STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/30/18 through 11/01/18. The facility was in substantial compliance with 42 CFR Part 483.73, requirements for Long-Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/30/18 through 11/01/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Eight complaints were investigated during the survey. The census in this 240 certified bed facility was 161 at the time of the survey. The survey sample consisted of 39 open and closed Resident reviews.	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 individuality. The facility must protect and promote the rights of the resident.	F 550		11/30/18

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

Electronically Signed | 11/19/2018

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F 550	Continued From page 1 §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 observations, clinical record review, and staff interviews, the facility failed, for one of 39 residents in the survey sample (Resident # 61), to ensure a dignified dining experience for the resident, and failed to ensure the personal dignity of the resident. Resident # 61, who needed assistance with feeding, was fed by a staff member who stood over him while feeding him, and the resident was allowed to leave the dining room with his sweat pants falling down, exposing his diaper. The findings include:	F 550	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; The deficient practice cited was fixed immediately on site when CNA #2 noticed CNA #3 feeding incorrectly and violating that residents rights. CNA #2 instructed CNA #3 what they were doing wrong (standing over him) and then CNA #3 pulled a chair next to the resident to assist resident in eating. CNA□s #1, #2 & #3 were identified and educated by the Administrator on Residents rights	

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F 550	Continued From page 2 1. Resident # 61 was admitted to the facility on 7/18/11, and most recently readmitted on 1/25/17 with diagnoses that included hyperlipidemia, Non-Alzheimer's dementia, Huntington's disease, anxiety disorder, depression, psychotic disorder, schizophrenia, generalized muscle muscle weakness, transient cerebral ischemic attack, and lack of coordination. According to the most recent Minimum Data Set, a Quarterly Review with an Assessment Reference Date of 9/14/18, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. Resident # 61's care plan, dated 9/22/16, and updated on 10/3/18, included the following problem: "At risk for chewing and swallowing problems (at risk for inadequate intake) related to Huntington's Disease, Schizophrenia, and other chronic conditions as evidenced by uncontrollable shaking/movements during meal periods. Unable to tolerate regular consistency at this time." The goal for the problem was, "Consume greater than 75% of meals daily, on average; Tolerate foods provided with no coughing or choking at meal times; No weights." The interventions to the stated problem included: "Diet/supplements as ordered; Monitor for aspiration with food and liquid each shift and report positive findings to RN (Registered Nurse), RDN (Registered Dietitian/Nutritionist), and MD; Observe resident during meals to ensure he is eating slowly and not taking large portions in his mouth all at once; Provide assistance as needed	F 550	specifically focusing on eating/feeding and residents dignity/exposure relating to proper clothing. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. Staff were re-educated on proper ADL care and to adjust residents cloths as needed while on the unit to ensure dignity. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The CNA staff were in-serviced by the DON/ADON on the importance of Residents Rights and how to properly assist a resident in feeding and proper clothing to respect dignity. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Facility Administrator will monitor and audit the feeding of residents weekly to ensure Resident Rights are respected and feeding is done properly. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 550	Continued From page 3 at meal times (opening containers, feeding, setting up for meal service); Provide meals, snacks and supplements as ordered to support energy and protein needs; Record and monitor meal intake per protocol; Record and monitor weight per protocol; Speech therapy referral." At 8:00 a.m. on 10/30/18, observation of the breakfast meal on the Third Floor Unit was started, at which time approximately 20 residents were seated in the dining room. Resident # 61, who was not among the seated residents, was seated in a chair next to the Third Floor nurses station. At approximately 10:15 a.m., two staff members went to Resident # 61's room where they found him lying on his bed. The staff members asked him if he wanted to eat, got him to his feet, and followed him to the dining room. In the dining room, the resident was placed in a chair at a table and a plate of food put in front of him. Resident # 61 immediately began to feed himself, taking large spoonfuls of food, one bite rapidly after another. CNA # 1 (Certified Nursing Assistant) moved to a position next to the resident and began to feed him as she stood over him, slowing down his food intake. CNA # 1 then alternated between standing over the resident and sitting on the arm of the chair next to the resident. After she was done feeding Resident # 61, CNA # 1 was asked where she obtained the plate of food he ate. "All plates are fixed, and then we keep them warm," she said. At approximately 8:00 a.m. on 10/31/18, a second	F 550		

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F 550	Continued From page 4 observation of breakfast on the Third Floor Dining Room was conducted. Resident # 61, who was sitting in a chair next to the Third Floor nurses station, entered the Dining Room at about 8:20 a.m. and sat at the same table where he ate breakfast the previous day. Several minutes later the resident left the dining room, but he returned at about 8:35 a.m. and sat back down at the same table. At approximately 9:00 a.m., staff began serving the food. There were seven other residents sharing the table with Resident # 61. Each of them was offered a choice of hot (oatmeal) cereal, or cold (corn flakes) cereal. Resident # 61 was not offered any cereal. At about 9:05 a.m., the seven other residents, as well as Resident # 61, were served their plates of food. As CNA # 1 was sitting down to feed Resident # 61, he got up and left the dining room. At about 9:10 a.m., Resident # 61 was returned to the dining room by staff and placed back at the table where had had been sitting. His plate of food was put back in front of him, but there were no eating utensils for him to use. CNA # 3 obtained eating utensils, went to the resident, and began feeding him while standing over him. CNA # 2 got the attention of CNA # 3 and told him to sit down to feed the resident. At one point, CNA # 3 left the resident to obtain some juice for him to drink. As soon as he left, Resident # 61 began rapidly eating large spoonfuls of food. As soon as CNA # 3 returned to the table, the resident abruptly got up and started to leave the dining room. When Resident # 61 got up from the table, he	F 550		

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F 550	Continued From page 5 went and stood in the center of the room. His sweat pants were falling down, and had fallen to the point that his diaper was fully exposed in the front. CNA # 3, who was feeding the resident, walked passed him and was asking other staff if they had gloves he could put on so he could wipe Resident # 61's mouth. CNA # 3 made no effort to help Resident # 61 pull up his sweat pants. Resident # 61 started walking, and as he reached the dining room door, he was able to partially pull up his sweat pants. CNA # 3 followed Resident # 61 to the nurses station where he assisted him to pull his sweat pants the rest of the way up. At that time, CNA # 3 was asked why he fed the resident. "We try to feed him, he is very temperamental," CNA # 3 said. "You saw when I got up to get him a drink, he got mad and started feeding himself." The dining observations regarding Resident # 61 were discussed during a meeting at 6:00 p.m. on 10/31/18 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.	F 550		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 608		11/30/18

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F 608	Continued From page 6 (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the coarse of a complaint investigation, the facility staff failed to implement written policies to ensure reporting of suspected abuse within the mandated time frames for one of 39 residents in the survey sample, Resident #71. Resident #71 had a injury of unknown source resulting in being sent to the emergency department and an allegation of sexual abuse that was not reported timely to the state agency. The findings include: Resident #71 was admitted to the facility on	F 608	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The deficient practice that was identified was not reporting of reasonable suspicion of a crime. This incident happened months ago and submitting a report now is not feasible. The staff members that failed to report this issue to the state are no longer working at this facility. Since this incident occurred facility staff have communicated to the state about this issue. How the facility will identify other residents having the potential to be affected by the same deficient practice; The facility	

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F 608	Continued From page 7 1/30/09 with a readmission on 5/22/18 with diagnoses that included: Multiple sclerosis, paraplegia, dementia with behaviors, depression, and urinary tract infection. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/22/18. Resident #71 was assessed as being cognitively intact with a score of 13 of 15. During a complaint investigation Resident #71's medical record was reviewed. A hospital discharge summary dated 2/23/18 documented that Resident #71 was brought to the emergency department after going to a urologist appointment due to possible urinary tract infection (UTI). Upon assessment in the emergency department it was determined that Resident #71 was diagnosed with urosepsis. A CT (computerized tomography) scan was also performed and indicated a foreign object in Resident #71's vagina, prompting an OBGYN (Gynecology) consult and leading to a surgical extraction of a 100 milliliter (ML) plastic normal saline bottle. Resident # 71 was discharged from the hospital on 2/23/18 and returned to the facility. During the hospital admission APS (Adult Protective Services) was contacted by the hospital for possible sexual abuse. Also during the hospital stay Resident #71 underwent a psychiatric evaluation which could not evidence sexual abuse due to unwillingness by Resident #71 to comment on any inappropriate actions at the facility. APS final report was also reviewed and did not evidence sexual abuse.	F 608	Administrator and DON concluded that all residents have the potential to be affected by the lack of reporting a reasonable suspicion of a crime. Currently no unusual instances have occurred that have not been reported to the state. If an unusual occurrence does happen it will be reported to the state. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The staff members that failed to report this incident are no longer with the company. The current DON and Administrator have been educated by the Corporate Director of Clinical Services on when to report unusual instances. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON will monitor and audit all unusual care related instances at the facility and report any unusual findings to the facility Administrator and the Corporate Director of Clinical Services. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 608	Continued From page 8 On 10/30/18 at 9:35 AM, Resident #71 was interviewed and was specifically asked if she (Resident #71) felt like she had ever been physically, sexually, mentally or verbally abused while in the facility. Resident #71 verbalized she has had no issues with abuse and verbalized that no one had abused her. Resident #71's care plan was reviewed and documented that Resident #71 has a history of sexually inappropriate behaviors toward male staff and also indicated masturbation at inappropriate times. On 10/31/18 at 9:30 AM, hospital records were presented to the director of nursing (DON) regarding the foreign object being removed from Resident #71's vagina and allegation of sexual abuse investigation. The DON was asked to present the facility's investigation of sexual abuse and a copy of the Facility Reported Incident (FRI) sent into the state agency. The DON verbalized that neither she nor the administrator were at the facility at the time of the event, but would look for the investigation and FRI. On 10/31/18 at 3:40 PM, the DON was again asked for the investigation and FRI. The DON verbalized that she had been talking to staff that was there at the time of the incident, and she knew an investigation was done because the police had came to the facility to investigate (based on what staff had told the DON). This surveyor verbalized to the DON that a investigation had been done by APS who contacted the police as a result of the hospital reporting to APS, but wanted the facility's investigation and FRI.	F 608		

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F 608	Continued From page 9 On 11/1/18 at 8:45 AM, the DON was interviewed again concerning the investigation and FRI. The DON verbalized that an investigation and FRI still had not been found and verbalized understanding that the facility was responsible to report and investigate independently of APS and police. The facility's abuse policy and procedure titled "Policy & Procedure Abuse, Neglect and Exploitation" was reviewed. Under the heading titled "Policy Interpretation and Implementation" documented the following: "Report allegations or suspected abuse, neglect or exploitation immediately to: Administrator Other Officials in accordance with state law State Survey and Certification agency through established procedures." No other information was presented prior to exit conference on 11/1/18. This is a complaint deficiency.	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		11/30/18

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F 609	Continued From page 10 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the coarse of a complaint investigation, the facility staff failed to report to the state agency an injury of unknown source and an allegation of sexual abuse timely, for one of 39 residents in the survey sample, Resident #71. Resident #71 had a injury of unknown source resulting in being sent to the emergency department and an allegation of sexual abuse that was not reported to the state agency. The findings include: Resident #71 was admitted to the facility on 1/30/09 with a readmission on 5/22/18 with diagnoses that included: Multiple sclerosis, paraplegia, dementia with behaviors, depression, and urinary tract infection. The most recent MDS (minimum data set) was a	F 609	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; The deficient practice that was identified was not reporting of alleged violations. This incident happened months ago and submitting a report now is not feasible. The staff members that failed to report this issue to the state are no longer working at this facility. Since this incident occurred facility staff have communicated to the state about this issue. How the facility will identify other residents having the potential to be affected by the same deficient practice; The facility Administrator and DON concluded that all residents have the potential to be affected by the lack of reporting alleged violations. Currently no unusual instances or alleged violations have occurred that have not been reported to the state. If an unusual occurrence does happen it will be	

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F 609	Continued From page 11 quarterly assessment with an ARD (assessment reference date) of 9/22/18. Resident #71 was assessed as being cognitively intact with a score of 13 of 15. During a complaint investigation Resident #71's medical record was reviewed. A hospital discharge summary dated 2/23/18 documented that Resident #71 was brought to the emergency department after going to a urologist appointment due to possible urinary tract infection (UTI). Upon assessment in the emergency department it was determined that Resident #71 was diagnosed with urosepsis. A CT (computerized tomography) scan was also performed and indicated a foreign object in Resident #71's vagina, prompting an OBGYN (Gynecology) consult and leading to a surgical extraction of a 100 milliliter (ML) plastic normal saline bottle. Resident # 71 was discharged from the hospital on 2/23/18 and returned to the facility. During the hospital admission APS (Adult Protective Services) was contacted by the hospital for possible sexual abuse. Also during the hospital stay Resident #71 underwent a psychiatric evaluation which could not evidence sexual abuse due to unwillingness by Resident #71 to comment on any inappropriate actions at the facility. APS final report was also reviewed and did not evidence sexual abuse. On 10/30/18 at 9:35 AM, Resident #71 was interviewed and was specifically asked if she (Resident #71) felt like she had ever been physically, sexually, mentally or verbally abused while in the facility. Resident #71 verbalized she has had no issues with abuse and verbalized that	F 609	reported to the state. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The staff members that failed to report this incident are no longer with the company. The current DON and Administrator have been educated by the Corporate Director of Clinical Services on when to report alleged violations. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON will monitor and audit all unusual care related instances at the facility and report any alleged violations to the facility Administrator and the Corporate Director of Clinical Services. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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	495114	A. BUILDING _____ B. WING _____	C 11/01/2018

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F 609	Continued From page 12 no one had abused her. Resident #71's care plan was reviewed and documented that Resident #71 has a history of sexually inappropriate behaviors toward male staff and also indicated masturbation at inappropriate times. On 10/31/18 at 9:30 AM, hospital records were presented to the director of nursing (DON) regarding the foreign object being removed from Resident #71's vagina and allegation of sexual abuse investigation. The DON was asked to present the facility's investigation of sexual abuse and a copy of the Facility Reported Incident (FRI) sent into the state agency. The DON verbalized that neither she nor the administrator were at the facility at the time of the event, but would look for the investigation and FRI. On 10/31/18 at 3:40 PM, the DON was again asked for the investigation and FRI. The DON verbalized that she had been talking to staff that was there at the time of the incident, and she knew an investigation was done because the police had came to the facility to investigate (based on what staff had told the DON). This surveyor verbalized to the DON that a investigation had been done by APS who contacted the police as a result of the hospital reporting to APS, but wanted the facility's investigation and FRI. On 11/1/18 at 8:45 AM, the DON was interviewed again concerning the investigation and FRI. The DON verbalized that an investigation and FRI still had not been found and verbalized understanding that the facility was responsible to report and investigate independently of APS and police.	F 609		

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F 609	Continued From page 13 The facility's abuse policy and procedure was reviewed. Under the heading titled "Investigation" documented the following: "The facility will investigate and report incidents of occurrences in accordance with federal and state regulations and guidelines." No other information was presented prior to exit conference on 11/1/18.	F 609		
F 610 SS=D	This is a complaint deficiency. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the coarse of a complaint investigation, the facility staff failed to	F 610	How the corrective action will be accomplished for those residents found to have been affected by the deficient	11/30/18

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F 610	Continued From page 14 initiate and complete a thorough investigation and maintain documentation that an alleged violation was investigated for one of 39 residents in the survey sample, Resident #71. Resident #71 had a injury of unknown source resulting in being sent to the emergency department, and an allegation of sexual abuse that was not investigated by the facility or evidenced documentation of the investigation. The findings include: Resident #71 was admitted to the facility on 1/30/09 with a readmission on 5/22/18 with diagnoses that included: Multiple sclerosis, paraplegia, dementia with behaviors, depression, and urinary tract infection. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/22/18. Resident #71 was assessed as being cognitively intact with a score of 13 of 15. During a complaint investigation Resident #71's medical record was reviewed. A hospital discharge summary dated 2/23/18 documented that Resident #71 was brought to the emergency department after going to a urologist appointment due to possible urinary tract infection (UTI). Upon assessment in the emergency department it was determined that Resident #71 was diagnosed with urosepsis. A CT (computerized tomography) scan was also performed and indicated a foreign object in Resident #71's vagina, prompting an OBGYN (Gynecology) consult and leading to a surgical extraction of a	F 610	practice; Resident #71 was sent to the hospital and the object was removed. The deficient practice that was identified was failure to investigate/prevent/correct alleged violations. Since this survey an investigation was completed. The staff members that failed to report this issue to the state are no longer working at this facility. Since this incident occurred facility staff have communicated to the state about this issue. How the facility will identify other residents having the potential to be affected by the same deficient practice; The facility Administrator and DON concluded that all residents have the potential to be affected by the lack of reporting/investigating an unusual occurrence. Currently no unusual instances have occurred that have not been investigated. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The staff members that failed to report this incident are no longer with the company. The current DON and Administrator have been educated by the Corporate Director of Clinical Services on when to investigate alleged violations. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON will monitor and audit all alleged violations at the facility and report any unusual findings to the facility Administrator and the Corporate Director of Clinical Services. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will	

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F 610	Continued From page 15 100 milliliter (ML) plastic normal saline bottle. Resident # 71 was discharged from the hospital on 2/23/18 and returned to the facility. During the hospital admission APS (Adult Protective Services) was contacted by the hospital for possible sexual abuse. Also during the hospital stay Resident #71 underwent a psychiatric evaluation which could not evidence sexual abuse due to unwillingness by Resident #71 to comment on any inappropriate actions at the facility. APS final report was also reviewed and did not evidence sexual abuse. On 10/30/18 at 9:35 AM, Resident #71 was interviewed and was specifically asked if she (Resident #71) felt like she had ever been physically, sexually, mentally or verbally abused while in the facility. Resident #71 verbalized she has had no issues with abuse and verbalized that no one had abused her. Resident #71's care plan was reviewed and documented that Resident #71 has a history of sexually inappropriate behaviors toward male staff and also indicated masturbation at inappropriate times. On 10/31/18 at 9:30 AM, hospital records were presented to the director of nursing (DON) regarding the foreign object being removed from Resident #71's vagina and allegation of sexual abuse investigation. The DON was asked to present the facility's investigation of sexual abuse and a copy of the Facility Reported Incident (FRI) sent into the state agency. The DON verbalized that neither she nor the administrator were at the facility at the time of the event, but would look for the investigation and FRI.	F 610	determine what, if any additional interventions are needed at the end of the three month period.	

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F 610	Continued From page 16 On 10/31/18 at 3:40 PM, the DON was again asked for the investigation and FRI. The DON verbalized that she had been talking to staff that was there at the time of the incident, and she knew an investigation was done because the police had came to the facility to investigate (based on what staff had told the DON). This surveyor verbalized to the DON that a investigation had been done by APS who contacted the police as a result of the hospital reporting to APS, but wanted the facility's investigation and FRI. On 11/1/18 at 8:45 AM, the DON was interviewed again concerning the investigation and FRI. The DON verbalized that an investigation and FRI still had not been found and verbalized understanding that the facility was responsible to report and investigate independently of APS and police. The facility's abuse policy and procedure was reviewed, titled "Policy & Procedure Abuse, Neglect and Exploitation." Under the heading titled "Policy Interpretation and Implementation" documented the following: "Investigations of Alleged Abuse, Neglect and Exploitation, when suspicion of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation include: [...] Document the entire investigation chronologically." No other information was presented prior to exit conference on 11/1/18. This is a complaint deficiency.	F 610		

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F 623 SS=B	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 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	F 623		11/30/18

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F 623	Continued From page 18 (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 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.	F 623		

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F 623	Continued From page 19 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, facility document review and clinical record review, the facility staff failed to provide written notice of transfer/discharge to the ombudsman for three of 39 residents in the survey sample. Residents #148, #146 and #103 were discharged from the facility with no written notifications issued to the ombudsman. The findings include: 1. Resident #148 was admitted to the facility on 6/13/13 and was discharged from the facility to a hospital on 3/17/18. Diagnoses for Resident #148 included end stage renal disease with hemodialysis, high blood pressure, atrial fibrillation and cerebrovascular accident (stroke). The minimum data set (MDS) dated 1/23/18 assessed Resident #148 with severely impaired cognitive skills. Resident #148's clinical record documented the	F 623	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents #148, #146 and #103 no longer reside in the facility. The notices for residents #148, #146 and #103 have been sent to the State Long Term Care Ombudsman□s office. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The SW Team will audit all transfers and discharges in the past 90 days to ensure that all notice of transfer were provided to a representative of the State Long Term Care Ombudsman monthly and if not one will be sent once identified. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The	

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F 623	Continued From page 20 resident was sent to the hospital on 3/17/18 for treatment following bleeding from her dialysis access site. The clinical record included no notification to the ombudsman of the emergency transfer/discharge from the facility. On 11/1/18 at 9:35 a.m., the facility's social worker was interviewed about a written notification to the ombudsman regarding Resident #148. After reviewing, the social worker stated the discharges were usually faxed to the ombudsman. The social worker stated he had no documentation or record of notification to the ombudsman regarding Resident #148's discharge. These findings were reviewed with the administrator and director of nursing during a meeting on 11/1/18 at 11:00 a.m. #2. Resident #146 was admitted to the facility on 08/20/18 with diagnoses including fracture of right femur, subsequent encounter for closed fracture with routine healing, cognitive communication deficit, Alzheimer's Disease, history of falls, difficulty walking, muscle weakness, anxiety disorder, other depressive disorders and gastro-esophageal reflux disease (GERD). The most recent minimum data set (MDS) dated 08/27/18 assessed Resident #146 as being severely cognitively impaired, with inattention continuously present and disorganized thinking fluctuating in severity. Resident #146's clinical record was reviewed on 10/31/18 at 9:25 a.m. A nursing progress note dated 8/31/18 at 8:30 p.m., documented "Resident was picked up by [name of transport company] and transported to [name of hospital], left in stable condition. A nursing home to	F 623	entire Social Work team were in-serviced by the Administrator on the Facilities policy titled Transfer and Discharge Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Social Work team will monitor and audit 3 transfers/discharges a week to ensure we are compliant with the facilities policy titled Transfer and Discharge Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 623	Continued From page 21 hospital transfer form documented the reason for the transfer as "Other - Fracture of the left hip." On 11/01/18 at 08:17 a.m., the social services director (SSD) was interviewed concerning notifying the State Ombudsman's office regarding Resident #146 being discharged to the hospital on 08/31/18. The SSD stated he would check with his staff and follow-up. On 11/01/18 at 9:35 a.m., the SSD provided a copy of the facility's Notice of Transfer or Discharge form dated 08/31/18 and stated Resident #146's responsible party was provided a copy of this form and notified of the transfer/discharge to the hospital. The SSD was asked if the State Ombudsman's office was notified of transfer/discharge to the hospital. The SSD stated "no, it needs to be faxed to them." The SSD was asked if the information had been faxed as of today (11/1/18) and the SSD stated "no". These findings were reviewed with the administrator, director of nursing, assistant director of nursing and social services director during a meeting on 11/01/18 at 10:57 a.m. 3. Resident #103 was admitted to the facility originally on 01/11/16, with the most current readmission on 09/28/18. Diagnoses for Resident #103 included, but were not limited to: high blood pressure, diabetes, anemia, peripheral vascular disease, renal insufficiency with hemodialysis,, and a history of stroke. The most current MDS (minimum data set) was a significant change assessment dated 10/05/18. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for	F 623		

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F 623	Continued From page 22 daily decision making skills. During the resident's clinical record review, nursing notes revealed the resident was having slurred speech and altered mental status on 09/13/18. The physician ordered for the resident to be transferred to the hospital via 911 on 09/13/18. The resident was admitted to a local hospital on 09/13/18 and was discharged back to the facility on 09/28/18. The resident's clinical record was reviewed for notification to the ombudsman of the emergency transfer. No notice was found. On 10/31/18 at approximately 5:00 p.m., the DON (director of nursing), the administrator, and ADON (assistant director of nursing) were informed of above and asked for assistance in locating the required notification to the resident and the ombudsman. On 11/01/18 at approximately 10:15 a.m., the SW (social worker) presented a copy of the notice of transfer for discharge form that was given to the resident on 09/13/18. The SW was asked if the ombudsman was notified. The SW stated there was no documentation to evidence the ombudsman was notified of the emergency transfer for this resident. The facility's policy titled Transfer and Discharge (2018) stated on page four regarding emergency transfers/discharges, "Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list." No further information and/or documentation was	F 623		

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F 623	Continued From page 23 presented prior to the exit conference on 11/01/18 at 1:00 p.m.	F 623		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a preadmission screening and resident review (PASARR) was completed prior to admission to the long term care facility for one of 39 residents in the survey sample, Resident #14. The facility staff failed to complete a PASARR for Resident #14 prior to admission on 04/27/17. A PASARR was completed on 07/20/17 by the facility, almost three months after admission. The PASARR completed on 07/20/17 failed to identify	F 644	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #14 still resides in the facility and the PASARR has be corrected and completed by the Social Work Manager. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents that qualify for this particular document have	11/30/18

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	495114	A. BUILDING _____ B. WING _____	C 11/01/2018

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REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

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F 644	Continued From page 24 that the resident had a serious mental illness of schizophrenia. Findings include: Resident #14, was admitted to the facility on 04/27/17. Diagnoses for Resident #14 included, but were not limited to: schizophrenia, depression, COPD (chronic obstructive pulmonary disease), nocturnal enuresis, and BPH (benign prostatic hypertrophy). The most current full MDS (minimum data set) was an annual assessment dated 05/01/18, which assessed the resident as having a cognitive score of 13, indicating the resident was intact for daily decision making skills. The resident was assessed as independent for most ADL's (activities of daily living) with supervision only, with one person physical assistance if needed. A quarterly assessment dated 07/31/18 documented the resident with a cognitive status of 10, indicating the resident had moderate impairment in daily decision making skills. The resident was again assessed as being independent for most ADL's (activities of daily living) with supervision only, with one person physical assistance if needed. The resident's 14 day admission assessment dated 05/11/17 documented the resident had a diagnoses for schizophrenia. A quarterly MDS assessment dated 07/31/17 documented the resident had a diagnoses of schizophrenia. During clinical record review the level I PASARR dated 07/20/17 was reviewed and documented	F 644	the potential to be affected. The social work team will audit 5 admissions a week for the last 60 days to ensure the PASARR is complete and correct when needed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Social work team were re-educated on the importance and correctness of a PASARR by the facilities DON. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Social Work Team will monitor and audit 5 Admissions per week for the next 90 days to ensure PASARR□s are completed and done properly. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 644	Continued From page 25 that the resident did not have a serious mental illness, although it was documented throughout the resident's clinical record that the resident had a history of schizophrenia. On 10/30/18 at approximately 2:00 p.m., the unit manger, RN (registered nurse) # 1 was interviewed regarding Resident #14's level I PASARR. The RN stated that the resident did have a diagnoses of schizophrenia and agreed that the information was incorrect and should have been completed prior to admission. On 10/31/18 at approximately 5:30 p.m., the DON (director of nursing), ADON (assistant director of nursing) and the administrator were made aware of the above information and were asked for any assistance regarding the inaccuracy of the document. On 11/01/18 at approximately 9:30 a.m., RN #1 presented another PASARR level I dated 10/31/18, completed the day prior for Resident #14. This PASARR was reviewed and was marked and identified the resident as having the serious mental illness of schizophrenia, but the form was not completed. The section on the level I form regarding a "recommendation" (for a resident with schizophrenia) was not completed, therefore the form was again inaccurate. On 11/01/18 at 11:30 a.m., the DON (director of nursing), the ADON (assistant director of nursing), and the administrator were made aware of the above information regarding Resident #14 and the fact that the information was still not complete, nor accurate information for this resident.	F 644		

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F 644	Continued From page 26 No further information and/or documentation was presented prior to the exit conference on 11/01/18 at 1:00 p.m.	F 644		
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 (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	F 655		11/30/18

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F 655	Continued From page 27 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 staff interview, and clinical record review, the facility staff failed to develop an baseline care plan for one of 39 residents, Resident #346. Resident #346 did not have a baseline care plan for isolation, dialysis, and a PICC (peripheral inserted central catheter). The Findings Include: Resident #346 was admitted to the facility on 10/27/18. The (minimum data set) was not completed at the time of the survey. Diagnoses for Resident #346 included: Urinary tract infection with extended spectrum beta lactamase resistance, end stage renal disease on dialysis, diabetes, and neuropathy. On 10/30/18 at approximately 12:15 PM, Resident #346's room was observed with an isolation sign. Also an isolation cart was outside the door and a nurse was in the resident's room wearing isolation garb. Licensed practical nurse (LPN) #1, was asked why Resident #346 was on isolation. The LPN verbalized that Resident was on dialysis and was receiving antibiotics through	F 655	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #346 still resides in the facility however the deficient practice has been corrected due to the nursing staff adjusting and updating the care plan correctly to reflect the patients isolation status, dialysis and PICC Line. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The nursing management team did an audit on 5 admissions per week for the last 30 days to ensure that other admissions would not lack an initial care plan. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The LPN/Rn□s were re-educated by the nursing management team on the importance of initial care plans to meet a residents clinical needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The nursing	

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F 655	Continued From page 28 a PICC line due to a urinary tract infection (UTI). On 10/30/18 at 12:21 PM, Resident #346's daughter was interviewed. Resident #346's daughter verbalized that Resident #346 was on isolation due to getting antibiotics through a PICC line, as Resident #346 was on dialysis secondary to a (UTI). Resident #346's medical record was reviewed on 10/30/18. The initial care plan did not evidence a care plan was developed for isolation, dialysis, or for a PICC line. On 10/30/18 at 3:59 PM, registered nurse (RN #1 unit manager) was interviewed concerning the baseline care plan. RN #1 verbalized the baseline should include at least pain, cognition, skin integrity, and accidents/safety. This surveyor asked RN #1 should the baseline care plan include care areas specific to a Resident's care needs, RN #1 verbalized yes. This surveyor verbalized that Resident #346 is on isolation, has a PICC line, and receives dialysis and asked should a care plan be developed for these care areas. RN #1 verbalized yes. At this time RN #1 was asked to review Resident #346's baseline care plan. RN #1 verbalized that Resident #346's initial care plan regarding isolation, dialysis and PICC line all should have been care planned. On 10/31/18 at 5:30 PM the above information was presented to the administrator and director of nursing. No other information regarding the above finding was provided prior to exit conference on 11/1/18.	F 655	management team will monitor and audit 5 admissions per week for the next 90 days to ensure initial care plans are developed based on the resident□s clinical needs. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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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 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	F 656		11/30/18

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F 656	Continued From page 30 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: The facility staff failed to develop and implement a person centered care plan for one of 39 residents in the survey sample, Resident # 14. The facility failed to develop a sufficient care plan and failed to implement a person centered care plan specific for Resident #14 for independent leaves of absence from the facility. Findings include: Resident # 14 was admitted to the facility on 04/27/17. Diagnoses for Resident # 14 included, but were not limited to: schizophrenia, depression, COPD (chronic obstructive pulmonary disease), nocturnal enuresis, and BPH (benign prostatic hypertrophy). The most current full MDS (minimum data set) was an annual assessment dated 05/01/18, which assessed the resident as having a cognitive score of 13, indicating the resident was intact for daily decision making skills. The resident was assessed as independent for most ADL's (activities of daily living) with supervision only, with one person physical assistance if needed. This MDS identified the resident as using tobacco products. A quarterly MDS assessment dated 07/31/18 assessed the resident with a cognitive status of 10, indicating the resident had moderate impairment in daily decision making skills. The resident was again assessed as being	F 656	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #14 still resides in the facility however the deficient practice has been corrected by the nursing staff updating/adjusting the care plan correctly and having a meeting with the resident about the leave of absence policy and importance of signing in and out. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The nursing management team did an audit on 5 annual/quarterly care plans per week for the last 30 days to ensure that if residents have improved/declined their comprehensive care plan is adjusted accordingly. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The LPN/Rn□s were re-educated by the nursing management team on the importance of updated care plans to meet a residents comprehensive clinical needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The nursing management team will monitor and audit 5 annual/quarterly care plans per week for the next 90 days to ensure comprehensive care plans are developed	

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F 656	Continued From page 31 independent for most ADL's (activities of daily living) with supervision only, with one person physical assistance if needed. This MDS was blank in the tobacco section, neither yes or no was marked for tobacco use. Resident # 14 was observed on 10/30/18 at approximately 7:30 a.m. entering the facility with a fountain drink. On 10/30/18 at approximately 11:30 a.m., the resident was interviewed. The resident had a large fountain drink at his bedside and stated that he had gotten it at the convenient store adjacent to the facility parking lot. The resident stated that sometimes he will go to the store and buy drinks and snacks. The resident was asked if anyone went with him when he goes to the store and the resident stated he goes by himself. The resident was asked if he informed staff (verbally) that he was leaving and where he was going when he went out. The resident stated that he did not. The resident was then asked if he signed himself out to go to the store. The resident again stated that he did not. The resident was asked if staff ask him to sign out before going to the store so that they know where he is. The resident stated that staff do not ask him to sign out. The resident was asked if staff become upset with him when he leaves the facility without signing out and the resident stated, "No." The resident was asked if staff educated him about signing out prior to leaving for safety reasons. The resident stated that they did not. Resident #14's current POS (physician's order set) was reviewed and documented that the resident could go out on leave with medications, could participate in activities, and could	F 656	based on the resident□s clinical needs. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 656	Continued From page 32	F 656		

participate in supervised field trips; no specific orders were found regarding leaving the facility for short time frames independently.

The resident's CCP (comprehensive care plan) was then reviewed and documented, "...behavior problem related to non-compliance...leaving facility without signing out or notifying staff...intervene as necessary to protect the rights and safety...divert attention...remove from situation...monitor behavior episodes of behavior and attempt to determine underlying cause...[start date: 06/27/17]..." No new updates or revisions were found in the resident's CPP regarding the above.

A wander risk scale was reviewed dated 01/25/18. The assessment documented the resident as a low risk for wandering.

A wander risk scale was reviewed dated 04/27/18. The assessment documented the resident as a low risk.

The resident was briefly interviewed again at approximately 3:30 p.m. on 10/31/18. The resident stated that he had been out about three times today (10/31/18) already and wasn't sure if he'd go back out or not.

On 10/31/18 at approximately 4:00 p.m., LPN (Licensed Practical Nurse) #1 was interviewed regarding residents going out of the facility. The LPN stated that the resident will either sign out on a sheet that is located on the their chart or sign out at the front desk prior to leaving. The LPN stated that when the resident comes back, we do a visual assessment, "kind of look them over" and sign them back in.

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F 656	Continued From page 33 Resident #14's clinical record was reviewed and revealed a sign out sheet with two sign outs by the resident, one on 2/26 [no year] at 2:45 p.m. and one on 5/25 [no year] 1:00 p.m. There was no sign in for either of these dates. On 10/31/18 at approximately 4:25 p.m., the front desk attendant was asked for copies of the sign out sheets for 10/30/18 and 10/31/18. Resident # 14's name was not on the sign out sheets for either day. At approximately 4:28 p.m., the resident entered the lobby area and walked past the front desk and out the front door of the facility without signing out and without staff intervention, as indicated on the resident's CCP. On 10/31/18 at approximately 5:30 p.m., the DON (director of nursing), the ADON (assistant director of nursing) and the administrator were made aware of the above information and concerns regarding Resident #14's care plan. The facility staff were made aware of the above observation of facility staff not intervening in an attempt to have the resident sign out prior to leaving the facility. The DON, ADON and administrator were also made aware that the resident's care plan was developed in 2017 and had not been reviewed/updated or had any new interventions added since then. The facility staff were made aware that the care plan for Resident #14 was not a person centered comprehensive care plan and did not include specific interventions designed to meet the needs, desires and outcomes of the resident. A policy on short term leaves of absence (not overnight) was requested at this time.	F 656		

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F 656	Continued From page 34 On 11/01/18 at 9:00 a.m. a leave of absence policy was presented and reviewed. The policy documented, "....ensure the resident has a right to participate in a leave of absence from the facility, both on and off the property, whether the resident is independent or in need of supervision...the resident's physician will determine if the resident may have a leave of absence and if it is with or without supervision and an order will be placed in the medical record...Residents deemed to be at risk for safety issues related to independent leaves of absence will have interventions incorporated into resident's plan of care to reduce the resident's safety risk..resident...will be requested to sign out of the facility...and reminded to sign back in..." No further information and/or documentation was presented prior to the exit conference on 11/01/18 at 1:00 p.m.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		11/30/18

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F 657	Continued From page 35 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview and clinical record review, the facility failed to review and revise the CCP (comprehensive care plan) for three of 39 residents in the survey sample. 1. The facility staff failed to review and revise the CCP for Resident #14 in the area of smoking. 2. The facility staff failed to review and revise the CCP for Resident #81 in the area of nail care. 3. The facility staff failed to review and revise the CCP for Resident # 106 in the area of an indwelling Foley catheter. Findings include: 1. Resident # 14 was admitted to the facility on 04/27/17. Diagnoses for Resident # 14 included, but were not limited to: schizophrenia, depression, COPD (chronic obstructive pulmonary disease), nocturnal enuresis, and BPH (benign prostatic hypertrophy).	F 657	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents #14, #81, and #106 still reside in the facility however the deficient action has been corrected due to nursing staff adjusting/updating the care plan correctly. Resident #14 CCP and POS now match. Resident #81 nails are now trimmed and resident #106 bed is in the lowest position without catheter bag touching the ground. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The nursing management team did an audit 5 annual/quarterly care plans per week for the last 30 days to ensure that if residents have improved/declined their comprehensive care plan is adjusted accordingly and timely. What measures will be put into place or systemic changes made to ensure that	

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F 657	Continued From page 36 The most current full MDS (minimum data set) was an annual assessment dated 05/01/18, which assessed the resident as having a cognitive score of 13, indicating the resident was intact for daily decision making skills. The resident was assessed as independent for most ADL's (activities of daily living) with supervision only, with one person physical assistance if needed. This MDS identified the resident as using tobacco products. A quarterly MDS assessment dated 07/31/18 assessed the resident with a cognitive status of 10, indicating the resident had moderate impairment in daily decision making skills. The resident was again assessed as being independent for most ADL's (activities of daily living) with supervision only, with one person physical assistance if needed. This MDS was blank in the tobacco section, neither yes or no was marked for tobacco use. On 10/30/18 at approximately 11:30 a.m., the resident was interviewed. The resident was asked if he smoked. The resident stated that he did smoke about 4 or 5 cigarettes a day, but not all the time. Resident #14's current POS (physician's order set) was reviewed and included orders for, but not limited to: "...NO TOBACCO PRODUCTS (order status: Active) (Order Date: 06/10/17)...TOBACCO CESSATION (order status: Active) (Order Date: 01/26/18)..." The resident's current CCP (comprehensive care plan) was then reviewed and documented, "...date initiated: 05/01/17 Resident is a smoker	F 657	the deficient practice will not recur; The LPN/Rn□s were re-educated by the nursing management team on the importance of timely updated care plans to meet a residents comprehensive clinical needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The nursing management team will monitor and audit 5 annual/quarterly care plans per week for the next 90 days to ensure comprehensive care plans are developed timely and based on the resident□s clinical needs. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 657	Continued From page 37 he ambulates self out to smoke unsupervised...can smoke supervised...smoking supplies are stored at nurse's station..." No information was found in the resident's CCP regarding the resident not having tobacco products or about smoking cessation. The resident's CCP had not been updated for smoking since May of 2017, a revision date of 8/8/17 was listed, but no interventions were added. On 10/31/18 at approximately 5:30 p.m., the DON (director of nursing), the ADON (assistant director of nursing) and the administrator were made aware of the above information and concerns regarding Resident #14's CCP, in addition to the resident's physician's orders did not match and that the resident's CCP had not been updated since May of 2017. The DON stated that the CCP are to be updated quarterly or more frequent if it is a significant change or something that needs to be added related to a resident's daily care and/or routine. No further information and/or documentation was presented prior to the exit conference on 11/01/18 at 1:00 p.m. to evidence Resident #14's CCP had been reviewed and revised for smoking. 2. Resident #81 was admitted to the facility on 05/06/18, with the most current readmission on 06/13/18. Diagnoses for this resident included, but not limited to: heart disease, anxiety disorder, contracture of right hand, history of stroke with right sided paralysis, Parkinson's disease, and aphasia. The most current MDS (minimum data set) was a	F 657		

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F 657	Continued From page 38	F 657		

quarterly assessment dated 09/28/18, which documented the resident had a cognitive score of 1, indicating the resident was severely impaired in daily decision making skills. The resident was extensive to total assistance from staff for all ADL's (activities of daily living).

Resident #81 was observed throughout the survey process with long, pointed nails.

Resident #81's current physician's orders were reviewed and documented an order for, but not limited to: "...shower as scheduled; Please offer bed bath if resident refused/contraindicated. Skin assessment, toe and finger nails checked during shower. Every day shift every Wednesday, Saturday (Order Date: 06/13/18)...(Start Date: 06/13/18)..."

The resident's CCP (comprehensive care plan) was then reviewed and documented, "...Foot/Nail care...monitor/document/report...any signs/symptoms of foot/toe nail problems...podiatry consult as indicated...staff to help with ADLs..." No information was found on the resident's CCP regarding fingernail care and maintenance.

On 10/31/18 at 5:30 p.m., the survey team met with the DON (director of nursing), ADON (assistant director of nursing), and the administrator and informed of the above information and that the resident's CCP had not been reviewed or revised to incorporate fingernail care in the ADL section. The DON stated that should be on everyone's care plan and was not sure why it wasn't on this residents. The DON was asked for a policy on nail care.

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F 657	Continued From page 39 On 11/01/18 at 9:00 a.m., a policy on nail care was presented and reviewed. The policy documented, "...the facility shall establish and utilize a systemic approach for nail care for each resident...assessments of nails will be conducted on admission and readmission...routine cleaning and inspection of nails will be provided during ADL care and on an ongoing basis...determine frequency of nail care to be provided...determine the person(s) responsible for providing nail care...each resident will have his/her own nail equipment...will not be shared between residents..." No further information and/or documentation was provided prior to the exit conference on 11/01/18 at 1:00 p.m. to evidence Resident #81's CCP was reviewed and revised for ADL fingernail care. 3. Resident # 106 admitted to the facility on 03/19/16 with the most recent readmission on 01/14/18. Diagnoses for this resident included, but not limited to: atrial fibrillation, DM, COPD, anemia, urinary retention, end stage renal disease, Parkinson's disease. The most current MDS (minimum data set) a quarterly dated 07/18/18 documented, the resident with a cognitive score of 15 indicating the resident was cognitively intact for daily decision making skills. The resident was assessed as requiring extensive assistance for most all ADL's (activities of daily living), the resident was coded for hospice and having an indwelling Foley catheter. Resident #106 was observed multiple times throughout the survey process with the resident's indwelling Foley catheter bag laying on the floor.	F 657		

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F 657	Continued From page 40 Resident #106's current physician's orders were reviewed and revealed an order for a Foley catheter #18 french with bag to be changed every month and as needed, and to provide Foley catheter care every shift. The resident's CCP (comprehensive care plan) was then reviewed and documented, "...the resident has indwelling catheter (neurogenic bladder)...Change catheter every week [sic]...position catheter bag and and tubing below the level of the bladder...check tubing for kinks each shift..." There was no information was on the resident's CCP regarding infection control practices. On 10/31/18 at 5:30 p.m., the DON (director of nursing) the ADON (assistant director of nursing) and the administrator were made aware of above observations and concerns with infection control. A policy was requested on care and maintenance of an indwelling catheter. No policy was presented. No further information and/or documentation, was presented prior to the exit conference on 11/01/18 at 1:00 p.m. to evidence the resident's CCP for an indwelling catheter was reviewed or revised to include infection control concerns regarding care and maintenance of an indwelling Foley catheter.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		11/30/18

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F 677	Continued From page 41 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide nail care to a dependent resident, Resident #81. The facility staff failed to cut and/or trim Resident #81's fingernails; the resident's nails were long and pointed. Findings included: Resident #81, was admitted to the facility originally on 05/06/18, with the most current readmission on 06/13/18. Diagnoses for this resident included, but were not limited to: heart disease, anxiety disorder, contracture of the right hand, history of stroke with right sided paralysis, Parkinson's disease, and aphasia. The most current MDS (minimum data set) was a quarterly assessment dated 09/28/18, which documented the resident had a cognitive score of 1, indicating the resident was severely impaired in daily decision making skills. The resident required extensive to total assistance from staff for all ADL's (activities of daily living) including personal hygiene and bathing. The resident's annual MDS assessment dated 02/17/18 was reviewed and documented the resident triggered in the CAAS section of this MDS for, but not limited to: cognition, vision, communication, and pressure. The resident was not triggered for ADL's on this MDS in the CAAS section and it was not marked to care plan.	F 677	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #81 still resides in the facility however this deficient practice has been corrected due to the CNA giving the resident proper ADL care and trimming the nails appropriately. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. A random audit of 15 residents per floor resulting in a total of 45 residents was completed to ensure that proper ADL care was provided for dependent residents. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Direct care staff consisting of CNA□s, LPN□s and RN□s will be re-educated on proper ADL care provided for Dependent Residents by the Director of Nursing or Assistant Director of Nursing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The nursing management team will monitor and audit 15 random residents per floor resulting in a total of 45 per week for the next 90 days to ensure proper ADI care is being provided to Dependent Residents. Results of the audit will be reported to the QAPI	

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F 677	Continued From page 42 Resident # 81 was observed on 10/30/18 at 3:12 p.m., lying in the bed with the resident's wife at the bedside. The resident was unable to speak. The resident's wife was interviewed regarding care for Resident #81. The wife stated that the staff do not cut or trim the resident's nails and showed the resident's long, pointy nails on both hands. The wife stated that the resident is not diabetic and that she (the wife) has trimmed them before, but does not know why staff aren't caring for the resident's nails. The wife asked if cutting the resident's nails was her responsibility. Resident #81 was observed throughout the survey process with long, pointed nails. Resident #81's current physician's orders were reviewed and documented an order for, but not limited to: "...shower as scheduled; Please offer bed bath if resident refused/contraindicated. Skin assessment, toe and finger nails checked during shower. Every day shift every Wednesday, Saturday (Order Date: 06/13/18)...(Start Date: 06/13/18)..." The resident's CCP (comprehensive care plan) was then reviewed and documented, "...Foot/Nail care...monitor/document/report...any signs/symptoms of foot/toe nail problems...podiatry consult as indicated...staff to help with ADLs..." No information was found on the resident's CCP regarding fingernail care and maintenance. On 10/31/18 at 5:30 p.m., the survey team met with the DON (director of nursing), ADON (assistant director of nursing), and the administrator and informed of the above. The DON stated that the nurses and CNAs (certified	F 677	Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 677	Continued From page 43 nursing aide) provide nail care to resident's who are not diabetic. The DON stated that the CNAs are supposed to be providing nail care to residents who are not diabetic and either the nurses or podiatry will provide nail care to resident's with diabetes. The DON was asked for a policy on nail care. On 11/01/18 at 9:00 a.m., a policy on nail care was presented and reviewed. The policy documented, "...the facility shall establish and utilize a systemic approach for nail care for each resident...assessments of nails will be conducted on admission and readmission...routine cleaning and inspection of nails will be provided during ADL care and on an ongoing basis...determine frequency of nail care to be provided...determine the person(s) responsible for providing nail care...each resident will have his/her own nail equipment...will not be shared between residents..." No further information and/or documentation was provided prior to the exit conference on 11/01/18 at 1:00 p.m.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		11/30/18

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F 684	Continued From page 44 by: Based on observation, family interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide a splint for one of 39 residents in the survey sample, Resident #81. The facility staff failed to ensure a resting hand splint was available for Resident #81. Findings included: Resident #81, was admitted to the facility originally on 05/06/18, with the most current readmission on 06/13/18. Diagnoses for this resident included, but were not limited to: heart disease, anxiety disorder, contractor of right hand, history of stroke with right sided paralysis, Parkinson's disease, and aphasia. The most current MDS (minimum data set) was a quarterly assessment dated 09/28/18, which documented the resident had a cognitive score of 1, indicating the resident was severely impaired in daily decision making skills. The resident required extensive to total assistance from staff for all ADL's (activities of daily living) including personal hygiene and bathing. The resident's annual MDS assessment dated 02/17/18 was reviewed and documented the resident triggered in the CAAS section of this MDS for, but not limited to: cognition, vision, communication, and pressure. The resident did not trigger for ADL's, nor was it marked to be addressed in the care plan on this MDS. Resident # 81 was observed on 10/30/18 at 3:12 p.m., lying in the bed with the resident's wife at	F 684	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #81 still resides in the facility however deficient practice has been corrected by the Rehab Team ordering the correct splint and applying it to the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents that qualify for splints have the potential to be affected. The rehab team will audit 100% of residents with current splint orders to ensure each resident has the correct type of splint and it is being used correctly. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The CNA staff were re-educated by the Director of Rehab on the importance of Quality of Care and why correctly wearing a splint as ordered by the Physician is important. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Rehab team will monitor and audit each splint order weekly for the next 90 days to ensure compliance with splints according to the plan of care to embrace quality of care. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional	

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F 684	Continued From page 45 the bedside. The resident was unable to speak. The resident's wife was interviewed regarding care for Resident #81. The wife stated that the resident is supposed to have a splint for his right arm/hand due to him having a stroke and that he cannot move that side and has a partially contracted right hand/fingers. The wife stated that the resident had a nice splint before going to the hospital in June and it mysteriously disappeared and has not been found, nor replaced. The wife stated that the resident went to the hospital 06/06/18 and returned to the facility on 06/13/18 and was seen briefly by therapy, but wasn't sure what they actually did for the resident. The wife stated that the therapy department stated that they were going to order a splint for the resident, but he still doesn't have one and that the therapy department gave him a little cotton wrap [palm protector], not a splint. She wasn't sure what the purpose of that was, but stated that it did not support his hand or wrist and that it "smelled." The wife stated that she couldn't remember for sure, but thought the nice splint had been missing since around early July. Resident #81's current physician's orders were reviewed and documented an order for, but not limited to: "...patient to wear a resting hand splint X [times] 8 hours daily for positioning upon tray [order date: 06/27/18]...Right hand resting splint when out of bed [order date: 07/18/18]..." The resident's current (comprehensive care plan) was then reviewed and documented, "...resident at risk for decline of ROM [range of motion] to right hand and wrist and total dependence on staff for all ADLs...evaluate skin before splint application and upon removal to check for [05/23/17]...irritation....joint	F 684	interventions are needed at the end of the three month period.	

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F 684	Continued From page 46 stiffness...swelling...decline in mobility...administer treatments as ordered..." On 10/31/18 at 3:10 p.m., the Director of Rehab was interviewed regarding Resident #81's missing splint. He stated that he had spoke with resident's wife and that he had ordered a new splint and that he told the wife he was not sure when the order will go in. The Director of Rehab was asked when that was and he stated that he wasn't sure, maybe a few weeks ago. He was asked if there was documentation of that conversation or of the order for the new splint and he stated that the conversation with the wife was "informal" and he didn't document that. The Director of Rehab was asked about the order invoice for the splint; he stated that one was ordered and he would check on the order form. No order form was presented to evidence that a resting hand splint was ordered for Resident #81. The Director of Rehab was asked to present the evaluation and discharge summary for Resident #81. An OT (occupational therapy) evaluation and treatment plan was reviewed dated 06/22/18. The plan documented, "...pt will have the most appropriate splint on Right hand for 4 hours to decrease further contracture (Target date: 7/5/18)...pt will have most appropriate splint on Right hand for 8 hours to decrease further contracture (Target date: 7/21/18)...Recommendations Orthotics: Splint/Orthotic Recommendations: R resting hand splint..." This was signed on 06/22/18. A treatment encounter note dated 06/22/18 documented, "..analysis...patient's response to	F 684		

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F 684	Continued From page 47 wearing orthotic/prosthetics device...for irritation, areas of pressure or breakdown after initial fitting...caregiver follow through...nursing notified, order written, educated on donning/doffing of splint...resident fitted for right resting hand splint to decrease /prevent contractures, order place; Right palm hand palm protector placed to prevent skin breakdown..." This was signed on 06/22/18. The OT discharge summary documented, "...pt will have most appropriate splint on Right hand for 4 hours to decrease further contracture...pt fitted with existing hand splint. Staff notified, order requested for 8 hours a day to maintain ROM...nursing to don hand splint daily..." This was signed on 06/27/18. The Director of Rehab presented an order form, which documented a air soft resting hand splint. The order did not identify who the splint was for. The order form dated 05/31/18 documented that this was a pending order approval notification. The Director of Rehab was made aware that this did not make sense, as this order date was before Resident #81's splint was missing. The Director of Rehab was also informed that this did not identify that the split was for this resident. The Director of Rehab was asked to present an order invoice confirmation for Resident #81's resting hand splint, along with shipment confirmation and evidence that the splint was received and when and when the splint was initiated for the resident. The resident was observed throughout the survey process (10/30/18 thru 11/01/18) and did not have a hand splint on at any time during the observations.	F 684		

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F 684	Continued From page 48 Resident # 81's TARs (treatment administration records) revealed that staff were signing off that the resident had a resting hand splint applied for the entire month of October 2018, including during the survey dates of 10/30/18 through 11/01/18, when the resident was observed not wearing a splint. On 10/31/18 at 5:30 p.m., the survey team met with the DON (director of nursing), ADON (assistant director of nursing), and the administrator, who were informed of the above information and was asked for assistance in providing order confirmation and delivery details for the splint for Resident #81. On 11/01/18 at 10:00 a.m., the above information was again requested from the DON, ADON and/or administrator. At approximately 11:45 a.m., the ADON stated that the above information could not be found. No further information and/or documentation was presented prior to the exit conference on 11/01/18 at 1:00 p.m. to evidence Resident #81 was ordered and/or presented with a new splint after the other splint was lost sometime in July. No evidence was provided to the resident had a resting hand splint per the physician's orders.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		11/30/18

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F 686	Continued From page 49 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to assess and/or implement interventions for the prevention of pressure ulcers for two of 39 residents in the survey sample. 1. Resident #92 developed a stage 2 pressure ulcer on her coccyx after going 6 weeks without a documented skin assessment. 2. Resident #133, treated for a pressure injury to his heel, was observed without a Prevalon boot in use as ordered by the physician. The findings include: 1. Resident #92 was admitted to the facility on 9/6/18 with diagnoses that included severe morbid obesity, high blood pressure, end stage renal disease, history of breast cancer, depression and hemiplegia following cerebral infarction. The minimum data set (MDS) dated 10/4/18 assessed Resident #92 as cognitively intact and requiring extensive assistance of one person for bed mobility, transfers and activities of daily living (dressing, toileting, hygiene).	F 686	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #92 still resides in the facility however the deficient practice has been corrected due to the nursing team doing skin assessments according to the Physician□s order. Resident #133 still resides in the facility and the staff are now providing care according to the Physician□s order in specific relation to the Prevalon boot. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The nursing management team will randomly audit 15 charts per floor equaling 45 total charts to ensure compliance with the facilities policy titled Skin Assessment and to ensure pressure reducing devices are used when ordered by the physician. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Direct care staff consisting of CNA□s, LPN□s and RN□s were re-educated by	

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F 686	Continued From page 50 Resident #92's clinical record documented the resident was assessed with a stage 2 pressure ulcer on her coccyx on 10/22/18. The wound assessment sheet dated 10/22/18 listed the ulcer was acquired at the facility and documented the wound measured 3 cm x 1.5 cm x 0.1 cm (length by width by depth in centimeters). Further description of the wound included pink epithelial tissue, no odor, no drainage and no pain. The physician was notified and treatment was started with cleansing and a foam dressing every three days. The clinical record documented no comprehensive skin assessments by licensed nurses in the six weeks prior to the development of the coccyx pressure ulcer. The resident's skin was assessed upon admission on 9/6/18 indicating the resident had a 1 cm by 1 cm (length by width) pressure ulcer on the lower back. There was no staging listed for this pressure ulcer. A skilled nursing note dated 9/7/18 documented, "No new changes to skin integrity noted" and listed no wound care and/or description of any areas of skin impairment. There was no further mention in the record of the lower back pressure ulcer. The clinical record documented no further body audits and/or weekly skin assessments for Resident #92 until the stage 2 pressure ulcer was noted on 10/22/18. A skilled nursing note dated 9/27/18 listed vital signs but the section for skin assessment was blank and not completed. Resident #92's care plan (revised 10/22/18) listed the resident was at risk of skin break down due to limited mobility and fragile skin. Interventions to	F 686	the DON/ADON on the importance and proper procedures relating to the facilities policy labeled Skin Assessment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Nursing Management team will monitor and audit 10 random residents per floor per week resulting in 30 residents total over the next 90 days to ensure the Skin Assessment is being followed correctly by staff. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 686	Continued From page 51	F 686		

prevent skin impairment included good nutrition, keep skin dry, pressure relief mattress, turning and repositioning, use of draw sheet, use of caution with transfers and following facility protocols for treatment of injury. The care plan made no mention of weekly skin assessments or audits.

On 10/30/18 at 3:34 p.m., the registered nurse (RN #5) caring for Resident #92 was interviewed about skin assessments and the stage 2 pressure ulcer. RN #5 stated nurses were required to perform weekly skin assessments on all residents with results documented on weekly skin sheets. RN #5 stated the certified nurses' aides (CNAs) also looked at skin during bathing and personal care. RN #5 reviewed Resident #92's clinical record and stated she could not find any past skin assessments for Resident #92 and she could only retrieve assessments that were coming due. RN #5 stated the unit manager would be able to access the weekly skin assessments for Resident #92.

On 10/30/18 at 4:19 p.m., the unit manager (RN #3) was interviewed about skin assessments prior to Resident #92's stage 2 pressure ulcer. RN #3 stated nurses were supposed to perform weekly skin assessments on all residents. RN #3 stated CNAs also reviewed skin during personal care and entered that information into a tracking system. When asked about skin audits by licensed nurses, RN #3 stated the weekly assessments were supposed to be documented on the weekly skin observation form. RN #3 stated he would check and see if he could find the assessments.

On 10/31/18 at 1:26 p.m., RN #3 stated nurses

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signed off the treatment record that skin assessments were done three times per week with baths/showers. When asked for the results of these assessments, RN #3 did not have any documentation of what was observed with these assessments. RN #3 stated the CNAs did not report any concerns with Resident #92 until 10/22/18. RN #3 stated he did not know why the licensed nurses did not perform the weekly skin assessments.

There were no associated assessments indicating any description of the resident's skin related to the nurse sign offs on the treatment records.

10/31/18 at 11:27 a.m., accompanied the wound nurse (RN #2), Resident #92's sacral pressure ulcer was observed. The wound was linear with measurements matching those listed on the facility's 10/22/18 assessment. The wound had dark pink edges, with light pink tissue in the center. There was a small amount of yellow slough present. The wound was clean with no drainage or odor. The resident stated the wound hurt when cleansed with gauze. In addition, the resident had excoriated skin on each of her buttock cheeks. RN #2 identified the excoriation as new and stated this had not been reported to her previously.

On 10/31/18 at 2:38 p.m., the director of nursing (DON) was interviewed about Resident #92. The DON stated nurses were supposed to perform weekly skin checks on the designated form. The DON stated if the sheets were not in the clinical record, they were not done.

The facility's policy titled Skin Assessment

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(revised 12/2017) stated, "It is our policy to perform a full body skin assessment as part of our systematic approach for pressure ulcer prevention and for the promotion of healing of various skin conditions, including pressure ulcers. This policy includes the following procedural guidelines in performing the full body skin assessment...A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure ulcer...Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions...Documentation of skin assessment...Include date and time of the assessment, your name, and position title...Document observations (e.g. skin conditions, how the resident tolerated the procedure...Document type of wound...Describe wound...Document other information as indicated or appropriate."

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure injury as, "localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear." (1)

The NPUAP defines a stage 2 pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not

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F 686	Continued From page 54 visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present..." (1) The NPUAP Prevention and Treatment of Pressure Ulcers: Quick Reference Guide states on page 16, "In individuals at risk of pressure ulcers, conduct a comprehensive skin assessment: as soon as possible but within eight hours of admission...as part of every risk assessment...ongoing based on the clinical setting and the individual's degree of risk...Increase the frequency of skin assessment in response to any deterioration in overall condition...Document the findings of all comprehensive skin assessments...Ongoing assessment of the skin is necessary in order to detect early signs of pressure damage, especially over bony prominences...Include the following factors in every skin assessment: skin temperature; edema; and change in tissue consistency in relation to surrounding tissue..." (2) These findings were reviewed with the administrator and director of nursing during a meeting on 10/31/18 at 5:15 p.m. (1) NPUAP Pressure Injury Stages. 2016. National Pressure Ulcer Advisory Panel. 11/02/18. www.npuap.org/ (2) National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Australia; 2014. 2. Resident #133 was admitted to the facility on 10/05/2018 with the following diagnoses, but not	F 686		

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F 686	Continued From page 55 limited to: Multiple Sclerosis, dependence on dialysis, Chronic kidney disease, type 2 diabetes mellitus, paraplegia, pressure ulcer of the sacral region, urine retention, and history of urinary tract infections. The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 10/12/2018. Resident #133 was assessed as cognitively intact with a summary score of "15". On 10/30/2018 at approximately 9:00 a.m., Resident #133 was observed lying in bed, the head of the bed was at 45 degrees and he was finishing up his morning bath. While speaking with Resident #133, registered nurse (RN) # 2, the wound nurse, came into the room and stated, "I understand there was blood on your sheets this morning...I think the dressing came off of your left foot, I need to check it." Resident #133 was in agreement. RN # 2 pulled the covers off of Resident #133's feet and stated, "Where are your Prevalon boots?" Resident #133 stated, "I don't have any." RN # 2 stated, "Yes, we have discussed this..maybe they are in laundry or therapy took them off." She then assessed Resident #133's left foot. She stated, "Your dressing is in place on the plantar area...it looks like you have a new area on your heel." She then left the room, went to the treatment cart outside the room and returned with supplies. She stated, "I am going to dress this and contact the doctor. She measured the area on the left heel and stated, "It's 1.0 X 1.5 X 0.1, it is a stage 2." She cleaned with area with Normal Saline and covered it with allevyn life foam dressing. RN # 2 stated, "This is a new area...he is suppose to have on Prevalon boots I don't know why they are	F 686		

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not in place." When RN # 2 left the room, Resident #133 stated he remembered having the conversation about the boots and that he wore them at home but he did not recall them ever being put on him since arriving at the facility.

RN # 2 was interviewed outside the room regarding the area to Resident #133's heel. She stated the resident had been admitted with an area to that heel that was resolved but now without the boots "we have a problem."

The physician order sheet was reviewed and contained the following order dated 10/08/2018: "Prevalon boots at all times while in bed." The TAR (treatment administration) record was reviewed, there were no initials for dayshift on 10/30/2018 for the entry: "Prevalon boots on at all times while in bed every shift."

The above information was reviewed with the administrator and the DON (director of nursing) during an end of the day meeting on 10/31/2018 at approximately 5:30 p.m.

On 11/01/2018 the Rehab Director was interviewed regarding Resident #133's prevalon boots. He stated, "We never remove them unless we need to for therapy and then we put them back on. OS (other staff) #10 was in the therapy department. He stated, "I am supposed to write a note saying that I saw them on him on Monday [10/29/2018]...I have seen them on him many times so I know that he had them...I don't know why he wasn't wearing them on Tuesday [10/30/2018]."

The DON was interviewed on 11/01/2018 regarding the prevalon boot entries on the TAR.

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F 686	Continued From page 57 She stated that the nurses would place initials on the TAR only to verify that the boots were in place. On 11/01/2018 at approximately 10;15 a.m., RN # 2 came to the conference room. She stated, "I think we had some confusion on Tuesday...the area on his [Resident #133] left heel was not new...it had been a suspected deep tissue injury [SDTI]." RN #2 and this surveyor reviewed the wound evaluations for the left heel from the time of admission on 10/06/2018 through 10/30/2018. On 10/25/2018 the wound on Resident #133's left heel was described as a "SDTI...Necrotic tissue present...improving." RN #2 stated, "When the necrotic tissue comes off you don't know what you are going to have...his came off and we had a Stage 2...it wasn't a new area, just what we had when the tissue came off." RN #2 was asked about the prevalon boots. She stated, "He should have had them on." No further information was obtained prior to the exit conference on 11/01/2018.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document	F 689	How the corrective action will be	11/30/18

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F 689	Continued From page 58 review, clinical record review and in the course of a complaint investigation, the facility failed to provide supervision and prevent accidents/falls for 1 of thirty-nine residents (Resident #146) in the survey sample and failed to ensure a safe room environment for 1 of thirty-nine residents (Resident #48) in the survey sample. 1. The facility staff failed to provide supervision to prevent accidents and falls for Resident #146. Resident #146 who had a history of falls was left unsupervised and had a fall from his wheelchair resulting in a left hip fracture which resulted in harm. 2. A portable oxygen tank was stored unsecured next to Resident #48's bed. The half-full oxygen tank was positioned in the floor between Resident #48's bed and the bed table. The tank was not in a storage rack or cart to prevent tipping over or accidental damage. The findings include: 1. Resident #146 was admitted to the facility on 08/20/18 with diagnoses including fracture of right femur, subsequent encounter for closed fracture with routine healing, cognitive communication, Alzheimer's Disease, history of falls, difficulty walking, muscle weakness, anxiety disorder, other depressive disorders and gastro-esophageal reflux disease (GERD). The most recent minimum data set (MDS) dated 08/27/18 assessed Resident #146 as being severely cognitively impaired, with inattention continuously present and disorganized thinking fluctuating in severity. Resident #146 was also assessed on this MDS as requiring extensive	F 689	accomplished for those residents found to have been affected by the deficient practice; Resident #146 no longer resides in the facility. Resident #48 still resides in the facility however the deficient practice was corrected immediately during survey when the ADON removed the oxygen tank directly after surveyor intervention. When resident #48 has an oxygen tank in their room it is stored correctly in a holder. How the facility will identify other residents having the potential to be affected by the same deficient practice; No other residents were affected by this citation, since date of survey there have not been any falls with significant injury in the therapy gym, a facility wide audit was completed by the Administrator to ensure all portable oxygen tanks were stored correctly What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The therapy department will be in -serviced by the DON on ensuring residents who require supervision while in the gym receive it according to the plan of care, Nursing staff including CNA□s, LPN□s and RN□s will be re-educated on storing portable oxygen tanks by the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Random weekly audits will be conducted by the DON on ensuring residents in the therapy gym are receiving the amount of supervision required. Random weekly audits will be conducted by the Administrator on	

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F 689	Continued From page 59 assistance for ambulation, with one person physical assistance. The MDS assessed Resident #146 balance as not steady, only able to stabilize with human assistance. Resident #146's closed clinical record was reviewed on 10/31/18 at 9:25 a.m. A nursing note dated 08/29/18 at 2:14 p.m. documented the following: "Patient was observed in floor in the therapy room, head to toe assessment done no injury sustained. Assisted patient back in his wheelchair. Spouse with patient during therapy. Neuro check initiated." A nursing noted dated 08/30/18 at 3:20 p.m. documented the following: "Per follow-up with therapist who were at the scene when the incident occurred, he (Therapist) went to set up a patient bike, when he turned around resident on the floor on his left side. Per PT (physical therapist), resident wife (name) told him (PT) that resident reached forward for a stool and slid out of his WC (wheelchair). Assisted patient back in his wheelchair by assigned nurse with the help of PT, patient refused vital signs to be done, per nurse. Head to toe assessment was done, able to stand with three people assist. Surgical site intact with staples, no sign of infection noted. Patient is being seen by PT. MD (medical director) aware. The resident needs activities that minimize the potential for falls while providing diversion and distraction. MD aware, will continue to monitor." A review of Resident #146's care plans documented the following focus area created on 08/27/18: "The resident is at high risk for falls r/t confusion, gait/balance problems and remains at risk for further falls due to hx (history) of fall."	F 689	ensuring residents with portable oxygen tanks have them stored correctly. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 689	Continued From page 60 The care plan goal was documented as: "The resident will be free of minor injury through the review date." The interentions/tasks were documented as the following: "Anticipate and meet the resident's needs...Be sure the resident's call ligt is within reach and encourage the resident to use it. CNA for assistance as needed. The resident needs prompt response to all requests for assistance...Educate the resident/family/caregivers about the safety reminders and what to do if a fall occurs." On 10/31/18, the director of nursing (DON) was asked for the facility's fall investigation report regarding Resident #146's fall on 8/29/18. The DON presented the a folder including the fall investigation report and a statement from the director of rehab. The DON stated "there is not much information included in the investigation report." A review of the facility's fall investigation documented the following under the incident description/nursing description section: "Nurse was called to the therapy room to assess patient on the floor before getting patient off the floor. Upon getting to the therapy room, patient observed on the floor, lying on left side hold head up. All therapy staff was not able to tell how patient gets on floor. Patient unable to express himself due to medical diagnosis." Documented under the immediate action taken section was the following: "Assisted patient back in his wheelchair, patient refused vital signs to be done. Head to toe assessment was done, able to stand with three people assist. Surgical site intact with	F 689		

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F 689	Continued From page 61 staples, no sign of infection noted." On 10/31/18 at 2:45 p.m., the director of rehab (DOR) was interviewed regarding Resident #146's fall incident. The rehab director stated he was out the facility at the time of the incident and the PRN (as needed) occupational therapist (OT) who was assigned to work with Resident #146 on the date of the incident was no longer employed with the company. He stated another therapist who was in the therapy room at the time of the incident could possibly give information on what happened. The rehab director provided copies of the therapy department's evaluations and progress notes for Resident #146. On 10/31/18 at 2:50 p.m., the Physical Therapist (PT) who was present in the room on the day of the fall incident was interviewed. Present during this interview was the rehab director. The PT said he was not working directly with Resident #146, but was in the therapy room. He stated the occupational therapist (OT) had turned away and the resident's wife had gotten up to take a phone call. He said the resident's wife told him the resident was reaching for a stool and slid out of his wheelchair, which was locked at the time. He said he observed the resident laying on his left side and the nurse was called to assess him for possible injuries. The rehab director stated Resident #146 had therapy on 8/30/18 and when it was observed that he appeared to be favoring his left leg, he (rehab director) suggested x-rays should be ordered. The rehab director stated the x-ray results were received on 8/31/18 which documented a left hip fracture.	F 689		

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F 689	Continued From page 62 On 10/31/18 at 3:30 p.m., the therapy department's evaluations and progress notes were reviewed. An occupational therapy note dated 08/29/18 at 12:52 p.m. documented the following: "Resident easily distracted and needs constant redirection. Therapist asked the PT to watch over the resident while this therapist walked out of the rehab gym for 40 seconds to get something. When this therapist came back resident was on the floor on the left side. Wheelchair breaks (sic) were both lock. According to the wife resident leans forward to reach for a stool and slid on the floor. The other therapist watching over just turned around for a second to set up somebody on the bike." A physical therapy note dated 08/29/18 at 04:46 p.m. documented the following: "Pt (patient) easily distracted and daughter w/ patient as therapist went to set up a patient on stationary bike then turned around and saw Pt (patient) on the floor on the left side. According to the wife, Pt (patient) reached forward for a stool and slid out of the wc (wheelchair). At the time wc (wheelchair) had the breaks (sic) on. Nurse in charge was called to assess Pt (patient) for possible injuries. Pt (patient) was assisted back to wc (wheelchair) with max assist of 4 people." On 10/31/18 at 4:25 p.m., the rehab director was interviewed regarding the OT's note documenting she had asked the PT to watch the resident while she stepped away. The rehab director said from his understanding the PT was standing in the room working on the stationary bike near the resident when he fell. The rehab director stated he believed the PT stepped away to move another resident who was near the therapy doorway, but he was not 100% sure. The rehab director was asked if the therapy department had	F 689		

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F 689	Continued From page 63 a policy on resident safety and supervision. He stated he would contact the corporate office for a copy of the policy. On 10/31/18 at 4:41 p.m., the rehab director said he contacted the corporate office for the resident safety and supervision policy; however, they did not have an actual written policy. He stated "resident safety and supervision is basically understood and that any therapist should know they are never to leave a resident unattended." He was asked what was the expectation regarding resident safety and supervision. He stated "it is a professional standard and best practice for the residents to be monitored and supervised while in therapy." A review of the director of rehab's written statement documented the following: "In reference to the incident regarding [resident's name] on Wednesday August 29. Though this therapist was not present when he slipped out of his chair the incident was reported to me as soon as I returned to the therapy room. I was notified of the incident and informed who was present and that the nursing staff had been notified and they checked the patient per protocol. I personally checked on the patient in his room later the same day. The following day, (August 30th) with wife present for therapy, three attempts were made to ambulate the patient after standing from wheelchair. The patient was not performing as well as previous sessions. It appeared he was tentative with taking steps though some of the same tentativeness had been exhibited in previous sessions as well, though the patient had been ambulatory at times as documented in previous therapy progress notes. This was discussed with the patient's spouse as she was	F 689		

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F 689	Continued From page 64 still present and had been present in previous attempts. Palpation to the left lower extremity was performed with no visible discomfort. It was discussed at this point with the patient's wife that if the same performance was exhibited the following day (August 31st) that x-rays would be ordered. The patient was brought to therapy August 31st. The wife was not present on this day. The patient was once again helped from sit to stand but showed avoidance of ambulating and it appeared to this therapist it may be due to the patient's left lower extremity weight bearing avoidance. At this time therapy was discontinued and patient was returned to room and nursing was notified to order x-rays. This therapist spoke with the patient's wife later that evening regarding having x-rays done with results at the time." The statement was dated and signed by the rehab director on September 4, 2018. Resident #146's clinical record documented a telephone order dated 08/31/18 at 1:18 p.m. for "X-ray (L) Leg Hip and Femur one time only for pain." A copy of the x-ray results documented the following: "Left femur, four views. Again, a basocervical fracture of the left hip was seen. The fracture was acute. The remainder of the femur was intact. A mild effusion was seen in the suprapatellar bursa." The results were signed and dated on 8/31/18 at 6:35 p.m. A nursing note dated 08/31/18 at 10:26 p.m. documented: "[MD's name] made aware of the x-ray results. New order received to transport resident to ER (emergency room) via Non-emergency transport further evaluation; RP [responsible party, wife's name] made aware of the x-ray results and also of new order received." A nursing note dated 08/31/18 at 10:30 p.m.	F 689		

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F 689	Continued From page 65 documented: "Resident picked up by [name of transport company] and transported to [name of hospital], left in stable condition." This above information was reviewed with the administrator, director of nursing and assistant director of nursing during a meeting on 10/31/18 at 05:13 p.m. No further information was provided to the survey team prior to the exit conference on 11/01/18 at 1:00 p.m. This is a complaint deficiency. 2. Resident #48 was admitted to the facility on 2/23/18 with diagnoses that included end stage renal disease, congestive heart failure, hypothyroidism, insomnia, depression and diabetes. The minimum data set (MDS) dated 8/30/18 assessed Resident #48 as cognitively intact. The resident's clinical record documented a physician's order dated 2/23/18 for oxygen at 2 liters per minute continuously due to shortness of breath. On 10/30/18 at 10:41 a.m., Resident #48 was observed in bed. A half-full portable oxygen tank was positioned in the floor between the resident's bed and bed table. The oxygen cylinder was unsecured and not in a rack or cart to ensure upright positioning. The portable oxygen tank was still in the floor without a rack/cart on 10/30/18 at 11:53 a.m. On 10/30/18 at 10:58 a.m., the registered nurse (RN #5) caring for Resident #48 was interviewed about the oxygen tank stored in the resident's	F 689		

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F 689	Continued From page 66	F 689		

room. RN #5 removed the portable tank from Resident #48's room and stated the tanks were supposed to be in a rack. RN #5 stated the portable tanks were used with Resident #48 when she went to dialysis or out of the facility. RN #5 stated the resident had been out earlier in the morning (10/30/18) for a physician appointment. RN #5 carried the portable tank by hand to a storage rack in a room behind the nursing station. When asked how they stored and/or transported the portable oxygen cylinders, RN #5 stated sometimes they have a rolling cart but if no cart was available, she transported the tanks manually.

On 10/30/18 at 12:10 p.m., the director of nursing (DON) was interviewed about the unsecured oxygen tank in Resident #48's room. The DON stated oxygen cylinders were supposed to be stored in racks and/or carts.

The facility's policy titled Oxygen Safety (revised 12/2017) stated, "It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment...When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders...Protect cylinders from damage by not storing in locations where heavy objects may strike them or fall on them, or where they can be tipped over by foot traffic or door movement..."

These findings were reviewed with the administrator and director of nursing during a meeting on 10/31/18 at 5:15 p.m.

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F 695	Continued From page 67	F 695		
F 695 SS=D	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 staff interview, and clinical record review, the facility staff failed to follow physician's orders for the use of oxygen for one of 39 resident's, Resident #3. Resident #3 did not receive physician ordered oxygen. The Findings Include: Resident #3 was admitted to the facility on 11/25/11 with a readmission on 10/6/18. Diagnoses for Resident #3 included obstructed sleep apnea, dementia, and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment dated 10/25/18. Resident #3 was assessed with long and short-term memory deficit and severely cognitively impaired. On 10/30/18 at 9:56 AM, Resident #3 was observed laying in bed sleeping. An oxygen concentrator was turned on and oxygen tubing was wrapped up in a plastic bag laying on a night stand.	F 695	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 still residents in the facility and the staff are applying oxygen as ordered by the physician. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The nursing management team will audit 100% of resident who have physician□s orders for the use of oxygen to ensure orders are being followed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Direct care staff consisting of CNA□s, LPN□s and RN□s were re-educated by the DON/ADON on the importance and proper procedures relating to following the physicians orders. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The nursing	11/30/18

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F 695	Continued From page 68 Resident #3's medical record was reviewed on 10/30/18. Physician's orders documented "Oxygen at 2L [liters] via nasal cannula continuous." This order was dated 10/24/18. Resident #3 was observed again at 11:30 AM and 3:00 PM without oxygen in place and tubing still in the plastic bag on the night stand. On 10/30/18 at 3:15 PM, Resident #3's nurse (license practical nurse #1, LPN #1) was asked to come to Resident #3's room and obtain an oxygen saturation level. The level registered 94% on room air. At this time LPN #1 also observed Resident #3 without oxygen in place. LPN #1 was interviewed concerning not placing oxygen on Resident #3. LPN #1 verbalized that it was on when medications were given that morning and that family were in to the see resident. LPN #1 was told that Resident #3 has been observed throughout the day and oxygen has not been in place with each observation, and the tubing had been in a plastic bag at each observation. LPN #1 verbalized that the Resident #3 was supposed to have oxygen on contiguously, but could not give the reason for why oxygen was not in place. On 10/31/18 at 5:30 PM the above information was presented to the administrator and director of nursing. No other information regarding the above finding was provided prior to exit conference on 11/1/18.	F 695	management team will audit 100% of residents who have physicians□ orders for the use of oxygen in the facility weekly times 3 weeks then randomly thereafter to ensure appropriate treatment in place. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		11/30/18

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F 758	Continued From page 69 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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F 758	Continued From page 70 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure a PRN (as needed) antipsychotic medication was not in use in excess of fourteen days for two of 39 residents in the survey sample (Residents # 57 and 61). 1. Resident # 57 had an order for PRN Seroquel that was written for longer than 14 days and without an end date. 2. Resident # 61 had orders for PRN Haldol and Clonazepam that were written for longer than 14 days and without an end date. The findings include: 1. Resident # 61 in the survey sample was admitted to the facility on 7/18/11, and most recently readmitted on 1/25/17, with diagnoses that included hyperlipidemia, Non-Alzheimer's dementia, Huntington's disease, anxiety disorder, depression, psychotic disorder, schizophrenia, generalized muscle muscle weakness, transient cerebral ischemic attack, and lack of coordination. According to the most recent Minimum Data Set, a Quarterly Review with an Assessment	F 758	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #61 and #57 still reside in the facility however the deficient practice has been corrected by adjusting the physicians orders as needed or discontinuing those medications. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with orders for psychotropic PRN meds have the potential to be affected. The Nursing management team will randomly audit 15 charts per floor equaling 45 total charts to ensure compliance with the facilities policy labeled Psychotropic Medication What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The LPN□s, RN□s and Medical Director in the building have been educated by the DON/ADON that psychotropic medications that are written PRN can only be written for 14 days, and that an end date is needed.	

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F 758	Continued From page 71 Reference Date of 9/14/18, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. Resident # 61 had a order for "Haloperidol Lactate Concentrate 2 mg/ml (milligrams per milliliter) give 1 ml by mouth every 6 hours as needed for increase agitation give 2 mg." The start date for the Haldol order was 10/17/18. There was no end date listed. As of 10/29/28, the date of record review, no PRN Haldol had been administered. Resident # 61 also had an order for "Clonazepam 0.5 mg one tablet by mouth every 3 hours as needed for spasticity." The start date for the Clonazepam order was 10/17/17. There was no end date listed. As of 10/29/18, no PRN Clonazepam had been administered during the months of August, September, and October 2018. NOTE: Haldol (Haloperidol) is an antipsychotic used in the treatment of psychotic disorders. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 579. NOTE: Clonazepam is an anticonvulsant (Benzodiazepine derivative) used in the treatment of myoclonic seizures, panic disorder, and off label use of anxiety. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 276. On 10/31/18, at 1:45 p.m., the Director of Nursing (DON) was interviewed about the PRN Haldol and Clonazepam orders. The surveyor pointed out that because both medications were classed as psychotropics, a PRN order could only be	F 758	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Nursing Management team will monitor and audit 15 random residents per floor per week resulting in 45 residents total over the next 90 days to ensure the Psychotropic Medication policy is followed and PRN orders are only written for 14 days and that an end date is written. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 758	Continued From page 72	F 758		

written for 14 days, and that an end date was needed for the order(s). The DON said the orders were written by the medical director and that she would contact him about an order to discontinue both medications.

The PRN Haldol and Clonazepam orders were also discussed during a meeting at 6:00 p.m. on 10/31/18 that included the Administrator, DON, Assistant Director of Nursing, and the survey team.

2. Resident # 57 was admitted to the facility 8/31/18 with diagnoses to include, but not limited to: unspecified psychosis, dementia with behaviors, high blood pressure, and GERD.

The admission MDS (minimum data set) dated 9/7/18 had Resident # 57 coded as having moderate cognitive impairment with a total summary score of 07 out of 15.

The clinical record was reviewed 10/31/18 at 4:30 p.m. The current POS (physician order summary) included an order carried forward from 9/1/18 for "Seroquel (an antipsychotic medication) 25 mg every 12 hours as needed for psychosis...End date: indefinite." The MAR (medication administration record) for September 2018 and October 2018 revealed Resident # 57 had been administered the medication three times in September, and none in October.

On 11/1/18 at 10:00 a.m. LPN (licensed practical nurse) # 3, who was identified as the nurse administering the resident's medication, was interviewed. LPN # 3 stated "I didn't know that an antipsychotic medication could not be used longer than 14 days; is that new? I knew there were changes to the narcotic medications..."

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F 758	Continued From page 73 On 11/1/18 at 10:45 a.m. the DON (director of nursing) was asked what the expectation was for staff administering medications; specifically PRN antipsychotic medication. She stated "I would expect the nurse administering the medication to contact the prescribing doctor and ask about any PRN antipsychotic past 14 days." The DON was informed at that time of the above interview with LPN # 3. The administrator, DON (director of nursing), ADON (assistant director of nursing), and social worker were informed of the above findings during a meeting with facility staff 11/1/18 beginning at 11:00 a.m. No further information was provided prior to the exit conference.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, facility document review and clinical record review, facility staff failed to ensure a medication error rate of less than five percent. There were a total of three errors out of 29 opportunities resulting in a total medication error rate of 10.34%. Facility staff failed to administer Depakote 250mg	F 759	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #6, #50 still reside in the facility and are now receiving their medications within 60 minutes of scheduled time as Policy and Procedure states. How the facility will identify other residents	11/30/18

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F 759	Continued From page 74 [milligrams] po [orally] tid [three times daily] in a timely manner for Resident #50 and failed to administer Amlodipine 2.5mg po bid [twice daily] and Neurontin 100mg po bid in a timely manner to Resident #6. Findings included: During the medication pass and pour observation on 10/30/18 at approximately 10:00 a.m.,LPN #2 (licensed practical nurse) was observed while she prepared and administered medications to Resident #50. Resident #50 had a total of three medications due at 9:00 a.m. She received these medications at 10:17 a.m. One of the medications was Depakote 250mg po tid. Resident #50's POS (physician order sheet) dated 10/01/18 through 10/31/18 included an order originally dated 08/06/2018 for "...Depakote Tablet Delayed Release 250 MG [milligrams] Give 1 tablet by mouth three times a day for Dementia..." LPN #2 was also observed while she prepared and administered medications to Resident #6. Resident #6 had a total of eight medications due at 9:00 a.m. She received these medications at 10:36 a.m. One of the medications was Amlodipine 2.5mg po bid. The second medication was Neurontin 100mg po bid. Resident #6's POS (physician order sheet) dated 10/01/18 through 10/31/18 included an order originally dated 01/16/2018 for "...Amlodipine 2.5mg Give 1 tablet by mouth two times a day for high BP [blood pressure]"...and an order originally dated 07/21/2016 for "Neurontin Capsule 100 MG Give 1 capsule by mouth two times a day for BLE [bilateral lower extremity] neuropathic pain..."	F 759	having the potential to be affected by the same deficient practice; All residents have the potential to be affected. All residents are now receiving their medications within 60 minutes of scheduled time. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The LPN□s and RN□s in the facility were re-educated by the DON/ADON on the Medication Administration Policy. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON will complete weekly medication audits for 3 months to ensure medications are passed according to the physician orders. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 759	Continued From page 75 LPN #2 was interviewed on 10/30/18 at approximately 11:00 a.m. regarding timeliness of medication administration. LPN #2 stated, "A lot of my residents don't like their meds until after they have had breakfast. Breakfast being late this morning has not helped. I cannot help it with the fire alarm and everything going off this morning. I give them when I can." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 10/31/18 at approximately 5:30 p.m. A copy of the facility medication administration policy was requested. The policy was received from the Administrator on 11/01/2018 at 8:55 a.m. The facility policy, "Medication Administration General Guidelines, Section 7.1, Dated 05/16" included: Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices...Procedures: ...Medication Administration: ...14. Medications are administered within 60 minutes of scheduled time..." No further information was received by the survey team prior to the exit conference on 11/01/18.	F 759		
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,	F 812		11/30/18

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F 812	Continued From page 76 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store, prepare, and served food in a sanitary manner in the main kitchen and in the third floor dining room. 1. During initial tour of the kitchen on 10/30/2018 the following observations were made: Expired cartons of milk were stored and available for use, an expired salad was available for distribution from the cook's refrigerator, oatmeal was served below temperature, the dishwasher was not washing or rinsing dishes at the manufacturer's recommended temperatures, and pans were stored wet and nested. 2. Facility failed to store coffee cups in a sanitary manner in the third floor dining room. Findings were: 1. On 10/30/2018 at approximately 7:30 a.m., initial tour of the kitchen conducted with the DM	F 812	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Due to surveyor interventions all deficient practices were corrected on the spot by the kitchen manager with surveyor oversight as they were identified. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. At the time of the survey there were no adverse reactions from the result of this citation. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The entire kitchen staff were in-serviced by the Dietary Manager on Food Procurement, Storage, Preparation and Sanitation. Indicate how the facility plans to monitor	

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F 812	Continued From page 77 (dietary manager) and OS (other staff) # 2 (cook). The tray line was set up and temperatures were taken. The oatmeal which was at 100 degrees. The oatmeal was in covered bowls sitting beside tray line, it was not on the steam table. Per OS # 2 the oatmeal had been placed in the bowls and positioned next to the tray line to be sent to the floor approximately 10 minutes prior to the temperature being obtained. The DM was standing nearby and instructed staff to discard the oatmeal and serve cold cereal instead. The walk-in refrigerator was observed and contained a milk crate with 2 % milk dated 10/29/2018 and available for distribution. The DM and OS # 2 were asked about the milk. OS # 2 stated, "It shouldn't be in here." The dietary manager picked the crate up and took it out of the walk-in before the exact number of cartons could be counted. OS #2 was asked where he (the DM) was going. She stated, "I think to throw the milk out." The dietary manger was observed coming into the kitchen from the outside door. He was asked where the milk was. He stated, "I threw it into the dumpster." This surveyor accompanied him back outside to the dumpster to ascertain how many cartons of milk had been in the refrigerator. The cartons were visible in the dumpster and 15 cartons could be counted. The dietary manager was asked how many he thought there were in total and he stated, "10-15-maybe 20". The "cook's refrigerator" contained a salad with lettuce, tomato, cheese and meat with the date 10/27/2018 on the top. OS # 2 was asked what the date meant. She stated that date was the use by date and should be discarded. She removed the salad from the refrigerator.	F 812	its performance to make sure that solutions are sustained; The Dietary Manager will audit the kitchen weekly to ensure there are no expired items stored for use, that the dishwasher is washing and rinsing according to the manufactures recommendations and that items on the floors are stored in a sanitary manner. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 812	Continued From page 78 The dishwashing area was observed. A dietary aid, OS # 3 was washing dishes. The temperatures on the dishwasher were observed as 156 during the wash cycle and 186 during the rinse cycle. The next load of dishes was pushed through with temperatures observed at 150 for wash and 176 for rinse. OS # 3 was asked what the temperature was supposed to be during the wash cycle. She stated, "100, 105?", looking at OS # 2 for guidance. OS # 2 directed her to look at the dial on the dishwasher machine. Per the manufacturer's recommendations the Minimum Wash temp was "160 degrees" and the minimum rinse temperature was "180 degrees." OS # 3 was asked if she had looked at the temperatures while washing the dishes. She stated, "No." OS # 2 stated that the temperatures were recorded every shift. The temperature log was requested and received. No temperatures were recorded for evening shift on 10/28/2018, dayshift or evening shift on 10/29/2018, nor for the morning shift 10/30/2018. The DM came over to the dishwashing area and asked what was wrong. He then turned the booster next to the dishwasher off and on. He was asked what he was doing. He stated, "This is a new booster, I am just turning it off and back on to see if the temperature will go up." He was asked how often that needed to be done. He stated, "It doesn't really I just did it to see if that will help." Within a couple of minutes the wash dial on the machine went up to 176 degrees. The DM stated, "See there it is it is heating up now." He then started to run dishes through the machine. The first load ran with a wash temperature of 160 degrees and a rinse temperature of 182 degrees, the next load ran at 160 degrees wash and 176 rinse temperature. The third load he ran was 156 degrees wash and	F 812		

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F 812	Continued From page 79 174 rinse. The DM stated, "I will call Echo lab...I don't know what is wrong with it...they were just here last week and it was fine. He was asked what he was going to do about the dishes needing to be washed. He stated, "We will do them by hand if he can't get here soon." The three compartment sink was observed in use. The sanitation was tested by OS #2, the expiration date on the test strips used was 09/30/2017. The date was pointed out to her. The DM stated, "I have more." He went to his office and obtained new test strips. He stated, "I didn't know there was a date on them [test strips]". Stored beside the three compartment sinks were cooking pans, available for use. The following pans were stored wet and nested: five full pans, six four inch pans, and 2 quarter pans. The DM stated, "We will re-wash those." At approximately 8:30 a.m., the tray line was again observed and the number of oatmeal bowls available had decreased. The tray line staff were asked where the oatmeal went. OS # 2 stated, "We served it." OS #2 and the tray line staff were asked if a new batch of oatmeal had been prepared or had served the cold oatmeal, since the DM had requested that they throw the batch below temperature away and serve cold cereal. OS #2 stated, "We used what was there...we will make some more hot now...we didn't hear him say to throw it away." At approximately 11:30 a.m., the Echolab representative, OS #4 and the DM came to the conference room to discuss the dishwasher. He stated, "The De-lime switch was on...when that happens the machine just runs and it won't stay	F 812		

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F 812	Continued From page 80 up to temperature. I turned it off and the temperatures are now reading 160-162 for the wash and 180 plus for the rinse cycle." The DM was asked how often the de-liming cycle was used and was it a scheduled maintenance. He stated, "No, it is not scheduled...we do it when we see lime on the machine...it is done maybe once a week." The Echolab representative stated, "The switch is in a place where it can get hit and turned on accidentally." He was asked if there was a light or anything to indicate when the cycle was running. He stated, "No, the machine just keeps cycling until you turn it off." He was asked how the staff would know that. He stated, "Training." The above information was discussed during an end of the day meeting on 10/31/2018 at approximately 5:30 p.m. with the administrator and the DON (director of nursing). No further information was obtained prior to the exit conference on 11/01/2018. 2. On 10/31/18, at approximately 8:50 a.m., a family member came into the Third Floor dining room and requested a tray on which to take breakfast to her family member's room. One of the staff approached CNA # 2 (Certified Nursing Assistant) to ask if she had a tray. CNA # 2, who was distributing drinks (juice, milk, coffee) from a cart, obtained a tray from a shelf in the cart.. The tray contained approximately 15 coffee cups, all of which were stored upside down on the tray, and which were being used to serve coffee to the residents. The cups were standing in approximately one quarter to one half inch of water on the tray. CNA # 2 was asked where the cups had come from, and she replied, "They	F 812		

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F 812	Continued From page 81 came from the kitchen." CNA # 2 removed the cups from the tray, stacked them on another tray in the cart, and gave the tray, with water on it, to another staff member to be dried and given to the family member. The observation of the coffee cups in standing water was discussed during a meeting at 6:00 p.m. on 10/31/18 that included the Administrator, Director of Nursing, Assistant Director of Nursing, and the survey team.	F 812		
F 880 SS=F	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;	F 880		11/30/18

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F 880	Continued From page 82 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 83 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility staff failed to develop and implement a water management program to identify the risk of Legionella; and failed to ensure infection control practices for the care of an indwelling Foley catheter for one of 39 resident, Resident # 106. 1. The facility staff failed to develop and implement a water management program to identify the risk of Legionella. 2. Resident # 106's indwelling catheter bag was observed on the floor on several occasions. Findings include: 1. On 10/30/18 at 9:30 a.m. the facility's water management program was reviewed. A facility risk assessment to identify where Legionella and other opportunistic waterborne bacteria could grow and spread in the facility water system was not done. On 10/30/18 at 10:00 a.m. the maintenance director was interviewed about the missing information. The maintenance director stated "I don't know anything about a risk assessment; I've only been here three years. I'm also not aware about the 'toolkit' from the CDC (Centers for Disease Control) you are referencing." On 10/31/18 at 5:15 p.m. during a meeting with facility staff the administrator, DON (director of nursing), and ADON (assistant director of nursing) were informed of the above findings.	F 880	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #106 still resides in the facility and the deficient practice was corrected by nursing staff raising the bed to ensure the bag was not touching the ground. The facility has conducted a risk assessment for Legionella and have started using the CDC Tool Kit. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The nursing management team audited 100% of residents with indwelling catheters to ensure compliance with infection control. The facility also contacted a local company to conduct a water and waste analysis of the facilities water to identify the risk of Legionella. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Direct care staff consisting of CNA□s, LPN□s and RN□s were re-educated by the DON/ADON on the importance and proper procedures relating to the facilities policy labeled Infection Control. The maintenance staff were also educated by the Administrator on the Legionella Surveillance Policy. We are now utilizing the Developing Water Management program by the CDC. Indicate how the facility plans to monitor	

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	495114	A. BUILDING _____ B. WING _____	C 11/01/2018

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F 880	Continued From page 84 No further information was presented prior to the exit conference. 2. Resident #106 was admitted to the facility on 03/19/16 with the most recent readmission on 01/14/18. Diagnoses for this resident included, but not limited to: atrial fibrillation, DM, COPD, anemia, urinary retention, end stage renal disease, Parkinson's disease. The most current MDS (minimum data set) a quarterly dated 07/18/18 documented the resident with a cognitive score of 15 indicating the resident was cognitively intact for daily decision making skills. The resident was assessed as requiring extensive assistance for most all ADL's (activities of daily living), the resident was coded for hospice and as having an indwelling Foley catheter. Resident #106 was observed on 10/30/18 at 11:39 AM. The resident was laying supine in bed, eyes closed, gown on, not covered, with a Foley catheter hanging on the frame of the bed. The bed was in the lowest position, very close to the floor. The Foley catheter bag was in a privacy bag and the bag was laying on floor beside a fall mat. Resident #106 was observed again on 10/30/18 at 03:04 PM. The resident laying supine, with eyes closed, bed in the lowest position; the catheter bag was observed laying on the floor. On 10/31/18 at 02:42 PM, Resident #106 was again observed laying supine in bed, bed in the lowest position, with the Foley catheter bag laying on the floor.	F 880	its performance to make sure that solutions are sustained; The nursing management team will monitor and audit 100% of residents weekly with indwelling catheters to ensure compliance with infection control. The facility has also conducted a facility risk assessment and implemented a water management program. Results of the audit will be reported to the QAPI Committee for a period of three (3) months. The QAPI committee will determine what, if any additional interventions are needed at the end of the three month period.	

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F 880	Continued From page 85 On 10/31/18 at 02:49 PM, CNA (certified nursing assistant) #5 came into the room to give the resident a snack. The CNA was asked about the resident's bed position and fall mats. The CNA confirmed that the resident was a fall risk and should have fall mats with the bed in the lowest position. The CNA was asked if the resident's catheter was supposed to be resting on the floor. The CNA looked and stated that the Foley was supposed to be flowing down and hanging on the side of bed. The CNA was asked again if the Foley catheter bag should laying on the floor. The CNA stated that the [Foley] bag was in a privacy bag and that was ok for it to be on the floor. The CNA was asked for clarification regarding the Foley catheter bag being on the floor and was asked if it was ok for the bag to be on the floor. The CNA stated, "No, it isn't ok to be on the floor, I will get my gloves and pick it up and fix it." The resident stated, "She is supposed to use this" (pointing to the bed control, to raise the bed up off the floor). The CNA went to the bathroom, donned gloves and raised the bed, just enough to prevent the Foley catheter bag from touching/resting on the floor. Resident #106's current physician's orders were reviewed and revealed an order for a Foley catheter #18 french with bag to be changed every month and as needed, and to provide Foley catheter care every shift. The resident's current CCP (comprehensive care plan) was then reviewed and documented, "...the resident has indwelling catheter (neurogenic bladder)...Change catheter every week [sic]...position catheter bag and tubing below the level of the bladder...check tubing for kinks each shift..." No information was on the resident's	F 880		

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F 880	Continued From page 86 CCP regarding infection control practices for the Foley catheter/bag. On 10/31/18 at 5:30 p.m., the DON (director of nursing) the ADON (assistant director of nursing) and the administrator were made aware of above observations and concerns with infection control. The DON stated that the Foley catheter bag should never be resting on the floor. A policy was requested on care and maintenance of an indwelling catheter. No further information and/or documentation, specifically a policy on care and maintenance of an indwelling catheter was presented prior to the exit conference on 11/01/18 at 1:00 p.m.	F 880		