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	495389	A. BUILDING _____ B. WING _____	C 10/12/2018

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/10/18 through 10/12/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/10/18 through 10/12/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 bed certified bed facility was 54 at the time of the survey. The survey sample consisted of 29 current Resident record reviews (Residents #55, 6, 211, 158, 38, 45, 26, 5, 16, 160, 48, 8, 7, 11, 4, 20, 3, 18, 44, 30, 17, 12, 13, 35, 50, 57, 210, 10, and 36) and five closed record reviews (Residents #216, 58, 500, 60, and 47).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		11/10/18

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

Electronically Signed | 11/01/2018

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a resident's dignity for one of 34 residents in the survey sample, Resident # 160. The facility staff failed to knock on the door of Resident # 160's room prior to entering. The findings include:	F 550	F550 1. Employee #2 was re-educated on the facilities policies and procedures on resident's privacy on 10/10/2018. 2. The resident privacy quality review was completed on 10/24/18 and no issues were noted. 3. Mandatory in-service for staff conducted by or before 11/01/2018 on residents rights in regards to right to	

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F 550	Continued From page 2 Resident # 160 was admitted to the facility on 10/04/2018 with diagnoses that included but were not limited to: respiratory failure (1), T-cell lymphoma (2), anemia (3) and vocal cord paralysis (4), PEG [percutaneous endoscopic gastrostomy (5)]-Tube, and NPO [nothing by mouth (6)]. Resident # 160's most recent MDS (minimum data set), was not due at the time of survey. The nursing admission assessment for Resident # 160 dated 10/04/10 documented, "Communication: Non-speech, usually understood and usually understands. Functional Status: Totally dependent for activities of daily living, orientated xs (times) 3 (three) [person, place time]." On 10/10/18 at 12:05 p.m., an interview was conducted with Resident # 160 in the presence of his wife and daughter in his room with the door to Resident # 160's room closed. During the interview with Resident # 160, CNA (certified nursing assistant) # 2 entered Resident # 160's room without knocking. When asked if he thought it was appropriate for staff to enter his room when the door was closed without knocking, Resident # 160 shook his head and mouthed "No." When asked if he was comfortable with staff entering his room when the door was closed without knocking, Resident # 160 shook his head and mouthed "No." When asked if he thought it violated his dignity, Resident # 160 nodded his head and mouthed "Yes." On 10/10/18 at 1:24 p.m., an interview was conducted with CNA (certified nursing assistant) # 2. When asked to describe the process for	F 550	privacy and knocking before entering residents room. 4. The Administrator is responsible for maintaining compliance. The DCS/Designee to complete Resident Privacy quality monitor 2x's a week. Findings reviewed at the facilities monthly QAPI meeting to ensure compliance. Follow up based on findings. Quality Monitoring schedule modified based on findings. 5. Corrective action will be completed on or before 11/10/2018	

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entering a resident's room, CNA # 2 stated, "Knock on the door before entering." When asked why you should knock before entering a resident's room, CNA # 2 stated "To let them know who you are and ask permission to enter the room." When asked how often you should knock on the resident's door, CNA # 2 stated, "Should be done all the time." When asked if she recalled coming into Resident # 160's room when this surveyor was conducting an interview with Resident #160, CNA # 2 stated, "Yes, I was looking for (Name of another Staff Member)." When asked if she knocked before entering Resident # 160's room, CNA # 2 stated, "I don't recall doing so."

The facility's "Resident's Rights and Responsibilities" documented, "Privacy. A. To be treated in a manner and in an environment that maintains or enhances your dignity, and respect in full recognition of your individuality and privacy."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Lippincott."

No further information was provided prior to exit.

References:
(1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(2) Lymphoma is a cancer of a part of the immune system called the lymph system. There are many types of lymphoma. One type is Hodgkin disease. The rest are called non-Hodgkin lymphomas. Non-Hodgkin lymphomas begin when a type of white blood cell, called a T cell or B cell, becomes abnormal. The cell divides again and again, making more and more abnormal cells. These abnormal cells can spread to almost any other part of the body. Most of the time, doctors don't know why a person gets non-Hodgkin lymphoma. You are at increased risk if you have a weakened immune system or have certain types of infections. This information was obtained from the website: http://salud.wikiplus.org/medlineplus/lymphoma.html.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) A multifacted problem that affects patients of all ages and presents initially to a wide range of healthcare professionals. It can cause laryngeal dysfunction ranging from slight hoarseness to life-threatening airway obstruction. When confronted with a patient with new onset vocal cord paralysis, the physician should determine the etiology of the paralysis. Only after an accurate diagnosis, can restoration of laryngeal function be addressed. Peripheral lesions injuring the vagus nerve or its branches are responsible for 90% of all vocal cord paralysis. Etiologies include neoplasms, surgical iatrogenic injury, and

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F 550	Continued From page 5 blunt and penetrating trauma in the head, neck, and thorax. Thyroid surgery has historically been accountable for almost a third of reported unilateral vocal cord paralyses. However, recent review has demonstrated a dramatic reduction in this incidence to less than 5%. Numerous treatment options exist for patients with vocal cord paralysis. These treatments can drastically reduce the social and economic disability incurred by these patients. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/9770942. (5) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm. (6) Nothing by mouth. This information was obtained from the website: https://www.merriam-webster.com/medical/NPO.	F 550		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		11/10/18

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because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that

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F 622	Continued From page 8 the facility staff failed to provide evidence of physician documented justification of why a resident was sent to the hospital and why the facility was not able to manage the residents health condition; and/or failed to evidence that all required documentation was provided to the receiving facility for facility initiated transfers to the hospital for 7 of 34 sampled residents, Residents #10, #18, #58, #35, #57, #55, and #50. 1. The facility staff failed to evidence that Resident #10's comprehensive care plan goals were sent to the receiving hospital for a facility initiated transfer on 8/27/18. 2. The facility staff failed to evidence the physician documented in the clinical record, the need for transfer to the hospital on 9/17/18, and why the Resident #18, could not be treated in the facility. 3. The facility staff failed to evidence the physician documented in the clinical record, the need for transfer to the hospital on 7/18/18, and why the Resident #58, could not be treated in the facility. 4. The facility staff failed to provide documented evidence all required documentation was provided to the receiving facility for Resident #35 on 6/21/18. 5. The facility staff failed to provide documented evidence all required documentation was provided to the receiving facility for Resident #57 on 6/17/18 and 6/24/18. 6. The facility staff failed to evidence that all required documentation and information was	F 622	1. Due to the nature of this issue, no corrective action is possible for residents #10, 18, 58, 35, 57, 55 and 50. Physician was educated on documenting that resident needs could not be met at this facility in a timely manner on 10/12/18. 2. Transfer/Discharge quality review was completed on 10/26/18 for all discharges since 10/23/18 and no other deficient practices were noted. 3. The transfer/discharge policy was reviewed and no changes are warranted at this time. Attending physicians and nursing staff re-educated on these requirements on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Transfer/discharge quality monitors for any discharges to ensure compliance is maintained. Follow up based on findings and reported monthly QAPI meeting. Quality monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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provided to the receiving provider for a facility-initiated transfer on 09/15/18 for Resident # 55.

7. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 06/29/18 for Resident # 50.

The findings include:

1. The facility staff failed to evidence that Resident #10's comprehensive care plan goals were sent to the receiving hospital for a facility initiated transfer on 8/27/18.

Resident #10 was admitted to the facility on 6/23/17 with the diagnoses of but not limited to joint pain, polyneuropathy, depression, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes, rheumatoid arthritis, anxiety disorder, stroke, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/8/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a "Nursing Home to Hospital Transfer Form" dated 8/27/18 which indicated that the resident was sent to the hospital on that date, and documented the resident was being sent to the hospital for a psychiatric evaluation for increasing behavioral changes and verbal aggressiveness. Further review of this document included pre-typed options of "Primary Goals of Care at time of transfer: _____Rehabilitation and/or Medical

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Therapy....; _____Chronic Long Term Care; _____Palliative or end-of life care; _____Receiving hospice care; _____Other." None of the boxes listed were marked.

Further review of the clinical record failed to reveal any evidence that the comprehensive care plan goals were sent to the receiving hospital.

On 10/12/18 at 9:09 a.m., an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing) and RN #1 (Registered Nurse) the Assistant Director of Nursing). When asked what is sent to hospital when a resident is transferred, ASM #2 stated the medication summary, care plan, bed hold policy, transfer form, face sheet, history and physical, SBAR (situation, background, assessment, recommendation) note and anything else needed. RN #1 stated that nurses should be documenting in the progress notes what was sent with the resident. She stated that this process was started about 3 weeks prior to this survey. A request was made for evidence that the Resident #10's comprehensive care plan goals were sent to the receiving hospital for the facility-initiated transfer on 8/27/18.

On 10/12/18 at 12:19 a.m., in an interview with ASM #2, she stated that there was no evidence the care plan goals were sent.

A review of the facility policy, "Transfer / Discharge Notification & Right to Appeal" documented, "Information provided to the receiving provider must include but is not limited to:....*Comprehensive care plan goals...."

On 10/12/18 at 12:59 a.m., at the end of day

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meeting, ASM #1 the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to evidence the physician documented in the clinical record, the need for transfer to the hospital on 9/17/18, and why the Resident #18, could not be treated in the facility.

Resident #18 was admitted to the facility on 9/9/2002 and most recently readmitted on 1/13/17 with the diagnoses of but not limited to osteoporosis, shoulder fracture, anxiety disorder, psychotic disorder, depression, anxiety disorder, insomnia, dysphagia, cerebral palsy, and Rheumatoid arthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/29/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a Nursing Home to Hospital Transfer Form dated 9/17/18, which indicated the resident was sent to the hospital on that date, and documented, "abrasion to right side forehead from fall."

Further review of the clinical record failed to reveal any evidence of physician documentation for why the resident could not be treated in the facility, what the facility did to attempt to treat the resident, and what services could the hospital provide to treat the resident that the facility could not.

On 10/12/18 at 10:50 a.m., an interview was

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conducted with ASM #2 (Administrative Staff Member) the Director of Nursing). ASM #2 stated that she had not seen where the physician would routinely document why the resident could not be treated in the facility, what did the facility do to attempt to treat the resident, and what services could the hospital provide to treat the resident that the facility could not. A request was made for any evidence that the physician documented in the clinical record why Resident #18 could not be treated in the facility and needed to be* transferred to the hospital on 9/17/18.

On 10/12/18 at 11:58 a.m., in an interview with ASM #2, she stated that she was unable to locate any such documentation in the clinical record.

A review of the facility policy, "Transfer / Discharge Notification & Right to Appeal" documented, "The center must permit each resident to remain in the center, and not transfer or discharge the resident from the center unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the center.....When the center transfers a resident under any of the circumstance listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation in the medical record to include: *The bases for the transfer; *In the case of inability to meet the resident needs (as per (a) above): *The specific resident need(s) that cannot be met, *The facility's attempts to meet the resident needs' *And the service available at the receiving facility to meet those needs(s). The documentation must be made by: The Resident's physician

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when transfer or discharge is necessary due to: *The resident's welfare and the resident's needs cannot be met in the center...."

On 10/12/18 at 12:59 p.m., at the end of day meeting, ASM #1 the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to evidence the physician documented in the clinical record, the need for transfer to the hospital on 7/18/18, and why the Resident #58, could not be treated in the facility

Resident #58 was admitted to the facility on 8/3/15, readmitted on 5/10/18, and discharged to the hospital on 7/18/18 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to hypoxemia, renal dialysis, anxiety disorder, depression, pulmonary hypertension, peripheral vascular disease, diabetes, atrial fibrillation, heart failure, end stage renal disease, and pacemaker. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/16/18.

A review of the clinical record revealed a Nursing Home to Hospital Transfer Form dated 7/18/18 which indicated that the resident went to the hospital on that date and documented, "Refused dialysis / Fluid overload?, lethargic, (decreased) O2 (oxygen) sat (saturation) 86%."

Further review of the clinical record failed to reveal any evidence of physician documentation for why the resident could not be treated in the

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facility, what did the facility did to attempt to treat the resident, and what services could the hospital provide to treat the resident that the facility could not.

On 10/12/18 at 10:50 a.m., an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing). ASM #2 stated that she had not seen where the physician would routinely document why the resident could not be treated in the facility, what did the facility do to attempt to treat the resident, and what services could the hospital provide to treat the resident that the facility could not. A request was made for evidence the physician documented clinical record the need for the transfer and why the resident could not be treated in the facility for the hospital transfer of Resident #58 on 7/18/18.

On 10/12/18 at 11:58 a.m., in an interview with ASM #2, she stated that she was unable to locate any such documentation in the clinical record.

On 10/12/18 at 12:59 p.m., at the end of day meeting, ASM #1 the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to provide documented evidence all required documentation was provided to the receiving facility for Resident #35 on 6/21/18.

Resident #35 was admitted to the facility on 10/21/16, with a most recent readmission of 7/6/18, with diagnoses that included but were not limited to: Barrett's Esophagus (a disorder in which the lining of the esophagus is damaged by stomach acid. The esophagus is also called the

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food pipe, and it connects your throat to your stomach) (1), high blood pressure, diabetes, heart disease, depression, anxiety, pain, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/12/18, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making.

The physician assistants (P.A.) note dated 6/21/18 at 11:31 a.m., documented in part, "Intractable vomiting, altered mental status ...please evaluate for aspiration pneumonia."

The nurse's "transfer to facility" note dated 6/21/18 at 11:50 a.m. documented in part, "Weak, cough with thick yellow sputum, congestion, NVD [nausea, +vomiting, and diarrhea], AMS [altered mental status or confusion] ... [Responsible Representative's name] left message on 6/21/18 at 12:00 p.m."

Review of the clinical record failed to evidence what resident information, including clinical information, was included in the Resident's transfer documentation.

An interview was conducted on 10/12/18 at 9:09 a.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. ASM #2 stated the transfer form, care plan goals, list of medications, resident's current status, and advanced directive. When asked where this

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information is documented, she stated, "It should be documented in the progress notes." When asked when the facility started this process, ASM #2 stated, "About three weeks or so ago." When asked if this information was available for Resident #35 since she was transferred to the hospital prior to this process, ASM #2 stated, "No."

ASM (administrative staff member), #1, the executive director, ASM #2, the director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, and RN (registered nurse) #1, where made aware of the above concerns on 10/12/18 at 12:35 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001143.htm

5. The facility staff failed to provide documented evidence all required documentation was provided to the receiving facility for Resident #57 on 6/17/18 and 6/24/18.

Resident #57 was admitted to the facility on 4/13/17, with a most recent readmission of 6/28/18, with diagnoses that included but were not limited to: heart failure, high blood pressure, lung disease, muscle weakness, low back pain, depression, and esophagitis (when the lining of the esophagus becomes swollen, inflamed, or irritated. The esophagus is the tube that leads from the back of the mouth to the stomach. It is also called the food pipe) (1).

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/19/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she has no cognitive impairment for daily decision making.

The nurse's note dated 6/17/18 at 10:45 a.m., documents in part, "[physician's name] phoned @ [at] 0800 [8 a.m.]. Made aware of pt.'s [patient's] constipation and also with ...bright red blood with coughing and blowing nose ...when EMS [emergency medical services] arrived, pt. had black blood on chin and chest. Appeared like coffee grounds."

The nurse's note dated 6/24/18 at 9:30 a.m., documents in part, "Epistaxis (nose bleed) (2), hemoptysis (coughing up blood) (3) ...severe esophagitis ...T.O. [telephone order] Please send to ER [emergency room] for uncontrolled nose bleeding/clotting/hemoptysis/epistaxis ...per [physician's name]."

Review of the clinical record failed to evidence what resident information, including clinical information, was included in the Resident's transfer documentation for her transfers to the hospital on 6/17/18 and 6/24/18.

An interview was conducted on 10/12/18 at 9:09 a.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. ASM #2 stated the transfer form, care plan goals, list of medications, resident's current status, and

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advanced directive. When asked where this information is documented, she stated, "It should be documented in the progress notes." When asked when the facility started this process, ASM #2 stated, "About three weeks or so ago." When asked if this information was available for Resident #57 since both of her transfer to the hospital were prior to this process, ASM #2 stated, "No."

ASM (administrative staff member), #1, the executive director, ASM #2, the director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, and RN (registered nurse) #1, where made aware of the above concerns on 10/12/18 at 12:35 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001153.htm

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003106.htm

3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003073.htm

6. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 09/15/18 for Resident # 55.

Resident # 55 was admitted to the facility on

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09/06/18 and a readmission on 09/20/18 with diagnoses that included but were not limited to: dementia (1), benign prostatic hyperplasia (2) and hypertension (3).

Resident # 55's most recent MDS (minimum data set), a 14-day assessment with an ARD (assessment reference date) of 09/27/18, coded Resident # 55 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 55 dated 09/15/18 documented, "1830 (6:30 p.m.) Resident's family with c/o) complaint of) resident having blank pain in the abd (abdomen), they requested for his transfer, ADON (assistant director of nursing) made aware, VS (vital signs) taken BP (blood pressure) 130/70 (one hundred thirty over seventy), R (respiration) 20, T (temperature) 97.8, and heart rate 80. 1900 (7:00 p.m.) call placed to 911 by (Name of LPN [licensed practical nurse]) 1915 (7:15 p.m.) transportation in the building, Resident transferred to stretcher, left via (by) stretcher, no distress."

On 10/12/18 at 9:10 a.m., an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing and ASM (administrative staff member) # 2, the interim director of nursing. When asked to describe the information provided to hospital staff when a resident is transferred to the hospital, RN # 1 stated, "We send the medication summary, care plan, bed hold policy, transfer form, face sheet, history and physical and the SBAR (Situation, Background Assessment, Recommendation)

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form." ASM # 2 stated, "The progress note would document that the care plan was sent."

On 10/12/18 at 10:28 a.m., ASM # 2 stated, "There's no documentation of care plans being sent for (Resident # 55)."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

7. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 06/29/18 for Resident # 50.

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Resident # 50 was admitted to the facility on 04/20/18 and a readmission on 07/06/18 with diagnoses that included but were not limited to: depressive disorder (1), gastroesophageal reflux disease (2), dementia (3) and hypertension (4).

Resident # 50's most recent MDS (minimum data set), a quarterly- assessment with an ARD (assessment reference date) of 09/18/18, coded Resident # 55 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact of cognition for making daily decisions.

The SBAR (Situation, Background Appearance, Review) form for Resident # 50 dated 06/29/18 documented, "The change in condition, symptoms, or signs observed and evaluated is/are: Fever, chills, hematuria [sic] (5)" Under "Review and Notify" it documented, "Emergency Medical Transport."

On 10/12/18 at 9:10 a.m., an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing and ASM (administrative staff member) # 2, the interim director of nursing. When asked to describe the information provided to hospital staff when a resident is transferred to the hospital, RN # 1 stated, "We send the medication summary, care plan, bed hold policy, transfer form, face sheet, history and physical and the SBAR (Situation, Background Assessment, Recommendation) form." ASM # 2 stated, "The progress note would document that the care plan was sent." RN # 1 was asked to provide the nurse's note for Resident # 50 dated 06/29/18.

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On 10/12/18 at 10:28 a.m., ASM # 2 stated, "There's no documentation of care plans being sent for (Resident # 50)."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References
(1) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

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F 622	Continued From page 23 (5) Blood in your urine is called hematuria. The amount may be very small and only detected with urine tests or under a microscope. In other cases, the blood is visible. It often turns the toilet water red or pink. Or, you may see spots of blood in the water after urinating. This information was obtained from the website: https://medlineplus.gov/ency/article/003138.htm.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		11/10/18

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be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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F 623	Continued From page 25 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide the required written notification to the resident representative and/or ombudsman upon a hospital transfer for six of 34 residents in the survey sample, Residents #10, #18, #58, #35, #57, and #50. 1. The facility staff failed to provide written notification to the Resident Representative and	F 623	F 623 1. Due to the nature of this issue, no corrective action is possible for residents #10, 18, 58, 35, 57 and 50. 2. Transfer/Discharge quality review was completed on 10/26/18 for all discharges since 10/23/18 and no other deficient practices were noted. 3. The transfer/discharge policy was	

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F 623	Continued From page 26 failed to notify the ombudsman of a hospital transfer on 8/27/18 for Resident #10. 2. The facility staff failed to provide written notification to the Resident Representative and failed to notify the ombudsman of a hospital transfer on 9/17/18 for Resident #18. 3. The facility staff failed to provide written notification to the Resident Representative and failed to notify the ombudsman of a hospital transfer on 7/18/18 for Resident #58. 4. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a transfer to the hospital on 6/21/18 for Resident #35. 5. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for transfers to the hospital on 6/17/18 and 6/24/18 for Resident #57. 6. The facility staff failed to provide Resident # 50 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 06/29/18. The findings include: 1. The facility staff failed to provide written notification to the Resident Representative and failed to notify the ombudsman of a hospital transfer on 8/27/18 for Resident #10. Resident #10 was admitted to the facility on	F 623	reviewed and no changes are warranted at this time. Nursing staff re-educated on issuing the transfer notice and Social Work staff re-educated on notifying the ombudsman of any transfers on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Transfer/discharge quality Monitor for any discharges to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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6/23/17 with the diagnoses of but not limited to joint pain, polyneuropathy, depression, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes, rheumatoid arthritis, anxiety disorder, stroke, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/8/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a "Nursing Home to Hospital Transfer Form" dated 8/27/18 which indicated that the resident was sent to the hospital on that date, and which documented the resident was being sent to the hospital for a psychiatric evaluation for increasing behavioral changes and verbal aggressiveness.

Further review of the clinical record failed to reveal any evidence that the Resident Representative was provided with a written notification of the hospital transfer. The clinical record also failed to evidence the ombudsman was notified of the transfer.

On 10/12/18 at 9:09 a.m., an interview was conducted with ASM #2 (Administrative Staff Member - the Director of Nursing) and RN #1 (Registered Nurse - the Assistant Director of Nursing). When asked about notifying the Resident Representative in writing, ASM #2 stated the Social Worker does that.

On 10/12/18 at 10:00 a.m., during an interview with OSM #2 (Other Staff Member - the social worker), OSM #2 stated she did not have any evidence that the written notification was provided to the Resident Representative or Ombudsman

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for Resident #10. She stated that she thought it was only if they were admitted to the hospital overnight, and not if they only went to the Emergency Room.

A review of the facility's policy, "Transfer/Discharge Notification and Right to Appeal", documents in part, "Before a center transfers or discharges a resident the center must:
* Notify the resident and the resident representative(s) of the transfer or discharge and the reasons for the move in writing
* The Center must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman."

On 10/12/18 at 12:59 p.m., at the end of day meeting, ASM #1 the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to provide written notification to the Resident Representative and failed to notify the ombudsman of a hospital transfer on 9/17/18 for Resident #18.

Resident #18 was admitted to the facility on 9/9/2002 and most recently readmitted on 1/13/17 with the diagnoses of but not limited to osteoporosis, shoulder fracture, anxiety disorder, psychotic disorder, depression, anxiety disorder, insomnia, dysphagia, cerebral palsy, and Rheumatoid arthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/29/18. The resident was coded as severely cognitively impaired in ability to make daily life

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decisions.

A review of the clinical record revealed a Nursing Home to Hospital Transfer Form dated 9/17/18 indicated the resident was sent to the hospital on that date, and documented, "abrasion to right side forehead from fall."

Further review of the clinical record failed to reveal any evidence that the Resident Representative was provided with a written notification for the transfer. The clinical record failed to evidence the ombudsman was notified of the hospital transfer.

On 10/12/18 at 9:09 a.m., an interview was conducted with ASM #2 (Administrative Staff Member - the Director of Nursing) and RN #1 (Registered Nurse - the Assistant Director of Nursing). When asked about notifying the Resident Representative in writing, ASM #2 stated the Social Worker does that.

On 10/12/18 at 10:00 a.m., during an interview with OSM #2 (Other Staff Member - the social worker), OSM #2 stated she did not have any evidence that the written notification was provided to the Resident Representative or Ombudsman for Resident #18. She stated that she thought it was only if they were admitted to the hospital overnight, and not if they only went to the Emergency Room.

On 10/12/18 at 12:59 p.m., at the end of day meeting, ASM #1 the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

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3. The facility staff failed to provide written notification to the Resident Representative and failed to notify the ombudsman of a hospital transfer on 7/18/18 for Resident #58.

Resident #58 was admitted to the facility on 8/3/15, readmitted on 5/10/18, and discharged to the hospital on 7/18/18 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to hypoxemia, renal dialysis, anxiety disorder, depression, pulmonary hypertension, peripheral vascular disease, diabetes, atrial fibrillation, heart failure, end stage renal disease, and pacemaker. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/16/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a Nursing Home to Hospital Transfer Form dated 7/18/18 which indicated that the resident went to the hospital on that date and documented, "Refused dialysis / Fluid overload?, lethargic, (decreased) O2 (oxygen) sat (saturation) 86%."

Further review of the clinical record failed to reveal any evidence that the Resident Representative was provided with a written notification for the transfer. The clinical record failed to evidence the ombudsman was notified of the hospital transfer.

On 10/12/18 at 9:09 a.m., an interview was conducted with ASM #2 (Administrative Staff Member - the Director of Nursing) and RN #1 (Registered Nurse - the Assistant Director of Nursing). When asked about notifying the

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Resident Representative in writing, ASM #2 stated the Social Worker does that.

On 10/12/18 at 10:00 a.m., during an interview with OSM #2 (Other Staff Member - the social worker), OSM #2 stated she did not have any evidence that the written notification was provided to the Resident Representative or Ombudsman for Resident #58. She stated that she thought it was only if they were admitted to the hospital overnight, and not if they only went to the Emergency Room.

On 10/12/18 at 12:59 p.m., at the end of day meeting, ASM #1 the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a transfer to the hospital on 6/21/18 for Resident #35.

Resident #35 was admitted to the facility on 10/21/16, with a most recent readmission of 7/6/18, with diagnoses that included but were not limited to: Barrett's Esophagus (a disorder in which the lining of the esophagus is damaged by stomach acid. The esophagus is also called the food pipe, and it connects your throat to your stomach) (1), high blood pressure, diabetes, heart disease, depression, anxiety, pain, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/12/18, coded the

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resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making.

The physician assistants (P.A.) note dated 6/21/18 at 11:31 a.m. documented in part, "Intractable vomiting, altered mental status ...please evaluate for aspiration pneumonia."

The nurse's "transfer to facility" note dated 6/21/18 at 11:50 a.m. documented in part, "Weak, cough with thick yellow sputum, congestion, NVD [nausea, vomiting, and diarrhea], AMS [altered mental status or confusion] ...[Responsible Representative's name] left message on 6/21/18 at 12:00 p.m."

On 10/1218 at 9:09 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. She stated that nursing calls the resident's responsible representative prior to the transfer to the hospital. When asked if written notification regarding the transfer is provided to the resident or responsible representative, she stated that the social worker takes care of that. ASM #2 stated she is responsible for sending written notification of the resident's transfer to the ombudsman. When asked if she could provide evidence of ombudsman notification for Resident #35's 6/21/18 transfer, she answered, "No, the process was not yet in place."

On 10/12/18 at 9/27 a.m., an interview was conducted with OSM (other staff member) #2, the social worker. OSM #2 stated that she provides a written letter to the responsible representative and sends a copy to the state ombudsman's

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office. In addition, she makes a copy and scans it into the resident's electronic medical record. When asked if she could provide evidence of this written documentation for Resident #35's transfer on 6/21/18, she stated, "No the process was only started about a couple of weeks ago."

ASM (administrative staff member), #1, the executive director, ASM #2, the director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, and RN (registered nurse) #1, were made aware of the above concerns on 10/12/18 at 12:35 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001143.htm

5. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for transfers to the hospital on 6/17/18 and 6/24/18 for Resident #57.

Resident #57 was admitted to the facility on 4/13/17, with a most recent readmission of 6/28/18, with diagnoses that included but were not limited to: heart failure, high blood pressure, lung disease, muscle weakness, low back pain, depression, and esophagitis (when the lining of the esophagus becomes swollen, inflamed, or irritated. The esophagus is the tube that leads from the back of the mouth to the stomach. It is also called the food pipe) (1).

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/19/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she has no cognitive impairment for daily decision making.

The nurse's note dated 6/17/18 at 10:45 a.m., documents in part, "[physician's name] phoned @ [at] 0800 [8 a.m.]. Made aware of pt.'s [patient's] constipation and also with ...bright red blood with coughing and blowing nose ...when EMS [emergency medical services] arrived, pt. had black blood on chin and chest. Appeared like coffee grounds."

The nurse's note dated 6/24/18 at 9:30 a.m., documents in part, "Epistaxis (nose bleed) (2), hemoptysis (coughing up blood) (3) ...severe esophagitis ...T.O. [telephone order] Please send to ER [emergency room] for uncontrolled nose bleeding/clotting/hemoptysis/epistaxis ...per [physician's name]."

On 10/1218 at 9:09 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. She stated that nursing calls the resident's responsible representative prior to the transfer to the hospital. When asked if written notification regarding the transfer is provided to the resident or responsible representative, she stated that the social worker takes care of that. ASM #2 stated she is responsible for sending written notification of the resident's transfer to the ombudsman. When asked if she could provide evidence of ombudsman notification for Resident #57's 6/17/18 and 6/24/18 transfers, she answered,

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"No, the process was not yet in place."

On 10/12/18 at 9/27 a.m., an interview was conducted with OSM (other staff member) #2, the social worker. OSM #2 stated that she provides a written letter to the responsible representative and sends a copy to the state ombudsman's office. In addition, she makes a copy and scans it into the resident's electronic medical record. When asked if she could provide evidence of this written documentation for Resident #57's 6/17/18 and 6/24/18 transfers, she stated, "No the process was only started about a couple of weeks ago."

ASM (administrative staff member), #1, the executive director, ASM #2, the director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, and RN (registered nurse) #1, were made aware of the above concerns on 10/12/18 at 12:35 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001153.htm

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003106.htm

3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003073.htm
6. The facility staff failed to provide Resident # 50 or the resident's representative and the ombudsman written notification when the resident

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was transferred to the hospital on 06/29/18.

Resident # 50 was admitted to the facility on 04/20/18 and a readmission on 07/06/18 with diagnoses that included but were not limited to: depressive disorder (1), gastroesophageal reflux disease (2), dementia (3) and hypertension (4).

Resident # 50's most recent MDS (minimum data set), a quarterly- assessment with an ARD (assessment reference date) of 09/18/18, coded Resident # 55 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact of cognition for making daily decisions. Resident # 50 was coded as requiring extensive assistance of one staff member for activities of daily living.

The SBAR (Situation, Background Assessment Recommendation) form for Resident # 50 dated 06/29/18 documented, "The change in condition, symptoms, or signs observed and evaluated is/are: Fever, chills, hematuria [sic] (5)" Under "review and Notify" it documented, "Emergency Medical Transport."

On 10/12/18 at 9:10 a.m., an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing and ASM (administrative staff member) # 2, the interim director of nursing. When asked about notifying the Resident Representative in writing, ASM #2 stated the Social Worker does that.

On 10/12/18 at 9:27 a.m., an interview was conducted with OSM (other staff member) # 2, social worker. When asked to describe the process for notifying the ombudsman and providing written notification to the resident and

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the resident's representative, OSM # 2 stated, "I provide a letter to the family and state ombudsman. I was informed a couple of weeks ago that it was my responsibility." When asked about the written notification to the resident, resident's representative and the ombudsman, OSM # 2 stated, "He is his own responsible party. There is no written notification to the resident or the ombudsman for Resident # 50.

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References
(1) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:
https://medlineplus.gov/ency/article/003213.htm.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:

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F 623	Continued From page 38 https://medlineplus.gov/ency/article/000739.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Blood in your urine is called hematuria. The amount may be very small and only detected with urine tests or under a microscope. In other cases, the blood is visible. It often turns the toilet water red or pink. Or, you may see spots of blood in the water after urinating. This information was obtained from the website: https://medlineplus.gov/ency/article/003138.htm.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		11/10/18

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F 625	Continued From page 39 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide a written bed hold policy/notification to the resident and/or resident representative, within 24 hours of a transfer to the hospital for two of 34 residents in the survey sample; Residents #58 and #55. 1. The facility staff failed to evidence that Resident #58 or the Resident Representative was provided a written bed hold notification for a facility initiated transfer of the resident to the hospital on 7/18/18. 2. The facility staff failed to provide Resident # 55 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/15/18. The findings include: 1. The facility staff failed to evidence that Resident #58 or the Resident Representative was provided a written bed hold notification for a facility initiated transfer of the resident to the hospital on 7/18/18. Resident #58 was admitted to the facility on 8/3/15, readmitted on 5/10/18, and discharged to	F 625	F625 1. Due to the nature of this issue, no corrective action is possible for residents #58 and 55. 2. Transfer/Discharge quality review was completed on 10/26/18 for all discharges since 10/23/18 and no other deficient practices were noted. 3. The transfer/discharge policy was reviewed and no changes are warranted at this time. Nursing staff re-educated on this policy and issuing bed hold notice on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Transfer/discharge quality monitor for any discharges to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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the hospital on 7/18/18 and did not return to the facility. The resident was admitted with the diagnoses of but not limited to hypoxemia, renal dialysis, anxiety disorder, depression, pulmonary hypertension, peripheral vascular disease, diabetes, atrial fibrillation, heart failure, end stage renal disease, and pacemaker. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/16/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a Nursing Home to Hospital Transfer Form dated 7/18/18 which indicated that the resident went to the hospital on that date and documented, "Refused dialysis / Fluid overload?, lethargic, (decreased) O2 (oxygen) sat (saturation) 86%."

Further review of the clinical record failed to reveal any evidence that a bed hold notification was provided to the resident and/or resident representative when the resident was transferred to the hospital on 7/8/18.

On 10/12/18 at 10:00 a.m., OSM #2 (Other Staff Member) the Social Worker stated that nursing sends the bed hold policy.

On 10/12/18 at 10:20 a.m., in an interview with OSM #5, the Business Office Coordinator, she stated she did not have any evidence of a bed hold being provided to the Resident Representative for Resident #58.

On 10/12/18 at 10:25 a.m., in an interview with LPN #4 (Licensed Practical Nurse) she stated that she does provide the bed hold policy,

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however she was new at the time of survey and was not in the facility in July when Resident #58 went to the hospital.

On 10/12/18 at 10:30 a.m., in an interview with RN #1 (Registered Nurse) the Assistant Director of Nursing, RN #1 stated she was not in the facility in July 2018. RN #1 stated that it was just in September 2018 that training and in-services were going on about transfer requirements, and therefore she thought that there would be no evidence if a bed hold was provided to the Resident Representative when Resident #58 was sent to the hospital on 7/18/18.

A review of the facility document, "Notice of Transfer and Bed Hold Policy for Residents Transferring to ED or Hospital" documented, "The purpose of this letter is to inform you that after careful consideration, it our plan to transfer _____ for the following reason: X The transfer is necessary for _____ welfare and _____ needs cannot be met in the facility as evidenced by the need for _____.....Notice of Bed Hold Policy: You are being sent to the hospital today. If you are a Medicaid/Medicare resident and you are admitted to the hospital, (state) Medicaid and Medicare does not pay to hold your bed. Whatever your payment source, unless the nursing home is paid to reserve the bed while you are in the hospital, the nursing home may move someone else into your room. However, even if the nursing home is not paid to hold your bed, you may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as you still need the services provided by this nursing home (and, if you are on Medicaid, you are eligible for Medicaid nursing home services).....If you wish to hold your bed at

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(facility) during your hospitalization, you will be responsible to pay privately for the room at the facilities {sic} per diem rate. Once you hold the bed, the only reason that you would not be able to be admitted to (facility) is if: 1. The level of care required is not provided at (facility). 2. The patient is judged by the physician to be of danger to themselves or others. 3. The resident at the time of readmission has an outstanding payment to the nursing home for which they are responsible...."

On 10/12/18 at 12:59 p.m., at the end of day meeting, ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to provide Resident # 55 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/15/18.

Resident # 55 was admitted to the facility on 09/06/18 and a readmission on 09/20/18 with diagnoses that included but were not limited to: dementia (1), benign prostatic hyperplasia (2) and hypertension (3).

Resident # 55's most recent MDS (minimum data set), a 14-day assessment with an ARD (assessment reference date) of 09/27/18, coded Resident # 55 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 55 dated 09/15/18 documented, "1830 (6:30 p.m.)

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Resident's family with c/o) complaint of) resident having blank pain in the abd (abdomen), they requested for his transfer, ADON (assistant director of nursing) made aware, VS (vital signs) taken BP (blood pressure) 130/70 (one hundred thirty over seventy), R (respiration) 20, T (temperature) 97.8, and heart rate 80. 1900 (7:00 p.m.) call placed to 911 by (Name of LPN [licensed practical nurse]) 1915 (7:15 p.m.) transportation in the building, Resident transferred to stretcher, left via (by) stretcher, no distress."

On 10/12/18 at 9:10 a.m., an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing and ASM (administrative staff member) # 2, the interim director of nursing. When asked about a bed hold for Resident #55, ASM # 2 stated, "There was no documentation that the bed hold policy was sent for (Resident # 55)."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) An enlarged prostate. This information was

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F 625	Continued From page 44 obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (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	F 655		11/10/18

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F 655	Continued From page 45 (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to develop and implement baseline care plans to provide person centered care for two of 34 residents in the survey sample, Resident # 160 and # 211. 1. The facility staff failed to develop the baseline care plan to address Resident #160's ability to suction himself and to address the residents use of prn (as needed) pain medication. 2. The facility staff failed to develop the baseline care plan for Resident #211 within 48 hours. The findings include: 1. The facility staff failed to develop the baseline care plan to address Resident #160's ability to suction himself and to address Resident #160's use of prn (as needed) pain medication.	F 655	F655 1. The baseline care plan for resident # 160 was updated to include documentation of resident's ability to suction himself on 10/11/18. No corrective action can be completed for resident #211 as 48 hour time period has passed. Resident #211 receives care as care planned. 2. Care Plan quality review was completed on 10/30/18 for residents and no other deficient practices were noted. 3. The Comprehensive Person Centered Care planning policy was reviewed and no changes are warranted at this time. Nurses re-educated on this policy on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Care Plan quality monitor for 10 resident records per month to ensure compliance is	

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F 655	Continued From page 46 Resident # 160 was admitted to the facility on 10/04/2018 with diagnoses that included but were not limited to: respiratory failure (1), T-cell lymphoma (2), anemia (3) and vocal cord paralysis (4), PEG [percutaneous endoscopic gastrostomy (5)]-Tube, and NPO [nothing by mouth (6)]. Resident # 160's most recent MDS (minimum data set), was not due at the time of survey. The nursing admission assessment for Resident # 160 dated 10/04/10 documented, "Communication: Non-speech, usually understood and usually understands. Functional Status: Totally dependent for activities of daily living, orientated xs (times) 3 (three) [person, place time]." On 10/10/18 at 8:24 a.m., Resident # 160 was observed turning on the suction machine, picking up the Yankauer suction tube (7) that was lying over the suction machine uncovered, and then suctioning himself. Resident #160 was then observed turning off the suction machine and replacing the Yankauer suction tube back over the suction machine. On 10/10/18 at 9:58 a.m., an observation of Resident # 160 revealed he was lying in bed, turning on the suction machine, picking up the Yankauer suction tube that was lying over the suction machine uncovered, suctioning himself, turning off the suction machine and replacing the Yankauer suction tube back over the suction machine. On 10/10/18 at 12:00 p.m., an observation of Resident # 160 revealed he was lying in bed,	F 655	maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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turning on the suction machine, picking up the Yankauer suction tube that was lying over the suction machine uncovered, suctioning himself, turning off the suction machine and replacing the Yankauer suction tube back over the suction machine.

The POS (physician order sheet) dated 10/05/18 for Resident # 160 documented, "Oral suctioning @ (at) bedside for excessive secretions PRN (as needed). Resident may section self." "Acetaminophen (8) 325mg. Take 2 (two) 650mg every 4 (four) hours as needed for pain, increased temperature."

Review of the MAR (medication administration record) for Resident # 160 dated October 2018 did not evidence the administration of acetaminophen.

Review of the baseline care plan for Resident # 160 dated 10/04/18 failed to evidence documentation of Resident # 160's ability to section his own secretions and failed to address the use of prn pain medication.

On 10/11/18 at 10:24 a.m., an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing. When asked to describe the procedure followed for a resident to self-suction, RN # 1 stated, "We assess and determine if the patient is able to suction themselves. If we find it to be true, we set up the suction machine and Yankauer at the bed side and keep the sleeve for the Yankauer attached to the suction machine so that they can put it back in there when it's not in use. When asked to describe the process staff follows for verifying that a resident is able to self-suction, RN # 1

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stated, "Upon admission we would do a 'return demonstration' with the resident to make sure they could do it and document this in the admission packet. RN # 1 was then asked to review the baseline care plan for Resident # 160. When asked if it was part of the baseline care plan for Resident # 160 to suction himself, RN # 1 stated, "It should be part of the baseline care plan. I don't see it on there." When asked about the use of prn pain medication on the baseline are plan, RN # 1 stated, "I don't see it on there."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(2) Lymphoma is a cancer of a part of the immune system called the lymph system. There are many types of lymphoma. One type is Hodgkin disease. The rest are called non-Hodgkin lymphomas. Non-Hodgkin lymphomas begin when a type of white blood cell, called a T cell or B cell, becomes abnormal. The cell divides again and again, making more and more abnormal cells. These abnormal cells can spread to almost any other part of the body. Most of the time, doctors don't know why a person gets

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non-Hodgkin lymphoma. You are at increased risk if you have a weakened immune system or have certain types of infections. This information was obtained from the website: http://salud.wikiplus.org/medlineplus/lymphoma.html.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) A multifacted problem that affects patients of all ages and presents initially to a wide range of healthcare professionals. It can cause laryngeal dysfunction ranging from slight hoarseness to life-threatening airway obstruction. When confronted with a patient with new onset vocal cord paralysis, the physician should determine the etiology of the paralysis. Only after an accurate diagnosis, can restoration of laryngeal function be addressed. Peripheral lesions injuring the vagus nerve or its branches are responsible for 90% of all vocal cord paralysis. Etiologies include neoplasms, surgical iatrogenic injury, and blunt and penetrating trauma in the head, neck, and thorax. Thyroid surgery has historically been accountable for almost a third of reported unilateral vocal cord paralyses. However, recent review has demonstrated a dramatic reduction in this incidence to less than 5%. Numerous treatment options exist for patients with vocal cord paralysis. These treatments can drastically reduce the social and economic disability incurred by these patients. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/9770942.

(5) A PEG (percutaneous endoscopic

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gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm.

(6) Nothing by mouth. This information was obtained from the website: https://www.merriam-webster.com/medical/NPO.

(7) A rigid hollow tube made of metal or disposable plastic with a curve at the distal end to facilitate the removal of thick pharyngeal secretions during oral pharyngeal suctioning. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/Yankauer+suction+catheter.

(8) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

2. The facility staff failed to develop the baseline care plan for Resident #211 to address the resident's use of a CPAP [Continuous Positive

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Airway Pressure (1)] machine within 48 hours of admission.

Resident #211 was admitted to the facility on 10/5/18 with diagnoses that included but were not limited to: arthritis in his knees, muscle weakness, difficulty in walking, high blood pressure and left total knee replacement.

The admission assessment completed on 10/5/18 documented that Resident #211 was alert with independent cognitive skills for decision-making. In addition, he was noted as being able to make self-understood as well as being able to understand others. The resident was documented as requiring the assistance of one staff member for bed mobility, transfers, ambulation, and bathing.

On 10/10/18 at 8:00 a.m., Resident #211 was observed reclining in bed. A CPAP machine, [a treatment that uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. (2)] mask, and gallon of distilled water was observed on his bedside table.

On 10/10/18 at 2:30 p.m., Resident #211 was interviewed in his room. When asked about the CPAP machine, Resident #211 stated he suffered with sleep apnea and the machine in the facility was his own. He stated, "I told the doctor I would rather use my own machine than one that is rented or available in the facility. I know my mask is clean and I keep my machine clean." Resident #211 verified that he used the CPAP machine while sleeping unless "I fall asleep before I put it on."

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A review of the baseline care plan dated 10/7/18, failed to document the resident's use of a CPAP machine for respiratory treatment.

An interview was conducted on 10/12/18 at 8:47 a.m. with RN (registered nurse) #1, the assistant director of nursing. RN #1 was asked to review the baseline care plan to see if it addressed the resident's CPAP treatment. She stated, "I do not believe he has a CPAP." When informed that it had been observed on Resident #211's bedside table on multiple occasions during the survey, RN #1 stated, "I will update the baseline care plan now." A review of the hospital orders, dated 10/1/18, with RN #1, documented that the resident used a homebased CPAP machine

On 10/12/18 at 9:15 a.m., Resident #211 was asked when the home machine was brought in to the facility for his use. He stated his sister brought it in on 10/6/18, the day after he was admitted to the facility, which was within 48 hours of his admission.

ASM (administrative staff member), #1, the executive director, ASM #2, the director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, and RN #1, where made aware of the above concerns on 10/12/18 at 12:35 p.m.

A review of the facility's policy, "Plans of Care", documents in part, "Develop and implement and Individualized Person-Centered baseline plan of care within 48 hours of admission that includes ...areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of

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F 655	Continued From page 53 care is completed." No further information was provided prior to exit. 1) This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/cpap 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001916.htm	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		11/10/18

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F 656	Continued From page 54 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement the comprehensive care plan for one of 34 residents in the survey sample, Resident # 13. The facility staff failed to implement the comprehensive care plan for the administration of Resident # 13's oxygen. The findings include: Resident # 13 was admitted to the facility on 05/16/18 with diagnoses that included but were not limited to: atrial fibrillation (1), diabetes mellitus (2), chronic kidney disease (3) and hypertension (4). Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 656	F 656 1. Resident #13's attending physician in collaboration with Hospice clarified residents order for oxygen to be 3 LPM on 10/11/18. 2. An oxygen quality review was completed on 10/30/18 for residents on oxygen and no other deficient practices were noted. 3. The Plans of Care policy was reviewed and no changes are warranted at this time. Nurses re-educated on this policy on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Oxygen observation quality monitor weekly times 4 weeks for residents receiving oxygen then for 10 residents per month to ensure compliance is maintained. Follow up based on findings and reported to the	

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F 656	Continued From page 55 (assessment reference date) of 08/23/18, coded Resident # 13 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 13 was coded as totally dependent of one staff member for all activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 49 was coded for "C. Oxygen therapy." On 10/10/18 at 8:31 a.m., an observation of Resident # 13 revealed she was lying in bed asleep, appeared clean, receiving oxygen by nasal cannula. Observation of the oxygen concentrator revealed the oxygen flow rate was between two and a half and three liters per minute. On 10/10/18 at 1:58 p.m., an observation of Resident # 13 revealed she was lying in bed asleep, receiving oxygen by nasal cannula, connected to an oxygen concentrator. Observation of the oxygen concentrator revealed the oxygen flow rate was set between two and a half and three liters per minute. On 10/11/18 at 9:24 a.m., an observation of Resident # 13 revealed she was sitting up in bed participated receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed the oxygen flow rate was set between two and a half and three liters per minute. On 10/11/18 at 5:00 p.m., an observation of Resident # 13 revealed she was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed the oxygen flow	F 656	facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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rate was set between two and a half and three liters per minute.

The POS (physician order sheet) for Resident # 13 dated 10/01/2018 and signed by the physician on 10/02/18 documented, "05/16/18: Oxygen at 2L/MIN (two liters per minute) as needed for shortness of breath."

The comprehensive care plan dated 09/01/2018 for Resident # 13 documented, "(Resident # 13) has the potential for an effective breathing pattern r/t (related to) heart failure, End stage disease process, shortness of breath when lying flat, Oxygen use. Date initiated: 09/01/2018." Under "Interventions" it documented, "Oxygen via (by) NC (nasal cannula) as ordered. Date initiated: 09/01/2018."

On 10/11/18 at 5:05 p.m., an interview was conducted with RN (registered nurse) # 2. When asked how the oxygen flow rate is read on the oxygen concentrator, RN # 2 stated, "Turn the knob to adjust the ball to the liter line. The liter line should pass through the middle of the ball." When asked what the oxygen flow rate for Resident # 13 should be, RN # 2 retrieved the clinical record for Resident # 13, and look at the physician order sheet. RN #2 then stated, "Two liters per minute." RN # 2 was then asked to accompany this surveyor to Resident # 13's room and was asked to read the oxygen flow rate on Resident # 13's oxygen concentrator. After entering the residents room RN #2 observed Resident #13's oxygen concentrator settings. RN # 2 then stated, "It's between two and a half and three liters per minute." RN # 2 was asked to review Resident # 13's respiratory care plan. When asked if the care plan was being followed

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based on the observation of Resident # 13's oxygen flow rate, RN # 2 stated no.

The facility's policy "Plans of Care" documented, "Procedure: Develop and implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team that includes but is not limited to: the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutritional staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and to the extent practicable, the participation of the resident and the resident's representative(s) with seven (7) days after completion of the comprehensive assessment (MDS)."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.
No further information was provided prior to exit.

References:
(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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F 656	Continued From page 58 (3) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview clinical record review, and during the course of a complaint investigation, it was determined the facility staff failed to follow professional standards of practice for two of 34 residents in the survey sample, Residents # 160 and # 216. 1a. The facility staff failed to assess Resident # 160 for self-suctioning. 1b. The facility staff failed to transcribe the physician's order for Resident # 160's PEG [percutaneous endoscopic gastrostomy (5)] - dressing change. 2. The facility staff failed to reorder pain medication for Resident #216.	F 658	F 658 1. Resident #160's peg tube dressing order was clarified and the dressing was changed on 10/10/18. Resident #160 was assessed to be safe to self suction on 10/10/18 and the care plan was updated. Due to the fact that resident #216 is no longer residing in facility, no corrective action can be taken. 2. A Professional standard of practice quality review was completed on 11/1/18 for residents potentially affected and no other deficient practices were noted. 3. The Physician orders policy was reviewed and no changes are warranted at this time. Nurses re-educated on this policy on or before 11/10/18.	11/10/18

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F 658	Continued From page 59 The findings include: 1a. The facility staff failed to assess Resident # 160 for self-suctioning. Resident # 160 was admitted to the facility on 10/04/2018 with diagnoses that included but were not limited to: respiratory failure (1), T-cell lymphoma (2), anemia (3) and vocal cord paralysis (4), PEG [percutaneous endoscopic gastrostomy(5)]-Tube, and NPO [nothing by mouth (6)]. Resident # 160's most recent MDS (minimum data set), was not due at the time of survey. The nursing admission assessment for Resident # 160 dated 10/04/10 documented, "Communication: Non-speech, usually understood and usually understands. Functional Status: Totally dependent for activities of daily living, orientated xs (times) 3 (three) [person, place time]." On 10/10/18 at 8:24 a.m., Resident # 160 was observed turning on the suction machine, picking up the Yankauer suction tube (7) that was lying over the suction machine uncovered, and then suctioning himself. Resident #160 was then observed turning off the suction machine and replacing the Yankauer suction tube back over the suction machine. On 10/10/18 at 9:58 a.m., an observation of Resident # 160 revealed he was lying in bed, turning on the suction machine, picking up the Yankauer suction tube that was lying over the suction machine uncovered, suctioning himself, turning off the suction machine and replacing the	F 658	4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Professional standard of practice quality monitor weekly times 4 weeks then for 10 residents per month to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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Yankauer suction tube back over the suction machine.

On 10/10/18 at 12:00 p.m., an observation of Resident # 160 revealed he was lying in bed, turning on the suction machine, picking up the Yankauer suction tube that was lying over the suction machine uncovered, suctioning himself, turning off the suction machine and replacing the Yankauer suction tube back over the suction machine.

The POS (physician order sheet) dated 10/05/18 for Resident # 160 documented, "Oral suctioning @ (at) bedside for excessive secretions PRN (as needed). Resident may section self."

Review of the baseline care plan for Resident # 160 dated 10/04/18 failed to evidence documentation of Resident # 160's ability to section his own secretions.

On 10/11/18 at 10:24 a.m., an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing. When asked to describe the procedure staff follows for a resident to self-suction, RN # 1 stated, "We assess and determine if the patient is able to suction themselves. If we find it to be true, we set up the suction machine and Yankauer at the bed side and keep the sleeve for the Yankauer attached to the suction machine so that they can put it back in there when it's not in use. When asked to describe the process for verifying that a resident is able to self-suction, RN # 1 stated, "Upon admission we would do a 'return demonstration' with the resident to make sure they could do it and documented it in the admission packet. When asked how it was verified that Resident #

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160 could safely suction himself, RN # 1 stated, "It should be documented in his admission packet." When asked to provide the documentation of Resident # 160's assessment to self-suction, RN # 1 reviewed Resident # 160's clinical record. RN # 1 then stated, "I don't see where the nurse assessed or conducted a return demonstration of his (Resident # 160) ability to self-suction. It wasn't done."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Lippincott."

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 10 read: "Patient Teaching: 4. 5. Documentation of patient teaching should be specific and include the degree of patient competence of the procedure."

No further information was provided prior to exit.

References:

(1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(2) Lymphoma is a cancer of a part of the

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immune system called the lymph system. There are many types of lymphoma. One type is Hodgkin disease. The rest are called non-Hodgkin lymphomas. Non-Hodgkin lymphomas begin when a type of white blood cell, called a T cell or B cell, becomes abnormal. The cell divides again and again, making more and more abnormal cells. These abnormal cells can spread to almost any other part of the body. Most of the time, doctors don't know why a person gets non-Hodgkin lymphoma. You are at increased risk if you have a weakened immune system or have certain types of infections. This information was obtained from the website: http://salud.wikiplus.org/medlineplus/lymphoma.html.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) A multifacted problem that affects patients of all ages and presents initially to a wide range of healthcare professionals. It can cause laryngeal dysfunction ranging from slight hoarseness to life-threatening airway obstruction. When confronted with a patient with new onset vocal cord paralysis, the physician should determine the etiology of the paralysis. Only after an accurate diagnosis, can restoration of laryngeal function be addressed. Peripheral lesions injuring the vagus nerve or its branches are responsible for 90% of all vocal cord paralysis. Etiologies include neoplasms, surgical iatrogenic injury, and blunt and penetrating trauma in the head, neck, and thorax. Thyroid surgery has historically been accountable for almost a third of reported unilateral vocal cord paralyses. However, recent

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review has demonstrated a dramatic reduction in this incidence to less than 5%. Numerous treatment options exist for patients with vocal cord paralysis. These treatments can drastically reduce the social and economic disability incurred by these patients. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/9770942.

(5) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm.

(6) Nothing by mouth. This information was obtained from the website: https://www.merriam-webster.com/medical/NPO.

1b. The facility staff failed to transcribe the physician's order for Resident # 160's PEG [percutaneous endoscopic gastrostomy (5)] - dressing change.

During an observation of Resident # 160 on 10/10/18 at 10:06 a.m., Resident # 160's daughter asked this surveyor to look at Resident # 160's g-tube dressing. The daughter stated that the dressing had not been changed. Resident # 160's daughter asked her father to show this surveyor his G-tube dressing. With permission from Resident # 160, this surveyor observed the dressing on Resident # 160's abdomen. Further observation of the dressing revealed it was dated "10/06/18."

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The POS (physician order sheet) dated 10/05/18 for Resident # 160 documented, "QD (every day) Peg tube DSG (dressing) change. Clean site with soap and water."

Review of the MAR (medication administration record) and TAR (treatment administration record) dated October 2018 for Resident # 160 failed to evidence documentation of the physician's order for Resident # 160's dressing change.

On 10/12/18 at 11:05 a.m., an interview was conducted with RN # 1, the assistant director of nursing. When asked about the treatment and physician's order for Resident # 160's G-tube dressing change, RN # 1 stated, "It should be documented as a treatment." After reviewing Resident # 160's MAR/TAR for October 2018, RN # 1 stated, "It's not documented on the MAR or TAR." When asked to describe the process for ensuring the physician's orders are transcribed on to the MAR or TAR, RN # 1 stated, "It should be transcribed from the physician's order sheet to the MAR or TAR." When asked about the missing order on the MAR or TAR for Resident # 160's PEG-tube dressing change, RN # 1 stated, "It should have been done on admission."

The facility's policy "Physician Orders" documented, "ROUTINE ORDERS: The order is transcribed to all appropriate areas (MAR, TAR, etc.) of electronic equivalent. The nurse shall sign off the orders upon completion or verification of transcription."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive

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director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Lippincott."

(5) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm.

2. The facility staff failed to reorder pain medication for Resident #216.

Resident #216 was admitted to the facility on 1/16/18 with diagnoses that included but were not limited to: cerebrovascular accident (stroke) with right sided weakness, morbid obesity, cellulitis [an infection of the skin and deep underlying tissues. (1)] of the right lower leg, depression, and anxiety.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 1/30/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she had no cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of one or more staff members for bed mobility, transfers, dressing, toileting, and personal hygiene. In

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Section N - Medications, the resident was coded as using opioids during the look back period.

In a complaint filed with the Office of Licensure and Certification on 3/5/18, the complainant, a former resident, alleges that she was told "twice" that her narcotic pain medication was on "order" and as a result she did not receive any narcotic pain medication for "at least 5 days". Resident was discharged home on 2/6/18.

A review of the physician's order dated 1/16/18 documented in part, "Norco [hydrocodone and acetaminophen combination which is a class of medications called opiate (narcotic) analgesics used to relieve moderate-to-severe pain (2)] 10-325 mg (milligrams) po (by mouth) Q (every) 6 hrs prn (as needed) for pain."

A review of the pharmacy's manifest documented that 20 Norco tablets were delivered to the facility on 1/16/18 for Resident #216.

A review of the facility's narcotic sign out sheet for Resident #216's Norco for the time period of 1/16/18-1/23/18, documented that Resident #216 was administered 2 tablets on 1/16/18, 1 tablet on 1/17/18, 3 tablets on 1/18/18, 4 tablets on 1/19/18, 3 tablets on 1/20/18, 3 tablets on 1/21/18, 3 tablets on 1/22/18 and 1 tablet on 1/23/18, which completed this prescription of 20 tablets.

A review of the clinical record documented a prescription for Norco 10/325 mg for 30 tablets was faxed to the pharmacy on 1/19/18. A review of the pharmacy's manifest documented that 30 Norco tablets were delivered to the facility on 1/23/18 for Resident #216.

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A review of the facility's narcotic sign out sheet for Resident #216's Norco for the time period of 1/23/18-2/2/18, documented that Resident #216 was administered 1 tablet on 1/23/18, 3 tablets on 1/24/18, 3 tablets on 1/25/18, 3 tablets on 1/26/18, 2 tablets on 1/27/18, 3 tablets on 1/28/18, 3 tablets on 1/29/18, 3 tablets on 1/30/18, 3 tablets on 1/31/18, 4 tablets in 2/1/18, and 2 tablets on 2/2/18, which completed this prescription of 30 tablets.

A review of the clinical record did not indicate that any additional Norco was prescribed by the physician nor was there any documentation to indicate an order for this resident was sent to the pharmacy.

A nursing note dated 2/3/18 at 3:55 a.m. documented in part, "Medicated for pain with prn Tylenol, [a non-narcotic analgesic used to relieve mild to moderate pain. (3)], with some relief noted."

A nursing note dated 2/5/18 for the time period of 7 p.m. to 11 p.m. documented in part, "Pain meds (medications) have not arrived yet."

A review of the medication administration record (MAR) documented that the resident received Tylenol 650 mgs for complaints of pain on 2/2/18, 2/3/18, 2/4/18 and 2/5/18.

The baseline care plan dated 1/18/18, with a most recent revision and review on 1/29/18 with Resident #216's signature indicating review of care plan, failed to document any pain issues for this resident.

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An interview was conducted with RN (registered nurse) #2 on 10/11/18 at 8:15 a.m. When asked to describe the process staff follows for renewing a prescription for a narcotic such as Norco, RN #2 stated that the physician is called and the request for the renewal is made. If the physician agrees, a hard copy of the prescription is provided by the physician and then faxed to the pharmacy for refilling.

Subsequent interviews with LPN (licensed practical nurse) #4 on 10/12/18 at 8:24 a.m. and with RN #1 on 10/12/18 at 8:37 a.m. confirmed the process as identified above. RN #1 confirmed that if the chart did not have any additional prescriptions for Norco, then the Norco was not reordered for this resident. When advised that nursing notes indicate that the medication was on order, RN #1 stated, "I don't know why they said that as the chart and the pharmacy manifests do not indicate this medication was in the process of being reordered." When asked if it was possible that the nursing staff failed to obtain a renewal for the Norco, RN #1 stated, "It is possible."

ASM (administrative staff member), #1, the executive director, ASM #2, the director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, and RN #1, where made aware of the above concerns on 10/12/18 at 12:35 p.m.

According to "Lippincott Manual of Nursing Practice", Seventh Edition: by Lippincott Williams & Wilkins, pg. 1141-1143 reads: "Quality pain

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F 658	Continued From page 69 management results when patients have access to safe, effective pain relief measures. Healthcare providers in addition to monitoring, delivering, and documenting administration of analgesics, also have responsibility to inform patients that effective pain relief is vital to their treatment. Patients also have the right to expect that their statements of pain will be heeded quickly." No further information was provided prior to exit. Complaint Deficiency 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/cellulitis.html 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a601006.html 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a681004.html	F 658		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 693		11/10/18

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F 693	Continued From page 70 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide care and services for one of 34 residents in the survey sample, Residents # 160. The facility staff failed to provide Resident # 106's PEG (percutaneous endoscopic gastrostomy) tube dressing changes according to the physician's order. The findings include: Resident # 160 was admitted to the facility on 10/04/2018 with diagnoses that included but were not limited to: respiratory failure (1), T-cell lymphoma (2), anemia (3) and vocal cord paralysis (4), PEG [percutaneous endoscopic gastrostomy (5)]-Tube, and NPO [nothing by mouth (6)]. Resident # 160's most recent MDS (minimum data set), was not completed at the time of	F 693	F 693 1. Resident #160's peg tube dressing order was clarified and the dressing was changed on 10/10/18. 2. A Professional standard of practice quality review was completed on 11/1/18 for all with peg tubes and no other deficient practices were noted. 3. The Physician orders policy was reviewed and no changes are warranted at this time. Nurses re-educated on this policy on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Professional standard of practice quality monitor weekly times 4 weeks then for 10 residents per month to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring scheduled modified based on findings	

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F 693	Continued From page 71 survey. The nursing admission assessment for Resident # 160 dated 10/04/10 documented, "Communication: Non-speech, usually understood and usually understands. Functional Status: Totally dependent for activities of daily living, orientated xs (times) 3 (three) [person, place time]." During an observation of Resident # 160 on 10/10/18 at 10:06 a.m., Resident # 160's daughter asked this surveyor to look at Resident # 160's g-tube dressing. The daughter stated that the dressing had not been changed. Resident # 160's daughter asked her father to show this surveyor his G-tube dressing. With permission from Resident # 160, this surveyor observed the dressing on Resident # 160's abdomen. Further observation of the dressing revealed it was dated "10/06/18." The POS (physician order sheet) dated 10/05/18 for Resident # 160 documented, "QD (every day) Peg tube DSG (dressing) change. Clean site with soap and water." Review of the MAR (medication administration record) and TAR (treatment administration record) dated October 2018 for Resident # 160 failed to evidence documentation of the physician's order for Resident # 160's dressing change. The baseline care plan for Resident # 160 dated 10/04/18 documented, "Nutrition and Hydration." Under "Resident Goal" it documented, "Will Maintain stable weight." Under "Interventions" it documented, "Tube feeding and flushes as ordered. NPO (nothing by mouth) with oral hygiene." Further review of the baseline care	F 693	5. All corrective action will be completed by 11/10/18.	

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plan for Resident # 160 did not evidence documentation of Resident # 160's PEG-tube dressing change.

On 10/12/18 at 11:05 a.m., an interview was conducted with RN # 1, the assistant director of nursing. When asked about the treatment and physician's order for Resident # 160's G-tube dressing change, RN # 1 stated, "It should be documented as a treatment." When informed of the observation on 10/10/18 of Resident # 160's G-tube dressing dated 10/06/18, RN # 1 stated it should have been done each time (Resident # 160's) tube feeding is hung up.

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Lippincott."

No further information was provided prior to exit.

References:
(1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(2) Lymphoma is a cancer of a part of the immune system called the lymph system. There are many types of lymphoma. One type is Hodgkin disease. The rest are called non-Hodgkin lymphomas. Non-Hodgkin

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lymphomas begin when a type of white blood cell, called a T cell or B cell, becomes abnormal. The cell divides again and again, making more and more abnormal cells. These abnormal cells can spread to almost any other part of the body. Most of the time, doctors don't know why a person gets non-Hodgkin lymphoma. You are at increased risk if you have a weakened immune system or have certain types of infections. This information was obtained from the website: http://salud.wikiplus.org/medlineplus/lymphoma.html.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) A multifacted problem that affects patients of all ages and presents initially to a wide range of healthcare professionals. It can cause laryngeal dysfunction ranging from slight hoarseness to life-threatening airway obstruction. When confronted with a patient with new onset vocal cord paralysis, the physician should determine the etiology of the paralysis. Only after an accurate diagnosis, can restoration of laryngeal function be addressed. Peripheral lesions injuring the vagus nerve or its branches are responsible for 90% of all vocal cord paralysis. Etiologies include neoplasms, surgical iatrogenic injury, and blunt and penetrating trauma in the head, neck, and thorax. Thyroid surgery has historically been accountable for almost a third of reported unilateral vocal cord paralyses. However, recent review has demonstrated a dramatic reduction in this incidence to less than 5%. Numerous treatment options exist for patients with vocal cord paralysis. These treatments can drastically

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F 693	Continued From page 74 reduce the social and economic disability incurred by these patients. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/9770942. (5) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm. (6) Nothing by mouth. This information was obtained from the website: https://www.merriam-webster.com/medical/NPO.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to ensure respiratory care and services were provided for seven of 34 residents in the survey sample, Residents #211, 26, 158, 3, 44, 13, and	F 695	F 695 1. A physician's order was obtained for the home CPAP for Resident #211 on 10/12/18. Respiratory equipment for Residents #26, 158, 3, 44, and 7 was	11/10/18

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F 695	Continued From page 75 7. 1. The facility staff failed to ensure that they had a physician's order for Resident #211's use, in the facility, of his home CPAP (continuous positive airway pressure) machine. 2. The facility staff failed to store Resident #26's oxygen equipment in a sanitary manner. 3. The facility staff failed to store Resident # 158's C-PAP [continuous positive airway pressure] (1) mask in a sanitary manner. 4. The facility staff failed to store Resident # 3's nebulizer mask in a sanitary manner. 5. The facility staff failed to store Resident #44's nebulizer mask in a sanitary manner. 6. The facility staff failed to administer Resident # 13's oxygen according to physician's orders. 7. The facility staff failed to store Resident # 7's nebulizer mask in a sanitary manner. The findings include: 1. The facility staff failed to ensure that they had a physician's order for Resident #211's use, in the facility, of his home CPAP (continuous positive airway pressure) machine. Resident #211 was admitted to the facility on 10/5/18 with diagnoses that included but were not limited to: arthritis in his knees, muscle weakness, difficulty in walking, high blood pressure and left total knee replacement.	F 695	replaced and placed in a sanitary storage bag on 10/12/18. Resident #13's attending physician in collaboration with Hospice clarified residents order for oxygen to be 3 LPM on 10/11/18. 2. An oxygen observation/respiratory equipment quality review was completed on 10/30/18 for residents using respiratory equipment and no other deficient practices were noted. 3. The Equipment Change policy was reviewed and updated to include sanitary storage of respiratory equipment. Nurses re-educated on this updated policy on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the Oxygen observation/respiratory equipment quality monitoring weekly times 4 weeks then for 10 residents per month to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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The admission assessment completed on 10/5/18 documented that Resident #211 was alert with independent cognitive skills for decision-making. In addition, he was noted as being able to make self-understood as well as being able to understand others. The resident was documented as requiring the assistance of one staff member for bed mobility, transfers, ambulation, and bathing.

On 10/10/18 at 8:00 a.m., Resident #211 was observed reclining in bed. A CPAP machine, [a treatment that uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep (1)], mask, and gallon of distilled water was observed on his bedside table.

On 10/10/18 at 2:30 p.m., Resident #211 was interviewed in his room. When asked about the CPAP machine, Resident #211 stated that he suffered with sleep apnea and the machine in the facility was his own. Resident #211 stated, "I told the doctor I would rather use my own machine than one that is rented or available in the facility. I know my mask is clean and I keep my machine clean." Resident #211 verified that he used the CPAP machine while sleeping unless "I fall asleep before I put it on."

On 10/12/18 at 8:45 a.m., review of the physician's orders for Resident #211 failed to indicate the resident was to use a CPAP machine.

An interview was conducted on 10/12/18 at 8:47 a.m. with RN (registered nurse) #1, the assistant director of nursing. RN #1 was asked to provide the physician's orders for Resident #211's CPAP.

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RN #1 stated, "I do not believe he has a CPAP." When informed that it had been observed on his bedside table on multiple occasions during the survey, RN #1 stated, "We will obtain the order for him to use his home CPAP machine." A review of the hospital orders, dated 10/1/18, with RN #1, documented that the resident used a home CPAP machine

On 10/12/18 at 9:15 a.m., Resident #211 was asked when the home machine was brought in to the facility for his use. He stated his sister brought it in on 10/6/18, the day after he was admitted to the facility.

A review of the baseline care plan dated 10/7/18, failed to document the resident's use of a CPAP machine for respiratory treatment.

ASM (administrative staff member), #1, the executive director, ASM #2, the director of nursing, ASM #3, regional director of clinical services, ASM #4, regional director of clinical services, and RN #1, where made aware of the above concerns on 10/12/18 at 12:35 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001916.htm

2. The facility staff failed to store Resident #26's oxygen equipment in a sanitary manner.

Resident #26 was admitted to the facility on 1/11/17 with the diagnoses of but not limited to oxygen dependence, dementia, heart failure, respiratory failure, atherosclerosis, anxiety

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disorder, hydrocephalus, cerebral fluid drainage device, peripheral vascular disease, chronic obstructive pulmonary disease, pulmonary embolism, atrial fibrillation, dysphagia, angina, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 9/11/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bed mobility, dressing, and toileting; extensive assistance for bathing, transfers and hygiene; supervision for eating; and was incontinent of bowel and bladder.

On 10/10/18 at approximately 12:30 p.m., Resident #26 was observed in the dining room for lunch. The resident's oxygen tubing was observed hanging on the back of the wheel chair, draped over the oxygen tank. The nasal cannula end of the tubing was not in use and was not in a bag to prevent contamination.

On 10/10/18 at 1:48 p.m., Resident #26 was observed up in her wheel chair in her room. There was no change in the status of the oxygen tubing from the previous observation.

A review of the clinical record revealed an order dated 4/18/18 that documented, "Oxygen at 2LPM (two liters per minute) via nasal cannula as needed [for] sats (oxygen saturation) less than 90%."

On 10/11/18 at 4:53 p.m., in an interview was conducted with RN #2 (Registered Nurse) she stated that when the resident is not wearing the oxygen, the tubing should be in a bag for infection control purposes.

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A review of the care plan "(Resident #26) has an ineffective breathing pattern r/t (related to) dx (diagnosis) of CHF (congestive heart failure) AEB (as evidenced by) increased anxiety when attempting to wean her oxygen per MD (medical doctor)" dated 2/21/18, did not include any interventions for maintaining the oxygen equipment in a sanitary manner.

A review of the care plan "(Resident #26) has decreased cardiac output r/t CHF and paroxamal A-fib (atrial fibrillation) AEB SOB (shortness of breath) with exertion, increased anxiety related to her oxygen. Chronic hypoxia related to Respiratory failure, PE (pulmonary embolism), has VP shunt/hydrocephalus" dated 2/21/18, did not include any interventions for maintaining the oxygen equipment in a sanitary manner.

A review of the facility policy that was provided, "Equipment Change Schedule" did not document any criteria for maintaining the nasal cannula tubing in a sanitary manner.

On 10/11/18 at 4:30 PM at the end of day meeting, ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to store Resident # 158's C-PAP [continuous positive airway pressure (1)] mask in a sanitary manner.

Resident # 158 was admitted to the facility on 10/04/2018 with diagnoses that included but were not limited to: fractured femur, muscle weakness and a history of falling. Resident # 158's most

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recent MDS (minimum data set), was not due at the time of survey. The nursing admission assessment for Resident # 158 dated 10/04/10 documented, "Communication: Non-speech, usually understood and usually understands. Functional Status: Assistance of one staff member for activities of daily living, orientated xs (times) 3 (three) [person, place time]."

On10/10/18 at 7:58 a.m., an observation of Resident # 158 revealed he was sitting up in his wheelchair watching television. Observation of the bedside table revealed a C-PAP mask setting on the CPAP machine uncovered.

On 10/11/18 at 1:25 p.m., an observation of Resident # 158 revealed he was sitting up in his wheelchair conversing with a visitor. Observation of the bedside table revealed a C-PAP mask setting on the CPAP machine uncovered.

On 10/12/18 at 10:49 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure for storing respiratory equipment, LPN # 4 stated, "All tubing and masks should be dated and placed in a bag with their name and room number on it when not in use." When asked why it was important to store respiratory in a bag when not in use, LPN stated, "To avoid bacteria growing on it."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

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No further information was provided prior to exit.

References:
(1) CPAP is an airway treatment that applies a constant pressure of forced air to keep the airway open. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9685.htm.

4. The facility staff failed to store Resident # 3's nebulizer mask in a sanitary manner.

Resident # 3 was admitted to the facility on 07/10/14 with diagnoses that included but were not limited to: diabetes mellitus (1), peripheral vascular disease (2), depressive disorder (3) and hypertension (4).

Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/11/18, coded Resident # 3 as scoring a 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive to total assistance of one staff member for activities of daily living.

On 10/10/18 at 8:06 a.m., an observation of Resident # 3 revealed he was sitting up in his wheelchair watching television. Observation of the bedside table revealed a nebulizer mask setting on the nebulizer uncovered.

On 10/10/18 at 9:26 a.m., during an interview with Resident # 3, an observation of the bedside table revealed a nebulizer mask laying on the bedside

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table uncovered.

On 10/10/18 at 1:39 p.m., Resident # 3 was not in his room. An observation of the bedside table revealed a nebulizer mask laying on the bedside table uncovered.

On 10/11/18 at 7:02 a.m., an observation of Resident # 3 revealed he was sitting up in his wheelchair watching television. Observation of the bedside table revealed a nebulizer mask setting on the nebulizer uncovered.

On 10/12/18 at 10:49 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure for storing respiratory equipment, LPN # 4 stated, "All tubing and masks should be dated and placed in a bag with their name and room number on it when not in use." When asked why it was important to store respiratory in a bag when not in use, LPN stated, "To avoid bacteria growing on it."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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(2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

5. The facility staff failed to store Resident #44's nebulizer mask in a sanitary manner.

Resident # 44 was admitted to the facility on 02/28/17 with diagnoses that included but were not limited to: atrial fibrillation (1), chronic obstructive pulmonary disease (2), depressive disorder (3) and hypertension (4).

Resident # 44's most recent MDS (minimum data

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set), a quarterly assessment with an ARD (assessment reference date) of 09/14/18, coded Resident # 44 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 44 was coded as requiring limited assistance of one staff member for activities of daily living.

On 10/10/18 at 8:03 a.m., an observation of Resident # 44 revealed he was lying in bed, awake. Observation of the bedside table revealed a nebulizer mask laying on the bedside table uncovered.

On 10/10/18 at 1:44 p.m., an observation of Resident # 44 revealed he was not in his room. Observation of the bedside table revealed a nebulizer mask laying on the bedside table uncovered.

On 10/10/18 at 3:35 p.m., an observation of Resident # 44 was lying in bed, awake. Observation of the bedside table revealed a nebulizer mask laying on the bedside table uncovered.

On 10/12/18 at 10:49 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure for storing respiratory equipment, LPN # 4 stated, "All tubing and masks should be dated and placed in a bag with their name and room number on it when not in use." When asked why it was important to store respiratory in a bag when not in use, LPN stated, "To avoid bacteria growing on it."

On 10/12/18 at approximately 5:00 p.m., ASM

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(administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/copd.html.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:
https://medlineplus.gov/ency/article/003213.htm.

(4) High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. The facility staff failed to administer Resident # 13's oxygen according to physician's orders.

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Resident # 13 was admitted to the facility on 05/16/18 with diagnoses that included but were not limited to: atrial fibrillation (1), diabetes mellitus (2), chronic kidney disease (3) and hypertension (4).

Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/18, coded Resident # 13 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 13 was coded as being totally dependent of one staff member for all activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 49 was coded for "C. Oxygen therapy."

On 10/10/18 at 8:31 a.m., an observation of Resident # 13 revealed she was lying in bed asleep, appeared clean, receiving oxygen by nasal cannula. Observation of the oxygen concentrator revealed the oxygen flow rate was between two and a half and three liters per minute.

On 10/10/18 at 1:58 p.m., an observation of Resident # 13 revealed she was lying in bed asleep, receiving oxygen by nasal cannula, connected to an oxygen concentrator. Observation of the oxygen concentrator revealed the oxygen flow rate was set between two and a half and three liters per minute.

On 10/11/18 at 9:24 a.m., an observation of Resident # 13 revealed she was sitting up in bed participated receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed

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the oxygen flow rate was set between two and a half and three liters per minute.

On 10/11/18 at 5:00 p.m., an observation of Resident # 13 revealed she was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed the oxygen flow rate was set between two and a half and three liters per minute.

The POS (physician order sheet) for Resident # 13 dated 10/01/2018 and signed by the physician on 10/02/18 documented, "05/16/18: Oxygen at 2L/MIN (two liters per minute) as needed for shortness of breath."

The comprehensive care plan dated 09/01/2018 for Resident # 13 documented, "(Resident # 13) has the potential for an effective breathing pattern r/t (related to) heart failure, End stage disease process, shortness of breath when lying flat, Oxygen use. Date initiated: 09/01/2018." Under "Interventions" it documented, "Oxygen via (by) NC (nasal cannula) as ordered. Date initiated: 09/01/2018."

On 10/11/18 at 5:05 p.m., an interview was conducted with RN (registered nurse) # 2. When asked how the oxygen flow rate is read on the oxygen concentrator, RN # 2stated, "Turn the knob to adjust the ball to the liter line. The liter line should pass through the middle of the ball." When asked what the oxygen flow rate for Resident # 13 should be, RN # 2 retrieved the clinical record for Resident # 13, and look at the physician order sheet. RN #2 then stated, "Two liters per minute." RN # 2 was then asked to accompany this surveyor to Resident # 13's room

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ENVOY OF WINCHESTER, LLC	110 LAUCK DR WINCHESTER, VA 22603

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and was asked to read the oxygen flow rate on Resident # 13's oxygen concentrator. After entering the residents room RN #2 observed Resident #13's oxygen concentrator settings. RN # 2 then stated, "It's between two and a half and three liters per minute." When asked how often the oxygen flow rate should be checked, RN # 2 stated, "Every shift and if the oxygen saturation changes." When asked why it was important to maintain the oxygen flow rate according to the physician's orders, RN # 2 stated, "It could raise their CO2 (carbon dioxide) level."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website:
https://medlineplus.gov/chronickidneydisease.htm

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(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

7. The facility staff failed to store Resident # 7's nebulizer mask in a sanitary manner.

Resident # 7 was admitted to the facility on 03/02/17 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), diabetes mellitus (2), dementia (3) and hypertension (4).

Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/24/18, coded Resident # 7 as scoring a (2) two on the brief interview for mental status (BIMS) under "Staff Assessment for Mental Status." A score of 2 (two) - being moderately impaired of cognition for making daily decisions. Resident # 7 was coded as being independent for all activities of daily living.

On 10/10/18 at 7:49 a.m., an observation of Resident # 7 revealed he was lying in bed, awake. Observation of the bedside table revealed a plastic tub with a nebulizer mask laying in the tub uncovered.

On 10/10/18 at 1:40 p.m., an observation of Resident # 7 revealed he was lying in bed, awake. Observation of the bedside table revealed a plastic tub with a nebulizer mask laying in the tub uncovered.

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On 10/12/18 at 10:49 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure for storing respiratory equipment, LPN # 4 stated, "All tubing and masks should be dated and placed in a bag with their name and room number on it when not in use." When asked why it was important to store respiratory in a bag when not in use, LPN stated, "To avoid bacteria growing on it."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Lippincott."

No further information was provided prior to exit.

References:
(1) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:

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F 695	Continued From page 91 https://medlineplus.gov/ency/article/000739.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 695		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and facility document review, it was determined that the facility staff failed to serve food at palatable temperatures and flavor during the evening meal service. The findings include: On 10/11/18 at 2:00 p.m., a group interview was conducted with nine current facility residents. All the residents in the group had complaints about the food being cold and not of good quality flavor. They said the food is not hot and is either undercooked or overcooked and tastes nasty. They stated if the staff had to eat the same food, they would not want it.	F 804	F804 1. Food is served at appropriate temperatures and palatability . 2. A quality review of food preparation completed on 10/23/18 and no other issues of temperature or poor taste was noted. 3. The facilities menu and recipes were reviewed with residents. Updates were made per Resident Council requests. The policy on Food Quality was reviewed and no changes were warranted at this time. Nutrition Staff re- educated on these polices on or before 11/10/18. A Resident During Resident Council residents to be queried regarding meals. Food Committee has been established 4. The Dietary Manager is responsible for	11/10/18

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F 804	Continued From page 92 On 10/11/18 at 4:56 p.m., an observation was made of the evening meal, tray line service. The following food items and temperatures were taken at the steam table by OSM #4 (Other Staff Member) the cook, with a facility thermometer: Sloppy joe 164 degrees Squash 183 degrees Mashed potatoes 154 degrees Peas 160 degrees Pureed sloppy Joe 175 degrees Pureed peas 163 degrees On 10/11/18 at 5:28 p.m., a test tray was requested for the last cart. On 10/11/18 at 5:47 p.m., the last cart left the kitchen to the unit. On 10/11/18 at 5:57 p.m., after all residents were served, the temperatures were taken of the test -tray food items by OSM #1 the Dietary Manager, with a facility thermometer, and were as follows: Sloppy joe 135 degrees, a 29 degree drop from the steam table temperature. Squash 140 degrees, a 43-degree drop from the steam table temperature. Mashed potatoes 137 degrees, a 17 degree drop from the steam table temperature. Peas 129 degrees, a 31 degree drop from the steam table temperature. Pureed sloppy Joe 134 degrees, a 41-degree drop from the steam table temperature. Pureed peas 127 degrees, a 36 degree drop from the steam table temperature. On 10/11/18 at approximately 6:00 p.m., two surveyors and OSM #1 tasted the food. All	F 804	maintaining compliance. The Dietary Manager/designee to complete the "Nutrition Services Audit Tool" twice per week to ensure food is served at a palatable temperature. Residents interviewed at the Resident Council committee monthly to ensure food taste and temperature is palatable. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring scheduled modified based on findings 5. Corrective Action will be completed on or before 11/10/18.	

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F 804	Continued From page 93 agreed that none of the food was at palatable temperatures. All agreed that the flavor was bland, poor to fair quality of flavor, and had no seasoning of any kind. OSM #1 stated that she could not put salt on the food due to some residents having salt restrictions on their diets; however, she also stated did not use anything else to season and flavor the food either. On 10/11/18 at approximately 6:15 p.m., ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. On 10/12/18 at 8:18 a.m., in an interview with OSM #3 the District Dietary Manager, she stated that the recipes were followed but that improvement could be made to add flavor and seasoning. A review of the facility policy, "Food: Quality and Palatability" documented, "Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature." No further information was provided by the end of the survey.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		11/10/18

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F 812	Continued From page 94 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to store and serve food in a sanitary manner. 1. The facility staff failed to store food in a sanitary manner. Food items were observed in the refrigerator and freezer, opened, and not resealed, exposing the food to the environment and potential contamination. 2. The facility staff failed to serve food in a sanitary manner. The cook was observed on tray line service touching multiple items with her gloved hands and then touching residents' food with the same gloves. The findings include: 1. The facility staff failed to store food in a sanitary manner. Food items were observed in the refrigerator and freezer, opened, and not resealed, exposing the food to the environment and potential contamination.	F 812	F 812 1. The turkey, sausage, beefsteak and hotdogs were discarded on 10/10/18. The cook was educated on 10/12/18 on handling food in a sanitary manner. 2.. All kitchen refrigerators/Freezers were checked on 10/12/18 for any open items and no issues were noted. A quality review of food preparation was completed on 10/23/18 and no other issues of sanitation was noted. 3. The policies Food Storage and Food preparation were reviewed and no changes were warranted at this time. Nutrition Staff re- educated on these polices on or before 11/10/18. 4. The Dietary Manager is responsible for maintaining compliance. The Dietary Manager/designee to comlete the “Nutrition Services quality monitoring daily times 2 weeks then twice per week to ensure food is not open to the air and food is prepared in a sanitary manner. Follow up based on findings and reported to the facilities monthly QAPI meeting.	

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F 812	Continued From page 95 On 10/10/18 at 8:03 a.m., a tour of the kitchen was conducted. The following concerns were identified: A box of white turkey patties was observed in the freezer, opened, and not resealed. The meat was exposed to the environment of the freezer. A box of sausage links was observed in the freezer, opened, and not resealed. The meat was exposed to the environment of the freezer. A box of beefsteak fritters was observed in the freezer, opened, and not resealed. The meat was exposed to the environment of the freezer. A package of hot dogs was observed in the refrigerator, opened and not resealed. The meat was exposed to the environment of the freezer. On 10/10/18 at 12:10 p.m., in an interview with OSM #1 (Other Staff Member) the dietary manager, she stated that these items should have been sealed shut. She stated the beefsteak fritter was on the menu on Saturday (10/6/18). OSM #1 stated the turkey patties was used as alternates "within the last week" (approximately 10/1/18 to 10/9/18). OSM #1 stated the sausage links were opened Monday morning (10/8/18). Each item had been opened for several days and it could not be stated how long they had remained unsealed in the refrigerator or freezer. On 10/12/18 at 8:18 a.m., in an interview with OSM 3, the District Dietary Manager, she stated the items should have been sealed. A review of the facility policy, "Food Storage: Cold	F 812	Quality Monitoring schedule modified base don findings. 5. Corrective Action will be completed on or before 11/10/18.	

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Foods" documented, "5. All foods will be wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination."

On 10/11/18 at 4:30 p.m., ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to serve food in a sanitary manner. The cook was observed on tray line service touching multiple items with her gloved hands and then touching residents' food with the same gloves.

On 10/11/18 at 4:56 p.m., an observation was made of the evening meal tray- line service. OSM #4 (Other Staff Member) the cook, was observed wearing gloves, however, she was observed touching multiple items such as plates, dome lid covers for the plates, serving spoons, and bowls, and then grabbing rolls for the sloppy joes, to put on the residents plates, wearing the same gloves. She was observed placing her gloved hands, which had touched multiple items, directly on the center of the plates, flat handed and she laid the outer edge of her hand along the edge of the plate on the top side of the plate as she plated food items. She was observed cupping her thumb and index or middle finger (varied back and forth as to which finger she used) as if to contain the food items into the area formed by her thumb and index or middle finger. OSM #4 was observed completing all of this with the same gloves on, that she had worn and touched multiple items with and then touching the

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F 812	Continued From page 97 food at times during the process of plating the food in this manner. On several occasions, OSM #4 left the steam table area to obtain other items. When she returned, she did change her gloves; however, she then repeated the process of touching multiple items as previously identified, contaminating her gloves again, and then touching the buns and other food items again. On 10/12/18 at 8:13 a.m., in an interview with OSM #4, when informed of the above observation, she stated that it was not sanitary. On 10/12/18 at 8:18 a.m., in an interview with OSM #3, the District Dietary Manager, when informed of the above observation, she stated that it was not sanitary. A review of the facility policy, "Food: Preparation" documented, "...2. The Food Services Director or Cook(s) are responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination....11. All staff will use serving utensils appropriately to prevent cross contamination...." On 10/12/18 at 12:59 p.m., at the end of day meeting, ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey.	F 812		
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.	F 842		11/10/18

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

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

§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.

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F 842	Continued From page 99 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for one of 34 residents in the survey sample, Resident # 160. The facility staff failed document the bathing schedule and preference on Resident # 160's kardex. The findings include: Resident # 160 was admitted to the facility on	F 842	F842 1. Resident #160's kardex was updated 10/10/18 to include his preferences for bathing. 2. Residents were interviewed for bath preferences and Kardex update and a quality review was completed on 10/20/18 for residents and no other deficient practices were noted. 3. The Clinical/Medical Records policy was reviewed and no changes are warranted at this time. Nurses	

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F 842	Continued From page 100 10/04/2018 with diagnoses that included but were not limited to: respiratory failure (1), T-cell lymphoma (2), anemia (3) and vocal cord paralysis (4), PEG [percutaneous endoscopic gastrostomy (5)]-Tube, and NPO [nothing by mouth (6)]. Resident # 160's most recent MDS (minimum data set), was not completed at the time of survey. The nursing admission assessment for Resident # 160 dated 10/04/10 documented, "Communication: Non-speech, usually understood and usually understands. Functional Status: Totally dependent for activities of daily living, orientated xs (times) 3 (three) [person, place time]." On 10/10/18 at 9:58 a.m., during an observation was conducted of Resident # 160 in his room in the presence of Resident # 160's daughter. Resident # 160's daughter expressed a concern regarding her father's bathing/showering. Resident # 160's daughter stated, "He does not get a bed bath every day. He arrived on the 4th and he has only received one bed bath on Sunday the 7th (seventh)." The facility's "Daily Showers" schedule documented, "(Room) 40B (Resident # 160) 3 to 11 (3:00 p.m. to 11:00 p.m. shift) Tuesday and Friday." The facility's activities of daily living tracking form entitled, "Documentation Survey Report v2 Oct - 18 (October 2018)" documented, "Resident: (Name of Resident # 160). Intervention/Task - Bathing." Further review of the form revealed documentation that Resident # 160 received a bed bath on Friday 10/05/18 at 2:59 p.m., Sunday	F 842	re-educated on this policy on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the kardex quality monitor for 10 residents per week times for weeks the 10 residents per month to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring scheduled modified based on findings 5. All corrective action will be completed by 11/10/18.	

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10/07/18 at 6:59 a.m., and Tuesday 0/09/18 at 9:39 p.m. The form also documented Resident # 160 received partial bed baths on Monday 10/08/18 at 10.13 p.m. and on Wednesday 10/10/18 at 2:48 a.m. and at 2:50 p.m.

The kardex for Resident # 160 was reviewed and was blank under the section "Bathing".

On 10/11/18 at 11:20 a.m., an interview was conducted with CNA (certified nursing assistant) # 1. When asked to describe the procedure for resident bathing, CNA # 1 stated, "Residents get baths or showers two times a week. We also give partials which includes washing their face, under arms, their bottom and private areas." When asked about the kardex, CNA # 1 stated, "It tells us how to take care of the resident and how much assistance they need." After reviewing Resident # 160's kardex, CNA # 1 stated, "Based on the kardex you can't tell what his preference is for bathing or showering. When asked who completes the kardex for the resident, CNA # 1 stated, "The admitting the nurse."

On 10/11/18 at approximately 1:30 a.m., interview was conducted with RN (registered nurse) # 1, assistant director of nursing. After reviewing Resident # 160's kardex, RN # 1 stated, "It's incomplete, the bathing section is blank." When asked about the kardex, RN # 1 stated, "It's an outline for CNAs to care for the residents." When asked if it was part of a resident's clinical record, RN # 1 stated, "Yes." When asked how staff would know bathing requirements for Resident # 160, if Resident # 160's kardex was incomplete, and RN # 1 stated, "I agree with you."

The facility's policy "Clinical/Medical Records"

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documented, "The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(2) Lymphoma is a cancer of a part of the immune system called the lymph system. There are many types of lymphoma. One type is Hodgkin disease. The rest are called non-Hodgkin lymphomas. Non-Hodgkin lymphomas begin when a type of white blood cell, called a T cell or B cell, becomes abnormal. The cell divides again and again, making more and more abnormal cells. These abnormal cells can spread to almost any other part of the body. Most of the time, doctors don't know why a person gets non-Hodgkin lymphoma. You are at increased risk if you have a weakened immune system or have certain types of infections. This information was obtained from the website: http://salud.wikiplus.org/medlineplus/lymphoma.html.

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(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) A multifacted problem that affects patients of all ages and presents initially to a wide range of healthcare professionals. It can cause laryngeal dysfunction ranging from slight hoarseness to life-threatening airway obstruction. When confronted with a patient with new onset vocal cord paralysis, the physician should determine the etiology of the paralysis. Only after an accurate diagnosis, can restoration of laryngeal function be addressed. Peripheral lesions injuring the vagus nerve or its branches are responsible for 90% of all vocal cord paralysis. Etiologies include neoplasms, surgical iatrogenic injury, and blunt and penetrating trauma in the head, neck, and thorax. Thyroid surgery has historically been accountable for almost a third of reported unilateral vocal cord paralyses. However, recent review has demonstrated a dramatic reduction in this incidence to less than 5%. Numerous treatment options exist for patients with vocal cord paralysis. These treatments can drastically reduce the social and economic disability incurred by these patients. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/9770942.

(5) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website:

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F 842	Continued From page 104 https://medlineplus.gov/ency/patientinstructions/000900.htm. (6) Nothing by mouth. This information was obtained from the website: https://www.merriam-webster.com/medical/NPO.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		11/10/18

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F 880	Continued From page 105 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to	F 880	F880 1. Resident #160's suction yankauer was replaced and placed in a sanitary	

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F 880	Continued From page 106 implement infection control practices for one of 34 residents in the survey sample, Resident # 160. 1a. The facility staff failed to store Resident # 160's suction Yankauer (7) and tubing in a sanitary manner. 1b. The facility staff failed to wash hands and change gloves during Resident # 160's wound care. The findings include: 1a. The facility staff failed to store Resident # 160's suction Yankauer (7) and tubing in a sanitary manner. Resident # 160 was admitted to the facility on 10/04/2018 with diagnoses that included but were not limited to: respiratory failure (1), T-cell lymphoma (2), anemia (3) and vocal cord paralysis (4), PEG [percutaneous endoscopic gastrostomy (5)]-Tube, and NPO [nothing by mouth (6)]. Resident # 160's most recent MDS (minimum data set), was not completed at the time of survey. The nursing admission assessment for Resident # 160 dated 10/04/10 documented, "Communication: Non-speech, usually understood and usually understands. Functional Status: Totally dependent for activities of daily living, orientated xs (times) 3 (three) [person, place time]." On 10/10/18 at 8:24 a.m., Resident # 160 was observed turning on the suction machine, picking up the Yankauer suction tube (7) that was lying	F 880	storage bag on 10/10/18. RN #2 was re-educated on hand hygiene and use of gloves during wound care on 10/11/18. 2. A respiratory equipment quality review was completed on 10/30/18 for all residents and no other deficient practices were noted. A quality review on wound care provision was completed on 10/30/18 and no other deficient practices were noted. 3. The Equipment change and PPE policies were reviewed and no changes are warranted at this time. Nurses re-educated on these policies on or before 11/10/18. 4. The Administrator is responsible for maintaining compliance. The DCS/designee to complete the respiratory equipment quality monitor and wound care provision quality monitor for 10 residents weekly times 4 weeks then 10 residents per month to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. All corrective action will be completed by 11/10/18.	

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over the suction machine uncovered, and then suctioning himself. Resident #160 was then observed turning off the suction machine and replacing the Yankauer suction tube back over the suction machine.

On 10/10/18 at 9:58 a.m., an observation of Resident # 160 revealed he was lying in bed, turning on the suction machine, picking up the Yankauer suction tube that was lying over the suction machine uncovered, suctioning himself, turning off the suction machine and replacing the Yankauer suction tube back over the suction machine.

On 10/10/18 at 12:00 p.m., an observation of Resident # 160 revealed he was lying in bed, turning on the suction machine, picking up the Yankauer suction tube that was lying over the suction machine uncovered, suctioning himself, turning off the suction machine and replacing the Yankauer suction tube back over the suction machine.

The POS (physician order sheet) dated 10/05/18 for Resident # 160 documented, "Oral suctioning @ (at) bedside for excessive secretions PRN (as needed). Resident may section self."

Review of the baseline care plan for Resident # 160 dated 10/04/18 failed to evidence documentation of Resident # 160's ability to section his own secretions.

On 10/11/18 at 10:24 a.m., an interview was conducted with RN (registered nurse) # 1, assistant director of nursing. When asked to describe the care of the suction tubing and Yankauer, RN # 1 stated, "It should be changed

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out weekly and prn (as needed) if there is secretion in the Yankauer, and the tubing. There should be a sleeve for the Yankauer to be placed in when not in use. Typically all oxygen tubing, nasal cannula, suctioning tubing, and Yankauer, and nebulizer tubing get changed out." When asked if the tubing and Yankauer are dated, RN # 1 stated, "It should be dated on the tubing and the Yankauer." At 10:40 a.m., RN # 1 accompanied this surveyor to Resident # 160's room. Upon entering the room an observation of Resident # 160's suction machine, suctioning tubing and Yankauer was conducted with RN # 1. When asked if the suctioning tubing and Yankauer was dated, RN # 1 examined the suctioning tubing and Yankauer and stated, "No, it's probably the same tubing and Yankauer he had when he came in." When asked about the sleeve for the Yankauer, RN # 1 examined inside and outside of the bedside table and stated, "There isn't a sleeve. It should be hanging from the machine to place the Yankauer in when it isn't in use." When asked why it was important to date the suctioning tubing and Yankauer and have a sleeve to place the Yankauer in when it is not being used, RN # 1 stated, "To prevent infection and to make sure we are changing it out."

On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) When not enough oxygen passes from your

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lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(2) Lymphoma is a cancer of a part of the immune system called the lymph system. There are many types of lymphoma. One type is Hodgkin disease. The rest are called non-Hodgkin lymphomas. Non-Hodgkin lymphomas begin when a type of white blood cell, called a T cell or B cell, becomes abnormal. The cell divides again and again, making more and more abnormal cells. These abnormal cells can spread to almost any other part of the body. Most of the time, doctors don't know why a person gets non-Hodgkin lymphoma. You are at increased risk if you have a weakened immune system or have certain types of infections. This information was obtained from the website: http://salud.wikiplus.org/medlineplus/lymphoma.html.

(3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(4) A multifacted problem that affects patients of all ages and presents initially to a wide range of healthcare professionals. It can cause laryngeal dysfunction ranging from slight hoarseness to life-threatening airway obstruction. When confronted with a patient with new onset vocal cord paralysis, the physician should determine the etiology of the paralysis. Only after an accurate diagnosis, can restoration of laryngeal function be addressed. Peripheral lesions injuring the vagus nerve or its branches are responsible

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for 90% of all vocal cord paralysis. Etiologies include neoplasms, surgical iatrogenic injury, and blunt and penetrating trauma in the head, neck, and thorax. Thyroid surgery has historically been accountable for almost a third of reported unilateral vocal cord paralyses. However, recent review has demonstrated a dramatic reduction in this incidence to less than 5%. Numerous treatment options exist for patients with vocal cord paralysis. These treatments can drastically reduce the social and economic disability incurred by these patients. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/9770942.

(5) A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm.

(6) Nothing by mouth. This information was obtained from the website: https://www.merriam-webster.com/medical/NPO.

(7) A rigid hollow tube made of metal or disposable plastic with a curve at the distal end to facilitate the removal of thick pharyngeal secretions during oral pharyngeal suctioning. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/Yankauer+suction+catheter.

1b. The facility staff failed to wash hands and change gloves during Resident # 160's wound

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care.

On 10/11/18 at 3:55 p.m., Resident # 160's wound care observed with RN (registered nurse) # 1, assistant director of nursing and RN # 2. RN # 1 assisted Resident # 160 to roll onto his right side for wound care of the coccyx and held Resident # 160 in position. RN # 2 put on clean gloves after washing hands, removed the old dressing, then removed gloves but did not wash hands. RN #2 donned new gloves, applied saline on 4x4 (four by four gauze pad) and cleaned the wound, threw out the 4x4, opened a package of two cotton tipped applicators, applied santyl (1) to the ends, spread the santyl on the wound, opened the boarder gauze pad, and placed it over the wound.

On 10/11/18 at 5:50 p.m., an interview was conducted with RN # 2. When asked to describe the procedure for gloves when providing wound care, RN # 2 stated, "Wash hands between tasks." When informed of the observation and asked about washing hands after removing gloves and changing gloves after cleaning the wound, RN # 2 stated, "I should have washed my hands and changed gloves from removing the dressing and cleaning the wound to applying treatment and a clean dressing." When asked why it was important to wash her hands and change gloves between wound care tasks, RN # 1 stated, "Want to keep the field clean."

The facility's policy "Personal Protective Equipment-Using Gloves" documented, "Miscellaneous: 5. Wash hands after removing gloves. (Note: Gloves do not replace handwashing)."

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F 880	Continued From page 112 On 10/12/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, RN (registered nurse) # 1, assistant director of nursing and ASM # 3, the corporate clinical nurse, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Lippincott." No further information was provided prior to exit. References: (1) An FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal. Proper wound care management is important to help remove nonliving tissue from your wound properly. This information was obtained from the website: https://santyl.com/	F 880		