is a chore."

On 6/3/18 at 7:30 PM CNA VII told the surveyor she had not had any problems with some of the residents--but knew some aides had problems with them (Residents #5, & 86). If I go in and they're in a mood, I just leave and come back later when they don't mind having care done. "Anybody can get in a mood and want to be left alone--I don't mind."

This information was provided to the administrator and DON on 6/4/18 prior to exit.

This was a complaint allegation deficiency.

3. Facility staff failed to treat Resident #5 with dignity and respect while providing care.

Resident #5 was admitted to the facility on 1/7/13. Her diagnoses included: Respiratory

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failure, chronic pain, neuropathy, anemia, heart failure, anxiety, depression, Schizophrenia, and chronic obstructive pulmonary disease.

The latest MDS (minimum data set) assessment dated 5/22/18 coded the resident with fully intact communication and cognitive skills. Her memory was unimpaired. The resident's mood documented she had little interest in doing thing, felt down, depressed and hopeless, had sleeping issues, felt tired, felt bad about herself, and had trouble concentrating on things.

The MDS documented the resident had no behaviors, hallucinations or delusions. She was not coded for physical, verbal or other behaviors towards staff or the other residents or her roomate. The resident was not coded for rejection of care.

The MDS coded the resident with antianxiety and antidepressant medications 7 days a week. This resident was not coded with the administration of antipsychotic medications.

The MDS documented the resident was very independent for the majority of ADLS (activities of daily living) but required the assistance of one staff member to help her dress and bath. The resident was totally continent of bowel, but was occasionally incontinent of bladder and required the assistance of one staff member for personal hygiene needs. She could walk to the toilet unassisted with her oxygen on.

Resident #5's CCP (comprehensive care plan) reviewed and revised 5/25/18 documented one page on her depression and the recommended interventions included offering her food and

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beverages she liked, telling her doctor if symptoms weren't improving to see if medication changes were needed and taking time to discuss her feelings when she was sad.

Resident #5's CCP included nine pages with different inappropriate behaviors dating from September 2013 until the current time frame. Some behaviors included shouting and refusing ADL care and refusing to change clothes. Another behavior was "likes to wear fingernails long." Different interventions were suggested. A review of the nursing progress notes for the past two months didn't indicate any of the behavioral interventions were applied/used.

On 5/29/18 at 2:37 PM Resident #5 was observed to be laying in her bed. She sat up to speak to the surveyor when questioned. The resident told the surveyor "I hate this place and they lie and treat you like a dog.

The resident said back in December of 2017 the late nite shift refused to provide incontinence care for her. The resident stated, "They stood in the door and refused to come in. Third shift did a little song and dance outside my door. A nurse and a CNA locked arms and sang and laughed, "We are happy, you are not. We get to go home at the end of this shift and you're stuck here...." The nurse and CNA were both identified and are in the notes as LPN III and CNA II.

She said they refused to bring her a wash-cloth to do AM care or even wash my hands and face in the morning. Some of them treat me bad and don't even know me, because the others told them to. The resident said she would really get into trouble if they found out she was talking to a

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member of the survey team.

On 6/1/18 at 10:00 AM the surveyor continued the interview with Resident #5. She told of another incidence when CNA II was bathing her. She said she had radiation to her chest for breast cancer and the skin there remained very tender. "(Name of CNA II) was washing me and got too rough with me scrubbing my chest. I told her she was hurting me. She said 'I'm not hurting you!' and continued."

Resident #5 said she went out and told LPN I and she came back in and asked, "Why are you crying, she didn't hurt you!" Resident #5 said she never looked at her skin or checked to see if she was red or bruised. She just walked out the door.

Resident #5 was tearful during this conversation. She stated, "I never thought I'd be in a place like this and be treated like this. They even come in and talk about other residents like they're dogs when they're in here. You live nervous everyday, not knowing who is going to be your aide."

On 5/30/18 at 11:06 AM the facility resident council was interviewed about the staff's care and attitudes. Resident #124 spoke up and told the surveyor "Some of the CNAs are horrible to us....I think it's because they're short of help and they're irritable."

Resident #33 stated, "The staff are nasty to us. We'll go to get a wash cloth from the linen cart because they won't bring us any. If they see you they holler at you, 'don't touch those rags' we need them!"

The resident council members refused to give

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any names of the offending staff members. One resident #124 stated, "We've complained about them before. They never respond to anything we complain about. We feel like we're wasting our breath.

On 6/3/18 at 7:45 PM LPN II was interviewed about the staff's attitudes towards resident. She said she never had any trouble with the residents and noted that it was all how staff approached them that made a difference. If they're not in the mood to be bothered, I come back at another time. "It's all how you treat somebody."

LPN II said CNA I was a "cold fish" and could really cop an attitude at times. She stated, "She acts like everything is a chore."

ON 6/3/18 at 7:30 PM CNA VII told the surveyor she had not had any problems with some of the residents--but knew some aides had problems with them (Residents #5, & 86). If I go in and they're in a mood. I just leave and come back later when they don't mind having care done. "Anybody can get in a mood and want to be left alone--I don't mind."

On 6/4/18 the administrative staff was informed of all findings prior to the survey team exit.

This was a complaint deficiency.
4. For Resident #26, the facility staff failed to treat the Resident with dignity and respect in regards to the Resident receiving a new roommate. The facility staff failed to inform the Resident she would be getting a new roommate and when Resident #26 asked about the roommate she stated she was told what goes on-on the other side of that curtain is none of your business.

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The record review revealed that Resident #26 had been admitted to the facility 09/28/15. Diagnoses included, but were not limited to, peripheral vascular disease, asthma, chronic kidney disease, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/18 included a BIMS (brief interview for mental status) summary score of 15.

On 05/30/18 at approximately 5:00 p.m., Resident #26 stopped one of the surveyors in the hallway and expressed a concern regarding a new roommate. Resident #26 stated she asked the staff about the roommate and was told what goes on-on the other side of that curtain is none of your business. Resident #26 was visibly upset during this conversation.

On 05/30/18 at approximately 5:40 p.m., during an interview with the admissions director. The admissions director stated she did not provide the Resident with any kind of notice prior to the new roommate being placed in the Residents room.

On 05/30/18 at approximately 6:30 p.m., the administrator and corporate nurse were notified of the issues regarding the Resident receiving a new roommate.

On 5/30/18 at approximately 5:55 p.m., during an interview with the surveyor the Resident stated she did not know she was getting a roommate and only found out when she entered her room and saw them in the bed.

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On 05/31/18 at approximately 7:50 a.m., the administrator verbalized to the surveyor that the admissions director had been suspended and an FRI (facility reported incident) had been completed due to some comments she had made to Resident #26 regarding the Residents new roommate.

On 5/31/18 at approximately 8:08 a.m., the surveyor spoke with Resident #26 about her evening. Resident #26 stated the roommate had been moved out of her room and she had been told they had put the Resident in the wrong room.

On 06/01/18, the administrator shared copies of witness statements regarding this incident. Witness statement #1 read in part "...I can tell you when your getting a roommate but you need to worry about B-side of the rooms and stay out of A-side business." Witness statement #2 read in part "...she should only be concerned with B-Bed side, her side of the room, and it's none of her business to know about A-side."

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 557 SS=D — Respect, Dignity/Right to have Prsnl Property
CFR(s): 483.10(e)(2) — F 557

§483.10(e) Respect and Dignity.
The resident has a right to be treated with respect and dignity, including:

§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing. as space permits, unless to do so would infringe

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F 557	Continued From page 17	F 557	1. Group re-education by Human Resources and Director of Nursing in regards to customer service completed on 06/12/2018 and 06/13/2018 with staff. Staff required to complete Relias Learning Training Courses for Resident's Rights, Customer Service, and Customer Service Essentials. Ombudsman to re-educate facility staff regarding respecting the dignity of the residents in the facility. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Group re-education by Director Of Nursing and Human Resources in regards to customer service completed on 6/12/2018 and 6/13/2018. Staff required to complete Relias Training Courses for Resident's Rights, Customer Service, and Customer Service Essentials. Ombudsman to re-educate facility staff regarding respecting the dignity of residents in the facility. Patient Interview & Observation (Dignity/Resident Rights) Audit to be completed by Social Service Director or Designee 5 times a week x 8 weeks to ensure facility staff respects the dignity of residents in the facility. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

upon the rights or health and safety of other residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed tomaintain dignity for 2 of 45 residents in the survey sample (Residents #61 and #13).

The findings included:

1. The facility staff failed to provide dignity during personal care for Resident #61.
Resident #61 was readmitted to the facility on 2/2/13 with the following diagnoses of, but not limited to anemia, dementia, seizure disorder, anxiety disorder, depression, Schizophrenia and Chronic Obstructive Pulmonary Disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/18/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #61 was also coded as being totally dependent on 2 staff members for transfers, bathing, personal care, and requiring extensive assistance of 2 staff members for bed mobility.
During an observation on 6/3/18 at 7:35 pm on the Patio unit, the surveyor observed a CNA #1 (Certified Nursing Assistant) standing in the doorway of Resident #61's room. The CNA was wearing gloves at this time. The surveyor introduced herself to the CNA then the CNA went back into the resident's room. As the CNA was walking back into the room, she attempted to close the door behind her but it not close. The surveyor stood in the hallway and observed that Resident #61 was left exposed with no sheet or brief on. The CNA pulled the privacy curtain

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between the two beds but it only provided privacy from the head of the resident to the chest area. CNA #1 proceeded to turn the resident away from her and towards the window with the resident lying on the edge of the bed. The surveyor observed CNA #1 removing the resident's brief and exposed the resident's buttocks.

On 6/4/18 at 9:00 am, the surveyor reviewed the MDS with ARD of 4/18/18, the resident was coded as being totally dependent on 2 staff members for transfers and extensive assistance of 2 staff members for bed mobility. At the time that the surveyor made the above documented observation there was only 1 CNA at the resident's bedside when turning the resident in the bed.

On 6/4/18 at approximately 10 am, the surveyor notified the corporate nurse of the above documented findings.

The surveyor also notified the administrator and director of nursing of the above documented observation on 6/4/18 at 4:15 pm. The administrator stated to the surveyor that that was not the way to provide care to any resident and especially if the resident was a 2 person assist.

No further information was provided to the surveyor prior to the exit conference on 6/5/18.

2. The facility staff failed to care for Resident #13 in such a manner as to promote the resident's dignity.

Resident #13 was readmitted to the facility on 2/14/18 with the following diagnoses of, but not limited to high blood pressure, anxiety disorder,

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depression, Manic Depression and respiratory failure. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/6/18, resident #13 was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15.

On 6/3/18 at 7:40 pm, the surveyor observed that Resident #13 was in the hallway and asked the surveyor if he could be changed now. The surveyor verbalized to the resident that she would find a staff member that could help with this request. As the resident turned the wheelchair that he was in, the surveyor noted a brief hanging on the back of the wheelchair. The surveyor accompanied the resident back to his room. The surveyor asked the resident if he had any concerns with a brief hanging from the back of the wheelchair when he was in the hallway. The resident did not understand what the surveyor was saying so the surveyor pointed to the brief he was holding and asked him if it bothered him to have this hanging from the back of his wheelchair. Resident #13 stated, "I don't want it back there." As the resident was saying this to the surveyor, CNA (Certified Nursing Assistant) #1 came into the room and stated to the resident, "Mr. _____ (name of resident) why did you put that brief on the back of your wheelchair." The resident became very upset and almost in a screaming voice, "I didn't put that back there. I don't want it there." CNA #1 removed the brief from the back of the wheelchair and discarded it in the trashcan.

The surveyor notified the corporate nurse of the above document observation on 6/4/18 at approximately 10 am in the conference room.

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F 557	Continued From page 20 The surveyor notified the administrator and director of nursing of the above documented observation at 4:15 pm in the conference room. The administrator stated, "I will take care of this with the CNA that was caring for this resident last night. This is not the way we want our residents to be cared for." No further information was provided to the surveyor prior to the exit conference on 6/4/18.	F 557		
F 558 SS=E	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 endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review the facility staff failed to honor the accommodation of needs for 8 of 45 residents (Residents # 77, 86, 85, 17, 101, 113, 63, & 26.) ~Residents #85 &77 for failing to provide accessible call lights. ~Residents #77, 86, 17, 101, 113, 63, & 26 for failure to provide side rails for bed mobility and or safety concerns when asked for/requested by the residents. Findings: 1. Facility staff refused to let Resident #77 use siderails when she requested them and failed to	F 558	1. Call bells for residents #85 and #77 placed within reach immediately. Resident #77, #86, #17, #101, #113, #63, & #26 will have assessment completed by interdisciplinary team to determine if side rails will be considered a restraint or an enabler. If an enabler is indicated, therapy and clinical staff will try other alternatives to enablers to promote the highest level of functioning. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Facility Management staff and Regional Clinical Nurse re-educated on 6/27/2018 by the Chief Clinical Officer on the correct process to evaluate for side-rails and other needs and preferences, taking in to consideration guidance from F604 Restraints and F700 Side Rails with a focus on resident's assessment for needs. Newly admitted residents will be evaluated by Interdisciplinary Team for use of devices and preferences. Group re-education by Human Resources and Director of Nursing in regards to customer service and accomodation of needs completed on 6/12/2018 and 6/13/2018. Devices and Enablers will be reviewed in the weekly restraint meeting. Audits to be completed by Department Heads and/or Designee daily per Care Keeper Rounds 5 x a week times 8 weeks to ensure the residents needs are honored by facility. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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place her call light within reach.

Resident #77 was admitted to the facility on 9/2/16. Her active diagnoses included hypertension, anemia, peripheral vascular disease, diabetes, vascular dementia, anxiety, depression, chronic obstructive pulmonary disease, and weight loss.

The latest MDS (minimum data set) assessment dated, 4/25/18, coded the resident with unimpaired communication ability, and intact cognitive ability. She was coded as not having any issues with her memory.

The MDS documented the resident as feeling down, depressed or hopeless, feeling tired and felling bad about herself. The resident was documented as not having any issues with psychosis or delusions.

The latest CCP (comprehensive care plan) reviewed and revised on 5/4/18 documented the resident as nervous and anxious at times. These concerns were addressed with interventions that included, "If I don't like what I am doing, let me do something else" and "If I'm upset, please redirect the conversation or task." The staff were instructed to "avoid things that made the resident more anxious."

On 05/30/18 at 11:49 PM during the resident council meeting, Resident #77 said she wanted her siderails back. She said they came in and took them off the bed and now she is afraid to go to sleep at nite without the siderails. She stated, "I want mine back!"

She and the other four members of the group

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council said they had complained during the group on numerous occasions that they came in and took the side rails away from them. The attending members all said they wanted them back and knew of other residents that did too. They told the surveyor the facility staff had told them the STATE said they were against the law and they had to throw them all away.

On 05/31/18 at 01:33 PM the surveyor walked into the resident's room to ask about her lunch. The resident was up in a wheelchair at the side of her bed. She sid she wanted to go back to bed--she'd been in wheelchair since before lunch. The resident stated, "I'm tired and I want to lay down."

The surveyor asked her if she had used her call light to summon facility staff to help her. The resident stated. "I cannot reach it."

The surveyor observed the call light located on the other side of the bed and not within the resident's reach. The surveyor called LPN II into room and asked her about the call lite. LPN II put the call lite within reach of the resident and exited the room.

On 5/31/18 at 2:50 PM the administrator and DON were informed of the issue regarding the siderails and the call lite. The administrator told the survey staff that the corporation had requested them to remove all side rails from the facility beds and the residents were not allowed to have them back.

2. Facility staff failed to provide Resident #86 siderails when he asked to have them placed back on his bed.

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Resident #86 was admitted to the facility on 8/17/18. His admission diagnoses included: Diabetes II, Anxiety, Complete amputation at knee level, bilateral, and anemia.

The resident's latest MDS (minimum data set) dated 5/3/18 coded the resident with unimpaired communications skills. His cognitive ability showed slight memory impairment during testing. The same interview tasting indicated the resident indicated the resident felt "down, depressed or hopeless", had trouble sleeping. and had little energy.

The MDS captured the resident's behaviors during the look back period. The resident had no indicators for psychosis and no indicators for physical, verbal or other behavior symptoms documented. The resident was documented as rejecting staff care every one to three days.

The MDS coded the resident as requiring the intervention of at least one staff member for all the ADLs (activities of daily living.) Resident #86 was documented as able to feed himself with set-up help only. The resident was incontinent of both bowel and bladder and required staff intervention to provide care.

On 6/1/18 at 3:06 PM the resident was observed to seated in his room with a guest. He introduced the surveyor to his sister.

The surveyor was asked about his siderails during this conversation. He told the surveyor that "they" came in and took them away because the STATE said it was against the law to keep them on the beds. The resident stated, I told them I

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wanted mine back and the staff told me I'd never get them back."

The resident then told the surveyor whenever he was rolled over in the bed for incontinence care he was afraid he was going to fall out of the bed, because part of his body was over the edge of the mattress. He stated, "I can't brace myself since the handrail is gone. I have to hang onto the headboard to keep from falling out of the bed."

On 6/1/18 prior to the survey team exit, the administrator, and DON were informed of the resident's request. The administrator said they would put them back on his bed.
3. The facility staff failed to ensure that that the call bell remained within reach for Resident # 85.

Resident # 85 is an 89-year-old-female who was originally admitted to the facility on 8/9/07 with a readmission date of 5/31/11. Diagnoses included but were not limited to: hypothyroidism, heart failure, hypertension, and chronic pain.

The clinical record for Resident # 85 was reviewed on 5/31/18 at 9:35 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/2/18. Section C assesses cognitive patterns. In section C1000, the facility staff coded that Resident # 85's cognitive status as severely impaired. Section G assesses functional status. In Section G0110, the facility staff documented that Resident # 85 required extensive assistance with one-person physical assist for bed mobility, locomotion on the unit, dressing, eating, and personal hygiene. The facility staff also documented that Resident # 85 was totally dependent requiring assistance of 2 or

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more persons in transfers and bathing. In Section G0400, which assesses functional limitation in range of motion, the facility staff documented that Resident # 85 had no impairments in upper and lower extremities.

The current plan of care for Resident #85 was reviewed and revised on 5/9/18. The focus area for "At risk for falls related to: Use of medication, assistance with mobility," has interventions that included but were not limited to "Call light or personal items available and in easy reach."

On 5/29/18 at 2:56 pm, the surveyor observed Resident # 85 lying in bed asleep. The call bell was observed at this time hanging off the top of the left side of the bed touching the floor and was not within reach of Resident # 85.

On 5/29/18 at 4:24 pm, the surveyor observed Resident #85 lying in bed with the call light hanging off the top of the left side of the bed touching the floor and was not within reach of Resident # 85.

On 5/29/18 at 5:41 pm, the surveyor observed Resident # 85 lying in bed. The call bell was observed
hanging off the top of the left side of the bed touching the floor and was not within reach of Resident # 85.

On 5/29/18 at 6:28 pm, the surveyor observed Resident # 85 in bed. The head of the bed was elevated and Resident # 85 was awake. The call bell was observed hanging off the top of the left side of the bed touching the floor and was not within reach of Resident # 85.

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On 5/31/18 at 3:50 pm, the administrative staff was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.

4. For Resident #17 the facility staff failed to accommodate Resident #17's needs and preferences regarding the use of side rails.

Resident #17 was a 78 year old female who was originally admitted on 11/24/09 and readmitted on 12/4/10. Admitting diagnoses included, but were not limited to: major depression, dysphagia, cataracts, contracture of the right hand and wrist, chronic pain, right leg above the knee amputation and diabetes mellitus.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/5/18. The facility staff coded that Resident #17 had a Cognitive Summary Score of 15. The facility staff coded that Resident #17 required extensive (3/2) to total nursing care (4/3) with Activities of Daily Living (ADL's). The facility staff coded that Resident #17 required 3/2 (extensive assistance of one) for turning and positioning.

On May 30, 2018 at 8:36 a.m., the surveyor observed Resident #17 lying in bed. No side rails were observed on the bed. Resident #17 had a hand splint on her right hand. The surveyor interviewed Resident #17. Resident #17 stated that a few weeks ago the facility staff came in and removed her side rails. Resident #17 stated that she was able to assist with turning and positioning when she had her side rails. Resident

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#17 stated that when the staff turned her she was afraid of falling out of the bed. Resident #17 stated usually only one staff member was in the room to assist with her turning and positioning. Resident #17 stated she did not know why the staff removed her side rails and she would like to have them put back on her bed.

On May 31, 2018 at 9:40 a.m., the surveyor met with the Director of Nursing (DON), Administrator (Adm) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #17 stated that a few weeks ago the facility staff came in and took her side rails off the bed. The surveyor also informed the AT that Resident #17 stated that she had been able to assist with turning and positioning when she had the side rails. The surveyor additionally notified the AT that Resident #17 stated that she felt safer when she had her side rails, as she was afraid of falling out of the bed. The Adm stated that a corporate executive gave a directive to remove all side rails due to a risk of entrapment. The surveyor notified the AT that Resident #17's personal needs/preferences had not been honored regarding her use of the side rails. The surveyor notified the AT that removal of the side rails had limited Resident #17's bed mobility and limited Resident #17's ability to assist with turning and positioning. The surveyor notified the AT that Resident #17 was afraid of falling out of the bed; therefore, her sense of safety had been compromised. Lastly, the surveyor notified the AT that Resident #17's accommodation of needs had not been met, as Resident #17 wanted the side rails for turning and positioning and for safety.

On June 1, 2018 at 11 a.m., the surveyor observed Resident #17 lying in bed. The surveyor

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observed that Resident #17 had two small grab bars on her bed. Resident #17 thanked the surveyor for getting the side rails/grab bars put back on her bed.

No additional information was provided prior to exiting the facility as to why the facility staff failed to accommodate Resident #17's preferences and needs regarding the use of side rails.

5. For Resident #63 the facility staff failed accommodate Resident #63's needs and preferences regarding the use of side rails and a bariatric bed.

Resident #63 was a 69 year female who was admitted on 7/24/14. Admitting diagnoses included, but were not limited to: chronic kidney disease (stage III), urinary tract infections, peripheral vascular disease, diabetes mellitus, anxiety, chronic pain syndrome, morbid obesity and schizophrenia.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 4/18/18. The facility staff coded that Resident #63 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #63 required total nursing care (4/3) with Activities of Daily Living (ADL's). The MDS additionally coded that Resident #63 required extensive assistance of 1 (3/2) with turning and positioning while in bed. The MDS also coded in Section K. Swallowing and Nutritional Status that Resident #63 was 5 foot 5 inches and weighed 295 pounds.

On May 30, 2018 at 3:26 p.m., the surveyor

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reviewed Resident #63's clinical record. Review of the weight record documented that Resident #63 weighed 301 pounds.

On May 30, 2018 at 8:17 a.m., the surveyor interviewed Resident #63. Resident #63 stated that her side rails had been removed from her bed recently. Resident #63 stated, "I'm a big woman. I have a big stomach and a big butt." Resident #63 stated that she only had about 2 inches of free space on each side of her bed. Resident #63 pointed to her bed and stated that she does not have room in her bed for turning and positioning. The surveyor noted that Resident #63 was lying on her right side and only had only about 2-3 inches of free space on each side of her bed. Resident #63 stated she is afraid of falling out of the bed. Resident #63 stated she requested a bigger bed and that she knew the facility had a larger bed down stairs in storage. Resident #63 stated that she was told she was not big enough for a larger bed. Resident #63 stated that she also wanted grab bars or side rails back on her bed.

On May 31, 2018 at 9:40 a.m., the surveyor met with the Director of Nursing (DON), Administrator (Adm) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #63 stated that the facility staff came in and took her side rails off the bed. The surveyor also informed the AT that Resident #63 stated she needed a bigger bed and only had about 2-3 inches of free space on each side of her bed for turning and positioning. The surveyor informed the AT that Resident #63 was told she was not big enough to receive a larger bed. The surveyor informed the AT that Resident #63 stated that she knew the facility had a larger bed

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downstairs in storage. The surveyor informed the AT that Resident #63 was afraid of falling out of the bed. The Adm stated that a corporate executive gave a directive to remove all side rails due to a risk of entrapment. The surveyor notified the AT that Resident #63's personal needs/preferences had not been honored regarding her use of the side rails and a larger bed. The surveyor notified the AT that removal of the side rails had limited Resident #63's bed mobility and limited her ability to assist with turning and positioning. The surveyor notified the AT that Resident #63 was afraid of falling out of the bed; therefore, her sense of safety had been compromised. Lastly, the surveyor notified the AT that Resident #63's accommodation of needs had not been met, as Resident #63 wanted the side rails for turning and positioning and for safety and wanted a larger bed.

On June 1, 2018 at 02:58 p.m. the surveyor entered Resident #63's room and observed Resident #63 lying in a bariatric bed that had 2 grab bars. Resident #63 profusely thanked the surveyor for getting her a larger bed and the grab bars.

No additional information was provided prior to exiting the facility as to why the facility staff failed to accommodate Resident #63's preferences and needs regarding the use of side rails and a larger bed.

6. For Resident #113 the facility staff failed to accommodate Resident #113's needs and preferences regarding the use of side rails.

Resident #113 was an 86 year old female who was originally admitted on 6/28/11 and readmitted

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on 7/6/17. Admitting diagnoses included, but were not limited to: congestive heart failure, atrial fibrillation, acute respiratory failure, osteoarthritis, chronic pain, polyneuropathy and hypothyroidism.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/18/18. The facility staff coded that Resident #113 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #113 required extensive assistance (3/2) with Activities of Daily Living (ADL's). The facility staff additionally coded that Resident #113 required extensive assistance of one (3/2) for turning and positioning.

On May 29, 2018 at 3:52 p.m., the surveyor observed that Resident #113 was lying on the bed and dressed in street clothes. The surveyor did not observed any side rails. Resident #113 stated that the facility staff had removed her side rails. Resident #113 stated she does not understand why the facility staff removed her side rails. Resident #133 stated she needed the side rails for turning and positioning. Resident #113 stated that she was afraid of falling out of bed.

May 30, 2018 at 8:30 a.m., the surveyor observed Resident #113 lying in bed heavily leaning to the left. A Certified Nursing Assistant (C.N.A.) entered room and attempted to pull Resident #113 up in bed for breakfast. The C.N.A. was unable to pull/position Resident #113 up in bed. The surveyor then observed a Licensed Practical Nurse (LPN) enter the room. The L.P.N walked over to Resident #113's bedside to help the C.N.A. position Resident #113 in bed. The L.P.N. and C.N.A. had to lower the head of the bed,

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raise the bed for proper body mechanics for lifting/pulling, pulled Resident #113 up with lift sheet and position Resident #113 in the bed. The surveyor noted that the process for staff to lift and position Resident #113 in bed took 10 minutes.

On May 31, 2018 at 9:40 a.m., the surveyor met with the Director of Nursing (DON), Administrator (Adm) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #113 stated that the facility staff came in and took her side rails off the bed. The surveyor also informed the AT that Resident #113 stated that she had been able to assist with turning and positioning when she had the side rails. The surveyor additionally notified the AT that Resident #113 stated that she felt safer when she had her side rails, as she was afraid of failing out of the bed. The Adm stated that a corporate executive gave a directive to remove all side rails due to a risk of entrapment. The surveyor notified the AT that Resident #113's personal needs/preferences had not been honored regarding her use of the side rails. The surveyor notified the AT that removal of the side rails had limited Resident #113's bed mobility and limited Resident #113's ability to assist with turning and positioning. The surveyor notified the AT that Resident #113 was afraid of falling out of the bed; therefore, her sense of safety had been compromised. Lastly, the surveyor notified the AT that Resident #113's accommodation of needs had not been met, as Resident #113 wanted the side rails for turning and positioning and for safety.

On .June 1, 2018 at 3:05 p.m. the surveyor observed Resident #113 being put to bed by C.N.A. The surveyor observed that the C.N.A.

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was repositioning Resident #113 in the bed. The surveyor observed Resident #113 reached over with the right hand to the left hand rail and assist to pull herself over.

No additional information was provided prior to exiting the facility as to why the facility staff failed to accommodate Resident #113's preferences and needs regarding the use of side rails.
7. The facility staff failed to provide reasonable accommodation of needs and preferences for Resident #101 in regard to side rails.

Resident #101 was admitted to the facility on 3/1/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, heart failure, high blood pressure, Peripheral Vascular Disease, End Stage Renal Disease, diabetes and depression. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/26/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident # 101 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.

During the wound care observation made by the surveyor on 5/31/18 at 11:15 am, the resident was observed to attempting to turn over in the bed. The surveyor noted that the resident was having difficulty in doing this. The surveyor asked Resident #101 if he needed any help in turning in bed. The resident stated, "They took my side rails off of my bed and now it's hard for me to turn without using them." The resident further stated, "You should know all about that because I was told that there was a state law against having side

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rails on the bed."

The surveyor notified the administrative team of the above documented findings at 4:15 pm. The administrator stated, "We were directed to look at all side rails and discontinue them so they could not be considered a restraint or have problems with bed rail entrapment." The survey team asked the administrator when the side rails were taken off the resident's beds and she stated, "I don't remember the exact date but it began from the end of January and followed through to March."

On 6/1/18 at 9:30 am, the surveyor returned to Resident #101's room and observed side rails were put back on the resident's bed. The resident stated to the surveyor, "They came in yesterday and put them back on the bed." The surveyor asked the resident if having the bed rails back on the bed helped him in turning in bed. The resident stated, "Yes it does. It's easier now."

The administrator came into the conference room on 6/4/18 at 9:20 am and provided a copy of all the side rails that were assessed by maintenance between January 29th through mid - March of this year. The surveyor asked the administrator if she knew the exact date that Resident #101's side rails were moved from the bed. The administrator stated, "I don't have the exact date for you." The surveyor asked the administrator if she could tell the room numbers that Resident #101 had been into since January 29th because the resident had been discharged and then readmitted back into the facility several times during the time frame the administrator had given to the survey team earlier in the discussion of the

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side rails. The administrator stated, "I will have to get back with you on this."

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

8. For Resident #26. the facility staff failed to accommodate the Resident in regards to bed rails/side rails.

The record review revealed that Resident #26 had been admitted to the facility 09/28/15. Diagnoses included, but were not limited to, peripheral vascular disease, asthma, chronic kidney disease, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/18 included a BIMS (brief interview for mental status) summary score of 15. Section G (functional status) was coded to indicate the Resident required extensive assistance of two people for bed mobility, was totally dependent on two persons for transfers, and had no limitations in range of motion to the upper extremity and impairment on both sides in the lower extremities. Section P (restraints and alarms) was coded to indicate the Resident did not use bed rails.

During a group interview with five alert and orientated Residents of the facility on 05/30/18 at approximately 11:00 a.m., the Residents expressed a concern regarding their bed rails/side rails being removed.

On 5/30/18 at approximately 6:15 p.m., during an interview with Resident #26 the Resident stated that the facility had taken away her bed rails (side

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rails) and that she had used them to pull herself over and up in the bed. Resident #26 stated they kept me from being scared. When asked if the bed rails restrained her in any way she stated no and the facility staff had told her the state made them remove them.

On 05/31/18 at approximately 8:08 a.m., Resident #26 stated she still has a concern over her bed rails being removed and that she had used them to put her call cord on so it would not fall in the floor.

A review of the Residents current CCP (comprehensive care plan) revealed that the CCP still included the intervention "per rsd (resident) request she prefers the call bell to be wrapped around bed rail."

On 5/31/18 at 9:15 a.m., the administrative staff were notified by the survey team that some of the Residents of the facility had expressed a concern over their bed rails/side rails being removed. The administrator stated it was a corporate decision related to restraints.

During an interview with LPN (licensed practical nurse) #3 on 06/01/18 at approximately 2:50 p.m., LPN #3 stated that the Residents side rails were more of a security issue due to the Resident being afraid.

On 06/01/18 at approximately 2:55 p.m., during an interview with CNA (certified nursing assistant) #1. CNA #1 verbalized to the surveyor that Resident #26 used her side rails to pull up and help her stand up. When asked if Resident #26 expressed a concern when they were removed she stated she was upset.

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F 558	Continued From page 37 The administrator was unable to provide an exact date when the Residents bed rails/side rails were removed and stated it was sometime between January 29-March 22, 2018. A review of the Residents quarterly side rail assessment dated 12/12/17 revealed that the facility staff had documented that the Resident had a history of falls, has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed, has difficulty with balance/poor trunk control, is currently using side rails for positioning and support. Under recommendations, the facility staff had checked the box beside the statement that read, "Side Rails are indicated and Serve as an Enabler to Promote Independence." During a meeting with the survey team on 06/01/18 at approximately 4:00 p.m., the administrator verbalized to the survey team that no assessments were completed prior to removing the rails. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 558		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable,	F 559		

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F 559	Continued From page 38	F 559	1. Resident #26 notified in regards to receiving a new roommate. Staff member identified and received disciplinary action due to failure to provide dignity to resident #26. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Staff re-education on F 559 - Choose/Be Notified of Room/Roomate Change on 06/12/2018 and 06/13/2018. Patient Interview & Observation (Resident Rights) Audit to be completed by Social Service Director or Designee 5 times a week x 8 weeks to ensure facility staff provides notice to resident when receiving a new roommate. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

when both residents live in the same facility and both residents consent to the arrangement.

§483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.
This REQUIREMENT is not met as evidenced by:
Based on Resident interview. staff interview, and clinical record review, the facility staff failed to provide notice when the Resident received a new roommate.

The findings included:

The facility failed to provide the Resident with any notice written or verbal when the Resident received a new roommate.

The record review revealed that Resident #26 had been admitted to the facility 09/28/15. Diagnoses included, but were not limited to, peripheral vascular disease. asthma, chronic kidney disease, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/18 included a BIMS (brief interview for mental status) summary score of 15.

On 05/30/18 at approximately 5:00 p.m., the Resident stopped one of the surveyors in the hallway to express some concerns she had. One of these concerns was related to receiving a new roommate without any notice.

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F 559	Continued From page 39 On 05/30/18 at approximately 5:40 p.m., during an interview with the admissions director, the admissions director verbalized to the surveyor that she did not provide any kind of notice prior to the Resident receiving a new roommate. When asked when the roommate arrived she stated today about an hour ago. On 5/30/18 at approximately 5:55 p.m., during an interview with the surveyor the Resident stated she did not know she was getting a roommate and only found out when she went into her room and saw them in the bed. On 5/30/18 at approximately 6:30 p.m., the administrator and corporate nurse were notified of the issue regarding no notification of the Resident receiving a new roommate. On 5/31/18 at approximately 8:08 a.m., the surveyor spoke with Resident #26 about her evening. Resident #26 stated the roommate had been moved out of her room and she had been told they had put the Resident in the wrong room. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 559		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		

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§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview and clinical record review it was determined the facility staff failed to allow 1 of 45 residents the choice of eating in her room (Resident #77).

Findings:

Facility staff failed to allow Resident #77 to eat in her room when she chose to do so. The resident's clinical record was reviewed on 5/30/18 at 3:00 PM.

Resident #77 was admitted to the facility on 9/2/16. Her active diagnoses included hypertension, anemia, peripheral vascular

F 561 1. Dietary Manager met with resident to identify preferences and it was noted that resident prefers to eat in her room. Social Services Director interviewed resident to ensure there were no psychological behaviors that was leading to self isolation. 7/4/2018
2. Residents that reside in facility have the potential to be effected by this deficient practice.
3. Staff re-education on Self Determination by Human Resources and Director of Nursing in regards to customer service completed on 6/12/2018 and 6/13/2018.
Group re-education by Human Resources and Director of Nursing in regards to customer service completed on 6/12/2018 and 6/13/2018.
Staff required to complete Relias Learning Courses for Resident Rights, Customer Service, and Customer Service Essentials.
Patient Interview & Observation (Dignity/ Resident Rights) Audit to be completed by Social Service Director or Designee 5 times a week x 8 weeks to ensure residents are given the choice of where they prefer to eat.
4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.

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disease, diabetes, vascular dementia, anxiety, depression, chronic obstructive pulmonary disease, and weight loss.

The latest MDS (minimum data set) assessment dated, 4/25/18, coded the resident with unimpaired communication ability, and intact cognitive ability. She was coded as not having any issues with her memory.

The MDS documented the resident as feeling down, depressed or hopeless, feeling tired and felling bad about herself. The resident was documented as not having any issues with psychosis or delusions.

The latest CCP (comprehensive care plan) reviewed and revised on 5/4/18 documented the resident as nervous and anxious at times. These concerns were addressed with interventions that included, "If I don't like what I am doing, let me do something else" and "If I'm upset, please redirect the conversation or task." The staff were instructed to "avoid things that made the resident more anxious."

The physician's orders signed and dated 1/8/18 documented a prescription for Depakote Sprinkles 125 mg two times daily for behavior. Lexapro 10 mg every day was ordered on 9/2/16. A review of the MAR (medication administration record) documented the medications were provided as ordered.

On 5/30/18 at 12:15 PM Resident #77 was in the dining room and seated at the table with peers. When the food trays start coming out of the kitchen a staff member grabbed the resident's wheelchair and wheeled her back to south unit

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and dropped her off at a table with two CNAs (CNA VI & II) on either side.

The surveyor asked why the staff had moved her out of the dining room and CNAs VI & II both said she eats second lunch and just likes to sit in the dining room and watch everybody else eat. They both started laughing at this point and saying "why would the resident want to do that?"

Resident #77 looked at surveyor and said she wanted to eat her lunch in her room. Before the surveyor could reply, the CNAs laughed CNA VI stated. "You don't want to go to your room--you wanna stay out here with us."

Both CNAs were laughing and talking over top of her everytime she tried to respond. The resident dipped head looking at the floor, pursed her lips and looked defeated. The surveyor asked the resident again if she wanted to eat lunch in room and resident looked up and said. "Tearfully, yes--I want to eat in my room."

The two CNAs continued to chortle and laugh and CNA VI stated, "I'll see if your nurse will let you eat in your room--but you're supposed to go to dining room." The surveyor asked the staff members if the resident could feed herself. They said, yes.

The surveyor then asked the CNAs why the resident needed the nurse's permission to eat in her room. They replied, "She don't."

When second lunch came the resident was observed to be back in the dining room and left to eat there--unassisted.

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F 561	Continued From page 43 At 1:45 PM resident observed to be laying in bed. She was asked how it made her feel when we had the meeting at the unit table. She stated, "I didn't like it much--you could see I just got quiet and wouldn't speak to them anymore." Resident #77 said the CNAs hurt her feelings when they laughed at her. On 5/30/18 at 4:00 PM the DON was informed of the findings. She said if the resident wanted to eat in her room, she should be allowed to.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565	1. Previous resident council meeting pulled and follow up concern forms filled out and addressed with each resident involved. Concern resolutions discussed with residents with concerns within 5 days. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Staff members re-educated regarding completing concern forms within 5 days and resolution is discussed with resident and/or resident's representative. Patient Interview & Observation (Dignity/Resident Rights) Audit to be completed by Social Services Director and/or Designee 5 x a week x 8 weeks to ensure facility staff responds to complaints and/or grievances expressed by the resident council members. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement(QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview and resident council meeting minutes review it was determined the facility staff failed to respond to complaints and/or grievances expressed by the facility Resident Council Members.

Findings:

On 05/30/18 at 11:49 PM during the resident council meeting, Resident #77 said she wanted her siderails back. She said they came in and took them off the bed and now she is afraid to go to sleep at nite without the siderails. She stated, "I want mine back!"

She and the other four members of the group council said they had complained during the group on numerous occasions that they came in and took the side rails away from them. The attending members all said they wanted them back and knew of other residents that did too. They told the surveyor the facility staff had told them the STATE said they were against the law and they had to throw them all away.

The surveyor reviewed the group council minutes and determined that the residents had submitted

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a number of issues in their meeting that had not been addressed by staff members. Side rails was one of those issues. Staff attitudes were another issue that had not been addressed.

On 5/30/18 at 11:06 AM the facility resident council was interviewed about the staff's care and attitudes. Resident #124 spoke up and told the surveyor "Some of the CNAs are horrible to us....I think it's because they're short of help and they're irritable."

Resident #33 stated, "The staff are nasty to us. We'll go to get a wash cloth from the linen cart because they won't bring us any. If they see you they holler at you, 'don't touch those rags' we need them!"

The resident council members refused to give any names of the offending staff members. Resident #124 stated, "We've complained about them before. They never respond to anything we complain about. We feel like we're wasting our breath.

The administrator and DON were informed of the above on 5/31/18 at 2:50 PM. The administrator said the company had decided to dispose of all siderails and no resident was allowed to use them on their bed.

The administrator told the survey team the following day that the resident complaint forms had not been filled out and reported to the administrative staff by the activities department when they took minutes for the meetings. The administrator said she had inserviced the staff about filling out the complaint forms and would address the resident's concerns in council going

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forward.

F 583 SS=D Personal Privacy/Confidentiality of Records
CFR(s): 483.10(h)(1)-(3)(i)(ii)

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced

F 583 1. MDS Scoop Sheet immediately removed from the nursing station and placed on a clip board with a cover sheet. 7/4/2018
2. Residents that reside in the facility have the potential to be effected by this deficient practice.
3. Facility staff to be re-educated regarding Personal Privacy/Confidentiality of Records by Director of Nursing and/or designee. Care Keeper Round Audits to be completed by Department Heads 5 x a week x 8 weeks to ensure facility staff provide confidentiality of a resident's personal and medical records.
4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement(QAPI) Meeting for review and recommendations implemented as indicated.

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by:
Based on observation and staff interview, the facility staff failed to provide confidentiality of a resident's personal and medical records on 1 out 3 units in the nursing facility (Patio Unit).

The findings included:

The facility staff failed to provide confidentiality of a resident's medical record in regards to a clip board lying on top of the nursing station in plain sight of anyone that walks up to this area which contained medical information on 20 residents. On 6/3/18 at 8:05 pm, the surveyor walked up to the nurses' station and observed a clipboard in plain sight on the top, which contained medical information on 20 residents that resided on the Patio Unit. At the top of the page, the paper was titled "MDS (Minimum Data Set) Scoop Sheet Date: 6/1/18).

The surveyor requested LPN (Licensed Practical Nurse) #1 to come to the nurses' station. LPN #1 looked at the top of the desk at the nurses' station and stated, "That should not be laying up here. I don't know who put it up there but I know that we keep it down here (pointing to the lower section of the desk)." The surveyor requested a copy of this sheet from LPN #1. LPN #1 gave a copy to the surveyor and then placed the sheet on the clipboard but added a cover sheet to the front.

The surveyor notified the administrative team of the above documented findings on 6/4/18 at 4:15 pm.

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

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F 584 Safe/Clean/Comfortable/Homelike Environment
SS=E CFR(s): 483.10(i)(1)-(7)

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to

F 584 7/4/2018
1. Shower rooms have been power scrubbed/pressure washed, shower curtains have been wiped down and floors swept.
Bathroom was thoroughly cleaned to including removing the ring in the toilet.
2. Residents that reside in the facility have the potential to be effected by this deficient practice.
3. Weekly power scrubbing will take place to clean floors and walls. Shower curtains will be wiped down daily during the cleaning completed by housekeepers assigned to each shower room.
Housekeeping staff re-educated by District Manager on 06/15/2018 regarding deep cleaning shower rooms and resident room bathrooms.
Housekeeping Shower Room/Bathroom Audits will be completed by the housekeeping manager or designee 5 x week x 8 weeks and record any areas needing attention on the monitoring form. Also, any items needing attention will be reported to the appropriate staff member.
4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.

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81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, Resident interview, and staff interview, the facility failed to maintain a clean, comfortable, and homelike environment on three of three units and for one of 45 Residents. Resident #92.

The findings included.

1. The shower rooms on the north and south units were observed by the surveyor to have a brown substance on the shower chairs. The patio unit shower room was observed to have debris in the floor.

On 05/30/18 at approximately 5:55 p.m.. during an interview with Resident #26 the Resident expressed a concern regarding the shower rooms being dirty.

On 06/01/18 at approximately 8:15 a.m., the surveyor and CNA (certified nursing assistant) #1 entered shower room #1 on the south unit. The surveyor observed a moderate amount of a brown substance on the shower chair. CNA #1 stated it looked like "poop." CNA #1 stated they had been told not to use this shower room due to a leak and there had been a sign on the door. However, no sign was observed on the door during this observation. The surveyor and CNA #1 then proceeded to shower room #2 "beauty shop." During this observation, the surveyor was able to observe a small brown spot in the floor of the shower room.

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On 06/01/18 at approximately 8:25 a.m., the surveyor and LPN (licensed practical nurse) #2 entered the shower room on the north unit and were able to observe a moderate amount of a brown substance on the shower chair. LPN #2 stated it was BM and needed to be cleaned.

On 06/01/18 at approximately 8:30 a.m., the surveyor entered the shower room on the patio unit. The surveyor was able to observe a blue glove and paper in a small area at the back of this shower room.

The housekeeping manager was notified of the issues in the shower room on 06/01/18.

On 06/01/18 at approximately 4:00 p.m., during a meeting with the survey team the administrator, DON (director of nursing), and nurse consultant were notified of the issues regarding the shower rooms.

No further information regarding this issue was provided to the survey team prior to the exit conference.
2. For Resident #92 the facility staff failed to ensure a clean, comfortable, homelike and well maintained bathroom.

Resident #92 was an 85 year old male who was admitted on 8/19/17. Admitting diagnoses included, but were not limited to: dehydration, hypotension, syncope with collapse, psychosis, fracture of the left femur, fractured humerus and depression.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a

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Medicare 30 Day MDS assessment with an Assessment Reference Date (ARD) of 5/5/18. The facility staff coded that Resident #92 had a Cognitive Summery Score of 3. The facility staff also coded that Resident #92 required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On May 29, 2018 at 4:42 p.m., the surveyor observed Resident #92's bathroom. The surveyor noted that the bathroom was shared between two rooms. The rooms housed two residents in each room. The bathroom accommodated four residents. The surveyor observed the bathroom and observed that two ceiling tiles were stained and the florescent light fixture on the ceiling was broken. The surveyor also observed that the toilet bowl had a brown circle at the water line of the commode. Lastly, the surveyor observed that the raised commode seat was badly rusted and soiled with a brown debris.

On May 31 2018 at 2:50 p.m., the survey team met with the Administrator (ADM), Director of Nursing (DON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #92's bathroom was not well maintained or clean. The surveyor notified the AT that the bathroom had broken ceiling tiles, the florescent light fixture was broken and that the raised toilet seat was badly rusted and dirty. Lastly, the surveyor notified the AT that the commode had a brown ring of debris at the water rim.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a clean, comfortable and homelike environment for Resident #92.

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641	1. Resident #10's MDS assessment modified on 5/31/2018 for accurate coding regarding the flu vaccine. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. MDS staff to be re-educated by the Vice President of Clinical Reimbursement regarding accuracy of Assessments to ensure compliance with MDS (Minimum Data Set) Accuracy and coding of Section O of the MDS. Administrator and/or Designee to audit Comprehensive Assessments completed in the facility 5 x week x 8 weeks to ensure facility staff maintain accurate MDS (Minimum Data Set) Comprehensive Assessments for residents in the facility. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to maintain an accurate MDS (Minimum Data Set) assessment on 1 of 45 residents in the survey sample (Resident #10)..

The findings included:

The facility staff failed to complete an accurate MDS in regards to Resident #10's flu vaccine documentation.

Resident #10 was admitted to the facility on 1/30/16 with the following diagnoses of, but not limited to anemia, stroke, seizure disorder, anxiety disorder, depression and Psychotic Disorder. On the annual MDS with an ARD (Assessment Reference Date) of 3/2/18, the resident was coded as having short term and long-term memory problems. Resident #10 was also coded as requiring extensive assistance of 2 staff members for dressing, extensive assistance of 1 staff member for personal hygiene and being totally dependent on 2 staff members for bathing.

The surveyor performed a review of Resident #10's clinical record on 5/30 and 5/31/18. During this review, the surveyor noted on the MDS with ARD of 10/13/17, under Section O 0250, the flu vaccine was documented as being given on 9/14/16. On the next MDS with ARD of 1/3/18 under Section O 0250, the flu vaccine was

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F 641	Continued From page 53 documented as being given on 10/4/17. On 5/31/18 at 3:20 pm, the surveyor notified the MDS nurse #1 of the above documented findings for Resident #10 in regards to the documentation of when the flu vaccine was given. The MDS nurse #1 stated, "Let me go back and look at this and then I will be back to talk to you." At 3:45 pm, MDS nurse #1 returned to the conference room and provided the surveyor a copy of the MDS with ARD of 10/13/17 that she had made a correction under Section O 0250. The MDS nurse #1 stated, "I just overlooked the correct date when I was coding the MDS. But you have a copy now of the modification that I made to correct this problem." The surveyor notified the administrative team of the above documented findings on 5/31/18 at 4:00 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 6/4/18.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656	1. Comprehensive Care Plan for Resident #92 updated on 5/30/2018 with a care plan for pressure ulcers and Discharge to Community Plan. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. MDS Staff to be re-educated regarding Development/ Implementing Comprehensive Care Plans by the Vice President of Clinical Reimbursement. MDS Staff also completed Relias Learning training on Care Planning and Implementation and Care Planning in Long Term Care. MDS Coordinator and/or designee to audit completed Comprehensive Care Plans 5 x week x 8 weeks to ensure the facility develops complete Comprehensive Care Plans. 4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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(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 staff interview and clinical record review it was determined that the facility staff failed to develop a Comprehensive Care Plan for 1 of 45 Residents in the sample survey, Resident #92.

For Resident #92 the facility staff failed to develop a Comprehensive Care Plan (CCP) to include a

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Care plan for Pressure Ulcers and a Discharge to Community Plan as identified on an Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/13/18.

The findings included:

Resident #92 was an 85 year old male who was admitted on 8/19/17. Admitting diagnoses included, but were not limited to: dehydration, hypotension, syncope with collapse, psychosis, fracture of the left femur, fractured humerus and depression.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Medicare 30 Day MDS assessment with an Assessment Reference Date (ARD) of 5/5/18. The facility staff coded that Resident #92 had a Cognitive Summery Score of 3. The facility staff also coded that Resident #92 required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On May 30, 2018 at 9:30 a.m., the surveyor reviewed Resident #92 clinical record. Review of the clinical record produced an Admission MDS assessment with an ARD of 4/13/18. The facility staff coded on the Admission MDS that Resident #92 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #92 required extensive assistance (3/2) with Activities of Daily Living (ADL's). The facility staff also documented in Section M. Skin Conditions that Resident #92 had a skin tear, used a bed and wheelchair pressure reducing surface and had the application of ointments/medications to areas other than the feet. In Section Q. Participation in Assessment and Goal Setting 0400. Discharge

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Plan the facility staff documented that there was an Active Discharge Plan to Return to the Community. In Section V. Care Area Assessments (CAA's) Resident #92 "triggered" for Pressure Ulcers and Return to Community Referral. The facility staff documented that a Care Plan (CP) would be developed for the "triggered" areas of Pressure Ulcers and Return to Community.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP) that was initiated in 4/8/18. Review of the CCP failed to produce a CP for Pressure Ulcers or a Discharge to the Community Plan.

On May 30, 2018 at 9:45 a.m., the surveyor requested to speak to the MDS Nurse. Within a few moments the MDS Nurse, who was a Registered Nurse (RN), approached the surveyor. The surveyor reviewed the Admission MDS with the ARD of 4/13/18 with the MDS Nurse. The surveyor specifically pointed out that Resident #92 "triggered" for Pressure Ulcers and a Discharge to the Community. The surveyor pointed out that the facility staff had documented that a CCP would be developed for Pressure Ulcers and a Discharge to Community. The surveyor then reviewed the CCP with the MDS Nurse. The surveyor pointed out that the CCP did not include a CP for Pressure Ulcers or a Discharge to Community Plan. The MDS Nurse stated that she did not know why a CCP had not been developed to include a CP for Pressure Ulcers and a Discharge to Community Plan.

On May 31, 2018 at 2:50 p.m., the survey team met with the Administrator (ADM), Director of Nursing (DON) Corporate Compliance Nurse

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F 656	Continued From page 57 (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP to include Pressure Ulcers and a Discharge Plan to Return to Community as identified on an Admission MDS with the ARD of 4/13/18. No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP for Resident #92 to include a CP for Pressure Ulcers and a Discharge to Community Plan.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657	1. Residents #82, #93, #49, and #26 remain in the facility. Care Plans have been revised to reflect current care needs. Resident #268 is a closed record review and has expired. No correction made to care plan. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Interdisciplinary Team re-educated by Vice President of Clinical Reimbursement on 6/27/2018 regarding Care Plan Timing and Revision. Facility staff to be re-educated by Director of Nursing and/or designee regarding comprehensive care planning and care plan timing and revision. DON and/or designee to audit care plans weekly following the routine care planning schedule as well as for new admissions and readmissions to the facility 5 x week x 8 weeks to ensure facility staff review and revise the Resident Centered Comprehensive Care Plan of residents in the facility. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation, the facility failed to review and revise the Comprehensive Resident Centered Care Plan for 5 of 45 residents in the survey sample (Resident #268, #82, #93, #49 and #26).

The findings included:

1. The facility staff failed to review and revise the Comprehensive Resident Centered Care Plan for Resident #268 in regards to pain management and Advance Directive.

Resident #268 was readmitted to the facility on 1/19/16 with diagnoses of, but not limited to high blood pressure, Alzheimer's Disease, cancer to the left breast, low back pain and osteoarthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/1/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. Resident #268 was also coded as requiring supervision with set up help from the facility staff for dressing, personal hygiene and bathing. The resident expired in the facility on 6/26/17.

The surveyor performed a closed clinical record review on Resident #268 on 6/1 and 6/4/18. During this review, it was noted by the surveyor that the facility staff had received physician orders for the following dates:

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" 11/10/16 Do Not Resuscitate
" 4/28/17 Fentanyl patch (used for pain) was started with a dose of 12 mcg/hr and then increased to 25 mcg/hr for uncontrolled pain.

The surveyor reviewed the Comprehensive Resident Centered Care Plan and under "Pain Management" there a date initiated was documented for 10/29/15 with a revision date of 6/26/17. Under "Advance Directive" on the care plan, the date initiated was documented for 4/13/16 with a resolved date of 12/14/16.

On 6/4/18 at 10 am, the surveyor notified the MDS nurse #1 of the above documented findings. The MDS nurse #1 stated, "I see that I just missed updating the care plan with the new orders we received."

At 4:00 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

This was a complaint investigation deficiency related to Resident #268.

2. The facility staff failed to review and review the Comprehensive Resident Centered Care Plan for Resident #82 in regards to a hospitalization.

Resident #82 was readmitted to the facility on 4/28/18 with the following diagnoses of, but not limited to high blood pressure, UTI, Parkinson's disease, anxiety disorder, depression, Psychotic Disorder and Schizophrenia. On the annual MDS (Minimum Data Set) with an ARD (Assessment

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Reference Date) of 2/1/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #82 was also coded as being totally dependent on 2 or more staff members for bed mobility, transfer and bathing. Then being totally dependent on 1 staff member for dressing and personal hygiene.

The surveyor performed a review on Resident #82's clinical record on 5/31 and 6/1/18. During this review of the nurses' notes. the surveyor noted that the resident had a fall from out of his bed resulting in being taken to the emergency room and the laceration above his left eye requiring 6 stitches. This fall occurred on 3/9/18. The surveyor also reviewed the Comprehensive Resident Centered Care Plan and under the focus of "At risk for falls ..." the date initiated was documented as being 6/6/17. Under "Interventions" there were 10 interventions listed with all revision dates for each intervention being documented as 6/6/17. The care plan did not reflect a revision date that corresponded with the fall on 3/9/18.

Resident #82 was admitted to the hospital on 3/13/18 and readmitted back to the nursing facility on 4/12/18 with a diagnosis of respiratory failure. The care plan was not revised to include the hospitalization that Resident #82 had.

The surveyor notified the director of nursing (DON) and corporate nurse of the above documented findings on 6/4/18 at 11:10 am.
The surveyor asked if a baseline care plan had been initiated on the resident once he was readmitted back to the facility. The DON stated, "Let me make a phone call and talk to MDS."

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The DON returned to the surveyor and stated, "A baseline care plan was not done because the resident had a comprehensive care plan in place." The surveyor asked if she could show the surveyor where on the care plan would the surveyor find the revision dates to reflect a fall that occurred on 3/9/18 and the date of revision when the resident returned to the facility from the hospital. The DON read over the comprehensive care plan and then stated, "I don't see where the care plan was updated." The surveyor asked if she would expect her staff to revise the care plan in each of the above documented circumstances and the DON replied, "Yes".

The surveyor notified the administrative team of the above documented findings on 6/4/18 at 4 pm.

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

3. The facility staff failed to review and revise the Comprehensive Resident Centered Care Plan for Resident #93 in regards to fluid restrictions. Resident #93 was readmitted to the facility on 9/2/15 with the following diagnoses of, but not limited to high blood pressure, diabetes, stroke, seizure disorder, anxiety disorder, depression and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference date) of 5/7/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 4 out of a possible score of 15. Resident #93 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for bathing.

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The surveyor performed a review of Resident #93's clinical record on 5/30 through 6/1/18. During this review, the surveyor noted the following entry made in the nurses for 2/26/18 at 13:43 (1:43 pm):

" "1.5 L (liter) fluid restriction daily every shift 1020 cc from dietary and 480 from nursing. Resident continues to be non- complaint with fluid restriction. Resident educated on the importance of following fluid restriction. Resident keeps personal cup with her at all times. Verbalizes understanding but continues to be non-complaint. Will continue to encourage compliance."

The comprehensive care plan was also reviewed by the surveyor for fluid restrictions on Resident #93. The surveyor did not find documentation on the resident's care plan for the resident being non-complaint with the above documented fluid restrictions. The last revision date on the care plan for fluid restriction was 1/16/17.

The surveyor notified the administrative team of the above documented findings on 5/31/18 at 4 pm in the conference room.

No further information was provided to the surveyor prior to the exit conference on 6/4/18.
4. For Resident #26, the facility staff failed to review and revise the Residents CCP (comprehensive care plan) when the Residents bed rails were removed.

The record review revealed that Resident #26 had been admitted to the facility 09/28/15.

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Diagnoses included, but were not limited to, peripheral vascular disease, asthma, chronic kidney disease, and diabetes.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/18 included a BIMS (brief interview for mental status) summary score of 15. Section P (restraints and alarms) had been coded (0) to indicate the Resident did not use bed rails.

On 5/30/18 at approximately 6:15 p.m., during an interview with Resident #26 the Resident stated that the facility had taken away her bedrails and that she had used them to pull herself over and up in the bed. Resident #26 stated they kept me from being scared.

On 05/31/18 at approximately 8:08 a.m., Resident #26 stated she still has a concern over her bedrails being removed and stated she also used them to put her call cord on so it would not fall in the floor.

A review of the Residents current CCP revealed that the CCP still included the interventions "per rsd (resident) request she prefers the call bell to be wrapped around bed rail" and "Call bell within reach-resident prefers to have call bell wrapped around left bed rail."

The administrator and DON (director of nursing) were notified of the concerns regarding the removal of the Residents siderails/bedrails on 05/31/18 at approximately 2:50 p.m.

The administrator was unable to provide an exact

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date when the Residents side rails were removed and stated it was sometime between January 29-March 22, 2018.

No further information regarding this issue was provided to the survey team prior to the exit conference.

5. For Resident #49, the facility staff failed to review and revise the Residents CCP (comprehensive care plan) in regards to contact isolation.

The Residents contact isolation had been discontinued on 03/27/18.

The record review revealed that Resident #49 had been admitted to the facility 03/16/18. Diagnoses included, but were not limited to, essential hypertension, gastroesophageal reflux disease, anxiety disorder, and major depressive disorder.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/23/18 included a BIMS (brief interview for mental status summary) score of 10 out of a possible 15 points.

The Residents CCP included the focus area "I am currently on contact isolation and not able to participate in my usual OOR (out of room) activities."

The clinical record included a physicians order dated 03/27/18 to discontinue contact precautions.

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F 657	Continued From page 65 On 5/30/18 at approximately 11:50 a.m., the MDS coordinator was asked about the CCP and the Residents isolation status. The MDS coordinator stated she would review the CCP. After reviewing the CCP, the MDS coordinator verbalized to the surveyor that the CCP was incorrect and she had updated it. The administrative staff were notified of the issue regarding the Residents CCP during a meeting with the survey team on 05/31/18 at approximately 2:50 p.m. No further information regarding the incorrect CCP was provided to the survey team prior to the exit conference.	F 657		
F 658 SS=E	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 staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to follow professional standards of practice when administrating medication to 1 of 45 residents in the survey sample (Resident #268). The findings included: The facility staff failed to follow professional standards of nursing practice when administering medications to Resident #268.	F 658	1. Resident #268 has been discharged from the facility and has expired. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing Staff re-educated on importance of medication times and signing off medication within the time frame they are ordered on 6/4/2018. Relias Learning Training regarding Medication Administration completed by Nursing Staff on or by 6/22/2018. Audit of Medication Administrations/ Medication Sign Offs to be completed by Unit Managers and/or Designee 5 x week x 8 weeks to ensure facility staff follow professional standards of practice when administering medication to the residents in the facility. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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Resident #268 was readmitted to the facility on 1/19/16 with diagnoses of, but not limited to high blood pressure, Alzheimer's disease, cancer to the left breast, low back pain and osteoarthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/1/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. Resident #268 was also coded as requiring supervision with set up help from the facility staff for dressing, personal hygiene and bathing. The resident expired in the facility on 6/26/17.

The surveyor performed a closed clinical record review on Resident #268 on 6/1 and 6/4/18 pertaining to a complaint that was received in the Office of Licensure and Certification on 6/1/17. The complainant alleges the facility staff failed to administer pain medications to Resident #268 as prescribed by the physician.

On 5/31/18 at 1:00 pm, the surveyor requested and was provided a copy of Resident #268's MAR (Medication Administration Record) and Time Analysis for medication administration for January, February, March, April and May 2018 from the director of nursing. The surveyor reviewed these reports and noted that the resident's pain medication that had scheduled times on the MAR was given 2-3 hours after these times that were varied among different shifts and nurses through the months of January, February, March, April and May.

On 6/4/18 at 11:30 am, the surveyor notified the corporate nurse and asked if _____ (name of resident) was administrated her pain medication in a timely manner. The corporate nurse stated,

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F 658	Continued From page 67 "Let me look over the reports that you have and then we can discuss this further." The corporate nurse reviewed the above requested reports and then stated, "According to the time analysis for each of the pain medications, they were not. Some of them were given 2-3 hours after the scheduled time that they were supposed to be given to the resident." The surveyor asked the corporate nurse what was the standard that she would hold her nursing staff accountable when administrating medications to the residents. The corporate nurse stated, "You have an hour before and an hour after the scheduled time." The surveyor requested a copy of the facility's standard of practice when administrating medications to the residents. At 12:10 pm, the director of nursing (DON) provided the surveyor with a copy of titled "Preventing Medication Errors ABC's Quick Reference" which read in part " ... Meds must be passed within one hour of scheduled times ..." The DON also provided the surveyor with another reference from Lippincott's Nursing Procedures, Sixth Edition (2013) page 530, which read in part, " ...Verify that the medication is being administrated at the proper time ..." The surveyor notified the administrative team of the above documented findings on 6/4/18 at 4 pm. No further information was provided to the surveyor prior to the exit conference on 6/4/18. *This is a complaint investigation deficiency related to Resident #268.	F 658		
F 675 SS=E	Quality of Life CFR(s): 483.24	F 675		

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F 675	Continued From page 68 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to provide 2 of 45 residents (Residents # 86 and 118) with physician ordered medications: ~ Failed to provide Residents #8 with insulin as ordered by the physician. ~ Failed to provide Resident #118 with Augmentin as ordered by the physician. Findings: 1. The facility staff failed to provide Residents #86 with insulin as ordered by the physician. Resident #86 was admitted to the facility on 8/17/18. His admission diagnoses included: Diabetes II, Anxiety, Complete amputation at knee level, bilateral, and anemia. The resident's latest MDS (minimum data set) dated 5/3/18 coded the resident with unimpaired communications skills. His cognitive ability showed slight memory impairment during testing. The same interview testing indicated the resident	F 675	1. Both resident #8 and #118's Physicians were notified that residents did not receive medications in a timely manner. No new orders noted. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing Staff re-educated by DON and Human Resources Director regarding medication administrations. Facility Staff educated by DON and Human Resources regarding physician ordered medications. Physician Order Sheet Audit to be completed by DON and or Designee regarding medication administration 5 x a week x 8 weeks to ensure facility staff administer medications per Physician's order. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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indicated the resident felt "down, depressed or hopeless", had trouble sleeping, and had little energy.

The MDS captured the resident's behaviors during the look back period. The resident had no indicators for psychosis and no indicators for physical, verbal or other behavior symptoms documented. The resident was documented as rejecting staff care every one to three days.

The MDS coded the resident as requiring the intervention of at least one staff member for all the ADLs (activities of daily living.) Resident #86 was documented as able to feed himself with set-up help only. The resident was incontinent of both bowel and bladder and required staff intervention to provide care.

The resident's CCP (comprehensive care plan) documented the resident with behaviors (refusing medicine, arguing with staff, calling 911, refusing care, cursing staff, name-calling staff and yelling). Interventions including providing doctor-ordered meds, attempting interventions before behavior begins, speaking in calm voice, diversion, check for pain, etc.

The physician's order, signed and dated 4/24/18, documented the insulin Novolog be administered four times daily, per sliding scale and according to the accuchecks done at the same time. The physician ordered the accuchecks and the sliding scale Novolog administration to be done prior to meals and at the hour of sleep every day. (6:30 AM, 11:30 AM, 4:30 PM and 9:00 PM.)

On 5/29/18 at 6:10 PM Resident # 86 was interviewed. He complained to the surveyor that

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his insulin was being provided at the wrong times. He said they'll come in and get my blood sugar (accucheck) and then 2-3 hours later they show up with my insulin.

Resident #86 stated, "You know my blood sugar is not the same by then--and they're giving me the wrong dose." The resident also complained they would come in at 5 AM to get his accucheck done and he didn't want to be waked up for that.

The resident's MARS were reviewed for April and May 2018. The insulin and accuchecks were both recorded at the same time on the computer by nursing staff so it was not possible to prove the accuchecks were taken several hours before the insulin was provided.

On several occasions the 6:30 AM/11:30 AM insulin was administered after breakfast or lunch and not before as the physician had ordered:
1. 4/2/18– 11:00 AM dose admin @ 1:47 PM
2. 4/4/18– 6:30 AM dose @ 9:46 AM
3. 4/5/18--6:30 AM dose @ 9:06 AM
4. 4/7/18--11:30 dose @ 1:06 PM
5. 4/8/18--6:30 dose @ 9:32 AM
6. 4/10/18--6:30 dose @ 9:35 AM
7. 4/10/18--11:30 AM dose @ 1:48 PM
8. 4/11/18--11:30 AM dose @ 1:12 PM
9. 4/13/18--11:30 AM dose @ 1:14 PM
10. 4/16/18--11:30 AM dose @1:13 PM
11. 4/19/18--11:30 AM dose @ 1:30 PM.
12. 4/21/18--11:30 AM dose @ 1:22 PM
13. 5/4/18--11:30 AM dose @1:53 PM
14. 5/5/18--11:30 AM dose@ 1:42 PM
15. 5/6/18--11:30 AM dose @1:33 PM
16. 5/8/18--11:30 AM dose @1:28 PM
17. 5/9/19--11:30 AM dose @ 1:18 PM
18. 5/10/18--11:30 AM dose@ 1:22 PM

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19. 5/14/18--11:30 AM dose@ 1:42 PM
20. 5/15/18--11:30 AM dose@ 1:26 PM
21. 5/21/18--11:30 AM dose @1:34 PM
22. 5/25/18--11:30 AM dose @ 2:00 PM

****Resident #86's lunch was observed to be delivered to his room between 12:45 PM and 1:00 PM during the onsite survey days.

The 4/18/18/ 9:00 PM insulin was administered on 4/19/18 at 12:28 AM.
On 4/28/18 and 4/29/18 the 6:30 AM insulin was administered at 5:37 AM both mornings--2 1/2 hours before breakfast.

The administrator and DON were informed of these findings on 5/31/18 at 2:51 PM.

This was a complaint deficiency.
2.For Resident #118, the facility staff failed to administer the Residents physician ordered antibiotic augmentin as ordered. This medication was available in the stat box for administration.

The record review revealed that Resident #118 had been admitted to the facility 11/05/14. Diagnoses included, but were not limited to, dementia without behavioral disturbance shortness of breath, diabetes, and pneumonia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/27/18 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.

The Residents clinical record included a

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F 675	Continued From page 72 physicians order (05/24/18) for the antibiotic augmentin 875-125 mg give 1 tablet via g-tube two times a day-pneumomia. A review of the Residents eMARs (electronic medication administration records) revealed that the nursing staff had documented on 05/24/18 at 22:34 (10:34 p.m.) that the medication was not available "awaiting in from pharmacy." The first dose was documented as being administered on 05/25/18 at 9:00 a.m. A review of the stat box list indicated that this medication would have been available for administration. The administrative staff were notified of the issue regarding the augmentin during a meeting with the survey team on 05/31/18 at approximately 2:50 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 675		
F 684 SS=E	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	F 684	1. Resident # 268 had discharged from the facility and is now deceased. Resident #116 had port-a-cath flushed on 6/5/2018, no issues. MD aware with no new orders. Resident #115's physician made aware, no new orders noted. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Staff re-educated by DON and Human Resources regarding maintaining the highest practical well being of the residents in the facility. Physician Order Sheet Audit to be completed by DON and/or Designee regarding medication administration 5 x a week x 8 weeks to ensure facility staff administer medications per Physician's order. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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by:
Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to maintain the highest practical well-being for 3 of 45 residents in the survey sample (Resident #268, #116 and #115).

The findings included:

1. The facility staff failed to administer a pain medication, Lortab, as prescribed by the physician for Resident #268.
Resident #268 was readmitted to the facility on 1/19/16 with diagnoses of, but not limited to high blood pressure, Alzheimer's disease, cancer to the left breast, low back pain and osteoarthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/1/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. Resident #268 was also coded as requiring supervision with set up help from the facility staff for dressing, personal hygiene and bathing. The resident expired in the facility on 6/26/17.

The surveyor performed a closed clinical record review on Resident #268 on 6/1 and 6/4/18 pertaining to a complaint that was received in the Office of Licensure and Certification on 6/1/17. The complainant alleges the facility staff failed to administer pain medications to Resident #268 as prescribed by the physician. It was noted that Resident #268 was prescribed Lortab 7.5 /325mg (milligram) 1 tablet by mouth after meals and at bedtime. The physician gave this order on 3/17/16. On 4/28/17, the physician increased the pain medication to 10 mg 1 tablet by mouth after meals and at bedtime.

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The surveyor requested and received copies of the "Time Analysis" reports for the months of January, February, March, April and May 2018. The reports were reviewed and the surveyor noted that the above ordered pain medications were given 2-3 hours after the ordered times on various shifts and by various nurses for the above requested months. On 6/4/18 at 11:30 am, the surveyor notified the corporate nurse and asked if _____ (name of resident) was administrated her pain medication in a timely manner. The corporate nurse stated, "Let me look over the reports that you have and then we can discuss this further." The corporate nurse reviewed the above requested reports and then stated, "According to the time analysis for each of the pain medications, they were not. Some of them were given 2-3 hours after the scheduled time that they were supposed to be given to the resident." The surveyor asked the corporate nurse what was the standard that she would hold her nursing staff accountable when administrating medications to the residents. The corporate nurse stated, "You have an hour before and an hour after the scheduled time." The surveyor requested a copy of the facility's standard of practice when administrating medications to the residents.

At 12:10 pm, the director of nursing (DON) provided the surveyor with a copy of titled "Preventing Medication Errors ABC's Quick Reference" which read in part " ... Meds must be passed within one hour of scheduled times ..." The DON also provided the surveyor with another reference from Lippincott's Nursing Procedures, Sixth Edition (2013) page 530, which read in part, " ...Verify that the medication is being

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administrated at the proper time ..."

The surveyor notified the administrative team of the above documented findings on 6/4/18 at 4 pm.

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

*This is a complaint investigation deficiency related to Resident #268.
2. The facility staff failed to administer IV antibiotics as ordered by the physician for Resident # 115.

Resident # 115 is 68-year-old- male who was originally admitted to the facility 4/6/99, with a readmission date of 5/29/18. Diagnoses included but were not limited to: urethral stricture, retention of urine, heart failure, vascular dementia without behavioral disturbance, and anxiety disorder.

On 5/30/18 at the 9:51 am, the clinical record for Resident # 115 was reviewed. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 5/16/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's Cognitive status was severely impaired. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 115 had an indwelling catheter.

The current plan of care for Resident # 115 was reviewed and revised on 5/23/18. A focus area for Resident # 115 is documented as "Urinary Tract infection, potential or actual due to history of

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chronic urinary tract infections, use of supra pubic catheter, bowel incontinence." Interventions included but were not limited to: "Observe and report signs and symptoms of UTI (urinary tract infection): Changes in color, odor, or consistency or urine, dysuria, frequency, fever, pain."

On 5/30/18 at 10:02 am, the surveyor reviewed the medication administration record for Resident # 115 and observed an order for "Cefepime 1g (gram) IV (intravenously) every 8 hours." The surveyor observed "H" documented in the clinical record for the 10:00 pm dose on 5/29/18. The surveyor spoke with the unit manager and asked her what "H" meant. Unit manager stated that "H" meant hold. Unit manager stated that the medication was an IV medication and that the medication was not in the facility. The surveyor asked the unit manager the facility utilized a backup pharmacy. Unit manager stated "yes." The surveyor reviewed the clinical record further and could not locate an order to hold the Cefepime for Resident # 115.

On 5/30/18 at 10:15 am, the unit manager provided the surveyor with a handwritten nurses note for Resident # 115 that was written on 5/29/18 at 10:30 pm. Documentation stated "Resident very agitated medication given with some relief, called pharmacy concerning, antibiotic Cefepime, had to refax unable to get medication until tomorrow notified DON (director of nursing), she stated MD (medical doctor) was aware that medication will not be in until tomorrow." The surveyor spoke with the unit manager about the nurse's note and the fact that this is not an actual physician's order to hold the medication. Unit Manager agreed that there was no order to hold the medication.

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On 5/31/18 at 3:40 pm, the administrative team was made aware of the findings as stated above. At this time, the DON also agreed that there was no actual order to hold the Cefepime for Resident # 115.

No further information was provided to the survey team prior to the exit conference on 6/4/18.

3. The facility staff failed to ensure that the port a cath for Resident # 116 was routinely flushed and as a result, an order was written for Resident # 116 to consult with a vascular surgeon.

Resident # 116 is a 63-year-old-male who was admitted to the facility on 4/10/13. Diagnoses included but were not limited to: schizophrenia, hypertension, major depressive disorder, and hypokalemia.

The clinical record for Resident # 116 was reviewed on 5/30/18 at 11:00 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/21/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff coded that Resident # 116 had a BIMS (brief interview for mental status) score of 5/15, which indicated that Resident # 116's cognitive status is severely impaired.

The current plan of care for Resident # 116 was reviewed and revised on 5/24/18. A focus area on the plan of care for Resident # 116 is documented as "Infection actual or at risk for related to: port-a cath-left chest." Interventions included but were not limited to: "Flush port-a-cath per order."

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"Observe for s/sx (signs and symptoms) of infection/problems-inform MD (medical doctor) PRN (as needed).

Upon review of the current physician's order sheet for Resident # 116, the surveyor could not locate orders to flush the port-a cath.
On 5/30/18 at 11:24 am, the surveyor spoke with the unit manager and asked if Resident # 116 had orders to have his port-a-cath flushed. Unit Manager stated "No."

According to the facility policy for "Accessing/De-Accessing an Implanted Port" has documentation that includes but is not limited to "3. If a port is not in use it must be accessed, flushed, and de accessed a minimum of once every 30 days."

On 5/31/18 at 3:40 pm, the administrative team was made aware of the findings as stated above. Upon being made aware that Resident # 116 was not having his port-a-cath flushed, the DON stated "He used to because I was the one who used to flush it."

On 6/4/18 at 1:15 pm, the surveyor requested information regarding follow up on Resident # 116's port-a-cath.

On 6/4/18 at 2:30 pm, the facility staff provided the surveyor with the following documentation.

A copy of the medication administration record for Resident # 116 that showed that his port-a-cath was last flushed on November 16, 2017.

An order for Resident # 116 was written on 5/31/18 at 7:25 pm that stated "Heparin Lock

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F 684	Continued From page 79 Flush Solution 10 unit/ml (milliliter) Use 5ml intravenously one time a day every 30 day(s) for Port-A-Cath. If cath to left chest is not able to be accessed-flush with 20 ml Normal Saline, then flush with 5ml Heparin (only to be done by RN) ."(Registered nurse) A telephone order for Resident # 116 was written on 6/1/18 at 11:15 pm, to refer to Vascular Surgeon regarding port-a-cath." A progress note was documented in the clinical record for Resident # 116 on 6/1/18 at 11:31 pm. The progress note stated, "Attempted to flush port a cath using sterile technique with Huber needle, unable to access. Md (medical doctor) notified ordered to refer to vascular surgeon. Left message with RP. (Responsible party) Transportation notified." No further information was provided to the survey team prior to the exit conference on 6/4/18.	F 684	1. Facility staff re-educated on transfers and usage of facility lifts by Aegis Therapy Department. Facility staff re- educated on reviewing resident's Kardex prior to providing care to residents. Resident #101's over the bed table immediately removed and replaced. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Facility staff to be re-educated by DON and/or Designee regarding transfer status of residents and reviewing Kardex to reflect resident's transfer and ADL assistance status, and removing any hazards that may be in resident's room. Unit Managers and/or Designee to audit to ensure Kardex' are complete and accurate to reflect resident's transfer and ADL status 5 x a week x 8 weeks. and Department Heads to complete Care Keeper Rounds 5 x a week x 8 weeks to ensure residents receive adequate supervision and assistance to prevent accidents. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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, clinical record review, staff interview, family interview, and over the course of a complaint investigation, the facility staff failed to	F 689		

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ensure that 3 of 45 Residents in the survey sample received adequate supervision and assistance to prevent accidents, Resident # 85, Resident # 82, and Resident # 101.

The findings included:

The facility staff failed to transfer Resident # 85 using the Hoyer Lift as determined necessary by the comprehensive plan of care, during a transfer from the wheelchair to the bed, resulting in the resident sustaining a 14 inch laceration to the lateral left leg which required that she be transferred to the emergency room where she received sutures, a Penrose drain, and required antibiotic therapy.

A facility reported incident was sent into the Office of Licensure and Certification on 11/9/17. The Office of Licensure and Certification converted this facility reported incident into a complaint, which was investigated during an unannounced Medicare/Medicaid recertification survey that took place on site at the facility on 5/29/18 through 6/4/18.

Resident # 85 was originally admitted to the facility on 8/9/07 with a readmission date of 5/31/11. Diagnoses included but were not limited to: hypothyroidism, heart failure, hypertension, and chronic pain.

The clinical record for Resident # 85 was reviewed on 5/31/18 at 9:35 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/2/18. Section C assesses cognitive patterns. In section C1000, the facility staff coded that Resident # 85's cognitive status

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as severely impaired. Section G assesses functional status. In Section G0110, the facility staff documented that Resident # 85 totally dependent requiring assistance of 2 or more persons for transfers.

The current plan of care for Resident #85 was reviewed and revised on 5/9/18. The focus area for "At risk for falls related to: Use of medication, assistance with mobility," has interventions that included but were not limited to "Transfer using the Hoyer lift with staff assistance."

On 5/31/18 at 9:42 am, the surveyor observed a progress note in the clinical record written on 11/4/17 at 2:57 pm. The progress note stated, "This nurse along with coworker was sitting at the nurses station and heard someone calling out for the nurse. Upon going down the hall observed patients left lower extremity bleeding with large approx. 10x10 cm (centimeter) gash. Skin flap was intact and adipose tissue exposed. Recovered gash with skin flap, applied pressure, contacted 911 for transport to ED (emergency department) elevated patient leg while applying pressure. Resident transported to ED via ambulance at 1425 (2:25 pm), resident RP (responsible party) notified at 1432 (2:32 pm) of incident and that patient was at ED. Will contact ED for update on the resident."

On 5/31/18 at 9:46 am, the surveyor observed a progress note in the clinical record written on 11/4/17 at 5:57 pm. The progress note stated "Returned from ER (emergency room) with orders to not get patient up to leave in bed, left leg wrapped in Coban with Penrose drain in place, return to ER on Monday to remove drainage bag, and return in 2 weeks for suture removal, 1 gram

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vancomycin given in hospital, started on Doxycycline 100 mg (milligram) BID (twice daily) for 10 days."

On 5/31/18 10:20 am, the surveyor spoke with the DON (director of nursing) about Resident # 85 sustaining an injury to her left leg on 11/4/17. The DON stated to the surveyor that the CNA (certified nursing assistant) in this situation did not use the lift and transferred the resident improperly.

On 5/31/18 11:25 am, the surveyor interviewed LPN # 3(licensed practical nurse) in the presence of the survey team. The surveyor asked LPN # 3 what happened during the incident on 11/4/17 in which Resident # 85 sustained an injury to her left leg. LPN # 3 stated that she heard CNA calling for help. LPN # 3 and another nurse rushed down there and "saw the extent of the wound." LPN # 3 stated that she put the skin back and applied pressure. The surveyor asked LPN # 3 to describe the wound to Resident # 85's left leg. LPN #3 stated that the wound was "Very long and deep and I knew it needed medical attention that I couldn't give. LPN # # stated that she contacted the physician and got Resident # 85 sent to the ER. LPN # 3 stated that she educated the CNA because she transferred the resident improperly. LPN # 3 stated that the CNA was using a stand and pivot technique when transferring Resident # 85 and stated that Resident # 85 was assisting with standing during the transfer and then Resident # 85 stated "My leg, my leg," and the CNA looked down and saw the blood and called for the nurses.

On 5/31/18 at 11:55 am, the surveyor interviewed CNA # 1 in the presence of the survey team. The

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surveyor asked CNA # 1 to tell what happened on 11/4/17 when Resident # 85 sustained an injury to her left leg. CNA #1 stated "That day I was in a hurry because I was behind." "I usually use the stand up and the lift wasn't available." "I think someone else was using it." "I transferred her using stand and pivot." CNA # 1 stated that Resident # 85 "stood and did fine and when I sat her on the bed she said oh my leg I looked down and saw the blood." CNA # 1 stated that she put Resident # 85's legs on the bed and called for the nurse. CNA # 1 stated, "I am assuming that she hit it on the bed rail that was on the bed at the time." CNA # 1 stated that she had worked with Resident # 85 before and was familiar with her plan of care and knew that she was supposed to use the lift. CNA # 1 stated again that she was behind and this is the reason she transferred incorrectly. CNA # 1 stated that she was placed on suspension and when she returned she was educated on the use of the lift with the residents.

On 5/31/18 at 1:43 pm, the surveyor reviewed the MDS assessment that was completed for Resident # 85 prior to the incident on 11/4/17. The MDS assessment was a quarterly assessment with an ARD of 10/4/17. In Section G 0110, the facility staff documented that Resident # 85 was totally dependent with transfers requiring the assistance of two or more persons.

On 5/31/18, the administrative staff was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 6/4/18.

*** This is a complaint deficiency***

2. The facility staff failed to maintain an accident

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free environment for Resident #82 in regards to a fall.

Resident #82 was readmitted to the facility on 4/28/18 with the following diagnoses of, but not limited to high blood pressure, UTI, Parkinson's disease, anxiety disorder, depression, Psychotic Disorder and Schizophrenia. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/1/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #82 was also coded as being totally dependent on 2 or more staff members for bed mobility, transfer and bathing. Then being totally dependent on 1 staff member for dressing and personal hygiene.

The surveyor performed a review on Resident #82's clinical record on 5/31 and 6/1/18. It was noted that the following documentation was made in the nurses' notes dated and timed for 3/9/18 at 1607 (4:07 pm): "Called to room by CNA. Upon entering room resident lying in floor on back, blood noted to head and floor. Approximately 2 in (inch) laceration noted to left eyebrow. Resident assessed. Pressure applied to laceration for approx. (approximately) 15 mins with bleeding controlled. Resident was not moved d/t (due to) fall with head injury ...Resident stated he was trying to hold on but is not used to not having side rails and could not hold on ...MD (medical doctor) notified new order to send to ER for evaluation ..."

Then on 3/9/18 at 2334 (11:34 pm) the nurses' notes read in part " ...Resident returned to facility @ 9 pm via stretcher transported by EMS accompanied by father ...Laceration to left eye with 6 stitches above eyebrow. L (left) eye

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swollen and purple. Sm (small) bump on right side of forehead. Abrasion to right knee. L (left) knee cap swollen and purple. Ice pack applied ...Father very verbally upset that rails were removed from bed and demanded that they be put back ...Supervisor talked to father about new policy concerning rails. Father stated he would be talking to Administration ..."

The surveyor reviewed the MDS with ARD of 2/1/18, in which the resident was coded as being totally dependent on 2 or more staff members for bed mobility, transfer and bathing.

The comprehensive care plan was also reviewed by the surveyor. Under the "Focus" section of the care plan it read in part " ...Mobility impairment ..." with the following interventions listed on the care plan:

" "Assist to turn and reposition frequently.
" Assistive device: w/c (wheelchair)
" Call bell within reach
" Encourage choices with care
" Inspect skin with care. Report reddened areas, rashes bruising or open areas to charge nurse
" Nail care PRN (as needed) -refer to the Podiatrist PRN.
" Observe and report changes in physical functioning ability
" Observe and report changes in ROM (range of motion) ability
" Praise effort at participation
" Provide all needed assistance w/ADL's (activities of daily living) & mobility.
" Provide all needed assistance w/toileting-provide incontinence care PRN.
" Resident to have left hand orthotic placed in

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AM. removed at night, and worn no more than 12 hours per order.
" Therapy per order."

The surveyor interviewed the director of nursing (DON) on 6/1/18 at 8:50 am in the conference room. The surveyor asked how the resident obtained a laceration above his left eyebrow on 3/9/18. The DON stated, "He got the laceration by sliding off the edge of the bed when the CNA was changing him. The doctor was called and he told us to send the resident to the ER for evaluation." The surveyor asked the DON if the side rails were present on the bed at the time of the accident. The DON stated, "No, they were not." The surveyor asked the DON what was the date that the side rails were removed from the resident's bed. The DON stated, "I don't know the exact date but I know we looked at the most ambulatory residents first and removed those first and then we worked our way through the rest of the residents. I know we began this around the 29th of January and ended taking the side rails off the beds the middle of March."

The surveyor interviewed CNA #2 at 9:05 am in the conference room. The surveyor asked CNA #2 to tell the events leading up to and surrounding _____ (name of resident) fall from his bed on 3/9/18. CNA #2 stated, "I was changing him and used the draw sheet to turn him towards the window which was away from the side of the bed that I was standing on. He began to start falling and I could see him grabbing at the sheet but he fell anyways." The surveyor asked CNA #2 if the side rails were on or off the bed at the time of this fall. CNA #2 stated, "I don't remember when the side rails were taken off but they were not on there when he fell out of the

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bed." The surveyor asked CNA #2 how many staff members were needed to turn this resident and how would you know about this information to care for the resident. CNA #2 stated, "In the past he could use the side rails to hold on if he felt like he was falling. We did only use 1 aide to turn him but since the accident we are required to have 2. There is a kardex on each unit that tells you how many aides are needed to do certain things with the resident and then we also get a report from the charge nurse."

This surveyor and the team leader for the survey went into Resident #82's room at 9:25 am to interview the resident about the above documented fall on 3/9/18. The surveyors spoke to the resident but the resident was attempting to speak but the surveyors were unable to understand what he was saying. The father was sitting at the bedside of the resident and this surveyor asked if he could remember what the staff told him about the fall that occurred on 3/9/18. The father stated, "they took his side rails off the bed that morning and by that afternoon, the aide was in here changing him and he slid off the bed, hit his head on the table over there and had to get 6 stitches above his left eye. I don't understand why they took the side rails off the bed." The surveyor asked what exactly was he told regarding the removal of the side rails from the bed. The father stated, "They said it was against state law to have side rails on the bed."

The surveyor again interviewed the DON at 11:05 am in the conference room. The surveyor requested a copy of the bed rail assessments that were performed prior to the removal of the side rails from the bed. The DON stated, "I don't think that we have an assessment immediately prior to

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the removal of the side rails but I could be wrong. I have only been the DON here since about March and this was started prior to me accepting this position."

At 1:38 pm, the surveyor interviewed LPN #2 by phone and asked if she could remember _____ (name of resident) falling off the side of the bed on 3/9/18. LPN #2 stated, "The CNA called me to come into the resident's room and told me that she was changing him and he rolled off the side of the bed. I know she told me that she had been standing on the right side of the bed and turned him towards the window and that's when he fell." The surveyor asked if she could recall if there were side rails present on the bed at the time of the fall and she replied, "No". The surveyor asked how many aides are needed to turn the resident in bed. LPN #2 stated, "At that time we only used 1 aide but now after the fall we are required to have 2 staff in there so this does not happen again."
The surveyor notified the administrative team on 6/4/18 at 4 pm of the above documented findings. The surveyor asked the administrative team if there was any other information that they would like for the survey team to consider in regards to the fall. The administrator stated, "I believe you have everything that we could give you at this point."

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

3. The facility staff failed to maintain a hazard free environment for Resident #101 in regards to the bedside table.

Resident #101 was admitted to the facility on

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3/1/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, heart failure, high blood pressure, Peripheral Vascular Disease, End Stage Renal Disease, diabetes and depression. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/26/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident # 101 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.

On 5/30/18 at 3:30 pm, the surveyor went into Resident #101's room. During the resident interview, the surveyor observed the bedside table had worn edges that had sharp edge. The resident stated, "It will cut you if you are not watching." The surveyor notified LPN #2 at 3:50 pm of the above documented findings concerning the sharp edges that were present on the bedside table. PN #2 and the surveyor retuned to the resident's room and stated, "I'll go and get another one. That is worn out and the edges are sharp and you could get a splinter because the wood is showing." The nurse went and found another bedside table and replaced the one in the room. LPN #2 stated that she had notified the maintenance director and the nurse manager of the condition of the bedside table in the resident's room.

The surveyor notified the administrative team of the above documented findings on 5/31/18 at 4 pm.

No further information was provided to the surveyor prior to the exit conference on 6/4/18.

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F 690 SS=D	Bowel/Bladder Incontinence. Catheter. UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical	F 690	1. Resident #115 had his catheter secured per physician order on 5/30/2018. 2. Residents with urinary catheters have the potential to be effected by this deficient practice. 3. Nursing staff re-educated in regards to infection control, catheter care, resident dignity with catheters and catheter covers on 6/12/2018 and 6/13/2018 by DON and Human Resources Director. Care Keeper Rounds Audit to be completed by Department Heads and/or Designee of residents with catheters 5 x weekly x 8 weeks to ensure residents receive appropriate treatment and services to prevent urinary tract infections. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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record review, and facility document review, the facility staff failed to ensure that 1 out of 45 Residents in the survey sample received appropriate treatment and services to prevent urinary tract infections. Resident # 115.

The findings included:

The facility staff failed to ensure that the suprapubic catheter for Resident # 115 was secured.

Resident # 115 was originally admitted to the facility 4/6/99, with a readmission date of 5/29/18. Diagnoses included but were not limited to: urethral stricture, retention of urine, heart failure, vascular dementia without behavioral disturbance, and anxiety disorder.

On 5/30/18 at the 9.51 am, the clinical record for Resident # 115 was reviewed. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 5/16/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's Cognitive status was severely impaired. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 115 had an indwelling catheter.

The current plan of care for Resident # 115 was reviewed and revised on 5/23/18. A focus area of "Alteration in elimination of bowel and bladder R/T (related to) bowel incontinence and D/T (due to) use of a supra-pubic catheter-has Dx's (diagnoses) of urethral stricture & neurogenic bladder." Interventions included but were not

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limited to: "Anchor catheter. avoid tugging on the catheter during transfer and delivery of care." "Check catheter anchor for placement Q (every) shift and change PRN (as needed)."

Resident # 115 has current orders that were signed by the physician on 5/2/18 that included but was not limited to "Catheter leg strap check every shift for placement. dignity bag (fig leaf) over drainage bag for dignity." and "Suprapubic catheter care every shift and prn." (as needed)

On 5/29/18 at 3:35 pm, the surveyor observed the facility staff providing care to Resident # 115. The surveyor observed a suprapubic catheter in place just above the pelvic region of Resident # 115. The suprapubic catheter was not secured at this time.

On 5/29/18 at 6:35 pm. the surveyor observed the facility staff providing care for Resident # 115. #16 FR (French) catheter with 10ml (milliliter) bulb is in place and the suprapubic catheter is not secured.

On 5/30/18 at 11:05 am, the surveyor observed Resident # 115 along with the unit manager. The unit manager and surveyor observed Resident # 115 with a # 16 Fr catheter with a 10 ml bulb in place. The unit manager and the surveyor observed that the suprapubic catheter for Resident # 115 was not secured at this time. The unit manager agreed that the catheter should be secured.

The facility standard of practice has documentation that includes but is not limited to: "Tape the catheter to the patient's abdomen or thigh to prevent pressure on the urethra at the

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F 690	Continued From page 93 penoscrotal junction." On 5/31/18 at 3:50 pm, the administrative staff was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.	F 690		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to coordinate care with the dialysis center for 2 of 45 residents in the survey sample (Resident #101 and #87). The findings included: 1. The facility staff failed to coordinate care with the dialysis center in regards to incomplete documentation for pre/post communication for Resident #101. Resident #101 was admitted to the facility on 3/1/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, heart failure, high blood pressure, Peripheral Vascular Disease, End Stage Renal Disease, diabetes and depression. On the MDS (Minimum Data Set)	F 698	1. Residents #101 and #87's MD notified and ESRD Communication forms updated. No new orders. 2. Residents currently receiving dialysis have the potential to be effected by this deficient practice. 3. Nursing staff re-educated on the importance of completion of the dialysis communication form for both pre-dialysis and post-dialysis by DON and/or Designee. Administrator spoke with Facility Administrator over Davita Dialysis Center on 6/4/2018. Dialysis Communication Form Audit to be completed by Unit Manager and/or Designee to ensure ESRD Communication Forms are completed 5x a week x 8 weeks to ensure the facility staff coordinate care with the dialysis center. 4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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with an ARD (Assessment Reference Date) of 3/26/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident # 101 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.

The surveyor performed a review of Resident #101's clinical record on 5/30 and 5/31/18. During this review, the surveyor noted that either the pre/post or both documentation was missing on the "Dialysis Communication Record" for the following dates: 3/8/18, 3/13/18, 3/15/18, 3/24/18, 3/27/18, 3/29/18, 4/7/18, 4/10/18, 4/12/18, 4/14/18, 4/17/18, 4/19/18, 4/21/18, 4/24/18, 4/26/18, 4/28/18, 5/3/18, 5/8/18, 5/10/18, 5/12/18, 5/15/18, 5/17/18, 5/22/18, 5/24/185/26/18 and 5/29/18.

On 6/1/18 at 1:30 pm, the surveyor requested and was provided a copy of the dialysis contract. The contract read in part " ...FACILITY will send to PROVIDER documentation as to how the resident's care is being managed ...Provider will promptly provide FACILITY complete and appropriate documentation of each service received by FACILITY resident(s) as well as any reaction to a service received ..."

The surveyor notified the administrative team on 6/4/18 at 4 pm the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 6/4/18.
2. The facility staff failed to ensure that dialysis communication sheets were completed for Resident # 87.

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Resident # 87 is a 53-year-old-female that was originally admitted to the facility on 4/13/12 with a readmission date of 4/4/18. Diagnoses included but were not limited to: ESRD (end stage renal disease), type 2 diabetes mellitus, vascular dementia without behavioral disturbance, hypertension, and anxiety disorder.

The clinical record for Resident # 87 was reviewed on 5/30/18 at 2:16 pm. The most recent MDS (minimum data set) assessment for Resident # 87 was a 30-day assessment with an ARD (assessment reference date) of 5/3/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #87 has a BIMS (brief interview for mental status) score of 9/15, which indicates moderate cognitive impairment. Section O assesses special treatments procedures and programs. In Section O0100, the facility staff documented that Resident # 87 has had dialysis treatments while a resident in the facility.

The current plan of care for Resident # 87 lists a focus area "Alteration in kidney function R/T (related to) DX (diagnosis) of ESRD (end stage renal disease), receiving hemodialysis." Interventions included but were not limited to: "Observe for post-dialysis hang over- vital signs, mental status, excessive weight gain between treatments, nausea, vomiting, weakness, headache, severe leg cramps."

The physician signed the current orders for Resident # 87 on 5/2/18. Orders included but were not limited to: "Dialysis Tuesday, Thursday, and Saturday at (facility name withheld)."

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Upon review of the "Dialysis Communication Record for the month of May 2018, the surveyor observed incomplete communication records for the following dates:
5/1/18, 5/8/18, 5/10/18, 5/15/18, 5/17/18, 5/19/18, and 5/21/18.

There was no "Dialysis Communication Record" in the clinical Record for Resident # 87 for the following dates:
5/3/18, 5/5/18, 5/12/18, 5/22/18, 5/24/18, 5/26/18, 5/29/18, and 5/31/18.

According to the facility policy on "Coordination of Hemodialysis" the "Procedure" is documented as:
"1. A communication format will be initiated by the facility for any resident going to an ESRD facility for hemodialysis. (please note that the ESRD may be facility specific due to the needs of the individual dialysis clinic)
2. Nursing will collect information regarding the resident to send to the ESRD facility with the resident-information recommended but not limited to:

a. Resident information -face sheet
b. Copy of current physician orders
c. Copy of plan of care
d. Blank progress note
e. Blank ESRD communication form

3. Nursing will send the resident information with the resident to the designated appointments at the ESRD facility. Nursing will give a brief summary of the residents physical, mental, and emotional condition, oral intake, activity tolerance and change in physician orders since last appointment.
4. The ESRD facility is to review and complete the ESRD communication form at each visit.
5. Upon the resident's return to the facility,

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F 698	Continued From page 97 nursing will review the ESRD communication form and communicate with the resident's physician and other ancillary departments as needed. 6. The facility will notify the ESRD facility of scheduled resident care conferences through communication forms." On 5/31/18 at 3:40 pm, the administrative staff was made aware of the findings as stated above. The administrator stated that she had been in contact with the dialysis facility because the facility was not returning the communication forms. The administrator was made aware at that time that the facility staff was also not completing their portion of the communication form. The administrator voiced understanding at that time. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.	F 698		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756	1. Medical Director reviewed and signed pharmacy recommendations on residents #22, #49, and #82. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Medical Director and DON re-educated on reviewing and signing pharmacy recommendations each month. Pharmacy Recommendation Audit to be completed by Director of Nursing and/or designee to monthly x 6 months to ensure the Medical Director has reviewed Pharmacy Recommendations. 4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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(d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure the medical director reviewed pharmacy recommendation for three of 45 Residents, Residents #22, #49, and #82.

The findings included.

1. For Resident #22, the facility failed to provide evidence that the medical director had reviewed a pharmacy recommendation dated 02/27/18.

The record review revealed that Resident #22 had been admitted to the facility 06/30/17.

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Diagnoses included, but were not limited to, down syndrome, cardiac arrest, anxiety disorder, dysphagia, and acute respiratory failure with hypoxia.

Section B (hearing/speech/vision) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/14/18 was coded to indicate the Residents was in a persistent vegetative state/no discernible consciousness.

The clinical record included a copy of a pharmacy recommendation dated 02/27/18. The attending physician had signed this recommendation on 02/28/18.

The facility was unable to provide any evidence to the surveyor that the medical director had reviewed the recommendation.

On 05/30/18 at approximately 9:00 a.m., the DON (director of nursing) and nurse consultant verbalized to the surveyor that they were unaware that it had to be reviewed by the medical director. The DON stated she had reviewed the recommendation and reviewed all recommendations from the pharmacy.

The administrative staff were notified of the issue regarding the pharmacy recommendation during a meeting with the survey team on 05/31/18 at approximately 2:50 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #49, the facility failed to provide

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evidence that the medical director had reviewed a pharmacy recommendation dated 03/19/18.

The record review revealed that Resident #49 had been admitted to the facility 03/16/18. Diagnoses included, but were not limited to, essential hypertension, gastroesophageal reflux disease, anxiety disorder, and major depressive disorder.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/23/18 included a BIMS (brief interview for mental status summary) score of 10 out of a possible 15 points.

The clinical record included a copy of a pharmacy recommendation dated 03/19/18. The attending physician had signed this recommendation on 03/20/18.

The facility was unable to provide any evidence to the surveyor that the medical director had reviewed the recommendation.

On 05/30/18 at approximately 9:00 a.m., the DON (director of nursing) and nurse consultant verbalized to the surveyor that they were unaware that it had to be reviewed by the medical director. The DON stated she had reviewed the recommendation and reviewed all the pharmacy recommendations.

The administrative staff were notified of the issue regarding the pharmacy recommendation during a meeting with the survey team on 05/31/18 at approximately 2:50 p.m.

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No further information regarding this issue was provided to the survey team prior to the exit conference.
3. The facility staff failed to ensure the director of nursing and the Medical Director signed the monthly drug regimen review 4/27/18 for Resident #82.

Resident #82 was readmitted to the facility on 4/28/18 with the following diagnoses of, but not limited to high blood pressure, UTI, Parkinson's disease, anxiety disorder, depression, Psychotic Disorder and Schizophrenia. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/1/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #82 was also coded as being totally dependent on 2 or more staff members for bed mobility, transfer and bathing. Then being totally dependent on 1 staff member for dressing and personal hygiene.

The surveyor performed a review on Resident #82's clinical record on 5/31 and 6/1/18. During this review, the surveyor noted on the monthly drug regimen review dated 4/27/18 was not signed by the director of nursing or by the Medical Director. This monthly review was noted to have an irregularity that the pharmacist had questioned during the monthly drug regimen reviews.

On 6/1/18 at 2 pm, the surveyor notified the director of nursing of the above documented findings. The director of nursing stated, "I didn't know that I had to sign these along with the Medical Doctor."

The surveyor notified the administrative team of

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F 756	Continued From page 102 the above documented findings on 6/4/18 at 4 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 6/4/18.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758	1. Behavior monitoring re-initiated on 5/31/2018 for resident #115. Resident #10's PRN Ativan was discontinued on 5/31/2018. 2. Residents receiving psychotropic medications have the potential to be effected by this deficient practice. 3. Nursing Department re-educated on PRN Psychotropic Medication use and completed on 6/22/2018. DON and Social Service Director to review residents receiving psychotropic medications weekly in Committee Meeting to review for appropriate behaviors, interventions, and gradual dose reductions. Behavior Audit to be conducted by Director of Nursing and/or designee 5 x a week x 8 weeks to ensure residents are free from unnecessary medications. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure that 2 of 45 Residents in the final survey sample was free from unnecessary medications, Resident # 115 and Resident # 10.

The findings included:

1. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Seroquel for Resident # 115.

Resident # 115 was originally admitted to the facility 4/6/99, with a readmission date of 5/29/18. Diagnoses included but were not limited to: urethral stricture, retention of urine, heart failure, vascular dementia without behavioral disturbance, and anxiety disorder.

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On 5/30/18 at the 9:51 am, the clinical record for Resident # 115 was reviewed. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 5/16/18. Section B of the MDS assesses hearing, speech, and vision. In Section B0700, Resident # 115 was assessed for the" ability to express ideas and wants, consider both verbal and nonverbal expression." The facility staff documented that Resident # 115 is "rarely/never understood." Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's Cognitive status was severely impaired. Section N of the MDS assesses medications. Section G of the MDS assesses functional status. In Section G0400, functional limitation in range of motion is assessed. The facility staff documented that Resident # 115 has bilateral impairment of the upper and lower extremities. In Section N0410, the facility staff documented that Resident # 115 received antipsychotic medications during the last 7 days since the ARD date.

The current plan of care for Resident # 115 was reviewed and revised on 5/23/18. A focus area documented on the plan of care is documented as "Potential for drug related complications associated with use of psychotropic medications related to: Antianxiety medication." Interventions included but were not limited to "Observe for target behaviors/symptoms of increased agitation, continuous yelling, pulling on peg tube and document," and "Provide non pharmaceutical interventions of repositioning, quiet environment to decrease target behaviors, anxiety, or depression.

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Resident # 115 has a current order for "Seroquel Tablet Give 25 mg via G-Tube one time a day related to other psychotic disorder not due to a substance or known physiological condition" that was initiated on 5/1/18. Upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, this surveyor could not locate monitoring of target behaviors, effectiveness of medication, side effects, or documentation of non-pharmacological interventions utilized associated with the use of Seroquel.

On 5/30/18 at 11:45 am, the surveyor spoke with the unit manager about the target behaviors for Resident # 115. The surveyor asked the unit manager what target behaviors are displayed by Resident # 115. Unit manager responds, "He (Resident #115) has these jerking movements. The surveyor asked unit manager if the jerking movements could be associated with the seizure disorder that Resident # 115 is also being medicated for. Unit manager stated "Yes." The surveyor asked the unit manager what behaviors were being managed with the use of the Seroquel. Unit manager did not provide an answer to the surveyor. The surveyor reviewed the medication administration record along with the unit manager. The unit manager agreed that appropriate target behaviors had not been identified and that there was no monitoring for side effects or effectiveness, nor were there non-pharmacological interventions listed associated with the use of Seroquel for Resident # 115.

On 6/4/18 at 10:32 am, RN (registered nurse) # 1 MDS coordinator reviewed the plan of care along with the surveyor to identify target behaviors

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specific to Resident # 115 associated with the use of Seroquel. RN # 1 did not locate resident specific target behaviors and stated, "I will fix that."

On 6/4/18 at 4:15 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.

2. The facility staff failed to discontinue a prn (as needed) order for Ativan after 14 days for Resident #10.

According to the Physician's Desk Reference, Ativan is a sedative/hypnotic medication used for the treatment of anxiety.

Resident #10 was admitted to the facility on 1/30/16 with the following diagnoses of, but not limited to anemia, stroke, seizure disorder, anxiety disorder, depression and Psychotic Disorder. On the annual MDS with an ARD (Assessment Reference Date) of 3/2/18, the resident was coded as having short term and long-term memory problems. Resident #10 was also coded as requiring extensive assistance of 2 staff members for dressing, extensive assistance of 1 staff member for personal hygiene and being totally dependent on 2 staff members for bathing.

The surveyor performed a review of Resident #10's clinical record on 5/30 and 5/31/18. During this review, the surveyor noted a physician order for Ativan 1 mg (milligram) Give 2 tablet by mouth every 8 hours as needed for anxiety. This order was dated 2/8/18.

The surveyor notified the administrative team of the above documented findings on 5/31/18 at 4

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F 758	Continued From page 107 pm. The director of nursing provided a telephone order dated for 5/31/18 at 1854 (6:54 pm) which stated, "Contacted Dr. ____ (name of doctor) at this time. New order noted to discontinue Ativan PRN ..." No further information was provided to the surveyor prior to the exit conference on 6/4/18.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on clinical record review and facility document review, and during a medication pass and pour observation, the facility failed to ensure a medication error rate of less than 5%. There were 2 errors in 31 opportunities for an error rate of 6.45%. These medication errors affected Resident # 60. The findings included The facility staff failed to instruct Resident # 60 to clear her nasal passages prior to administering Flonase and failed to provide water and instruct Resident #60 to rinse her mouth after using a Combivent Respimat inhaler. Resident # 60 was admitted to the facility on 12/30/15. Diagnoses included but were not	F 759	1. Resident #60's MD notified of improper administration of medication with no new orders. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing staff completed a Relias Learning Course on Medication Administration- Avoiding Common Med Errors. Nursing Staff re-educated by DON and Human Resources Director regarding Medication Errors 6/12/2018 and 6/13/2018. Unit Manager and/or Designee will perform medication pass audits with staff charge nurses 5 x week for 8 weeks to ensure ensure a medication error rate of less than 5%. 4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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limited to: chronic obstructive pulmonary disease, dry eye syndrome, chronic pain, and hyperlipidemia.

The most recent MDS (minimum data set) for Resident # 60 was a quarterly assessment with an ARD (assessment reference date) of 4/17/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 60 has a BIMS (brief interview for mental status) score of 15/15 which indicated that Resident # 60 is cognitively intact.

The physician signed the current orders for Resident # 60 on 5/28/18. Orders included but were not limited to: "Combivent Respimat Aerosol Solution 20-100 MCG/ACT 1 inhalation orally four times a day related to acute upper respiratory infection," and "Flonase Suspension 50 MCG/ACT 1 spray in both nostrils one time a day for sinus relief."

On 5/30/18 at 8:40 am, the surveyor observed a medication pass with LPN (licensed practical nurse) #2. During the observation LPN # 2 administered the Combivent Respimat inhaler to Resident # 60. LPN # 2 did not provide Resident # 60 with water or instructions to rinse her mouth after use. LPN # 2 then proceeded to administer Flonase Suspension to Resident # 60. LPN # 2 did not instruct Resident # 60 to clear her nasal passages prior to administering the Flonase suspension.

The manufacturer's instructions for Flonase contains information that included but is not limited to:
"For best results, it's important to get a full dose. Here's how, in five easy steps.

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1. Shake- Gently shake spray bottle. Remove translucent cap.
2. Prime- Aim away from face. Pump until mist appears.
3. Blow- Blow nose gently to clear nostrils.
4. Aim- Close one nostril and put tip of spray nozzle in other nostril.
5. Breathe and Spray- While sniffing gently, press down on spray nozzle once or twice (according to dosing instructions). You'll feel a light mist in your nose. Breathe out through your mouth."

According to Davis Drug Guide for Nurses Combivent is a combination of ipratropium bromide and albuterol. "Patient and Family Teaching" for these medications has documentation that includes but is not limited to "Advise patient to rinse mouth with water after each inhalation dose to minimize dry mouth."

Deglin, J.H., Vallerand, A. H., & Sanoski, C.A. (2011). Davis's drug guide for nurses (12th ed.). Philadelphia PA: F.A. Davis.

On 5/31/18 at 3:40 pm, the administrative staff was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.

F 761 SS=D — Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the

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MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(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 761	Continued From page 110 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure that drugs were labeled in accordance with currently accepted professional principles on 1 of 6 medication carts. The findings included The facility staff failed to label a Combivent Respimat inhaler with a discard date. On 5/30/18 at 3:45 pm, the surveyor observed a Combivent Respimat inhaler on the medication cart on the south wing that had been used was not dated. The surveyor spoke with LPN (licensed practical nurse) #1 in reference to the undated	F 761	1. Combivent Respimat Inhaler discarded on 05/30/2018. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing Staff re-educated regarding proper labeling and storage of medications in accordance with currently accepted professional principles by DON and Human Resources Director on 6/12/2018 and 6/13/2018. Pharmerica Cart Audit to be conducted by Unit Managers and/or Designee of Unit medication carts 5 x a week x 8 weeks to ensure the proper labeling and storage of medications. 4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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F 761	Continued From page 111 Combivent Respimat inhaler. LPN #1 looked at the inhaler and agreed that there was no discard date written on the Combivent Respimat inhaler. The manufacturer's guidelines contains information that includes but is not limited to: "Write the discard date on the label (3 months from the date the cartridge is inserted)." On 6/4/18 at 4:02 pm, the administrative staff was made aware of the issues as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.	F 761		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	1. Resident #92's medication was discontinued by physician on 5/3/2018. Resident #48's allergy list updated on 5/30/2018 to reflect that resident does not have an allergy to Gabapentin. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing Staff re-educated regarding maintaining a complete and accurate medical record by DON and Human Resources Director on 6/26/2018. Chart Audits to be conducted by Unit Manager and/or Designee 5 x a week x 8 weeks to ensure the facility accurately maintains medical records. 4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
The facility failed to maintain an accurate medical recored for two out of 45 residents (Residents #92 and #48).

Findings included:

1. For Resident #92 the facility staff failed to ensure a complete and accurate clinical record. The facility staff failed to ensure complete and accurate Physician Order Sheets (POS's)

Resident #92 was an 85 year old male who was admitted on 8/19/17. Admitting diagnoses included, but were not limited to: dehydration, hypotension, syncope with collapse, psychosis, fracture of the left femur, fractured humerus and depression.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Medicare 30 Day MDS assessment with an Assessment Reference Date (ARD) of 5/5/18. The facility staff coded that Resident #92 had a Cognitive Summery Score of 3. The facility staff also coded that Resident #92 required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On May 30, 2018 at 9:30 a.m., the surveyor reviewed Resident #92 clinical record. Review of the clinical record produced signed physician orders on 5/8/18.

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Continued review of the clinical record produce two telephone orders dated 5/2/18. The telephone orders read ... "5/2/18 10:25 Depakote Tablet Delayed Release 125 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9). 5/2/18 10:25 TraMADol HCL Tablet 50 MG Give 0.5 tablet by mouth every 4 hours as needed for Pain ½ tab (tablet) (25mg) po (by mouth) q (every) 4 hours prn (as needed)." (sic)

Further review of the signed and dated, 5/8/18, POS's did not document that the orders for Depakote and Tramadol had been transcribed to the POS's. The POS's did not include the orders for the Depakote and Tramadol.

On May 30/18 at 10:44 a.m., the surveyor notified the Unit Manager, who was a Licensed Practical Nurse, that Resident #92's POS's were inaccurate. The surveyor notified the UM that physician telephone orders for Tramadol and Depakote ordered 5/2/18 were not on the current signed and dated, 5/8/18, POS's. The surveyor reviewed Resident #92's clinical record with the UM. The surveyor specifically pointed out that the POS's signed and dated 5/8/18 did not include the physician telephone orders for Tramadol and Depakote. The surveyor notified the UM that the orders for the Tramadol and Depakote were obtained on 5/2/18 and should have been transcribed to the POS's. The UM stated that she had only worked at the facility for about three weeks and did not know why the orders had not been transcribed to the POS's.

On May 31, 2018 at 2:50 p.m., the survey team

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met with the Administrator (ADM), Director of Nursing (DON) Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate clinical record for Resident #92. The surveyor notified the AT that the facility staff failed to transcribe physician telephone orders obtained on 5/2/18 to the POS's that were signed by the physician on 5/8/18.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #92. The facility staff failed to ensure complete and accurate POS's.
2. The facility staff failed to maintain an accurate clinical record for Resident # 48. The clinical record indicated that Resident # 48 had an active allergy to Gabapentin but was taking the medication as prescribed by the physician.

Resident # 48 was admitted to the facility on 3/22/18. Diagnoses included but were not limited to: idiopathic peripheral autonomic neuropathy, fibromyalgia, anxiety disorder, hypertension, and constipation.

The clinical record for Resident # 48 was reviewed on 5/29/18 at 4:33 pm. The most recent MDS (minimum data set) assessment for Resident # 48 was a significant change assessment with an ARD (assessment reference date) of 4/12/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 48 had a BIMS (brief interview for mental status) score of 14/15, which indicated that Resident # 48 was cognitively intact.

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On 5/29/18 at 4:33 pm, the surveyor observed allergies handwritten on the front of Resident # 48's clinical record. Allergies included but were not limited to "Gabapentin."

Resident # 48 has a current order that was signed on 5/2/18 for "Neurontin Capsule 100 mg (milligrams) (Gabapentin). Give 100 mg by mouth at bedtime for neuropathy." "Gabapentin" is listed as a current allergy on the signed physician's order sheet for Resident # 48 that was signed by the physician on 5/2/18.

On 5/30/18 at 12:00 pm, the surveyor spoke with LPN #4 (licensed practical nurse) about the resident having an allergy to Gabapentin, yet being administered the medication. LPN # 4 stated that the medication was not given during her time working. LPN #4 went into Resident # 48's room and asked her if she was aware that she had an allergy to Gabapentin. Resident # 48 stated to LPN # 4 that she is not allergic to Gabapentin and has been taking the medication.

On 5/30/18 at 2:00 pm, the surveyor spoke with the DON (director of nursing) and made her aware of the findings as stated above.

On 5/30/18 at 3:06 pm, the DON provided the surveyor with a copy of a progress note that was written on 3/30/18 at 7:15 pm. The progress note stated "(Pharmacy name withheld) called stated rsd (resident) has allergy to gabapentin. rsd has allergy. MD (medical doctor) notified of allergy stated continue med and monitor. Will continue to observe." The surveyor asked the DON if Resident # 48 was taking Gabapentin with no issues would this be considered a true allergy. DON stated "No."

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F 842	Continued From page 117 On 5/31/18 at 3:40 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880	1. Residents #109 and #101 MD notified of failure to follow infection control guidelines. No new orders noted. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Nursing staff completed Relias Learning Training regarding Infection Control by 06/15/2018. DON and Human Resources Director re-educated staff in regards to no lanyards and nothing hanging from name tags on 06/15/2018. DON will observe dressing changes 3 x a week x 8 weeks to ensure the maintenance of the infection and prevention control program. 4. Results of audits will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

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infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.30(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and during a medication pass and pour

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observation, the facility staff failed to follow established infection control guidelines on the south unit, a resient's room and for two of 45 Residents, Resident #109 and #101.

The findings included.

1. For Resident #109, LPN (licensed practical nurse) #1 touched a pill with her bare hands prior to administering the medication to the Resident.

The record review revealed that Resident #109 had been admitted to the facility 12/05/17. Diagnoses included, but were not limited to, Alzheimer's, insomnia, allergic rhinitis, chronic kidney disease, and cystitis.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/14/18 included a BIMS (brief interview for mental status summary) score of 15.

On 05/29/18 beginning at approximately 4:30 p.m., the surveyor observed LPN #1 prepare and administer Resident #109's medications. When preparing the Residents diltiazem LPN #1 was observed to pop the medication out of the blister pack, place it into her bare hands, and drop it into the medication cup along with the Residents other prepared medications. LPN #1 was then observed by the surveyor to administer all the medications in the cup to the Resident.

After this administration, the surveyor asked LPN #1 about placing the medication into her bare hand prior to putting it into the cup. LPN #1 stated she had not realized she had done this and then stated she had used hand sanitizer.

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On 05/31/18 at approximately 9:00 a.m., during an interview with the DON (director of nursing) who was the designated infection control nurse. The DON verbalized to the surveyor that she would have expected the nurse to discard the medication in the sharps container.

The facility policy/procedure titled "PREVENTING MEDICATION ERRORS ABC's Quick Reference ..." read in part "...Punch pills directly into the med cup. Never touch the med with your fingers ..."

The administrative staff were notified of the issue regarding infection control during a meeting with the survey team on 05/31/18 at approximately 2:50 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to follow infection control guidelines during the wound care observation on Resident #101.

Resident #101 was admitted to the facility on 3/1/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, heart failure, high blood pressure, Peripheral Vascular Disease, End Stage Renal Disease, diabetes and depression. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/26/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident # 101 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.

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On 5/31/18 at 11:30 am, the surveyor conducted an observation of wound care that was performed by the wound care nurse on Resident #101. The wound care was performed as ordered by physician but the wound care nurse's name badge touched the dirty dressing to the resident's stump when removed by the nurse. Then when the clean dressing was applied to the resident's stump, the name badge touched the clean dressing. The nurse did not clean the name badge. After the dressing was applied, the surveyor interviewed the wound care nurse. The surveyor asked the nurse where her name badge was while she bent over to perform the dressing change to the resident's stump. The nurse stated, I don't know, it is attached to the top of my shirt." The surveyor notified the nurse that the name badge touched the dirty dressing and then touched the clean dressing. The nurse stated, "Oh, I see when I bend over the badge is swinging and it could touch the dressings."

At 4 pm, the surveyor notified the administrative team of the above documented findings. The surveyor requested a copy of the facility's policy regarding to infection control to be used when performing wound care.

On 6/4/18 at 2:15 PM, the surveyor was provided a copy of the policy titled "Exposure Control Plan: Decontamination". Under the Procedure section, #2 read: All environment surfaces or items that contact or are likely to contact the resident ...shall be cleaned with an approved disinfectant ..."

No further information was provided to the surveyor prior to the exit conference on 6/4/18.
3. The facility staff failed to follow infection

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control policies and procedures during a medication pass and pour observation on the south wing.

On 5/30/18 at 8:40 am, the surveyor observed LPN # 2 (licensed practical nurse) during a medication pass and pour observation. The surveyor observed LPN # 2 administer a Combivent Respimat inhaler, Flonase, and Artificial tears to a resident without changing gloves. After administering these medications to the resident LPN # 2 picked up the medications with the same gloves and returned to the hallway, where the medication cart was and returned the medications into the cart. LPN # 2 then removed the gloves and sanitized her hands with hand sanitizer on the cart.

On 5/30/18 at 8:54 am, the surveyor observed LPN # 2 as she prepared another resident's medication and went into the room. LPN # 2 was not wearing loves at this time. LPN # 2 handed the resident the medication cup along with a cup of water and the resident took the medication, drank the water from the cup and returned the medication cup and the empty water cup to LPN #2. LPN # 2 exited the room without washing her hands and discarded the medication cup and empty water cup into the wastebasket on the medication cart. LPN # 2 did not sanitize or wash her hands.

On 5/30/18 at 9:00 am, the surveyor observed LPN #2 as she prepared pain medications for another resident and had not washed or sanitized her hands.

According to the facility Policies and Procedures for "Disposable Non-Sterile Gloves," Procedure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING ____ _____ ____	C 06/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(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 880	Continued From page 123	F 880		

documentation includes but is not limited to:
"4. Indications for glove use include the actual or potential for cleaning or touching blood, fecal material, urine, bloody body fluids or drainage. Also use gloves when other body fluids that apply to Standard Precautions are present. These include: infected material from isolation residents, wounds, tissues, open skin or mucous membranes.
5. Remove gloves and dispose of.
6. Wash hands.
7. Change gloves and wash hand between residents and between different body site procedures performed subsequently on the same resident."

On 5/31/18 at 3:40 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 6/4/18.
4. Facility staff failed to follow the infection control policy for hand washing. On 6/4/18 at 10:00 AM LPN II was observed to clean off an overbed table in a resident's room. With her bare hands she swept off the top of the table, which had spaghetti noodles on it. She then put some soap and water on the surface of the table and cleaned it off with paper towels.

LPN II the exited the room with a pill cup full of medication for another resident and entered their room without washing her hands or using hand sanitizer.

This was reported to the facility DON on 6/3/18 at 11:00 AM. She said the facility infection control policy required staff members to wash their hands

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	495143	A. BUILDING _____ B. WING _____	C 06/04/2018

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F 880	Continued From page 124 in between administering care to residents and when going from one room to another. No additional information was provided prior to exit.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to ensure a clean, comfortable environment and homelike environment on 3 of 3 units. The facility had a pervasive odor of urine on three of three units. The findings included: On May 29, 2018 at 2 p.m., the survey team entered the facility and were escorted to the conference room. This surveyor noted a pervasive odor of urine in the hallways on the main floor of the facility. On May 29, 2018 at 2:45 p.m., the surveyor made an initial tour of the facility. The surveyor noted a pervasive odor of urine in the hallways on all three units in the facility. On May 30, 2018 at 8 a.m., the surveyor noted a pervasive odor in the hallways on the two units on the main level of the facility. The surveyor took the elevator down to the lower level of the facility. The surveyor noted a pervasive odor of urine in	F 921	1. Housekeeping has cleaned resident rooms to ensure proper cleanliness. 2. Residents that reside in the facility have the potential to be effected by this deficient practice. 3. Housekeeping staff re-educated on the proper procedures for cleaning resident's rooms on 6/15/2018. Care Keeper Rounds to be completed by Department Heads 5 x week x 8 weeks to ensure a clean, comfortable and homelike environment for residents in the facility. 4. Results of audits will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	7/4/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 06/04/2018

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F 921	Continued From page 125	F 921		

the hallways on the unit on the lower level of the facility.

On May 31, 2018 at 2:50 p.m., the survey team met with the Administrator (ADM), Director of Nursing (DON) Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the hallways on all three units had a pervasive odor of urine.

No additional information was provided prior to exiting the facility as to why the facility had a pervasive odor of urine throughout the facility.