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GREENSPRING VILLAGE	7470 SPRING VILLAGE DR SPRINGFIELD, VA 22150

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E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 8/7/18 through 8/9/18. Corrections are required for compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018		9/19/18

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

Electronically Signed | 08/30/2018

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E 018	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by:	E 018		

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E 018	Continued From page 2 Based on review of the facility's Emergency Preparedness Plan, and staff interview, the facility failed to develop a plan to account for residents not in the facility at the time of an emergency event or situation requiring evacuation from the facility. The findings were: Review of the facility's Emergency Preparedness Plan at "Section D: Full Building Evacuation Plan" revealed a process for resident identification by the application of a wrist band or some other method, and inclusion of hardcopy medical information (Face Sheet, Physician Order and Nursing Notes, Medications List, Physicians History and Physical Findings, Advanced Directives, Responsible Party information) for all residents physically in the facility at the time of evacuation. There was no provision in the Evacuation Plan to account for residents not in the facility at the time of the event, including residents out of the facility due to a Leave of Absence (LOA), or out for a short term absence such as an appointment with a physician, a shopping trip, a day trip with a family member, etc. During a meeting at approximately 1:30 p.m. on 8/9/18, that included the Administrator, Director of Nursing, and the survey team, the findings regarding accounting for residents not in the facility at the time of an evacuation was discussed. At approximately 1:45 p.m. on 8/9/18, the Assistant Administrator was interviewed regarding the accounting for residents. According to the Assistant Administrator,	E 018	1. The EPP was updated to include the Facility□s LOA policy which includes procedures for identifying residents who are out of the facility at the time of an emergency event. 2. All residents have the potential to be impacted. 3. The Staff Development Coordinator or designee will educate the Facility EPP Committee, facility staff and campus security on the Facility LOA policy and the revised EPP which accounts for residents who may be out of the facility at the time of an emergency or event. 4. The EPP will be reviewed in accordance with the Facility□s policy review protocol annually, and as a component of the Facility□s periodic EPP drills as appropriate. The Administrator or designee will conduct random staff interviews monthly X3 months to evaluate staff knowledge and ability to reference these procedures. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 9/19/2018	

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E 018	Continued From page 3 residents on LOA could be accounted for through a LOA log book maintained on the nursing units. The Assistant Administrator went on to say that accounting for residents out of the facility who were not on a LOA was probably covered in some other part of the Emergency Preparedness Plan. At the time of the Exit Conference the Assistant Administrator had not produced any information regarding the accounting for residents out of the facility that were not on a LOA. For further information regarding the facility's process of accounting for residents who leave the facility, please refer to F-tag 689, found in the Medicare/Medicaid survey report, form 2567.	E 018		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/07/2018 through 08/09/2018. An extended survey was conducted 08/08/2018 through 08/09/2018. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. Widespread Substandard Quality of Care/Immediate Jeopardy (IJ) was identified in the area of Quality of Care (Free of Accident Hazards/Supervision) on 08/08/2018 at 6:10 p.m. The facility removed the immediacy on 08/08/2018 at 8:55 p.m. After removal of the immediacy the Scope and Severity was lowered to a Level II, widespread. The census in this 136 bed facility was 126 at the time of the survey. The final survey sample	F 000		

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F 000	Continued From page 4 consisted of 25 current resident reviews and three closed record reviews. The expanded survey sample consisted of two current resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, facility staff failed to ensure one of 31 residents in the survey sample was free from abuse, Residents #8; and one of 31 residents was free from neglect, Resident #3. 1. Resident #8 was physically restrained by facility staff on 04/26/18 during completion of a skin assessment, causing bruising on her right upper arm and mid-right thigh. 2. Resident #3 was left without care and supervision for approximately 3 hours after returning to the facility from a family outing.	F 600	1. Resident #8 discharged from the facility prior to the commencement of the Survey. Resident #3 remains in the facility with no further care issues identified upon return from family outings. 2. After the cited incident with Resident #8 was identified, a skin audit was conducted of current residents to identify any areas of bruising or skin alterations that would require a follow up investigation. There were no additional issues identified. An additional skin audit will be conducted of	9/19/18

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F 600	Continued From page 5 When found, Resident #3 was slumped and partially out of her wheelchair, glassess in the floor, and without incontinence care. Findings included: 1. Resident #8 was originally admitted to the facility on 10/29/14 and readmitted on 04/13/18 with diagnoses including, but not limited to: Stage 4 Pressure Ulcer, Dementia, Depression, Anxiety, and CHF (congestive heart failure). The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/12/18. Resident #8 was assessed as severely impaired in her short term memory and moderately impaired in her daily decision making skills. The Stage Agency received a FRI (facility reported incident) on 06/15/2018 involving Resident #8. The FRI documented: "Date of Alleged Event: 06/04/2018 Standard Notes: Allegation that resident was held down by staff member so that clinical team could do an assessment of her skin. Investigation pending." The final report of the investigation was received at the State Agency on 06/17/18. Included on the final report was "Date of this report: 06/12/2018; Date of Occurrence: 04/26/2018" The date of occurrence on the original FRI was 06/04/2018. The actual date of occurrence listed on the final report was corrected to 04/26/2018. The final report included the following documentation: "...Describe Occurrence: ...It was reported on June 12, 2018 that [Name] Resident #8 was forcefully held down by a staff	F 600	current residents to identify any areas of bruising or skin alterations with a follow up investigation if required.A wound care observation audit will be conducted of current residents that are seen during wound rounds to ensure that care is being provided without restraint. Any discrepancies will be addressed in the accordance with the abuse prevention policy. With respect to Resident #3, all residents have the potential to be impacted. 3. With respect to Resident #8, the Director of Nursing or designee will educate facility staff on the policy for abuse identification and reporting. The Director of Nursing or designee will educate licensed nursing staff and nurse practitioners on the facility restraint policy including not physically retraining residents while providing care. In addition, licensed nursing staff will be educated on the facility policy for conducting investigations of alleged abuse, person centered care, resident rights and appropriate intervention/communication when a resident refuses care. 4. The Administrator or designee will conduct random audits of facility staff knowledge related to the facility abuse policy for identification and reporting of alleged abuse weekly X4 weeks, then monthly X2 months. The Director of Nursing or designee will conduct random wound care observations weekly	

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F 600	Continued From page 6 member so the neighborhood clinical team could do an assessment of her skin...Actions Taken: An investigation was immediately initiated. All involved employees are suspended pending an investigation. Conclusion: Allegation of physical Abuse: Substantiated Our investigation revealed that on April 26, 2018, the CNA [certified nursing assistant] listed above held the resident down by the top of her right arm and her right thigh in an attempt to assist the nurses and NP [nurse practitioner] to complete a scheduled skin assessment. The resident was refusing and verbalizing (saying "No, No, No") that she did not want the assessment done and was striking out and trying to hit the staff. Even with the resident refusing, the staff continued to complete the assessment and then left the resident's room. The actions of the CNA resulted in bruising to right arm and right thigh. Neither the nurses nor the NP stepped in to stop the actions nor tried any other method to calm the resident in order to complete the assessment. Clinical Manager, 2 licensed nurses and CNA were suspended and terminated at completion of investigation..." The final report was submitted by the former Administrator. During review of the clinical record a clinical note dated 4/26/2018 at 3:53 PM included the following documentation, "...Her schedule skin assessment was done onshift..." (sic) The Investigative Summary part 2 included, "...One nurse stated that PCA [person centered approach] and respecting residents wishes prevented care from being performed. One She [sic] said, "We have taught them the language to say, "I have rights." "This is my right. She exercised that right. We should have pushed the	F 600	X4weeks, then monthly X2 months to validate compliance with the restraint policy. The Director of Nursing or designee will conduct random audits of licensed nursing staff to validate knowledge of facility policy for conducting investigations of alleged abuse, person centered care, resident rights and appropriate intervention/communication when a resident refuses care, weekly X4 weeks and then monthly X2 months. The Director of Nursing or designee will conduct random audits of resident skin assessments to validate no abuse has occurred weekly X4 weeks and then monthly X2 months. Monitoring continues in accordance with the Plan of Correction submitted during survey as cited above. Random audits and staff interviews will be conducted to ensure residents received appropriate care and supervision upon return from a leave of absence weekly x4 weeks, and every other week x2 months Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 9/19/2018	

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envelope a little bit more." (sic) The nurse manager stated, "we were looking at PCA. She would say "no, no, no." She doesn't want you to do something, you have to leave her alone." "When blood was found on her wheelchair, the nurses thought it was vaginal bleeding. She kept resisting. We had an idea to take her to the doctor's medical center. We set everything up with the medical center. The niece backed away. We had to do something." "I said, "we have to have her seen today. We have to get everybody in the room. (NP, Nurse Manager, [Name], Charge Nurse, CNA). She fought getting on the bed. We got her on the bed. She was scratching, punching, saying no, spitting. We pulled down her undergarments and examined her. It was a stage 3 on her left gluteal fold..." (sic) This investigative summary was not dated or signed by any facility employee.

The above mentioned documentation is the only documentation regarding the incident of the resident being held down during said skin assessment. No other information was included in the facility investigation.

The Administrator and DON (director of nursing) were interviewed on 08/08/18 at approximately 2:35 p.m. The Administrator stated regarding the facility investigation not being dated or signed, "We will have to reach out to staff that were involved in the investigation because neither of us were here during the investigation." The DON stated, "This incident was discovered during another investigation regarding documentation. It was noted on her shower sheet, bruising. Then the investigation was started for the bruising. It wasn't discovered until June. The CNA involved admitted to holding her down during the

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investigation. That is what prompted the abuse investigation in June. All involved staff were suspended pending the investigation. The NP had resigned from employment before the investigation started." Subsequently, all involved staff were terminated from employment upon completion of the investigation.

On 08/09/18 at approximately 11:30 a.m. the Administrator stated, "The only person still here that was involved in the investigation is the Assistant Administrator. She may be able to answer your questions."

The Assistant Administrator was interviewed on 08/09/18 at 1:15 p.m. She stated, "I was not privy to information regarding the bruising. I was only in on the piece of investigating the falsification of documentation."

At 1:30 p.m. the Director of Clinical Operations was interviewed regarding the bruising piece of the investigation. She stated, "I interviewed [Name-the nurse who documented bruising on the skin assessment], and she stated she told [Name], the Clinical Manager about the bruising. [Name-Clinical Manager] dropped the ball. She was one of the people involved in holding her down, hence why she was terminated. She [Clinical Manager] didn't think it was that big of a deal. I spoke with [Name-Nurse] and [Name-Clinical Manager] and both agreed that [Name-Nurse] had reported the bruising to [Name-Clinical Manager]."

No further information was received by the survey team prior to the exit conference on 08/09/18.

2. Resident #3 was admitted to the facility on 1/18/2017 with diagnoses that included

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hyperlipidemia, Alzheimer's Disease, Non-Alzheimer's dementia, hypertension, Vitamin-D Deficiency, hypothyroidism, and gastro-esophageal reflux disease (GERD).

The minimum data set (MDS) dated 07/16/2018 assessed Resident #3 with severely impaired cognitive skills. This MDS indicated that Resident #3 was always incontinent of bowel and bladder, and was totally dependent with one-person assistance for care, including incontinence care.

A facility reported incident (FRI) dated 06/22/18 for the incident on 06/16/18 documented the following: on 06/18/18 the spouse of Resident #3 reported that at approximately 1 p.m., on the afternoon of 06/16/18, his daughter returned with the resident to her room. The daughter requested that staff clean her (Resident #3) up and then put her in bed for a nap, according to her afternoon routine. When the spouse arrived at approximately 4 p.m. to spend time with her (Resident #3), he allegedly found his wife (Resident #3) in her wheelchair, slumped over, almost falling out. Her eyeglasses were on the floor. The spouse stated he "thought she had died." He reported, "feeling there was no evidence that she (Resident #3) had been rounded on as she was still in her chair, not put in bed and he 'seriously doubts' whether or not she had been cleaned up since her return at 1 p.m."

The facility's investigation of the incident included interviews with the staff providing care for Resident 3. The investigation reported the aide who routinely cared for Resident #3 stated she assisted Resident #3 on the morning of the incident and that her husband had taken her out. The report stated the aide said she had not seen

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Resident #3 the rest of the shift. The reports stated the said she stopped by the room during her "normal rounds" at approximately 12:45, and that the resident was not there. Both individuals assigned to the resident claim they were unaware of her return to the facility.

The clinical record was reviewed on 08/08/18, to include the care plan. Resident #3's care plan under section 3f. documented "Assistance in Bathroom-Functional Status/Continence documented the resident required total dependence with one person physical assist." Resident #3 required assistance "to pull up or down my garments. To make sure I cleanse myself (perineal care). To manage protective garments and/or continence products."

Resident #3's Physician's Order Form documented an order for Honey Thickened Liquid's 6-8oz at 10 a.m. and 2 p.m. A review of Resident #3's medication administration record (MAR) documented the following handwritten note on the "PRN, STAT AND MEDICATIONS NOT ADMINISTERED" page of the MAR : 06 16 18 LH (initials) juice given at 4p - LOA (leave of absence) at 2."

Resident #3's clinical record documented nothing further about her leaving or returning to the facility on the date of the incident.

On 08/08/18 at 10:50 a.m., the director of nursing (DON) and the Assistant Administrator were interviewed regarding the FRI. The DON and Assistant Administrator were asked if the facility had a sign in/out policy. The Assistant Administrator stated there was a sign out book at the front desk and they ask family and visitors to

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use the front desk book, however it does not always happen. The Assistant Administrator stated the resident was not signed out at the front desk downstairs and provided a copy of the front desk's arrival and departure log for 06/16/18. The DON and Assistant Administrator were asked how staff knew when a resident leaves and returns to the facility. The DON stated the family or resident representative (RR) would notify the staff when the resident leaves and returns to the facility. The DON and Assistant Administrator stated the expectation was for staff to round on individuals to make sure they are capturing if the residents are on or off the unit.

On 08/08/18 at 12:12 p.m., Resident #3's husband was interviewed and he stated he takes her out of the facility daily for dinner to the cafe located on the Independent Living (IL) side of the community property. Resident #3's husband stated his daughters brought his wife back to the facility around 1 p.m. He stated his daughters said they reported to someone on the floor that his wife was in her room and needed changing and then to lay her down for her afternoon nap. Resident #3's husband stated neither he, nor his daughters, knew the name of the person who was advised that Resident #3 had returned to her room. Resident #3's husband stated when he returned to the facility at approximately 4 p.m. he found Resident #3 in her room, sitting slumped over in her wheelchair, with her glasses on the floor beside her. He stated, "I thought she had died." He said the room was very hot and the thermostat was on 90 degrees. He said he rubbed her back and started to talk to her and she seemed to go back to her usual self. He said, "I took her out of there (room) and told someone about the room temperature." Resident

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F 600	Continued From page 12	F 600		

#3's husband stated for a year and a half he has done daily visits with his wife, this is their routine to spend time together and they enjoy going to the IL cafe for dinner. He stated, "When I arrived at 4 p.m. and found her in that condition, I knew there was no way they rounded on my wife or took care of her for those 3 hours. I feel she was just left there alone in that hot room." Resident #3's husband stated during the time she is with him he does not provide incontinent care. Resident #3's husband stated he normally arrives around 4 p.m. to pick up Resident #3 and she (Resident) remains with him for approximately two and half to three hours depending on how long it takes her to eat. He then returns Resident #3 to the facility where she remains for the evening and night. He stated he normally signs her out each time using the sign out book at the nurses' station. He stated there is no sign-in sheet, so when he returns he tells a staff member. He continued and said he notifies the aide or nurse who is assigned to Resident #3; however, he knows most of the staff so if her assigned person is not available then he will notify another staff member that he has brought her back.

The certified nursing assistant (CNA) caring for Resident #3 on 06/16/18 was not available for interview.

On 08/08/18 at 12:37 p.m., CNA #2, providing care for Resident #3 was interviewed about the sign in/out policy and rounding. CNA #2 stated they used a resident sign out sheet. CNA #2 presented a white 3 ring binder tabled as "RC 4th Floor Resident Sign Out Sheet". CNA #2 stated the binder was kept at the nurses' station desk on the unit. The form titled "Resident Monitoring

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Sheet" had columns labled as date/time, resident activities and initials. There was no column to sign-in listed on the sheet. CNA #2 stated this was their tracking system. CNA #2 was asked if the resident was not signed in/out and was noted not on the unit during rounds how they handle locating resident. CNA #2 stated she does walking rounds on the entire unit if she cannot locate a resident and if there is no knowledge of the resident signing in/out. CNA #2 stated she would check the resident's room, the entire unit and/or common areas to verify whether the resident has or has not returned. CNA #2 stated if it is at shift change, she passes the information on to the oncoming shift if the resident has not returned to the unit.

A copy of the "RC 4th Floor Resident Sign Out Sheet" was provided and reviewed, there was no evidence showing Resident #3 had been signed out or back in to the facility on 06/16/18.

On 08/08/18 at 4:45 p.m. the licensed practical nurse (LPN) #3 on the fourth floor caring for Resident #3 was interviewed about the resident sign in/out procedure. LPN #3 stated we have a sign-out book on this floor. LPN #3 presented the same binder as CNA #2. LPN #3 stated some residents sign back in and some do not. LPN #3 stated we also have a sign in/out book downstairs at the front desk in the lobby. LPN #3 was asked if the family and/or resident would be stopped if they did not sign in/out downstairs. LPN #3 stated "no, I don't think so, rather the front desk will call the unit to make sure it is ok for the resident to leave." LPN #3 stated if she noticed a resident has not returned and appears to be out longer than normal then she would call the family to check on the status of the resident's return.

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F 600	Continued From page 14 LPN #3 stated the staff communicates residents' locations during rounds and shift changes. On 08/08/18 at 4:58 p.m., the front desk staff was interviewed about family members signing resident's out. The staff stated, "that log book is for visitors coming into the facility; it is not a sign out book for families to sign out the resident(s)." There was no evidence that staff checked on or provided care for the Resident #3 when she returned from a family outing. Not until her husband returned approximately 3 hours later and found her in her room, did staff check on and provide care to her. The facility's Abuse Prevention policy (Version 2, Version Date 11/3/17) defines neglect as "the failure of facility, its employees or service provider to provide goods and/or services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment, rehabilitation, care, attention, food, clothing, shelter, supervision, or medical services by a caregiver. Neglect could include instances where competent resident's wishes are not honored, restricting contact with family, ignoring the resident's need for verbal and emotional contact. These findings were reviewed with the administrator and director of nursing during a meeting on 08/08/18 at 6:10 p.m. This was a complaint deficiency.	F 600		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		9/19/18

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F 655	Continued From page 15	F 655		

Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting

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F 655	Continued From page 16 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to develop an initial care plan for two of 30 residents, Resident"s #324 and #101. 1. Resident #324 did not have an initial care plan to address antipsychotic medications. 2. Resiedent #101 did not have an initial care plan for a shoulder sling and knee immobilizer. The Findings Include: 1. Resident #324 was admitted to the facility on 8/6/18. The MDS (minimum data set) was not complete at the time of the survey due to being a new admission. Diagnoses for Resident #324 included: Psychosis, depression and anxiety. On 08/07/18 at 01:48 PM, Resident #324's record was reviewed. Orders for the following were documented: Wellbutrin 150 MG (milligrams) for depression, Seroquel 150 MG for psychosis, Ativan 0.5 MG for anxiety, Percocet 5-325 MG as needed for pain, and Ambien 10 MG for sleep. Review of Resident #324's initial care plan was reviewed and did not indicate a care plan was put in place for antipsychotic medications. On 08/08/18 on 10:33 AM, licensed practical nurse (LPN #1, responsible for developing care plans) was interviewed regarding the above finding. LPN #1 reviewed Resident #324 initial	F 655	1.Resident #324□s care plan was updated during the survey, and currently reflects the active antipsychotic orders. Resident #101 is no longer utilizing the sling or knee immobilizer; the care plan has been reviewed and reflects the resident□s current status. 2.The Director of Nursing and/or Designee will conduct a 100% audit of current residents on antipsychotic medications to ensure they are care planned appropriately. The Director of Nursing and/or Designee will conduct a 100% audit of residents with orders for shoulder slings or knee immobilizers to ensure they are care planned appropriately. Any discrepancies will be addressed with the licensed nurses and care plans updated as appropriate. 3.The Staff Development Coordinator (SDC) or Designee will conduct education with licensed nursing staff on the facility policy for development of the initial care plan to include the use of antipsychotic medications. The SDC or designee will educate the licensed nursing staff and therapy staff on the facility policy for development of the initial care plan to include the use of shoulder slings and knee immobilizers. 4.The Director of Nursing or designee will	

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F 655	Continued From page 17 care plan and physician orders and verbalized that an initial care plan for medications should have been put in place. On 08/08/18 02:31 PM during a staff meeting with administrator and DON the above information was presented, the DON or administrator did not comment. No other information was provided prior to exit conference on 8/9/18. 2. Resident # 101 was admitted to the facility originally on 05/10/18, with the most recent readmission on 07/16/18. Diagnoses for Resident # 101 included, but were not limited to: Right hip dislocation (surgery), closed left clavicle fracture, muscle weakness, cognitive deficit, depression and hypothyroidism. The most recent MDS (minimum data set) was a 5 day-unplanned discharge assessment dated 05/13/18. The resident's cognitive status was not assessed. The resident was assessed as requiring extensive assistance for bed mobility, transfers, dressing, toileting, and bathing with the assistance from one person assistance. The resident was documented as having a fall in the last month, a fall in the last six months (with fracture) and as having a one fall since admission (05/10/18) with major injury. The CAAS (care area assessment summary) on this MDS triggered for, but were not marked to care plan: urinary, falls, pressure, psych drugs, and pain. On 08/08/18 at 10:57 AM, the clinical record was reviewed, along with the resident's admission orders. The admission orders dated 05/10/18 documented, "...S/P [status post] fall...R [right] hip dislocation...L [left] clavicle fracture..."	F 655	conduct audits of 20% of new residents initial care plans to validate the use of antipsychotic medications, shoulder slings and knee immobilizers weekly X4 weeks and then monthly X2 months. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5.Date of Completion: 9/19/2018	

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F 655	Continued From page 18	F 655		

A PT [physical therapy] evaluation and plan of care dated 05/11/18 documented, "...precautions: LUE [left upper extremity] NWB [non weight bearing]/sling, RLE [right lower extremity] in knee immobilizer at all times until follow up...left arm sling..."

An OT [occupation therapy] evaluation and plan of care dated 05/11/18 documented, "...LUE NWB precaution, sling to LUE, R hip precaution....R knee immobilizer..."

The resident's initial (baseline) care plan, dated 05/11/18 (the day after admission) was reviewed and documented, '...Assistance in bathroom...extensive assistance one person physical assist...will need extensive assist with all ADL's..." Nowhere in the resident's initial care plan was any information regarding the resident's arm sling and/or knee immobilizer; no information that the two treatment interventions existed for this resident.

The resident's MARS/TARS (medication administration records/treatment administration records) were reviewed for May 10th through May 13th 2018. No information was found regarding the above information.

On 08/09/18 at approximately 9:45 a.m., PT # 1 was interviewed. The PT stated that when the resident came in she (PT # 1) evaluated the resident on this admission (05/10/18). The PT stated that the resident came from the hospital with the sling and knee immobilizer. The PT was made aware of concerns that the resident did not have any information about this in the initial care plan or that there was not information on the

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F 655	Continued From page 19 resident's MARs/TARs to ensure that the resident had these in place. The PT stated that the resident came in with a fractured clavicle (left side) and dislocated hip (right side) and agreed that sling and kneed immobilizer should be part of the resident's initial care plan, since that is what she was admitted for. On 08/09/18 at approximately 10:30 a.m., the DON (director of nursing) was made aware that the initial care plan did not include treatment devices that were part of the resident's admission to the facility. No further information and/or documentation was presented prior to the exit conference on 08/09/18 at 15:25 p.m.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		9/19/18

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F 656	Continued From page 20 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed to develop a comprehensive care plan for 4 of 30 residents in the survey sample. 1. Resident #3 had no comprehensive care plan developed regarding leave of absence, safety and accountability for out of facility visits. 2. Resident #429's care plan did not include interventions for her safety when leaving the unit. 3. The facility staff failed to develop a CCP (comprehensive care plan) for leaves of absence for Resident # 93.	F 656	1.The care plans for Resident #3 has been updated to reflect leave of absence preference and safety considerations. The care plans for resident #429 has been updated to reflect leave of absence preference. The care plan for resident #93 has been updated to reflect leave of absence preferences. Resident #54 is no longer experiencing the noted acute health concern, and has had a care plan review to ensure the comprehensive care plan is reflective of this resident□s current status.	

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F 656	Continued From page 21 4. The facility staff failed to develop a plan of care with measurable goals and objectives to address the problem of acute health concerns for Resident #54. The findings include: 1. Resident #3 was admitted to the facility on 1/18/2017 with diagnoses that included hyperlipidemia, Alzheimer's Disease, Non-Alzheimer's dementia, hypertension, Vitamin-D Deficiency, hypothyroidism, and gastro-esophageal reflux disease (GERD). The minimum data set (MDS) dated 07/16/2018 assessed Resident #3 with severally impaired cognitive skills. This MDS indicated that Resident #3 was total dependent with one-person assistance for care including incontinence care. A facility reported incident (FRI) dated 06/22/18 for the incident on 06/16/18 documented the following: on 06/18/18 the spouse of Resident #3 reported that at approximately 1 p.m., on the afternoon of 06/16/18, his daughter returned with the resident to her room. The daughter requested that staff clean her (Resident #3) up and then put her in bed for a nap, according to her afternoon routine. When the spouse arrived at approximately 4 p.m. to spend time with her (Resident #3), he allegedly found his wife (Resident #3) in her wheelchair, slumped over, almost falling out. Her eyeglasses were on the floor. The spouse stated he "thought she had died." He reported, "feeling there was no evidence that she (Resident #3) had been rounded on as she was still in her chair, not put in bed and he 'seriously doubts' whether or not she had been cleaned up since her return at 1 p.m."	F 656	2.The Director of Nursing or designee will conduct a 100% audit of current residents to ensure the care plans are reflective of the resident□s preferences regarding leaves of absence including safety considerations. The Director of Nursing or designee will conduct a 100% audit of current residents with acute infections to ensure they are care planned appropriately in accordance with their current treatment plan. Any discrepancies will be addressed with the licensed nurses and care plans updated as appropriate 3.The Staff Development Coordinator or designee will conduct education with licensed nursing staff on the facility policy for completion and utilization of the comprehensive care plan including leave of absence preferences and acute infection treatment plans. 4.The Director of Nursing or designee will conduct audits of 20% of residents comprehensive care plans to ensure they are reflective of the resident□s preferences regarding leaves of absence and acute infection treatment plans weekly X4 weeks, then monthly X2 months. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5.Date of Completion: 9/19/2018	

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The facility's investigation of the incident included interviews with the staff providing care for Resident 3. The investigation reported the aide who routinely cared for Resident #3 stated she assisted Resident #3 on the morning of the incident and that her husband had taken her out. The report states the aide said she had not seen Resident #3 the rest of the shift. The reports states the said she stopped by the room during her "normal rounds" at approximately 12:45, and that the resident was not there. Both individuals assigned to the resident claim they were unaware of her return to the facility.

The clinical record was reviewed on 08/08/18. Resident #3 had no care plan developed regarding leave of absence, safety and accountability for out of facility visits with her spouse. Observed on Resident #3's holistic care plan under section 12. Activities and Socialization, was the following statement: "I (Resident)...enjoy eating dinner in another neighborhood of the community..." Observed under section 13. Cognitive Patterns, Moods, and Expressions listed under the care plan approaches, was the following statement "Her husband (Resident #3)..., visits daily and most nights takes her to IL (Independent Living) for dinner. Continue to encourage this as this appears to be for for (Resident #3)." There were no interventions regarding safety protocols for Resident #3 leaving or returning to the facility.

On 08/08/18 at 12:12 p.m., Resident #3's husband was interviewed and he stated he takes her out of the facility daily for dinner to the cafe located on the Independent Living (IL) side of the community property. Resident #3's husband

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stated his daughters brought his wife back to the facility around 1 p.m. He stated his daughters said they reported to someone on the floor that his wife was in her room and needed changing and then to lay her down for her afternoon nap. Resident #3's husband stated neither he, nor his daughters, knew the name of the person who was advised that Resident #3 had returned to her room. Resident #3's husband stated when he returned to the facility at approximately 4 p.m. he found Resident #3 in her room, sitting slumped over in her wheelchair, with her glasses on the floor beside her. He stated, "I thought she had died." He said the room was very hot and the thermostat was on 90 degrees. He said he rubbed her back and started to talk to her and she seemed to go back to her usual self. He said, "I took her out of there (room) and told someone about the room temperature." Resident #3's husband stated for a year and a half he has done daily visits with his wife, this is their routine to spend time together and they enjoy going to the IL cafe for dinner. He stated, "When I arrived at 4 p.m. and found her in that condition, I knew there was no way they rounded on my wife or took care of her for those 3 hours. I feel she was just left there alone in that hot room." Resident #3's husband stated during the time she is with him he does not provide incontinent care. Resident #3's husband stated he normally arrives around 4 p.m. to pick up Resident #3 and she (Resident) remains with him for approximately two and half to three hours depending on how long it takes her to eat. He then returns Resident #3 to the facility where she remains for the evening and night. He stated he normally signs her out each time using the sign out book at the nurses' station. He stated there is no sign-in sheet, so when he returns he tells a staff

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member. He continued and said he notifies the aide or nurse who is assigned to Resident #3; however, he knows most of the staff so if her assigned person is not available then he will notify another staff member that he has brought her back.

On 08/08/18 at 2:30 p.m., the director of nursing (DON) was interviewed about the leave of absence for Resident #3. The DON stated she reviewed and decided interventions based on the resident's needs.

On 08/09/18 at 8:20 a.m., the assistant director of nursing (ADON) was interviewed about the care plan regarding the leave of absence for Resident #3. The ADON stated that nursing does visual checks and incontinence care when Resident #3 returns from her visits with her husband. The ADON reviewed Resident #3's care plan and stated there was not a care plan about the leave of absence. The ADON stated her expectation was for nursing to take care of her (Resident #3), monitor her needs, provide incontinent care, check vitals, and to document their findings when Resident #3 comes and goes with her husband.

These findings were reviewed with the administrator and director of nursing during a meeting on 08/08/18.

2. Resident #429 was originally admitted to the facility on 07/31/2018. Her diagnoses included but were not limited to: Cerebral vascular accident (stroke), Alzheimer's, atrial fibrillation, generalized anxiety, and type II diabetes mellitus.

The admission MDS (minimum data set) with an ARD (assessment reference date of 08/07/2018, assessed Resident #429 with a cognitive

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summary score of "06", indicating severe impairment in her cognitive status.

On 08/08/2018 at approximately 4:40 p.m., Resident #429 was observed being pushed down the hallway by a family member. Resident #429 was asked if she was going to the dining room, the family member responded, "No, not yet. We are going to stroll around a little bit and get a change of scenery." She pushed the resident down the hallway and out of the unit door.

There were no nurses in the hallway, the nurse's station where clinical records were contained was a room with a locked door and no windows. LPN (licensed practical nurse) # 2 was in the nurse's station. She was interviewed regarding the location of residents on the unit. She stated, "If they have an appointment it is on the 24 hour report." She was asked if there was a sign in/sign out book for when residents left the unit to go to dinner with a family member or friend or just out off the unit. She stated, "If they are cognitively intact we make sure it is okay with them, if they aren't we check with the responsible party that is listed in the record...if they go out of the building they sign them out downstairs at the door." She was asked if she was aware that Resident #429 had just left the unit. She stated, "No."

At approximately 5:30 p.m., Resident #429 was observed in the dining room. Her family member was with her and was helping her with her meal. The family member was interviewed. She stated that Resident #429 normally lived in a different area of the facility in assisted living and that she was on this unit to get therapy. She stated, "I'm only here visiting for a few days...Mom lived down on (name of unit) before coming up

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here...sometimes I push her back over there, or we go outside to get some fresh air...just a while ago we went down the long hall to the other side to get a change of scenery." She was asked if she spoke with anyone or had to sign her mother out before leaving the unit. She stated, "No, I usually just wave to whoever is in the hallway to let them know we are leaving."

At approximately 6:30 p.m., Resident #429 was observed leaving the front door of the facility with the same family member. The family member stated, "We're going outside for some fresh air and to see how hot it is."

The care plan was reviewed on 08/09/2018 at approximately 8:30 a.m. The following was documented: "My personal story: ...I have always been a very social lady enjoying my time with friends and family, hosting events and gatherings. My entire life I have always been engaging and being out and about with others...The following actions, words, phrases, scents, etc. upset me? When I feel closed in or that I am missing out on something I want to do. I get confused and may need redirecting to get to a place at times." An area on the care plan: Activities and Socialization included the following information: "I like interactive programs, I like to spend time with my neighbors in the living room of my neighborhood....I enjoy: Everything on the calendar. I am out of my room all day going to different neighborhoods and participating in activities." Care plan approaches were: "Staff will continue to encourage resident to attend activities of their interest." Under the section "Safety and Exploring" the following information was observed: "I do not explore the neighborhood. At times I may forget exactly where my room is, but I

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am easily redirected." There were no other care plan approaches listed.

The care plan was discussed with the DON (director of nursing) at approximately 10:00 a.m. on 08/09/2018. She stated, "There should be interventions about her leaving the unit, and how the staff will know where she is."

The above information was discussed with the administrator and the DON during a meeting on 08/09/2018 at approximately 11:35 a.m.

No further information was obtained prior to the exit conference on 08/09/2018.

3. Resident # 93 admitted to the facility on 10/16/17, with the most current readmission on 02/09/18. Diagnoses included, but were no limited to: orthostatic hypotension, DM (diabetes mellitus), increased lipids, Parkinson's disease, depression, glaucoma, COPD (chronic obstructive pulmonary disease), and macular degeneration.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/02/18. This MDS assessed the resident with a cognitive score of '14', indicating the resident was cognitively intact for daily decision making skills. This MDS assessed the resident as requiring extensive assistance with one person assist for most ADL's (activities of daily living). The resident's mode of mobility was documented as a walker and/or w/c (wheel chair).

On 08/08/18 at approximately 4:30 p.m. the resident was observed with other females in the lobby, with one women pushing the resident in

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her w/c. The resident was asked if she was going out and the resident stated, "Yes."

At approximately 4:45 p.m., CNA (certified nursing assistant) # 8 was asked about how the process works when a resident leaves the facility for an outing. The CNA stated that when a resident goes out, the family or whoever (may not be family) is supposed to sign them (the resident) out in a book at the nurses station, "they (the family) knows they are supposed to do that." The CNA stated that when they (a resident) come back they (the person returning the resident) will tell the nurse or whoever (other staff) or they see the resident and let them know that way that the resident is back. The CNA was asked if the resident is supposed to be signed back in by staff and/or family. The CNA stated, "I don't know if they sign back in, for that part I don't know, for that part I am not sure."

On 08/08/18 at 5:02 PM, OS (Other Staff) # 6, the unit 3 secretary, was asked if there was a sign out book/sheet for residents when they go out. OS # 6 stated, "For what...appointments?" OS# 6 was asked if there were any any types of sign out book/sheet for a resident leaving for anything, any type of appointment, or any type of leave from the unit and/or the building. OS # 6 stated that there is a sign out sheet on the resident's chart, under the miscellaneous tab and that not everyone (resident) has one in their chart because everyone doesn't go out. It is a leave of absence sheet located on the resident's chart.

OS # 6 further stated that this (sign out sheet) is not part of the packet (admission packet) that we (staff) do when they (residents) are admitted. OS # 6 stated, "We don't know who can go out until

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the family or whoever comes and tells us; then we have a sheet we put in the resident's chart, located in the back that they (family) sign out the resident."

Resident # 93's chart was reviewed, including the sheet, titled "Leave of Absence Log". The form had a date column, time column, name of resident column, print name of person accepting responsibility column, relationship column, expected time of return column, on campus or off campus, staff name, sign in date, sign in time, and staff name. OS # 6 explained that the family or other will fill out the form indicting if they are going to remain on campus or off campus, the person then puts their signature, along with the date, and enters an expected return time. The secretary stated, "We will fill out the form sometimes that the resident is returned, but as you can see with this one (Resident # 93) that didn't happen." When asked if staff are supposed to sign the resident back in, OS # 6 stated that she didn't know and that maybe when they come back, they (the family) will just tell the nurse and they (staff) see them, so they (staff) don't sign them back in.

OS # 6 was asked if there was any other areas or locations to log this information, OS # 6 stated that this form is where staff document when a resident leaves.

On 08/09/18 at 11:17 AM, Resident # 93's leave of absence log was received, along with the resident's physician's orders sheet and care plan. The resident was signed out by her daughter on the evening of 08/08/18 at 4:30 p.m., the expected time of return was documented for 7:30 p.m., the off campus block was checked, but no

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other information was completed. The resident was signed out a total of seven times (since January 2018) and for each of the sign outs on the sheet, no documentation was found to regarding the resident's return, the time of the return, or the staff member receiving the resident from the return.

The resident's physician's orders were reviewed and did not evidence that the resident had a physician's order to leave the facility. The resident's CCP (comprehensive care plan) was reviewed and documented the following, "...safety and exploring...I like to sit outside but will need you to check on me frequently...I am not an elopement risk, I will need assistance from my care team to help me with mobility in my wheelchair inside and outside of my room...I will need assistance in and outside my neighborhood...Activities and Socialization...I enjoy visitation from my family...I vote at the polls...going to catholic mass, exercise and going outside when weather is good..." No other information was found regarding Resident # 93 leaving the facility.

The administrator and DON (director of nursing) were made aware of the concerns in a meeting with the survey team on 08/08/18 at approximately 5:10 p.m.

4. Resident # 54 in the survey sample, was admitted to the facility on 3/16/15, and readmitted on 11/15/15 with diagnoses that included atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, Non-Alzheimer's dementia, seizure disorder, diabetes mellitus, depression, chronic kidney disease, hyperlipidemia, and acute encephalopathy.

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According to the most recent Minimum Data Set, an Annual with an Assessment Reference Date of 5/28/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

At approximately 9:45 a.m. on 8/8/18, Resident # 54's holistic care plan, dated 5/28/18, was reviewed and found to include the following problem, "Acute Health Concerns." The primary one word goal listed for the problem was unable to be read. A hole, punched on the paper copy of the care plan page (page 12 of 24), rendered the word unreadable.

At 10:10 a.m. on 8/8/18, RN # 2 (Registered Nurse), the Unit Manager on the third floor Rose Court, was interviewed regarding the care plan and the unreadable word. RN # 2 surmised the word was "Other." She went on to say she would check the computer version of the care plan for the exact word. As of the time of the Exit Conference, on 8/9/18, RN # 2 had provided no further information.

The holistic care plan also listed the following as a secondary goal, "I will be free from sign (sic) of infection." The Care Plan Approach(es) portion of the care plan was blank. Asked about the lack of approaches to the problem of infection, RN # 1 said the approaches were covered under the care plan problem for "Assistance in Bathroom."

The holistic care plan for "Assistance in Bathroom" was reviewed, and RN # 2 was asked to point out the approaches that applied to the prevention of infection. RN # 2 pointed out the

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following, "I need assistance: To make sure I cleanse myself properly (perineal care); To get on and off commode; To manage protective garments and/or continence products."

The surveyor reminded RN # 2 that the resident was diagnosed with a Urinary Tract Infection (UTI) on 6/13/18. When asked if there was any other information or approaches for the prevention of infection, RN # 2 was unable to provide any. At the request of the surveyor, RN # 2 provided a copy of the holistic care plan for "Acute Health Concerns."

Review of the Nurse's Notes in Resident # 54's Electronic Health Record revealed the following:

6/9/18 - 7:22 a.m. - "...order for urine c and s (Culture and Sensitivity) for increase confusion unable to obtain this shift."
6/9/18 - 3:35 p.m. - "...urine dip stick done should possible (sic). Urine C&S sent to lab for further test."
6/12/18 - 4:16 p.m. - "...new order received for UA/C&S to rule out UTI...."
6/13/18 - 11:37 p.m. - "...received a telephonic order from Dr. (name) for a resident (Resident # 54) to start ABT (Antibiotic Therapy) tx (treatment) Ceftin 250 mg (milligrams) BID (two times a day) X (times) 7 days for UTI (E. coli urine)...."

At 8:05 a.m. on 8/9/18, the resident's holistic care plan for "Acute Health Concerns" was reviewed again. The review revealed a line had been drawn through the Other Goals of "I will be free from sign of infection," and the notation "D/C" (discontinued) was written in by hand. A copy of the altered "Acute Health Concerns" page (page

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F 656	Continued From page 33 12 of 24), as well as pages 3 through 10, which included the "Assistance in Bathroom" page (page 6 of 24), were provided to the surveyor. During a meeting at approximately 1:30 p.m. on 8/9/18, that included the Administrator, Director of Nursing, and the survey team, the findings regarding Resident # 54's holistic care plan for infection was discussed. During the discussion, the surveyor asked why the goal of "I will be free from sign of infection" was discontinued, and who approved the goal being discontinued. There was no immediate response at the time nor by the time of the Exit Conference.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical	F 688	1. Resident #26 has been placed in an	9/19/18

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F 688	Continued From page 34 record review, the facility staff failed to ensure proper wheelchair positioning for one of 30 residents in the survey sample: Resident # 26. Resident # 26 was observed in a wheelchair with no footrest applied and her feet unable to reach the floor. Findings include: Resident # 26 was admitted to the facility 2/22/05 with diagnoses to include, but not limited to: Alzheimer's disease, GERD, high blood pressure, and osteoporosis. The most recent MDS (minimum data set) was an annual review dated 5/7/18. Resident # 26 was coded with long term and short term memory problems, and severe impairment in daily decision making skills. On 08/07/18 at 08:10 a.m. during the breakfast dining observation, Resident # 26 was observed in a wheelchair being pushed by staff. Resident # 26's wheelchair did not have footrests applied and her feet were hanging several inches from the floor. There was a cushion in the seat of the wheelchair which sat the resident up in the chair a little higher that the wheelchair seat. The clinical record was reviewed 08/07/18 at 11:00 a.m. Resident # 26 had been discharged from physical therapy 9/29/16 using a front rolling walker. There was no further documentation located of the resident's current wheelchair use or that therapy had evaluated the resident for the appropriateness of the wheelchair. On 8/7/18 at 11:20 a.m. Resident # 26 was observed in an activity. Footrests had been	F 688	appropriately fitting wheelchair that allows for self-propelling. The wheel chair has been fitted with appropriate sized leg rests. 2. A 100% audit of current residents utilizing wheelchairs will be conducted by the Rehabilitation Director or designee to identify any issues with wheel chair positioning and leg rests. Any discrepancies will be addressed with the rehabilitation department and the appropriate fitting wheelchair and leg rests will be obtained. 3. The Rehabilitation Director or designee will conduct training with licensed nursing staff on identifying issues related to devices and equipment including circumstances that may inhibit a residents mobility, and the facility policy regarding referring residents for a therapy consult when issues are identified. 4. The Rehabilitation Director or designee will audit of 20% residents in wheelchairs, including new admissions, to ensure proper positioning and placement of leg rests weekly for one month and then monthly X2 months. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 9/19/2018	

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F 688	Continued From page 35	F 688		

applied to the wheelchair, but the resident's feet did not reach the footrests. The resident's left foot was partially on the footrest, and her right foot was not on the footrest but hanging mid-air beside the footrest. CNA (certified nursing assistant) # 1 was asked about the wheelchair and footrests. CNA # 1 stated the resident's daughter did not want the footrests on as she wanted the resident to self-propel the wheelchair in an attempt at independence. CNA # 1 was asked if she had observed the resident self-propelling the wheelchair, and that her feet did not touch the floor. CNA # 1 stated "No; she isn't able to self-propel the wheelchair."

On 8/8/18 at 8:50 a.m. the therapy department staff was interviewed about wheelchair. Other Staff (OS) # 1 stated "I think she was discharged some ago from therapy. We haven't evaluated her for a wheelchair. She must be using the facility's wheelchair. I'll get (name of rehab director) to come down; she might have information I am not aware of." The rehab director, identified as OS # 2, stated "I have no idea how long she may have been in the wheelchair...I have been here 5 months. However, if she's in an ill-fitting wheelchair, we can certainly look at that and see what we can do. We have not had any referral on her."

On 8/8/18 at 10:45 a.m. OS # 2 was observed in Resident # 26's room with a new wheelchair. CNA # 1 again stated "Her daughter doesn't want her to have the foot rests on her chair because she doesn't want her feet up in the air and get contracted. When her daughter comes on Sundays she puts the footrests on to take her out. The daughter bought the wheelchair and the cushion." OS # 2 stated "I have evaluated her

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F 688	Continued From page 36 and this wheelchair a much better fit. I put a different cushion in the seat, which sits her down further in the chair." OS # 2 was also applying blue foam to the footrests to accommodate the residents short stature so her feet were comfortably on the footrests. OS # 2 stated "We will order her a new wheelchair; it should be here maybe this week. We'll keep an eye on it." CNA # 1 was asked how the referral process worked for the resident to have been referred to have the wheelchair evaluated. CNA # 1 stated "When the CNA's notice a problem, they are to tell the charge nurse so the referral can be done." Registered Nurse (RN) # 1 was interviewed 8/8/18 at 11:00 a.m. She stated she was not aware the resident was in an ill-fitting wheelchair. She was advised of the findings and stated "Thank you." The administrator and DON (director of nursing) were informed of the above findings during a meeting with facility staff 8/8/18 beginning at 2:30 p.m. No further information was provided prior to the exit conference.	F 688		
F 689 SS=L	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	F 689		9/19/18

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F 689	Continued From page 37 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to provide care and supervision to ensure resident safety for three of 30 residents in the survey sample. In addition, the facility staff failed to implement a system to prevent accidents and promote safety for residents returning to the facility from a short-term leave basis. This resulted in potential harm and the identification of immediate jeopardy and substandard quality of care due to lack of a facility-wide accounting system of residents leaving and returning to the facility following short-term outings. 1. Resident #3 was left without care and/or supervision for approximately 3 hours after returning to the facility from a family outing. When found, Resident #3 was slumped and partially out of her wheelchair, glasses in the floor and without incontinence care. 2. Resident #429 was observed leaving Unit two with a family member on 08/08/2018 at approximately 4:40 p.m. Resident #429's family member did not sign the resident out as being off the unit. Resident #429 was also observed leaving through the front door of the facility with the same family member at approximately 6:30 p.m. Resident #429 was not signed out on the unit or at the front desk of the facility as to her whereabouts. 3. The facility staff failed to ensure an appropriate method of supervision for leaves of absence for Resident # 93. Resident # 93 was leaving the	F 689	1. Residents #3, # 429 and #93 were appropriately accounted for on 8/8/18 shortly after notification by the Survey Team of the Immediate Jeopardy. There were no identified care or service issues at that time. 2. With respect LOA policy, all residents have the potential to be impacted. 3. Licensed nursing staff will be re-educated on rounding and shift change reporting requirements to ensure that timely care is provided for residents. Training on the LOA policy has been added to new employee orientation. On 8/8/19 the Survey Team approved the plan of correction that was submitted by the Administrator. The IJ was abated on 8/9/18 once the credible evidence that was submitted had been reviewed and approved by the Survey Team. The plan of correction submitted is as follows: a)[Resident #3] is currently being supervised and is in her room sitting in her chair watching Television. (8/8/18 @ 8:20pm) b)A Security guard will be assigned to the entrance/exit until nursing staff is trained. A house wide audit was conducted. We have accounted for all residents on our current census. (8/8/18	

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facility with family via a sign out method, but there was no system in place to ensure the resident's return and/or that staff were aware of the resident's return or what to do in the event the resident was gone longer than expected.

The facility administration was notified of the finding of Immediate Jeopardy on 08/08/18 at 6:10 p.m. Following the presentation and the acceptance of the Plan of Removal, the finding of Immediate Jeopardy was abated on 08/09/18 at 11:10 a.m. Subsequently, the deficiency was assigned a scope and severity of Level 2, widespread.

The findings include:

1. Resident #3 was admitted to the facility on 1/18/2017 with diagnoses that included hyperlipidemia, Alzheimer's Disease, Non-Alzheimer's dementia, hypertension, Vitamin-D Deficiency, hypothyroidism, and gastro-esophageal reflux disease (GERD).

The minimum data set (MDS) dated 07/16/2018 assessed Resident #3 with severely impaired cognitive skills. This MDS indicated that Resident #3 was always incontinent of bowel and bladder, and was totally dependent with one-person assistance for care, including incontinence care.

A facility reported incident (FRI) dated 06/22/18 for the incident on 06/16/18 documented the following: on 06/18/18 the spouse of Resident #3 reported that at approximately 1 p.m., on the afternoon of 06/16/18, his daughter returned with the resident to her room. The daughter requested that staff clean her (Resident #3) up and then put her in bed for a nap, according to

@ 8:20pm)

c)Administrator or designee/s are currently educating nursing staff in the building on Resident Leave of Absence (LOA) policy, specifically signing in and out in the log book on the neighborhood. We will complete educating the remaining Nursing staff, Health Care Sales staff, Security and Social Work staff within the next 72 hours. (8/11/18)
Resident and Families/Responsible Parties will be contacted to Review the LOA process, specifically notifying staff and signing in and out in the log book on the neighborhood. Communication will be documented. (8/11/18)
Each neighborhood will have a binder/notebook with Leave of Absence (LOA) log and the Leave of Absence □ Off Campus forms. (8/8/18)

d)Administrator/ designees will round every two hours to verify location of Residents, LOA logs in place, and to conduct random staff interviews by neighborhood to validate knowledge of LOA policy. (8/11/18)
Two hour Rounds will be conducted x 72 hours, Random audits of log books and staff interviews will be conducted weekly x4 weeks, and every other week x2 months.
Results of audit will be reported to the QAPI committee to monitor for progress for improvement for 3 months.

4. Monitoring continues as prescribed in

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F 689	Continued From page 39 her afternoon routine. When the spouse arrived at approximately 4 p.m. to spend time with her (Resident #3), he allegedly found his wife (Resident #3) in her wheelchair, slumped over, almost falling out. Her eyeglasses were on the floor. The spouse stated he "thought she had died." He reported, "feeling there was no evidence that she (Resident #3) had been rounded on as she was still in her chair, not put in bed and he 'seriously doubts' whether or not she had been cleaned up since her return at 1 p.m." The facility's investigation of the incident included interviews with the staff providing care for Resident 3. The investigation reported the aide who routinely cared for Resident #3 stated she assisted Resident #3 on the morning of the incident and that her husband had taken her out. The report stated the aide said she had not seen Resident #3 the rest of the shift. The reports stated the said she stopped by the room during her "normal rounds" at approximately 12:45, and that the resident was not there. Both individuals assigned to the resident stated they were unaware of her return to the facility. The clinical record was reviewed on 08/08/18, to include the care plan. Resident #3's care plan under section 3f. documented "Assistance in Bathroom-Functional Status/Continence documented the resident required total dependence with one person physical assist." Resident #3 required assistance "to pull up or down my garments. To make sure I cleanse myself (perineal care). To manage protective garments and/or continence products." Resident #3's Physician's Order Form documented an order for Honey Thickened	F 689	the Plan of Correction cited above. Random audits and staff interviews will be conducted to ensure residents received appropriate care and supervision upon return from a leave of absence weekly x4 weeks, and every other week x2 months Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 9/19/2018	

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Liquid's 6-8oz at 10 a.m. and 2 p.m. A review of Resident #3's medication administration record (MAR) documented the following handwritten note on the "PRN, STAT AND MEDICATIONS NOT ADMINISTERED" page of the MAR : 06 16 18 LH (initials) juice given at 4p - LOA (leave of absence) at 2."

Resident #3's clinical record documented nothing further about her leaving or returning to the facility on the date of the incident.

On 08/08/18 at 10:50 a.m., the director of nursing (DON) and the assistant administrator were interviewed regarding the FRI which occurred on 06/16/18. The DON and assistant administrator were asked if the facility had a sign in/out policy. The assistant administrator stated there was a sign out book at the front desk and they ask family and visitors to use the front desk book, however it doesn't always happen. The Assistant Administrator stated Resident #3 was not signed out at the front desk downstairs, and provided a copy of the front desk's arrival and departure log for 06/16/18. The DON stated the family or resident representative (RR) will notify the staff when the resident leaves and returns to the facility. The DON and assistant administrator were asked about the expectation regarding the staff knowing the residents' location. They both stated the expectation was for staff to round on individuals to make sure they are capturing if the residents are on or off the unit.

On 08/08/18 at 12:12 p.m., Resident #3's husband was interviewed and he stated he takes her out of the facility daily for dinner to the cafe located on the Independent Living (IL) side of the community property. Resident #3's husband

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stated his daughters brought his wife back to the facility around 1 p.m. He stated his daughters said they reported to someone on the floor that his wife was in her room and needed changing and then to lay her down for her afternoon nap. Resident #3's husband stated neither he, nor his daughters, knew the name of the person who was advised that Resident #3 had returned to her room. Resident #3's husband stated when he returned to the facility at approximately 4 p.m. he found Resident #3 in her room, sitting slumped over in her wheelchair, with her glasses on the floor beside her. He stated, "I thought she had died." He said the room was very hot and the thermostat was on 90 degrees. He said he rubbed her back and started to talk to her and she seemed to go back to her usual self. He said, "I took her out of there (room) and told someone about the room temperature." Resident #3's husband stated for a year and a half he has done daily visits with his wife, this is their routine to spend time together and they enjoy going to the IL cafe for dinner. He stated, "When I arrived at 4 p.m. and found her in that condition, I knew there was no way they rounded on my wife or took care of her for those 3 hours. I feel she was just left there alone in that hot room." Resident #3's husband stated during the time she is with him he does not provide incontinent care. Resident #3's husband stated he normally arrives around 4 p.m. to pick up Resident #3 and she (Resident) remains with him for approximately two and half to three hours depending on how long it takes her to eat. He then returns Resident #3 to the facility where she remains for the evening and night. He stated he normally signs her out each time using the sign out book at the nurses' station. He stated there is no sign-in sheet, so when he returns he tells a staff

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member. He continued and said he notifies the aide or nurse who is assigned to Resident #3; however, he knows most of the staff so if her assigned person is not available then he will notify another staff member that he has brought her back.

The certified nursing assistant (CNA) caring for Resident #3 on 06/16/18 was not available for interview.

On 08/08/18 at 12:37 p.m., CNA #2, providing care for Resident #3 was interviewed about the sign in/out policy and rounding. CNA #2 stated they used a resident sign out sheet. CNA #2 presented a white 3 ring binder labeled as "RC 4th Floor Resident Sign Out Sheet." CNA #2 stated the binder was kept at the nurses' station desk on the unit. The form titled "Resident Monitoring Sheet" had columns labeled as date/time, resident activities and initials. There was no column to sign-in listed on the sheet. CNA #2 stated this was their tracking system. CNA #2 was asked if the resident was not signed in/out and was noted not on the unit during rounds how they handle locating resident. CNA #2 stated she does walking rounds on the entire unit if she cannot locate a resident and if there is no knowledge of the resident signing in/out. CNA #2 stated she would check the resident's room, the entire unit and/or common areas to verify whether the resident has or has not returned. CNA #2 stated if it is at shift change, she passes the information on to the oncoming shift if the resident has not returned to the unit.

A copy of the "RC 4th Floor Resident Sign Out Sheet" was provided and reviewed. There was no evidence showing Resident #3 had been signed

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out or back in to the facility on 06/16/18.

On 08/08/18 at 4:20 p.m., the team leader went to the administrator's office to obtain the facility policy regarding residents leaving the facility, signing in/out, etc. The assistant administrator presented a facility policy regarding Leave of Absence (LOA). She stated, "This is the policy we have for extended leaves of absence, we haven't given this to you because we were looking to see if there are any other pieces." She was asked what constituted extended leave. She stated, "Anything overnight or when the resident is going to be gone for an extended time, over the holidays...we ask to be given notice so we can get their medications together, we clear it with the doctor and the social worker is involved." She was asked if they had found any other pieces to the policy. She stated, "No, this is what we have." She was asked what the policy was for residents leaving to go out to appointments, out to dinner with family, or to another area on campus. She stated, "We don't have a policy for that, this is all we have. There are sign out sheets on the units and at the front desk."

On 08/08/18 at 4:45 p.m. the licensed practical nurse (LPN) #3 on the fourth floor caring for Resident #3 was interviewed about the resident sign in/out procedure. LPN #3 stated we have a sign-out book on this floor. LPN #3 presented the same binder as CNA #2. LPN #3 stated some residents sign back in and some do not. LPN #3 stated we also have a sign in/out book downstairs at the front desk in the lobby. LPN #3 was asked if the family and/or resident would be stopped if they did not sign in/out downstairs. LPN #3 stated "no, I don't think so, rather the front desk will call the unit to make sure it is ok for the

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resident to leave." LPN #3 stated if she noticed a resident has not returned and appears to be out longer than normal then she would call the family to check on the status of the resident's return. LPN #3 stated the staff communicates residents' locations during rounds and shift changes.

On 08/08/18 at 4:58 p.m. the front desk staff was interviewed about family members signing resident's out. The staff stated "That log book is for visitors coming in to the facility; it is not a sign out book for families to sign out the resident(s)."

On 08/08/18 at approximately 4:40 p.m., two residents, one on another unit and one in the lobby, were observed leaving the facility without signing out. At 5:30 p.m., the survey team inspected the other two units and found there was no use of facility-wide sign out/in book for residents leaving or returning to the facility.

On 08/08/18 at 5:45 p.m., the state agency supervisors were notified the facility did not have a facility-wide system for tracking and accounting for residents who were on short-term leave of absence.

On 08/08/18 at 6:10 p.m. the administrator and DON were informed of the finding of Immediate Jeopardy and Substandard Quality of Care due to the facility failed to have facility-wide system to account for residents leaving and returning to the facility following short-term outings.

The administrator presented the survey team with the plan for abatement of the Immediate Jeopardy 08/08/18 at approximately 8:35 p.m. which included:

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1. (Name of Resident #3) is currently being supervised and is in her room sitting in her chair watching television. (08/08/2018 @ 8:20 p.m.)

2. A security guard will be assigned to the entrance/exit until nursing staff is trained. A house wide audit was conducted. We have accounted for all residents on our current census. (08/08/2018 at 8:20 p.m.)

3. Administrator or designee are currently educating nursing staff in the building on Resident Leave of Absence (LOA) policy, specifically signing in and out in the log book on the neighborhood. We will complete the remaining nursing staff, health care sales staff, security and social work staff within the next 72 hours. (08/11/2018)

Resident and Families/Responsible Parties will be contacted to review the LOA process, specifically notifying staff and signing in and out in the log book on the neighborhood. Communication will be documented. (08/11/2018)

Each neighborhood will have a binder/notebook with Leave of Absence (LOA) log and the Leave of Absence-Off Campus forms. (08/11/2018)

4. Administrator/designee will round every two hours to verify location of residents, LOA logs in place, and to conduct random staff interviews by neighborhood to validate knowledge of LOA policy. (08/11/2018)

Two-hour rounds will be conducted X (times) 72 hours. Random audits of log books and staff interviews will be conducted X 4 weeks, and

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every other X 2 months.

Results of the audit will be reported to the QAPI committee to monitor for progress for improvement for 3 months.

The survey team, reviewed the plan of correction and accepted the removal of the immediacy on 08/08/18 at 8:55 p.m., when security guards were put in place at the door.

The survey team observed the following, accepted the plan of correction, and fully abated the IJ on 08/09/18 at 11:10 a.m.:

1. Resident #3 was observed on her unit eating breakfast and being supervised.

2. The security guards were observed at the front entrance and exit with clipboards signing residents in and out. A copy of the house wide audit was presented and reviewed documenting all residents were accounted for.

3. Staff were interviewed on each unit regarding the training for the short tern LOA policy and signing residents in and out of the logbook on each unit. Copies of the training logs were presented and reviewed that documented the training. A LOA logbook binder was observed on each unit's nurses' station. Residents and/or family members were observed being told about the LOA policy and sign in/out logbook as they were entering and exiting the building.

4. Copies of the Two-hour rounding sheets were presented and reviewed which documented each unit was completing 2-hour rounds on each resident on each unit.

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2. Resident #429 was originally admitted to the facility on 07/31/2018. Her diagnoses included but were not limited to: Cerebral vascular accident (stroke), Alzheimer's, atrial fibrillation, generalized anxiety, and type II diabetes mellitus.

The admission MDS (minimum data set) with an ARD (assessment reference date of 08/07/2018, assessed Resident #429 with a cognitive summary score of "06", indicating severe impairment in her cognitive status.

On 08/08/2018 at approximately 4:40 p.m., Resident #429 was observed in a wheelchair being pushed down the hallway of the 200 unit by a family member. Resident #429 was asked if she was going to the dining room, the family member responded, "No, not yet. We are going to stroll around a little bit and get a change of scenery." She pushed the resident down the hallway and out of the unit door.

CNA (Certified Nursing Assistant) #5 was observed standing in the hallway. She was asked if Resident #429 signed out when she left the unit. She stated, "No, the residents or the family usually tell us when they are leaving...we don't have a sign out book. It's downstairs at the front door." CNA #5 was asked if the family member of Resident #429 had told her where they were going just now when they left. She stated, "No, but they will be back for dinner." CNA #5 was asked how the residents were accounted for if there was an emergency and they had not left through the front door but were on another unit or another area of the facility campus. She stated, "I try to tell the nurse's when the residents leave, if I see them going...I don't know what the nurse's do with the information." CNA #5 was asked if any of

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the nurse's were aware that Resident #429 had left the unit that evening. She stated, "I don't know."

There were no nurse's in the hallway, the nurse's station where clinical records were contained was a room with a locked door and no windows. LPN (licensed practical nurse) # 2 was in the nurse's station. She was asked if she was aware that Resident #429 had just left the unit. She stated, "No." She was interviewed regarding the location of residents on the unit. She stated, "If they have an appointment that is scheduled and they are leaving we write it on the 24 hour report." She was asked if there was a sign in/sign out book for when residents left the unit to go to dinner with a family member or friend or just out off the unit. She stated, "No, we do not have a sign in or out book up here...there is a book downstairs at the front door...if the resident is cognitively intact and they are leaving we make sure they want to go...if they are not cognitively intact we check with the responsible party that is listed on the record to make sure it is okay...if they are going to be gone overnight we write it on the 24 hour report and send their medicine with them."

At approximately 5:30 p.m., Resident #429 was observed in the dining room. Her family member was with her and was helping her with her meal. The family member was interviewed. She stated that Resident #429 normally lived in a different area of the facility in assisted living and that she was on this unit to get therapy. She stated, "I'm only here visiting for a few days...Mom lived down on (name of unit) before coming up here...sometimes I push her back over there, or we go outside to get some fresh air...just a while ago we went down the long hall to the other side

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to get a change of scenery." She was asked if she spoke with anyone or had to sign her mother out before leaving the unit. She stated, "No, I usually just wave to whoever is in the hallway to let them know we are leaving."

At approximately 6:30 p.m., Resident #429 was observed leaving the front door of the facility with the same family member. The family member stated, "We're going outside for some fresh air and to see how hot it is." The sign in/sign out book at the front desk was reviewed at that time. Resident #429 had not been signed out as leaving the building.

The care plan was reviewed on 08/09/2018 at approximately 8:30 a.m. The following was documented: "My personal story: ...I have always been a very social lady enjoying my time with friends and family, hosting events and gatherings. My entire life I have always been engaging and being out and about with others...The following actions, words, phrases, scents, etc. upset me? When I feel closed in or that I am missing out on something I want to do. I get confused and may need redirecting to get to a place at times." An area on the care plan: Activities and Socialization included the following information: "I like interactive programs, I like to spend time with my neighbors in the living room of my neighborhood....I enjoy: Everything on the calendar. I am out of my room all day going to different neighborhoods and participating in activities." Care plan approaches were: "Staff will continue to encourage resident to attend activities of their interest." Under the section "Safety and Exploring" the following information was observed: "I do not explore the neighborhood. At times I may forget exactly where my room is, but I

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am easily redirected." There were no other care plan approaches listed.

The above information was discussed with the administrator and the DON (director of nursing) during a meeting on 08/08/2018 at approximately 6:05 p.m. They were informed that the survey team had identified a system wide failure regarding the facility's ability to account for residents at all times. The facility staff did not know the whereabouts of residents when they were off the units or when they would be returning. This lead to the identification of Immediate Jeopardy and Widespread Substandard Quality of Care at 6:10 p.m.

The immediacy was abated at 8:55 p.m. on 08/08/2018.

No further information was obtained regarding Resident #429 prior to the exit conference on 08/09/2018.

3. Resident # 93 admitted to the facility on 10/16/17, with the most current readmission on 02/09/18. Diagnoses included, but were no limited to: orthostatic hypotension, DM (diabetes mellitus), increased lipids, Parkinson's disease, depression, glaucoma, COPD (chronic obstructive pulmonary disease), and macular degeneration.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/02/18. This MDS assessed the resident with a cognitive score of "14", indicating the resident was cognitively intact for daily decision making skills. This MDS assessed the resident as requiring extensive assistance with one person assist for most ADL's (activities

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of daily living). The resident's mode of mobility was documented as a walker and/or w/c (wheel chair).

On 08/08/18 at approximately 4:30 p.m. the resident was observed with other females in the lobby, with one women pushing the resident in her w/c. The resident was asked if she was going out and the resident stated, "Yes."

At approximately 4:45 p.m., CNA (certified nursing assistant) # 8 was asked about how the process works when a resident leaves the facility for an outing. The CNA stated that when a resident goes out, the family or whoever (may not be family) is supposed to sign them (the resident) out in a book at the nurses station, "they (the family) knows they are supposed to do that." The CNA stated that when they (a resident) come back they (the person returning the resident) will tell the nurse or whoever (other staff) or they see the resident and let them know that way that the resident is back. The CNA was asked if the resident is supposed to be signed back in by staff and/or family. The CNA stated, "I don't know if they sign back in, for that part I don't know, for that part I am not sure."

On 08/08/18 at 5:02 PM, OS (Other Staff) # 6, the unit 3 secretary, was asked if there was a sign out book/sheet for residents when they go out. OS # 6 stated, "For what...appointments?" OS# 6 was asked if there were any any types of sign out book/sheet for a resident leaving for anything, any type of appointment, or any type of leave from the unit and/or the building. OS # 6 stated that there is a sign out sheet on the resident's chart, under the miscellaneous tab and that not everyone (resident) has one in their chart because

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everyone doesn't go out. It is a leave of absence sheet located on the resident's chart.

OS # 6 further stated that this (sign out sheet) is not part of the packet (admission packet) that we (staff) do when they (residents) are admitted. OS # 6 stated, "We don't know who can go out until the family or whoever comes and tells us; then we have a sheet we put in the resident's chart, located in the back that they (family) sign out the resident."

Resident # 93's chart was reviewed, including the sheet, titled "Leave of Absence Log". The form had a date column, time column, name of resident column, print name of person accepting responsibility column, relationship column, expected time of return column, on campus or off campus, staff name, sign in date, sign in time, and staff name. OS # 6 explained that the family or other will fill out the form indicting if they are going to remain on campus or off campus, the person then puts their signature, along with the date, and enters an expected return time. The secretary stated, "We will fill out the form sometimes that the resident is returned, but as you can see with this one (Resident # 93) that didn't happen." When asked if staff are supposed to sign the resident back in, OS # 6 stated that she didn't know and that maybe when they come back, they (the family) will just tell the nurse and they (staff) see them, so they (staff) don't sign them back in.

OS # 6 was asked if there was any other areas or locations to log this information, OS # 6 stated that this form is where staff document when a resident leaves.

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On 08/09/18 at 11:17 AM, Resident # 93's leave of absence log was received, along with the resident's physician's orders sheet and care plan. The resident was signed out by her daughter on the evening of 08/08/18 at 4:30 p.m., the expected time of return was documented for 7:30 p.m., the off campus block was checked, but no other information was completed. The resident was signed out a total of seven times (since January 2018) and for each of the sign outs on the sheet, no documentation was found to regarding the resident's return, the time of the return, or the staff member receiving the resident from the return.

The resident's physician's orders were reviewed and did not evidence that the resident had a physician's order to leave the facility. The resident's CCP (comprehensive care plan) was reviewed and documented the following, "...safety and exploring...I like to sit outside but will need you to check on me frequently...I am not an elopement risk, I will need assistance from my care team to help me with mobility in my wheelchair inside and outside of my room...I will need assistance in and outside my neighborhood...Activities and Socialization...I enjoy visitation from my family...I vote at the polls...going to catholic mass, exercise and going outside when weather is good..." No other information was found regarding Resident # 93 leaving the facility.

The administrator and DON (director of nursing) were made aware of serious concerns in a meeting with the survey team on 08/08/18 at approximately 5:10 p.m. regarding the facility not having an adequate tracking system in place to ensure the whereabouts of all resident's at all

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F 689	Continued From page 54 times. This lead to the identification of Immediate Jeopardy and Widespread Substandard Quality of Care at 6:10 p.m. The immediacy was abated at 8:55 p.m. on 08/08/2018. No further information was obtained regarding Resident #93 prior to the exit conference on 08/09/2018.	F 689		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on survey findings, observation, staff interviews, family interview, clinical record review, complaint investigation, and facility document review, the facility staff failed to provide effective administration to prevent substandard quality of care and immediate jeopardy in the area related to supervision to prevent accidents. The findings include: An onsite survey was conducted from 08/07/18 through 08/09/18. During the survey deficient practice was identified in the area of supervision to prevent accidents, at F689 with a scope and severity level of level 4, widespread regarding the facility's failure to implement a system to prevent accidents and promote safety for residents out of	F 835	1. Residents #3, # 429 and #93 were appropriately accounted for on 8/8/18 shortly after notification by the Survey Team of the Immediate Jeopardy. There were no identified care or service issues at that time. 2. With respect LOA policy, all residents have the potential to be impacted. 3. Licensed nursing staff will be re-educated on rounding and shift change reporting requirements to ensure that timely care is provided for residents. Training on the LOA policy has been added to new employee orientation.	9/19/18

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F 835	Continued From page 55 the facility on a short-term basis. This resulted in the identification of immediate jeopardy and substandard quality of care due to lack of a facility-wide accounting system of residents leaving and returning to the facility following short-term outings. Substandard quality of care and immediate jeopardy was initiated on 08/08/18. During the process, interviews took place with the administrator, assistant administrator and the director of nursing. On 08/08/18 at 4:20 p.m., the team leader went to the administrator's office to obtain the facility policy regarding resident's leaving the facility, signing in/out, etc. The Assistant Administrator presented a facility policy regarding Leave of Absence. She stated, "This is the policy we have for extended leaves of absence, we haven't given this to you because we were looking to see if there are any other pieces." She was asked what constituted extended leave. She stated, "Anything overnight or when the resident is going to be gone for an extended time, over the holidays...we ask to be given notice so we can get their medications together, we clear it with the doctor and the social worker is involved." She was asked if they had found any other pieces to the policy. She stated, "No, this is what we have." She was asked what the policy was for residents leaving to go out to appointments, out to dinner with family, or to another area on campus. She stated, "We don't have a policy for that, this is all we have. There are sign out sheets on the units and at the front desk." On 08/08/18 at 4:58 p.m. the front desk staff was interviewed about family members signing	F 835	On 8/8/19 the Survey Team approved the plan of correction that was submitted by the Administrator. The IJ was abated on 8/9/18 once the credible evidence that was submitted had been reviewed and approved by the Survey Team. The plan of correction submitted is as follows: a.[Resident #3] is currently being supervised and is in her room sitting in her chair watching Television. (8/8/18 @ 8:20pm) b.A Security guard will be assigned to the entrance/exit until nursing staff is trained. A house wide audit was conducted. We have accounted for all residents on our current census. (8/8/18 @ 8:20pm) c.Administrator or designee/s are currently educating nursing staff in the building on Resident Leave of Absence (LOA) policy, specifically signing in and out in the log book on the neighborhood. We will complete educating the remaining Nursing staff, Health Care Sales staff, Security and Social Work staff within the next 72 hours. (8/11/18) Resident and Families/Responsible Parties will be contacted to Review the LOA process, specifically notifying staff and signing in and out in the log book on the neighborhood. Communication will be documented. (8/11/18) Each neighborhood will have a binder/notebook with Leave of Absence (LOA) log and the Leave of Absence □ Off Campus forms. (8/8/18)	

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F 835	Continued From page 56 resident's out. The staff stated "That log book is for visitors coming in to the facility; it is not a sign out book for families to sign out the resident(s)." On 08/08/18 at approximately 8:35 p.m. the administrator stated that after she reviewed the LOA policy it was determined the facility had the log forms, however failed to use them. When asked why the forms were not presented earlier in the day as previously asked, the administrator stated the forms were available, but not being used. On 08/09/18 at 1:37 p.m., the director of nursing stated she was not aware of the LOA policy not being followed. No further information was provided prior to the exit conference on 08/09/18.	F 835	d.Administrator/ designees will round every two hours to verify location of Residents, LOA logs in place, and to conduct random staff interviews by neighborhood to validate knowledge of LOA policy. (8/11/18) Two hour Rounds will be conducted x 72 hours, Random audits of log books and staff interviews will be conducted weekly x4 weeks, and every other week x2 months. Results of audit will be reported to the QAPI committee to monitor for progress for improvement for 3 months. 4. Monitoring continues as prescribed in the Plan of Correction cited above. Random audits and staff interviews will be conducted to ensure residents received appropriate care and supervision upon return from a leave of absence weekly x4 weeks, and every other week x2 months Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 9/19/2019	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		9/19/18

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

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F 842	Continued From page 58 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure a complete and accurate clinical record for one of 30 residents in the survey sample, Resident # 101. The facility failed to document pertinent information regarding Resident # 101's care while at the facility. Findings include: Resident # 101 was admitted to the facility originally on 05/10/18 and discharged on 05/13/18. Diagnoses for Resident # 101 included, but were not limited to: Right hip dislocation (surgery), closed left clavicle fracture,	F 842	1. Resident #101 is no longer utilizing the sling or knee immobilizer. The care plan has been updated and reviewed to reflect the resident□s current status. 2. The Director of Nursing or designee will conduct a 100% audit of current residents with orders for shoulder slings or knee immobilizers to ensure they are documented on MARS/TARS in accordance with physician orders and care planned appropriately. Any discrepancies will be addressed with the licensed nurses and care plans updated as appropriate	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 59 muscle weakness, cognitive deficit, depression and hypothyroidism. The most recent MDS (minimum data set) was a 5 day-unplanned discharge assessment dated 05/13/18. The resident's cognitive status was not assessed. The resident was assessed as requiring extensive assistance for bed mobility, transfers, dressing, toileting, and bathing with the assistance from one person assistance. The resident was documented as having a fall in the last month, a fall in the last six months (with fracture) and as having a one fall since admission (05/10/18) with major injury. The CAAS (care area assessment summary) on this MDS triggered for, but were not marked to care plan: urinary, falls, pressure, psych drugs, and pain. On 08/08/18 at 10:57 AM, the resident's clinical record was reviewed, along with the resident's admission orders. The admission orders dated 05/10/18 documented, "...S/P [status post] fall...R [right] hip dislocation...L [left] clavicle fracture..." A PT (physical therapy) evaluation and plan of care dated 05/11/18 documented, "...precautions: LUE (left upper extremity) NWB (non weight bearing)/sling, RLE (right lower extremity) in knee immobilizer at all times until follow up...left arm sling..." An OT (occupation therapy) evaluation and plan of care dated 05/11/18 documented, "...LUE NWB precaution, sling to LUE, R hip precaution....R knee immobilizer..." The resident's initial (baseline) care plan, dated 05/11/18 (the day after admission) was reviewed and documented, '....Assistance in	F 842	3. The Staff Development Coordinator or designee will conduct education with licensed nursing staff on the facility policy for reviewing physician orders including residents with slings or knee immobilizers, placing orders on the MARS/TARs and development of the initial care plan as appropriate for these devices. 4. The Director of Nursing or designee will conduct audits of 20% of new resident physician orders, MAR/TAR documentation and initial care plans to validate the use of shoulder slings and knee immobilizers weekly X4 weeks and then monthly X2 months. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 9/19/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495354	A. BUILDING _____ B. WING _____	C 08/09/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 60	F 842		

bathroom...extensive assistance one person physical assist...will need extensive assist with all ADL's..." Nowhere in the resident's initial care plan was any information regarding the resident's arm sling and/or knee immobilizer, no information that the two treatment interventions existed for this resident.

The resident's MARS/TARS (medication administration records/treatment administration records) were reviewed for May 10th through May 13th 2018. No information was found regarding to evidence staff were putting the sling and knee immobilizer on and/or removing them.

On 08/09/18 at approximately 9:45 a.m., PT # 1 was interviewed. The PT stated that when the resident came in she (PT # 1) evaluated the resident on this admission (05/10/18). The PT stated that the resident came from the hospital with the sling and knee immobilizer. The PT was made aware of concerns regarding that the resident did not have any information about this in the initial care plan or that there was not information on the resident's MARs/TARs to ensure that the resident had these in place. The PT stated that the resident came in with a fractured clavicle (left side) and dislocated hip (right side) and agreed that sling and knee immobilizer should be part of the residents initial care plan and clinical record, since that is what she was admitted for.

On 08/09/18 at approximately 10:30 a.m., the DON (director of nursing) was made aware that the resident's clinical record had no information about this at all, except for the therapy documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 61 No further information and/or documentation was presented prior to the exit conference on 08/09/18 at 15:25 p.m., to evidence a complete and accurate clinical record for Resident # 101.	F 842		