State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0108	A. BUILDING: _____ B. WING _____	03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 3/4/19 through 3/6/19. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Complaints were investigated during the survey process. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 148 at the time of the survey. The survey sample consisted of 45 current record reviews and six closed record reviews.	F 000	**F 001** **12 VAC 5-371-250 (F) & (G)** Cross References to F656 Cross Reference POC for F656 **12 VAC 5-371-200 B** - Cross Reference to F658 Cross Reference POC for F658 **12 VAC 5-371-220 C1** - Cross Reference to F686 Cross Reference POC for F686	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 250 F +G cross reference to F 656. 12 VAC 5 - 371 - 200 B - cross references to F 658. 12 VAC 5 - 371 - 220 C1 - cross references to F 686 12 VAC 5 - 371 - 220 B - cross references to F 686. 12 VAC 5- 371 - 220 B - cross refererences to F 695. 12 VAC 5 - 371 - 220 B - cross references to F 697. 12 VAC 5 - 371 - 180 A - cross references to F 880.	F 001	**12 VAC 5-371-220 B** - Cross Reference to F686 Cross Reference POC for F686 **12 VAC 5-371-220 B** Cross Reference to F695 Cross Reference POC for F695 **12 VAC 371-220 B** - Cross Reference to F697 Cross Reference POC for F697 **12 VAC 371-180 A** - Cross Reference to F880 Cross Reference POC for F880 **12 VAC 371-140** Policy and Procedures Cross Reference to F550, F622, F623 Cross Reference POC for F550, F622, F623 **12 VAC 371-150** Resident Rights Cross Reference to F550, F622, F623 Cross Reference POC for F550, F622, F623	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane D Barksdale — TITLE: Administrator — (X6) DATE: 3-28-19

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F 001	Continued From page 1 12VAC5-371-140. Policies and Procedures. Cross reference to F550, F622, F623 12VAC5-371-150. Resident Rights. Cross reference to F550, F622, F623. 12VAC5-371-360. Clinical Records. Cross reference to F622 Nursing Services 12VAC5-371-220 cross reference to F693 12VAC5-371-360. Clinical Records cross reference to F842. 12 VAC 5-371-250 (F) Cross Referenced to F-tag 657 12 VAC 5-371-220 (A) and (B) and (D) Cross Referenced to F-tag 689 12VAC5-371-110. Staff Treatment of Residents. Cross reference to F607 and F609. 12VAC5-371-140. Policies and Procedures. Cross reference to F609.	F 001	**12 VAC 371-360** Clinical Records Cross Reference to F622 Cross Reference POC for F622 **12 VAC 371-220** Nursing Services Cross Reference to F693 Cross Reference POC for F693 **12 VAC 371-360** Clinical Records Procedures Cross Reference to F842 Cross Reference POC for F842 **12 VAC 371-250 (F)** Cross Reference to F657 Cross Reference POC for F657 **12 VAC 371-220 (A) & (B) & (D)** Cross Reference to F689 Cross Reference POC for F689 **12 VAC 371-110** Staff Treatments of Residents Cross Reference to F607 & F609 Cross Reference POC for F607 & F609 **12 VAC 371-140** Policy and Procedures Cross Reference to F609 Cross Reference POC for F609 **Completion Date: April 17, 2019**	

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/04/2019 through 03/06/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/4/19 through 3/6/19. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 148 at the time of the survey. The survey sample consisted of 45 current record reviews and six closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident 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	**F550** **Corrective Action(s):** An Incident & Accident form was completed for the cafeteria style tray delivery for the residents in the cottage dining room. The staff involved in the tray delivery received one-on-one inservice training on the proper procedure for delivery and set up of resident meal trays in the dining room to provide a home-like dining experience. C.N.A. #3 involved in feeding resident #86 has been inserviced on resident Rights and Dignity regarding sitting and not standing while providing feeding assistance to residents. A facility Incident & Accident form has been completed for this incident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane W. Barksdale — TITLE: Administrator — (X6) DATE: 3-28-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

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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 observation, staff interview and facility document review, it was determined that the facility staff failed to provide a dignified, homelike dining experience in one of 3 facility dining rooms, the Cottage dining room and failed to promote resident dignity during a meal for one of 51 sampled residents, Resident # 86's. 1. In the Cottage dining room (the memory care unit), the 27 residents present for the lunch meal on 3/5/19, were served their meals cafeteria style, on trays.	F 550	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have the potentially been affected. The Administrator and/or DON will assess the dining experience and process for meal delivery in all facility dining rooms to establish a formal tray set up, delivery and feeding assistance process to ensure all staff are providing a dignified dining experience for all residents and providing appropriate assistance with their meal trays in a timely and appropriate manner. **Systemic Change(s):** Facility policy and procedures were reviewed. No changes are warranted at this time. The administrator, DON and/or Social Services will inservice all staff on the facility policy and procedure regarding resident rights and dignity. The inservice will also cover the procedure for proper meal tray delivery, set up and appropriate assistance to ensure all residents are served in a timely, dignified and home-like manner. **Monitoring:** The DON and Administrator are responsible for compliance. The DON, Administrator and/or designee will complete the 3 random meal pass audits weekly to monitor for compliance. All negative findings will be corrected at the time of discovery. The audit findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: April 17, 2019**	

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F 550	Continued From page 2 2. The facility staff failed to respect Resident # 86's dignity by standing next to her while providing assistance with feeding during the breakfast meal on 3/6/19. The findings include: 1. On 3/05/19 at 1:08 p.m., observation of the Cottage dining room was conducted during the lunch meal. There were 27 residents in the dining room when the tray cart arrived at this time. The dining room staff served all 27 residents their meal on the trays, cafeteria style. No attempt was made to remove the residents' meals from the trays and place them on the table for a homelike dining experience. On 3/05/19 at 3:44 p.m., an interview was conducted with CNA #4 (Certified Nursing Assistant), one of the staff members serving the residents. When asked if the residents should be served their meals that way, CNA #4 stated, "That's how I've been taught for 9 years." When asked if that is a cafeteria or homelike dining experience, CNA #4 she stated, "Cafeteria." When asked what kind of dining experience are they supposed to have, CNA #4 stated, "A home setting." When asked is it homelike if they are being served on trays, CNA #4 stated, "Probably not, I don't think so." CNA #4 then stated, "It isn't that way on the other units but on this unit that is how they do it. I don't know if it is because it is a different unit." When asked should it be different, CNA #4 stated, "No, it should be the same." A review of the facility policy "Quality of Life - Dignity" documented, "1. Residents shall be treated with dignity and respect at all times. 2. "Treated with dignity" means the resident will be	F 550		

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F 550	Continued From page 3	F 550		

assisted in maintaining and enhancing his or her self-esteem and self-worth..." The policy did not specifically identify what style of dining should be utilized for a dignified, homelike dining experience.

On 3/05/19 at 5:07 p.m., ASM #1 (Administrative Staff Member - The Administrator) was made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to respect Resident # 86's dignity by standing next to her while providing assistance with feeding.

Resident # 86 was admitted to the facility on 04/17/15 with diagnoses that included but were not limited to: schizophrenia (1), anxiety (2), bipolar disorder (3), and dysphagia (4).

Resident # 86's most recent comprehensive MDS (minimum dada set) a quarterly assessment with an ARD (assessment reference date) of 01/12/19 coded the resident as scoring a 6 (six) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 6 (six) being severely impaired of cognition for daily decision making. Resident # 86 was coded as totally dependent of one staff member for activities of daily living. Resident # 86 was coded as totally dependent of one staff member for eating. Under Section K "Swallowing/Nutritional Status" Resident # 86 was coded as having a mechanically altered diet.

On 03/06/19, an observation was conducted of Resident # 86 from 8:33 a.m. to 8:44 a.m. Resident # 86 was observed in her bed with the head of the elevated and the bed lowered close to the floor. CNA (certified nursing assistant) # 3 was observed bringing in Resident # 86's

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breakfast on a tray. CNA # 3 then placed the breakfast tray on Resident # 89's over-the-bed table, opened all the containers moved the table over the bed in front of Resident # 86 and provided verbal prompts to encourage Resident # 86 to try to feed herself. While standing next to Resident # 86's bed, CNA # 3 provided total assistance to Resident # 86 by feeding her the breakfast meal.

On 03/06/19 at 8:46 a.m., an interview was conducted with CNA # 3. When asked if Resident # 86 was able to feed herself, CNA # 3 stated, 'Yes but she doesn't eat much so I provide assistance to try and get her to eat more." When asked what her position should be when assisting a resident with eating, CNA # 3 stated, "I should be sitting down." When asked if she was sitting down while feeding Resident # 86 her breakfast, CNA # 3 stated, "No I didn't think about it. I just wanted to get it done." When asked why it is important to sit next to or in front of a resident when feeding them, CNA # 3 stated, "So you can be eye level with them."

The comprehensive care plan for Resident # 86 dated 01/12/9 documented, "Problem/Need. NUTRITIONAL RISK DUE TO MULTIPLE DIAGNOSIS MECHANICALLY ALTERED DIET RESTRICTIONS BELOW NORMAL IBW (ideal body weight) RANGE. Swallowing issues. Poor intake." Under "Approaches" it documented, "Provide diet as ordered. Monitor weight as ordered. Monitor and provide food preferences."

The facility's "Resident Rights" documented, "10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his

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F 550	Continued From page 5 personal needs." The facility's policy "Quality of Life - Dignity" documented, "policy Statement. Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality." Under "Policy Interpretation and Implementation" it documented, "2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 12. Staff shall treat cognitively impaired residents with dignity and sensitivity." The facility's policy "Assistance with Meals" documented, "3. Residents Requiring Full Assistance: b. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: (1) Not standing over residents while assisting them with meals ..." On 03/26/19 at approximately 3:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (3) A brain disorder that causes unusual shifts in	F 550		

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F 550	Continued From page 6 mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of 51 residents in the survey sample, Resident # 89. The facility staff failed to ensure Resident # 89's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. The findings include: Resident # 89 was admitted to the facility on 12/22/93 with a re-admission of 04/14/16 with diagnoses that included but were not limited to intellectual disabilities (1), dementia (2),	F 558	**F558** **Corrective Action(s):** Resident #89's call bell was corrected and is now properly placed. CNA #3 was inserviced on checking for the proper placement of resident call bell for resident #89. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. The DON, ADON and/or unit managers will screen 100% of residents for proper call bell placement and use to identify residents at risk. This is to include adaptive call bells. Any/all negative findings identified will be corrected at the time of discovery. An Incident and Accident form will be completed for each negative finding.	

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F 558	Continued From page 7 gastroesophageal reflux disease (3) and Parkinson's disease (4). Resident # 89's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/16/19, coded Resident # 89 as scoring an 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 89 was coded as being totally dependent of one staff member for activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 89 as "No impairment" on both sides of her upper extremities (shoulder, elbow, wrist, hand). On 03/04/19 at approximately 7:00 p.m., an observation of Resident # 89 revealed she was lying in bed, awake, neat and clean. The head of the bed was slightly raised and a pillow was under Resident # 89's head. Observation of the call bell's placement revealed it was lying on the floor on the left side of the bed. When asked if she could locate the call bell Resident # 89 was unable to respond to the request and verbalized unintelligible speech On 03/05/19 at 3:04 p.m., an observation of Resident # 89 revealed she was lying in bed, awake, neat and clean. The head of the bed was slightly raised and a pillow was under her head. Observation of the call bell's placement revealed it was hanging off the left side of the bed just above the floor not within reach of Resident # 89. On 03/06/19 at 8:33 a.m., an observation of Resident # 89 revealed she was lying in bed,	F 558	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes warranted at this time. All staff will be inserviced by the DON on the proper placement and use of resident call bells to ensure they are properly placed within reach of all residents when in their rooms. **Monitoring:** The Unit Managers are responsible for maintaining compliance. DON and/or Unit Managers will complete random daily rounds throughout the day to monitor for correct placement of call bells to monitor for compliance. Any negative findings will be corrective at time of discovery and disciplinary action will be taken as required. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: April 17, 2019**	

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F 558	Continued From page 8	F 558		

awake, neat and clean, watching television. The head of the bed was slightly raised. Observation of the call bell revealed it was a flat pressure switch. Observation of the call bell's placement revealed it was hanging off the left side of the bed just above the floor not within reach of Resident # 89.

On 03/06/19 at 8:46 a.m., an observation of Resident # 89's call bell placement was conducted with CNA (certified nursing assistant) # 3. When asked if the call bell was placed in a position that Resident # 89 could reach and activate sated, "It's not in reach." When asked to describe the procedure for the placement of a cell bell for a resident CNA # 3 stated, "They should be placed in reach for when they need you. When asked how often the placement of the call bell should be checked CNA # 3 stated, "Every time you go into the room." When asked if she was in Resident # 89's room earlier that morning CNA # 3 stated, "I brought in tray for breakfast and set her up to feed herself and I just didn't think to check the call bell."

On 03/26/19 at approximately 3:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as

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F 558	Continued From page 9 autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.	F 558		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607	**F607** **Corrective Action(s):** A facility Incident and Accident form was completed for the resident to resident altercation and potential abuse between resident #29 and resident #123 that was not reported in the required 2-hour time frame.	

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F 607	Continued From page 10 by: Based on staff interview, clinical record review, facility document review, and in the course of an investigation of a Facility Reported Incident (FRI), it was determined that the facility staff failed to implement abuse policies and procedures for reporting allegations of potential abuse for two of 51 residents in the survey sample; Resident #29 and Resident #123. The facility staff failed to implement the abuse policy to ensure timely reporting to the State Agency and other officials of a resident to resident altercation and potential abuse between Resident #29 and Resident #123 that occurred on 4/25/19 at approximately 6:30 p.m. The incident was not reported until 4/26/19 at 11:04 a.m., approximately 16 hours after the incident occurred. The findings include: Resident #29 was admitted to the facility on 3/12/15 with the diagnoses of but not limited to cerebral vascular disease, high blood pressure, diabetes type 2, anxiety, depression, psychosis with hallucinations. Resident #29's Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/14/18, and coded Resident #29 as severely cognitively impaired in ability to make daily life decisions. The resident required total care for hygiene, bathing, dressing, ambulation, transfers; limited assistance for eating; and was incontinent of bowel and bladder. Resident #123 was admitted to the facility on 5/29/12 with the diagnoses of but not limited to dementia, depression, and asthma. The most	F 607	**Identification of Deficient Practices and Corrective Action(s):** All residents involved in resident to resident altercations may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 60 days have been reviewed to identify residents at risk for late reporting of resident to resident altercations with potential abuse allegations. Any/all negative findings will be reviewed, and a facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The Policy & Procedure for reporting and investigating abuse, neglect, misappropriation of resident property and injuries or unusual/unknown occurrences has been reviewed. No changes are warranted at this time. All staff will be inserviced and issued copies of the Abuse and Investigation Policy and Procedure. These educational inservices will focus on prevention, identifying, reporting, and investigating incidents and allegations of abuse, neglect or mistreatment of residents that are reported. The Administrator is responsible for completing internal investigations for all reported incidents of unknown origin, abuse, neglect, unusual occurrences, misappropriation of resident property and resident to resident altercations. The Administrator will review all findings and verify that the appropriate notification to the RP, attending physician and State agencies was completed as indicated.	

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F 607	Continued From page 11 recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 1/16/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for dressing, toileting, hygiene and bathing; and limited assistance for transfers and eating. A review of a FRI (Facility Reported Incident) investigation dated 4/25/18 involving Resident #29 and Resident #123 documented the following: "At approximately 6:30 p.m., name of [Resident #29] and name of [Resident #123] were seen by name of [CNA #5] swinging at each other. The residents were located in the commons are of unit 400. Name of [Resident #29] lost his balance and fell hitting the back of his head on the wall. The residents were immediately separated. A head to toe assess was done by name of LPN #7 (Licensed Practical Nurse). Name of [Resident #123] was found to have two small scratches on the back of his neck. Name of [Resident #29] does not have any visible injury at this time. Both residents deny pain or discomfort. RP and MD [responsible party and medical doctor] are aware. Both residents were place on Q [every] 15 minute checks for 48 hours to monitor behaviors. There have been no further incidents at this time. An investigation is in progress and final outcome to follow." Further review of the FRI investigation revealed witness statements as follows: A written statement dated 4/25/18 by CNA #5 documented, "I came around the corner and	F 607	**Monitoring:** The Administrator is responsible for compliance. All resident to resident incidents, resident abuse and neglect allegations, unusual occurrences and injuries of unknown origin will be thoroughly investigated, reported to the RP, attending physicians and appropriate agencies as needed and implement disciplinary action for staff members as warranted. Confidential files of all reported incidents and all follow-up documentation will be maintained in the Administrator's office. All incidents will be thoroughly investigated. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: April 17, 2019**	

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F 607	Continued From page 12	F 607		

name of resident [Resident #29] and name of resident [Resident #123] were fighting. So I hollered for name of [CNA #6] and tried to break it up. Then name of [Resident #29] fell on the floor while they were fighting and hit his head on the wall then name of [CNA #6] and name of [CNA #7] were able to make them stop fighting and picked name of [Resident #29] up off the floor."

A written statement dated 4/25/18 by CNA #6 documented, "I was coming down the hall when another CNA asked me for help with names of [Resident #123 and Resident #29]. When I got over there I helped get them apart. Neither one of them said anything."

A written statement dated 4/25/18 by CNA #7 documented, "Coming back on unit, dont {sic} no {sic} how is {sic} started. Name of [CNA #5] call for another CNA. Then I came around and name of [Resident #29] was punching name of [Resident #123]. Name of [Resident #123] was cursing and trying to pull is {sic} arm away from name of [Resident #29] and we separted {sic} the two. Got name of [Resident #29] off floor. Name of [Resident #123] just told name of [Resident #29] turn him the hell a loose."

Further review of the FRI revealed that on 4/26/18 at approximately 11:04 a.m., the facility faxed the FRI to the Office of Licensure (OLC) as noted on the fax confirmation report.

An interview was conducted on 3/5/19 at approximately 5:24 p.m., with the ASM #1 (Administrative Staff Member, the Administrator). When asked about the reporting date and time of the FRI, ASM #1 stated, "I don't have an answer right now to be honest with you. Let me look to

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F 607	Continued From page 13 see when I was notified." When asked which facility staff report FRI to the OLC, ASM #1 stated, "the supervisor, the DON (Director of Nursing), the ADON (Assistant Director of Nursing) and the Assistant Administrator." In a follow up interview on 3/7/19 at approximately 6:26 p.m., with AMS #1, she stated, "I have no further information and it was my fault it was missed." A review of the facility policy, "Abuse, Neglect and Exploitation Prevention and Reporting" documented, "The Administrator, Director of Nursing or facility appointed designee should report allegations or suspected abuse, neglect or exploitation immediately to: Administrator...OLC...Other state Agencies in accordance with State Law...In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must:...Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse...to the administrator of the facility and to other official (including the State Survey Agency...in accordance with State Law." No further information was provided by the end of the survey.	F 607		
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:	F 609	**F609** **Corrective Action(s):** A facility Incident and Accident form was completed for the resident to resident altercation and potential abuse between resident #29 and resident #123 that was not reported in the required 2-hour time frame.	

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F 609	Continued From page 14 §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 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, clinical record review, facility document review, and in the course of an investigation of a Facility Reported Incident (FRI), it was determined that the facility staff failed to implement abuse policies and procedures for reporting allegations of potential abuse for two of 51 residents in the survey sample; Resident #29 and Resident #123. The facility staff failed to ensure timely reporting to the State Agency and other officials in accordance with State law through established	F 609	**Identification of Deficient Practices & Corrective Action(s):** All residents may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 60 days have been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties. **Systemic Change(s):** The facility Policy and Procedure for reporting resident abuse & neglect has been reviewed and no changes are warranted at this time. All facility administrative staff will be inserviced on the facility Abuse prevention and reporting policy and procedures regarding reporting, investigation and proper notification to state agencies of allegations of abuse, neglect, misappropriation of resident property, injuries of unknown origin and resident to resident altercations by the Regional Nurse Consultant. All facility staff will be inserviced on the Abuse prevention, investigation and reporting policy and procedure. These educational inservices will focus on prevention, identifying, reporting and investigating incidents and allegations of abuse, neglect or mistreatment of residents, resident to resident altercations and misappropriation of property that are reported. The Administrator is responsible for completing internal investigations for all reported incidents of injuries of unknown	

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F 609	Continued From page 15 procedures for a resident to resident altercation and potential abuse between Resident #29 and Resident #123 that occurred on 4/25/19 at approximately 6:30 p.m. The incident was not reported to the State Agency until 4/26/19 at 11:04 a.m., approximately 16 hours after the incident occurred. The findings include: Resident #29 was admitted to the facility on 3/12/15 with the diagnoses of but not limited to cerebral vascular disease, high blood pressure, diabetes type 2, anxiety, depression, psychosis with hallucinations. Resident #29's Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/14/18, and coded Resident #29 as severely cognitively impaired in ability to make daily life decisions. The resident required total care for hygiene, bathing, dressing, ambulation, transfers; limited assistance for eating; and was incontinent of bowel and bladder. Resident #123 was admitted to the facility on 5/29/12 with the diagnoses of but not limited to dementia, depression, and asthma. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 1/16/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for dressing, toileting, hygiene and bathing; and limited assistance for transfers and eating. A review of a FRI (Facility Reported Incident) investigation dated 4/25/18 involving Resident #29 and Resident #123 documented the	F 609	origin, abuse, neglect, unusual occurrences, misappropriation of resident property and resident to resident altercations. The administrator will review all findings and verify that the appropriate notification to the RP, attending physician and State agencies was completed as indicated. **Monitoring:** The Administrator is responsible for maintaining compliance. All Facility Incident & Accidents forms will be reviewed daily by the Administrator to ensure any reportable items are investigated and reported as required. Confidential files of reported incidents and all follow-up documentation will be maintained in the Administrator's office. The Risk Management Committee will review I&A Reports to identifying and/or correcting negative patterns of completion weekly. All negative findings will be reported and investigated. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: April 17, 2019**	

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F 609	Continued From page 16	F 609		

following:

"At approximately 6:30 p.m., name of [Resident #29] and name of [Resident #123] were seen by name of [CNA #5] swinging at each other. The residents were located in the commons are of unit 400. Name of [Resident #29] lost his balance and fell hitting the back of his head on the wall. The residents were immediately separated. A head to toe assess was done by name of LPN #7 (Licensed Practical Nurse). Name of [Resident #123] was found to have two small scratches on the back of his neck. Name of [Resident #29] does not have any visible injury at this time. Both residents deny pain or discomfort. RP and MD [responsible party and medical doctor] are aware. Both residents were place on Q [every] 15 minute checks for 48 hours to monitor behaviors. There have been no further incidents at this time. An investigation is in progress and final outcome to follow."

Further review of the FRI investigation revealed witness statements as follows:

A written statement dated 4/25/18 by CNA #5 documented, "I came around the corner and name of resident [Resident #29] and name of resident [Resident #123] were fighting. So I hollered for name of [CNA #6] and tried to break it up. Then name of [Resident #29] fell on the floor while they were fighting and hit his head on the wall then name of [CNA #6] and name of [CNA #7] were able to make them stop fighting and picked name of [Resident #29] up off the floor."

A written statement dated 4/25/18 by CNA #6 documented, "I was coming down the hall when another CNA asked me for help with names of

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[Resident #123 and Resident #29]. When I got over there I helped get them apart. Neither one of them said anything."

A written statement dated 4/25/18 by CNA #7 documented, "Coming back on unit, dont {sic} no {sic} how is {sic} started. Name of [CNA #5] call for another CNA. Then I came around and name of [Resident #29] was punching name of [Resident #123]. Name of [Resident #123] was cursing and trying to pull is {sic} arm away from name of [Resident #29] and we separted {sic} the two. Got name of [Resident #29] off floor. Name of [Resident #123] just told name of [Resident #29] turn him the hell a loose."

Further review of the FRI revealed that on 4/26/18 at approximately 11:04 a.m., the facility faxed the FRI to the Office of Licensure (OLC) as noted on the fax confirmation report.

An interview was conducted on 3/5/19 at approximately 5:24 p.m., with the ASM #1 (Administrative Staff Member, the Administrator). When asked about the reporting date and time of the FRI, ASM #1 stated, "I don't have an answer right now to be honest with you. Let me look to see when I was notified." When asked which facility staff report FRI to the OLC, ASM #1 stated, "the supervisor, the DON (Director of Nursing), the ADON (Assistant Director of Nursing) and the Assistant Administrator."

In a follow up interview on 3/7/19 at approximately 6:26 p.m., with AMS #1, she stated, "I have no further information and it was my fault it was missed."

A review of the facility policy, "Abuse, Neglect and

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F 609	Continued From page 18 Exploitation Prevention and Reporting" documented, "The Administrator, Director of Nursing or facility appointed designee should report allegations or suspected abuse, neglect or exploitation immediately to: Administrator...OLC...Other state Agencies in accordance with State Law...In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must:...Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse...to the administrator of the facility and to other official (including the State Survey Agency...in accordance with State Law." No further information was provided by the end of the survey.	F 609		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622	**F622** **Corrective Action(s):** The facility staff failed to ensure the comprehensive care plan goals were submitted to the receiving hospital for Residents #38, #45, #95, #137, #141 and #153 when transferred to the hospital. A facility Incident & Accident Form has been completed for each resident involved. The facility staff failed to provide the receiving Hospital with the appropriate information when transferring resident #92 to the hospital to include, the attending physician contact information, Resident Representative contact information, resident and comprehensive care plan goals for Resident #92.	

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F 622	Continued From page 19 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)	F 622	**Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The DON, ADON and/or Unit Managers will conduct a 100% audit of all residents who have been discharged and/or transferred from the facility in the past 30 days to identify residents that did not have the required documentation submitted to the receiving facility. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice facility licensed staff on the documentation required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outside health care facility. **Monitoring:** The DON/designee will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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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 622	Continued From page 20 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to evidence all required documentation was provided to the receiving facility at the time of a facility initiated transfer, for seven of 51 sampled residents; (Residents #95, #141, #137, #45, #153, #92, and #38).	F 622		

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F 622	Continued From page 21 1. The facility staff failed to evidence that the comprehensive care plan goals for Resident #95 were provided to the receiving facility when the resident was transferred to the hospital on 1/11/19. 2. The facility staff failed to evidence that the comprehensive care plan goals for Resident #141 were provided to the receiving facility when the resident was transferred to the hospital on 12/13/18, 12/23/18, and 1/23/19. 3. The facility staff failed to evidence that comprehensive care plan goals for Resident # 137 were sent with the resident to the hospital for the transfer on 02/19/19. 4. The facility staff failed to provide the receiving facility with the Resident #45's comprehensive care plan goals for a facility initiated hospital transfer that occurred on 11/25/18. 5. The facility staff failed to evidence that the comprehensive care plan goals for Resident #153 were provided to the receiving facility when the resident was transferred to the hospital on 2/15/19. 6. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #92 was transferred to the hospital on 10/3/18. 7. The facility staff failed to evidence that the comprehensive care plan goals were provided to	F 622		

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F 622	Continued From page 22 the receiving facility when Resident #38 was transferred to the hospital on 11/9/18. The findings include: 1. The facility staff failed to evidence that the comprehensive care plan goals for Resident #95 were provided to the receiving facility when the resident was transferred to the hospital on 1/11/19. Resident #95 was admitted to the facility on 1/26/17 with the diagnoses that included, but are not limited to atrial fibrillation, stroke, dementia with behaviors, bipolar disorder, anxiety disorder, and dysphagia. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 1/25/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 1/11/19 at 11:24 a.m. that documented, "Resident reported to have discoloration to left lower extremity. Resident assessed by supervisor and pedal pulses unable to be found. Provider called and order obtained to send patient to ER (emergency room) for evaluation. RP (responsible party) called and messages left for two contacts to call back for updates. (Name of county) called for emergency transport. Resident unable to understand reason for transport and is unable to sign bed hold form. (Name of hospital) ER called and given report to (name of ER staff). (Name of county ambulance) departing with patient at 10:33 am to (name of	F 622		

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F 622	Continued From page 23 hospital) ER." Further review of the clinical record failed to reveal what documentation was provided to the hospital. On 3/06/19 at 2:04p.m., an interview was conducted with LPN #8 (Licensed Practical Nurse), the unit manager for Resident #95. LPN #8 stated that when the resident goes to the hospital, the facility sends 2 copies of the facesheet, one for transport and one for hospital, the resident's History and Physical, immunization record, last recertification, last progress note, labs, Medication Administration Record, the transfer form, and the bed hold policy agreement. When asked about the comprehensive care plan goals, LPN #8 stated, "We do not send the care plan." When asked what is included on the transfer form. LPN #8 stated, "The resident's name, date time, where they are being sent to, the address, phone number, allergies, the reason for sending them, the code status. We use a checklist; it is in a packet of forms to be filled out." LPN #8 provided a copy of this packet and checklist. A review of the "When Sending A Resident To The Hospital" checklist failed to include that comprehensive care plan goals must be provided. The facility policy, "Transfer or Discharge, Emergency" was reviewed. The policy did not include requirements of what documentation, including comprehensive care plan goals, must be provided to the receiving facility. On 3/06/19 at 6:36 p.m., ASM #1 (Administrative Staff Member - the Administrator) was made aware of the findings. No further information was	F 622		

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F 622	Continued From page 24 provided by the end of the survey. 2. The facility staff failed to evidence that the comprehensive care plan goals for Resident #141 were provided to the receiving facility when the resident was transferred to the hospital on 12/13/18, 12/23/18, and 1/23/19. Resident #141 was admitted to the facility on 8/7/14 with diagnoses that include but are not limited to dementia with behaviors, psychosis, psychotic disorder with hallucinations and delusions, anxiety disorder, glaucoma, chronic obstructive pulmonary disease, abdominal aortic aneurysm, Parkinsonism, benign prostatic hyperplasia, ileus, and dysphagia. The most recent MDS (Minimum Data Set) was a 30 day readmission assessment with an ARD (Assessment Reference Date) of 3/6/19. The resident was coded as being mildly impaired in ability to make daily life decisions. A review of the clinical record revealed the following: Regarding the 1/23/19 hospitalization: A nurse's note dated 1/23/19 documented, "Nurse was at the nursing station when the gentleman that transports residents across the street for church service at 7 pm states that he went in resident's room and resident was unresponsive and drooling allover {sic} himself....charge nurse immediately went to evaluate resident. Resident noted to be slouched over to the right side of his wheelchair and drool dripping from mouth....Nurse called out resident's name a couple of times with no response so then nurse performed a forceful sternal rub again no	F 622		

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F 622	Continued From page 25 stimulation verbally or physically from resident....Supervisor contacted MD (medical doctor) to make aware of resident's condition. Order obtained to send to ER (emergency room) for further evaluation....Charge nurse stayed with resident upon nursing assessment right sided face droop present, both pupils fixed, resident unable to speak all these symptoms are new onset. Symptoms appear to be stroke like....EMS (emergency medical service) arrived to transport resident via stretcher to (name of hospital) for further evaluation...." Regarding 12/23/18 hospitalization: A nurse's note dated 12/23/18 documented, "At 5:30 am CNA (certified nursing assistant) notified this writer of rectal bleeding; upon assessment: moderate amount dark red blood, mixed with clots oozing from rectum; blood continued to ooze post area being cleansed....order given to transfer resident to acute care...." Regarding 12/13/18 hospitalization: A nurse's note dated 12/13/18 documented, "Resident being transported to (hospital) via ambulance for eval (evaluation) of possible ileus and obstruction. Resident started with cold symptoms on 12/8 (2018) which led to a chest x-ray to rule out pneumonia....the chest x-ray suggested possible colonic ileus, MD (medical doctor) made aware. MD ordered KUB (Kidney, Ureter, Bladder test) to investigate since resident had two bowel movements on the 11th. KUB performed on the 12th, called for results on the 13th, verbal results given as positive for colonic ileus, possible obstruction and abnormal gas pattern. MD notified and order obtained to send to hospital for eval (evaluation)...."	F 622		

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F 622	Continued From page 26	F 622		

Further review of the clinical record failed to reveal what documentation was provided to the hospital for each of the above hospitalizations.

On 3/06/19 at 2:22 p.m., in an interview with RN #1 (Registered Nurse, the unit manager for Resident #141), when asked what paperwork is sent to the hospital, he stated, "We send the transfer packet, face sheet, immunizations, we go right down the checklist." When asked if the comprehensive care plan goals are sent, RN #1 stated, "We do not send the care plan goals."

A review of the "When Sending A Resident To The Hospital" checklist failed to include that comprehensive care plan goals must be provided.

The facility policy, "Transfer or Discharge, Emergency" was reviewed. The policy did not include requirements of what documentation, including comprehensive care plan goals, must be provided to the receiving facility.

On 3/06/19 at 6:36 p.m., ASM #1 (Administrative Staff Member - the Administrator) was made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to evidence that comprehensive care plan goals for Resident # 137 were sent with the resident to the hospital for the transfer on 02/19/19.

Resident # 137 was admitted to the facility on 01/08/2017 with a readmission of 02/21/19 with diagnoses that included but were not limited to sepsis (1), gastrostomy (2), and hemiplegia (3). Resident # 137's most recent MDS (minimum

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F 622	Continued From page 27 data set), a quarterly assessment with an ARD (assessment reference date) of 02/14/19, coded Resident # 137 as scoring a 3 (three) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 3(three) - being severely impaired of cognition for making daily decisions. The nurse's "Progress Notes," dated 02/19/2019 for Resident # 137 documented, "On last evening rounds this shift (2/18/19) resident was noted with (increased) audible congestion and had rbronchi (right bronchial) [lung] in upper lobes and rattles in all lung fields. VS (vital signs) were 101.8 (temperature), 189/96 (189 over 96 blood pressure). Pulse went to 127. PRN (as needed) Tylenol elixir 20.3 cc (cubic centimeters) per peg (tube feeding) given for (increased) temp (temperature) with cool water via (by) peg. Pox (Pulse oximetry) 88-91% on O2 (oxygen) 2 (two) L/nc (liters by nasal cannula), O2 (increased) to 4l?nc. NP (nurse practitioner) (Name of Nurse Practitioner) notifies and [sic] ordered send resident out to [sic] hospital ER (emergency room) for evaluation. RP (responsible party) (Name of Responsible Party) made aware and stated she would decline bed hold offer. Squad notified and in to p/u (pick up) resident at 0015 (12:15 a.m.), [sic] nonbreather mask applied, pox (increased) to 95% with O2. (Name of Transport) squad left facility with resident for (Name of Hospital) via stretcher at 0030 (12:30 a.m.) RP was called back and notified that resident was sent to (Name of Hospital) ER. Stated to let her know if resident will be admitted to hospital."." Review of the clinical record and the facility's "Resident Transfer Form" dated 02/19/19 for Resident # 137 failed evidence documentation that the care plan goals were sent to (Name of	F 622		

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F 622	Continued From page 28 Hospital) upon the transfer of Resident # 137. On 3/06/19 at 2:04p.m., an interview was conducted with LPN #8 (Licensed Practical Nurse), the unit manager for Resident #95. LPN #8 stated that when the resident goes to the hospital, the facility sends 2 copies of the facesheet, one for transport and one for hospital, the resident's History and Physical, immunization record, last recertification, last progress note, labs, Medication Administration Record, the transfer form, and the bed hold policy agreement. When asked about the comprehensive care plan goals, LPN #8 stated, "We do not send the care plan." The facility policy, "Transfer or Discharge, Emergency" was reviewed. The policy did not include requirements of what documentation, including comprehensive care plan goals, must be provided to the receiving facility. On 03/06/19 at approximately 3:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm. (2) A gastrostomy feeding tube insertion is the	F 622		

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F 622	Continued From page 29 placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm. (3) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 4. The facility staff failed to provide the receiving facility with the Resident #45's comprehensive care plan goals for a facility initiated hospital transfer that occurred on 11/25/18. Resident # 45 was admitted to the facility on 07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to: retention of urine, urinary tract infection (1), benign prostatic hyperplasia (2), diabetes mellitus (3) and hypertension (4). Resident # 45's most recent MDS (minimum data set), a 30-day assessment with an ARD (assessment reference date) of 12/19/18, coded Resident # 45 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. The nurse's "Progress Notes," dated 11/25/2018	F 622		

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for Resident # 45 at 11:53 p.m. documented, "At end of evening shift (2200) [10:00 p.m.] res (resident) was again offered water and juice, refused both. Total intake for shift was approx. (approximately) 120 cc (cubic centimeters), with much effort. Res cont (continues) to say "I don't want any water or juice." Foley (catheter) 0 (zero) - (to) 100 cc cloudy amber urine, no stool in colostomy bag this shift. Res denies any pain when asked. At 2230 (10:30 p.m.) NP (nurse practitioner) (Name of Nurse Practitioner) notified and gave verbal order to send resident out to hospital ER (emergency room) for evaluation to rule out possible bowel obstruction. Night supervisor was made aware. Attempts made to contact RP (responsible party) on all 3 numbers. (Name of Transport) squad in, stated both (Name of two Hospitals) were on diversion. Call placed by EMT (emergency medical technician) to (Name of Hospital) ER nurse, who stated they had no available beds but would accept resident with possible transfer to another hospital. Squad left with res en route to (Name of Hospital) at 2345 (11:45 p.m.)."

Review of the facility's "Resident Transfer Form" dated 11/25/18 for Resident # 45 failed evidence documentation that the care plan goals were sent to (Name of Hospital) upon the transfer of Resident # 45.

On 3/06/19 at 2:04p.m., an interview was conducted with LPN #8 (Licensed Practical Nurse), the unit manager for Resident #95. LPN #8 stated that when the resident goes to the hospital, the facility sends 2 copies of the facesheet, one for transport and one for hospital, the resident's History and Physical, immunization record, last recertification, last progress note,

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labs, Medication Administration Record, the transfer form, and the bed hold policy agreement. When asked about the comprehensive care plan goals, LPN #8 stated, "We do not send the care plan."

The facility policy, "Transfer or Discharge, Emergency" was reviewed. The policy did not include requirements of what documentation, including comprehensive care plan goals, must be provided to the receiving facility.

On 03/06/19 at approximately 3:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.

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

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

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

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F 622	Continued From page 32 essure.html. 5. The facility staff failed to evidence that the comprehensive care plan goals for Resident #153 were provided to the receiving facility when the resident was transferred to the hospital on 2/15/19. Resident #153 was admitted to the facility on 9/13/16. Diagnoses for Resident #153 included but are not limited to dementia with behavioral disturbances, bipolar disorder, high blood pressure, and asthma. Resident #153's Minimum Data Set (MDS) was a significant change in status assessment with an Assessment Reference Date (ARD) of 1/15/19, and coded Resident #153 as severely impaired for cognitive skills for daily decision-making. A review of the clinical record revealed a nurse's note dated 2/15/19 at 12:45 p.m., that documented, "1:1 monitoring has continued since beginning of shift. at 1140-(Name of Doctor) in and spoke with md (medical doctor) re (regarding): transferring resident to more appropriate setting for safety of resident and other, and order written to go to (Name of hospital) er (Emergency Room) for psych (psychiatric) eval (evaluation) for possible admission re: behaviors. This writer left msg (message) for rp (Responsible Party) to return call to facility. resident was oriented that he was being sent to (Name of hospital) er in (Name of town, state) by stretcher for eval (evaluation) and possible admit to hospital to help with his previous behaviors, resident smiled and said 'okay.' at 1150 spoke with (Name of transport staff) at (Name of transport ambulance) to transport resident to (Name of hospital) er. at 1225 2 attendants with (Name of transport	F 622		

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F 622	Continued From page 33 ambulance) in facility and enroute via stretcher to (Name of hospital) er at 1235. at 1242 report was given to (name of ER staff) rn (Registered Nurse) at (Name of hospital) er." Further review of the clinical record failed to reveal what documentation was provided to the hospital. On 3/06/19 at 2:04p.m., an interview was conducted with LPN #8 (Licensed Practical Nurse), the unit manager for Resident #95. LPN #8 stated that when the resident goes to the hospital, the facility sends 2 copies of the facesheet, one for transport and one for hospital, the resident's History and Physical, immunization record, last recertification, last progress note, labs, Medication Administration Record, the transfer form, and the bed hold policy agreement. When asked about the comprehensive care plan goals, LPN #8 stated, "We do not send the care plan." The facility policy, "Transfer or Discharge, Emergency" was reviewed. The policy did not include requirements of what documentation, including comprehensive care plan goals, must be provided to the receiving facility. On 3/7/19 at approximately 6:26 p.m., AMS #1 (Administrative Staff Member - the Administrator) was made aware of the findings. No further information was provided by the end of the survey. 6. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for	F 622		

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ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #92 was transferred to the hospital on 10/3/18.

Resident #92 was admitted to the facility on 11/3/11. Resident #92's diagnoses included but were not limited to high blood pressure, high cholesterol and convulsions. Resident #92's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/19, coded the resident as being cognitively intact.

Review of Resident #92's clinical record revealed the resident presented with a fever and nausea, and was transferred to the hospital on 10/3/18. Further review of Resident #92's clinical record (including nurses' notes) failed to reveal evidence that the facility staff provided the required information to hospital staff when the resident was transferred.

On 3/6/19 at 10:28 a.m., an interview was conducted with LPN (licensed practical nurse) #4 and RN (registered nurse) #1. LPN #4 and RN #1 were asked to describe the information that is provided to hospital staff when a resident is transferred to the hospital. LPN #4 stated she provides physician orders, recent labs, recent x-rays, a history and physical, immunization record and face sheet. LPN #4 confirmed she does not provide comprehensive care plan goals. LPN #4 stated the nurses have a transfer form with instructions and a check off list. RN #1 stated a copy containing all the information on the check off list is sent to the hospital and a copy is placed in the resident's clinical record. RN #1 stated the process for sending information to the

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hospital had been revised multiple times over the last year and the process was recently revised so he was not sure if this process was in place when Resident #92 was transferred to the hospital.

On 3/6/19 at 3:41 p.m., RN #1 confirmed he could not provide evidence that the required information was provided to hospital staff when Resident #92 was transferred to the hospital on 10/3/18.

On 3/6/19 at 4:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the regional vice president of operations) was made aware of the above concern.

No further information was presented prior to exit.
7. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving facility when Resident #38 was transferred to the hospital on 11/9/18.

Resident #38 was admitted to the facility on 12/15/16 with a recent readmission on 11/21/18, with diagnoses that included but were not limited to: urinary tract infection, diabetes, depression, dementia, kidney stones, and sepsis (destruction of tissue by bacterial toxins, contamination, infection) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 2/27/19, coded the resident as having both short and long term memory difficulties.

The nurse's note dated 11/10/18 at 2:02 a.m. documented in part, "Late entry for evening shift - Res (resident) rested well in bed, IV (intravenous) of NS (normal saline) infusing in rt (right)

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F 622	Continued From page 36 forearm...Noted with increased coughing episode at supper, only ate a few bites. RP (responsible party) in to visit. Attendants in to pick up resident for (Name of Hospital) for evaluation of lethargy and decreased intake." Review of the clinical record failed to reveal any documentation evidencing what information was provided to the receiving hospital at the time of the residents transfer on 11/10/19. On 3/06/19 at 2:04p.m., an interview was conducted with LPN #8 (Licensed Practical Nurse), the unit manager for Resident #95. LPN #8 stated that when the resident goes to the hospital, the facility sends 2 copies of the facesheet, one for transport and one for hospital, the resident's History and Physical, immunization record, last recertification, last progress note, labs, Medication Administration Record, the transfer form, and the bed hold policy agreement. When asked about the comprehensive care plan goals, LPN #8 stated, "We do not send the care plan." Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 527.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

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F 623	Continued From page 37 §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	**F623** **Corrective Action(s):** Resident #141's responsible party has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 12/23/18. Resident #45 and their responsible party has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 11/25/18. Resident #153's responsible party has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 2/5/19. Resident #92 and their responsible party has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 10/3/18. Resident #38 and their responsible party has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 11/9/18.	

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F 623	Continued From page 38 (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	**Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible party and the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s) and nursing administration on the requirement that the resident and/or the resident's responsible party and the state ombudsman be notified of a resident's discharge/transfer.	

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F 623	Continued From page 39 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence written notification of the hospital transfer was provided to the resident and or responsible party for five of 51 residents in the survey sample; Residents #141, #45, #153, #92, #38. 1. The facility staff failed to evidence that Resident #141's responsible party was provided with written notification of the hospital transfer when the resident was transferred to the hospital on 12/23/18. 2. The facility staff failed to provide Resident # 45 or the resident's representative written notification when the resident was transferred to the hospital on 11/25/18. 3. The facility staff failed to evidence that Resident #153's responsible party was provided	F 623	**Monitoring:** The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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with written notification of the hospital transfer when the resident was transferred to the hospital on 2/15/19.

4. Resident #92 was transferred to the hospital on 10/3/18. The facility staff failed to provide written notification of the transfer to Resident #92 and/or the resident's representative.

5. The facility staff failed to provide written notification to the resident and/or responsible party, of a facility initiated transfer for Resident #38 on 11/9/18.

The findings include:

1. The facility staff failed to evidence that Resident #141's responsible party was provided with written notification of the hospital transfer when the resident was transferred to the hospital on 12/23/18.

Resident #95 was admitted to the facility on 1/26/17 with the diagnoses that included, but are not limited to atrial fibrillation, stroke, dementia with behaviors, bipolar disorder, anxiety disorder, and dysphagia. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 1/25/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A nurse's note dated 12/23/18 documented, "At 5:30 am CNA notified this writer of rectal bleeding; upon assessment: moderate amount dark red blood, mixed with clots oozing from

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rectum; blood continued to ooze post area being cleansed....order given to transfer resident to acute care...."

Further review of the clinical record failed to reveal any evidence that the responsible party was notified in writing of the hospital transfer.

On 3/06/19 at 2:45 p.m., in an interview with OSM #2 (Other Staff Member, Director of Social Services) she stated that she sends the Discharge/Transfer form to the responsible party, but that this only started in January 2019.

A review of the "Discharge/Transfer Form" which was documented as being created January 2019, documented, "I understand that I am being discharged/transferred from (facility). I understand the reason for discharge/transfer is: (two long lines provided for writing in the reason for the transfer)....Responsible Party Signature: (long line provided for signature); Date: (line provided for date); Copy Given (a box to check for this option provided); Copy Mailed on: (a line provided for the writing in of the date the notice was mailed to the responsible party)...." This form was not utilized during the time of the above hospital transfer.

A review of the facility policy, "Transfer or Discharge, Emergency" documented, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures....e. Notify the representative (sponsor) or other family member..." The policy did not specify that notification must occur in writing.

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F 623	Continued From page 42 On 3/06/19 at 6:36 p.m., ASM #1 (Administrative Staff Member - the Administrator) was made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to provide Resident # 45 or the resident's representative written notification when the resident was transferred to the hospital on 11/25/18. Resident # 45 was admitted to the facility on 07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to: retention of urine, urinary tract infection (1), benign prostatic hyperplasia (2), diabetes mellitus (3) and hypertension (4). Resident # 45's most recent MDS (minimum data set), a 30-day assessment with an ARD (assessment reference date) of 12/19/18, coded Resident # 45 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. The nurse's "Progress Notes," dated 11/25/2018 for Resident # 45 at 11:53 p.m. documented the resident was transferred to the hospital emergency room for evaluation. The note further documented, "Attempts made to contact RP (responsible party) on all 3 numbers. (Name of Transport) squad in, stated both (Name of two Hospitals) were on diversion. Call placed by EMT (emergency medical technician) to (Name of Hospital) ER (emergency room) nurse, who stated they had no available beds but would accept resident with possible transfer to another hospital. Squad left with res en route to (Name of Hospital) at 2345 (11:45 p.m.)."	F 623		

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F 623	Continued From page 43 Further review of the clinical record failed to reveal any evidence that the responsible party was notified in writing of the hospital transfer. On 3/06/19 at 2:45 p.m., an interview was conducted with OSM #2 (Other Staff Member, Director of Social Services). OSM #2 stated she sends the Discharge/Transfer form to the responsible party, but that this only started in January 2019. A review of the "Discharge/Transfer Form" which was documented as being created January 2019, documented, "I understand that I am being discharged/transferred from (facility). I understand the reason for discharge/transfer is: (two long lines provided for writing in the reason for the transfer)....Responsible Party Signature: (long line provided for signature); Date: (line provided for date); Copy Given (a box to check for this option provided); Copy Mailed on: (a line provided for the writing in of the date the notice was mailed to the responsible party)...." This form was not utilized during the time of the above hospital transfer. On 03/06/19 at approximately 3:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.	F 623		

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F 623	Continued From page 44 (2) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. The facility staff failed to evidence that Resident #153's responsible party was provided with written notification of the hospital transfer when the resident was transferred to the hospital on 2/15/19. Resident #153 was admitted to the facility on 9/13/16. Diagnoses for Resident #153 included but are not limited to dementia with behavioral disturbances, bipolar disorder, high blood pressure, and asthma. Resident #153's Minimum Data Set (MDS) was a significant change in status assessment with an Assessment Reference Date (ARD) of 1/15/19, and coded Resident #153 as severely impaired for cognitive skills for daily decision-making. A review of the clinical record revealed a nurse's note dated 2/15/19 at 12:45 p.m. that documented, "1:1 monitoring has continued since beginning of shift. at 1140-(Name of Doctor) in and spoke with md (medical doctor) re	F 623		

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F 623	Continued From page 45 (regarding): transferring resident to more appropriate setting for safety of resident and other, and order written to go to (Name of hospital) er (Emergency Room) for psych (psychiatric) eval (evaluation) for possible admission re: behaviors. This writer left msg (message) for rp (Responsible Party) to return call to facility. resident was oriented that he was being sent to (Name of hospital) er in (Name of town, state) by stretcher for eval (evaluation) and possible admit to hospital to help with his previous behaviors, resident smiled and said 'okay.' at 1150 spoke with (Name of transport staff) at (Name of transport ambulance) to transport resident to (Name of hospital) er. at 1225 2 attendants with (Name of transport ambulance) in facility and enroute via stretcher to (Name of hospital) er at 1235. at 1242 report was given to (name of ER staff) rn (Registered Nurse) at (Name of hospital) er." Further review of the clinical record revealed a nurse's note dated 2/15/19 at 5:46 p.m., that documented, "at 1400 rp returned call to facility and made aware resident was sent to (Name of hospital) er for psych (psychological) eval with possible admit. rp was asked about holding residents bed at $195 per day, rp declined stating 'I dont {sic} have the money.' (Name of administrative director) aware." Further review of the clinical record failed to reveal any evidence that the responsible party was notified in writing of the hospital transfer. A review of the "Discharge/Transfer Form" which was documented as being created January 2019, documented, "I understand that I am being discharged/transferred from (facility). I	F 623		

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F 623	Continued From page 46	F 623		

understand the reason for discharge/transfer is: (two long lines provided for writing in the reason for the transfer)....Responsible Party Signature: (long line provided for signature); Date: (line provided for date); Copy Given (a box to check for this option provided); Copy Mailed on: (a line provided for the writing in of the date the notice was mailed to the responsible party)...." The information regarding the mailing of notification of transfer to RP was not completed on the form.

On 3/06/19 at 2:45 p.m., in an interview with OSM #2 (Other Staff Member, Director of Social Services) she stated that she sends the Discharge/Transfer form to the responsible party, but if the information is not completed regarding the mailing of notifying the RP of the transfer, I did not mail it."

A review of the facility policy, "Transfer or Discharge, Emergency" documented, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures....e. Notify the representative (sponsor) or other family member..." The policy did not specify that notification must occur in writing.

On 3/06/19 at 6:36 PM, ASM #1 (Administrative Staff Member - the Administrator) was made aware of the findings. No further information was provided by the end of the survey.

4. Resident #92 was transferred to the hospital on 10/3/18. The facility staff failed to provide written notification of the transfer to Resident #92 and/or the resident's representative.

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F 623	Continued From page 47 Resident #92 was admitted to the facility on 11/3/11. Resident #92's diagnoses included but were not limited to high blood pressure, high cholesterol and convulsions. Resident #92's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/19, coded the resident as being cognitively intact. Review of Resident #92's clinical record revealed the resident presented with a fever and nausea, and was transferred to the hospital on 10/3/18. Further review of Resident #92's clinical record failed to reveal written notification of the transfer was provided to the resident and/or the representative. On 3/6/19 at 10:28 a.m., an interview was conducted with LPN (licensed practical nurse) #4 and RN (registered nurse) #1. LPN #4 and RN #1 was asked if nurses provide written notification to residents and/or their representatives when residents are transferred to the hospital. RN #1 stated they call the representative and send a written notice in a packet when residents are sent to the hospital. RN #1 stated he was not sure if written notice was provided when Resident #92 was transferred to the hospital on 10/3/18. On 3/6/19 at 3:41 p.m., RN #1 confirmed he could not provide evidence that written notice was provided to Resident #92 and/or the representative when the resident was transferred to the hospital on 10/3/18. On 3/6/19 at 4:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the	F 623		

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F 623	Continued From page 48 regional vice president of operations) was made aware of the above concern. No further information was presented prior to exit. 5. The faciltiy staff failed to provide written notification to the resident and/or responsible party, of a facility initiated transfer for Resident #38 on 11/9/18. Resident #38 was admitted to the facility on 12/15/16 with a recent readmission on 11/21/18, with diagnoses that included but were not limited to: urinary tract infection, diabetes, depression, dementia, kidney stones, and sepsis (destruction of tissue by bacterial toxins, contamination, infection) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 2/27/19, coded the resident as having both short and long term memory difficulties. The nurse's note dated 11/10/18 at 2:02 a.m. documented in part, "Late entry for evening shift - Res (resident) rested well in bed, IV (intravenous) of NS (normal saline) infusing in rt (right) forearm...Noted with increased coughing episode at supper, only ate a few bites. RP (responsible party) in to visit. Attendants in to pick up resident for (Name of Hospital) for evaluation of lethargy and decreased intake." Review of the clinical record failed to evidence the resident and or the resident representative were provided written notification of the 11/10/18 hospital transfer. On 3/06/19 at 2:45 p.m., in an interview with OSM #2 (Other Staff Member, Director of Social Services) she stated that she sends the Discharge/Transfer form to the responsible party,	F 623		

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F 623	Continued From page 49 but that this only started in January 2019. Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 527.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625	**F625** **Corrective Action(s):** Resident #45 & #92 and their RP's have been notified that the facility failed to provide them with the facility Bed-Hold policy when transferred to the hospital. Resident #45 & #92 and their RP's have had the facility bed-hold policy reviewed with them by the admissions director. An Incident and Accident report has been completed for each resident identified in the review. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties.	

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F 625	Continued From page 50 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for two of 51 residents in the survey sample, Residents # 45 and # 92. 1. The facility staff failed to provide Resident # 45 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 11/25/18. 2. The facility staff failed to provide Resident #92 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 10/3/18. The findings include: 1. The facility staff failed to provide Resident # 45 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 11/25/18. Resident # 45 was admitted to the facility on 07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to:	F 625	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed nursing staff have been inserviced by the administrator on the bed-hold requirement and the proper use and notification of Bed-Hold policy. **Monitoring:** The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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retention of urine, urinary tract infection (1), benign prostatic hyperplasia (2), diabetes mellitus (3) and hypertension (4). Resident # 45's most recent MDS (minimum data set), a 30-day assessment with an ARD (assessment reference date) of 12/19/18, coded Resident # 45 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions.

The nurse's "Progress Notes," dated 11/25/2018 for Resident # 45 at 11:53 p.m. documented the resident was transferred to the hospital emergency room for evaluation. The note further documented, "Attempts made to contact RP (responsible party) on all 3 numbers. (Name of Transport) squad in, stated both (Name of two Hospitals) were on diversion. Call placed by EMT (emergency medical technician) to (Name of Hospital) ER (emergency room) nurse, who stated they had no available beds but would accept resident with possible transfer to another hospital. Squad left with res en route to (Name of Hospital) at 2345 (11:45 p.m.)."

Review of the EHR (electronic health record) and the clinical record for Resident # 45 failed to evidence that Resident # 45 or the resident's representative was provided a written notification of the bed hold policy when the resident was transferred to the hospital on 11/25/18.

On 03/06/19 at 2:55 p.m., an interview was conducted with OSM (other staff member) # 3, admissions director regarding the facility's bed hold policy for residents who are transferred to the hospital. OSM # 3 stated, "If they verbally said they want to hold the bed I will hold the bed.

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It's part of the discharge and transfer form." After review of Resident # 45's transfer form dated 11/25/18, OSM #3 stated that Resident # 45's transfer was before they developed the new forms and that there was no evidence that the bed hold policy was provided to Resident # 45 or Resident # 45's responsible party at the time of his transfer.

The facility's policy "Bed Hold Prior to Transfer" documented, "Prior to transferring a resident to the hospital, the facility will provide written information to the resident and/or the resident representative regarding bed hold."

On 03/06/19 at approximately 3:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.

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

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

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F 625	Continued From page 53	F 625		

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.
2. The facility staff failed to provide Resident #92 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 10/3/18.

Resident #92 was admitted to the facility on 11/3/11. Resident #92's diagnoses included but were not limited to high blood pressure, high cholesterol and convulsions. Resident #92's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/19, coded the resident as being cognitively intact.

Review of Resident #92's clinical record revealed the resident presented with a fever and nausea, and was transferred to the hospital on 10/3/18. A nurse's note signed by RN (registered nurse) #1 on 10/4/18 documented Resident #92 was admitted to the hospital for kidney stones and the resident's representative did not wish to have a bed hold. Further review of Resident #92's clinical record failed to reveal the resident and/or representative was provided written information regarding the facility bed hold policy.

On 3/5/19 at 11:38 a.m., an interview was conducted with Resident #92. The resident voiced concern that she was not permitted to return to the same room when she was readmitted to the facility from the hospital on 10/12/18. When asked if she was provided the facility bed hold policy when she was sent to the hospital, Resident #92 stated she was not.

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F 625	Continued From page 54 On 3/6/19 at 3:41 p.m., an interview was conducted with RN #1. RN #1 stated he provided verbal notice of the facility bed hold policy to Resident #92's representative when the resident was sent to the hospital. RN #1 stated he did not provide written notice of the bed hold policy to the representative. RN #1 stated the current facility process is to send the bed hold policy with the resident to the hospital but he could not provide evidence the bed hold policy was provided to Resident #92 (or the representative) when she was sent to the hospital on 10/3/18. On 3/6/19 at 4:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the regional vice president of operations) was made aware of the above concern. No further information was presented prior to exit.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656	**F656** **Corrective Action(s):** Resident #53's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include her noncompliance with wearing her physician ordered oxygen. A Facility Incident & Accident Form was completed for this incident.	

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F 656	Continued From page 55 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for four of 51 residents in the survey sample, Residents #53, #104, #98 and #138. 1. On 3/5/19, Resident #53 was observed on separate occasions without her physician ordered continuous oxygen in place. The clinical record failed to evidence any documentation regarding staff reapplying the oxygen or the resident being	F 656	Resident #104's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include her diagnosis of diabetes and the care being delivered for the diabetes. A Facility Incident & Accident Form was completed for this incident. Resident #98's comprehensive care plan has been reviewed and revised to reflect the current goals and interventions and approaches to address the resident's specific medical and treatment needs to include the use of a Prevalon Boots while in bed, the care and treatment for the sacral wound and the use of bilateral fall mats to the residents bed at all times while in bed. A Facility Incident & Accident Form was completed for this incident. Resident #138's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include the care and treatment needed to manage the resident's pain. A Facility Incident & Accident Form was completed for this incident.	

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F 656	Continued From page 56 noncompliant with wearing her oxygen and notification to the physician per the comprehensive care plan. 2. The facility staff failed to develop a comprehensive care plan to address Resident #104's diabetes and the care required. 3a. On 3/5/19 during separate observations Resident #98 was observed without prevalon boots in place per the physician orders and comprehensive care plan. 3b. The facility staff failed to develop a comprehensive care to address Resident # 98's sacral wound and the care required. 3c. The facility staff failed to implement Resident #98's comprehensive care plan for fall mats per physician order. On 3/5/19, separate observations revealed Resident #98 in bed with only one fall mat on the floor, on the left side of the resident's bed, instead of a fall mat to each side of the bed per the physician's order and comprehensive care plan. 4. The facility staff failed to develop Resident #138's a comprehensive care plan to address the residents pain and the care required to address the residents pain. The findings include: 1. On 3/5/19, Resident #53 was observed on separate occasions without her physician ordered continuous oxygen in place. The clinical record failed to evidence any documentation regarding staff reapplying the oxygen or the resident being noncompliant with wearing her oxygen and	F 656	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, ADON, RCC and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.	

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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 656	Continued From page 57 notification to the physician per the comprehensive care plan. Resident #53 was admitted to the facility on 2/24/17 with diagnoses that included but were not limited to: hypothyroid disease [decreased activity of the thyroid gland (1)]; rhabdomyolysis [is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage (2)], degenerative disc disease [disc disease is a common condition characterized by the breakdown (degeneration) of one or more of the discs that separate the bones of the spine (3)], and COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (4)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/18, coded the resident as scoring a "8" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as completely dependent upon one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs the resident was coded as using oxygen while a resident in the facility. Resident #53 was observed on 3/5/19 at 9:05 a.m., the resident was in her bed, drinking some water. The oxygen tubing was not on the resident. The oxygen tubing was observed hanging over the end of the tubing closest to the concentrator. The tubing was not touching the ground. The oxygen concentrator was running.	F 656	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 656	Continued From page 58 A second observation was made of Resident #53 on 3/5/19 at 12:33 p.m. The resident was in bed asleep. The oxygen concentrator was running and the tubing remained hanging off the tubing closet to the concentrator, and was not on the resident. The third observation of Resident #53 on 3/5/19 at 3:42 p.m. revealed the resident receiving her oxygen via a nasal cannula (a tubing with two prongs that insert into the nose) connected do an oxygen concentrator that was running. The physician order dated 6/22/18, documented, "O2 (oxygen) at 2L/min (liters per minute) continuous." The comprehensive care plan reviewed on 12/21/18, documented in part, "Problem: Per staff Resident is non-compliant with O2 at times, takes O2 off." The "Approaches" documented in part, "Encourage O2 use as ordered. Educate resident about being non-compliant with O2 use. Document and report to MD (medical doctor) and RP (responsible party) as needed. Replace O2 when noticed off." Review of the nurse's notes for 3/5/19 failed to evidence documentation of the staff reapplying the resident's oxygen or, that the resident was noncompliant with wearing her oxygen and notification to the physician of non-compliance. An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/6/19 at 3:15 p.m. RN #1 was asked if a resident has an order for oxygen and to document noncompliance and notify the doctor and the residents oxygen was	F 656		

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F 656	Continued From page 59	F 656		

observed off the resident, is the staff following the comprehensive care plan if staff documented nothing, regarding reapplying the oxygen, noncompliance with wearing the oxygen, or physician notification. RN #3 stated it would not be following the care plan.

An interview was conducted with LPN (licensed practical nurse) #9 on 3//6/19 at 3:33 p.m. When asked if the resident did not have her oxygen on per the physician order, and the care plan documents to administer oxygen per the physician order, were the staff following the care plan, LPN #9 stated, "No."

The facility policy, "Care Plans, Comprehensive Person-Centered" documented in part, "1. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident."

Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 286.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000473.htm
(3) This information was obtained from the

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F 656	Continued From page 60 following website: https://ghr.nlm.nih.gov/condition/intervertebral-disc-disease. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 2. The facility staff failed to develop a comprehensive care plan to address Resident #104's diabetes and the care required. Resident #104 was admitted to the facility on 1/5/19 with diagnoses that included but were not limited to: diabetes, chronic kidney disease requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine (1)], history of amputation of his left leg and toes on his right foot, and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 2/2/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring from limited to total assistance for his activities of daily living. In Section I - Health Conditions, the resident was coded as having diabetes. The comprehensive care plan dated 1/13/19 was reviewed. The care plan failed to address the resident's diabetes and care required including that he receives insulin.	F 656		

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F 656	Continued From page 61 The physician orders dated 1/11/19 documented in part, "Lantus Solostar 100unit/ML (milliliters) (a long acting insulin used to treat diabetes) (2) 5 units SQ (subcutaneously) daily for diabetes." An interview was conducted with LPN (licensed practical nurse) #1 on 3/6/19 at 11:55 a.m. When asked if a resident has diabetes, should that be addressed on their care plan, LPN #1 stated, "I believe so." LPN #1 was asked to review Resident #104's care plan. After the review, LPN #1 was asked if the resident's diagnosis of diabetes was in the resident's plan of care, LPN #1 stated, "I don't see it." An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/6/19 at 11:57 a.m. When asked if a resident with diabetes should have a care plan to address the diabetes, RN #3 stated, "Yes, it should be." RN #3 was asked to review Resident #104's care plan. After the review, RN #3 stated, "It's not there." RN #3 looked in the clinical record and found the diabetes addressed on the baseline care plan but she said it didn't get carried over to the comprehensive care plan. When asked if it should have been carried over to the comprehensive care plan, RN #3 stated, "Yes." Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the	F 656		

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F 656	Continued From page 62 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a600027.html 3a. On 3/5/19 during separate observations Resident #98 was observed without prevalon boots in place per the physician orders and comprehensive care plan. Resident #98 was admitted to the facility on 12/17/2018. Diagnoses for Resident #98 included but were not limited to Heart Failure, High Blood Pressure, and Depression. Resident #98's Minimum Data Set (significant change in status) with an Assessment Reference Date of 01/18/2019 coded Resident #98 with severe cognitive impairment. In addition, the Minimum Data Set coded Resident #98 as requiring total assistance of one staff member with activities of daily living and total dependence for eating (tube feeding). On 03/05/2019 at approximately at 8:40 a.m., Resident #98 was observed lying in bed, on her right side, under a light green colored blanket with feet exposed. Resident #98 had on gray socks and both feet were propped up on a pillow. On 03/05/2019 at approximately 1:59 p.m., Resident #98 was observed lying in bed, on her back, under a light green colored blanket with feet exposed. Resident #98 had on gray socks and both feet were observed propped up on a pillow. On 03/05/2019, Resident #98's care plan was reviewed. Resident #98's care plan and physician	F 656		

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F 656	Continued From page 63 order documented, "Prevalon boots to bilateral lower extremities at all times" dated 01/18/2019. Resident #98 did not have prevalon boots on when observed at approximately 8:40 a.m. and at 1:59 p.m. On 03/05/2019 at approximately 3:51 p.m., Resident 98 was observed lying in bed, on her back, under a light green colored blanket with feet covered. Resident #98's feet were covered. LPN (Licensed Practical Nurse) #4 was asked to remove Resident #98's blanket to reveal both feet. Resident #98 had on gray socks and both feet were observed propped up on a pillow. Resident # 98 was not wearing prevalon boots. LPN #4 asked Resident #98, "Where are your prevalon boots?" Resident # 98 did not respond. LPN #4 then placed prevalon boots on Resident #98's feet, which were located behind the television. An interview was conducted on 03/06/2019 at approximately 10:23 a.m. with RN #1 (Registered Nurse) (Unit Manager). RN #1 was asked what the purpose of the resident's care plan is. RN #1 stated that the care plan is what's used to let nursing staff know what the resident needs are. RN #1 was asked who is responsible for developing the care plan. RN #1 stated that the MDS (Minimal Data Set) Coordinator is responsible for developing the care plan. RN #1 was asked who is responsible for implementing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 was asked staff ensure care plan interventions are in place and implemented. RN #1 stated that rounds are made to ensure that care planned interventions are in place. RN #1 was made aware of Resident #98 not wearing	F 656		

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prevalon boots as ordered and care planned. RN #1 stated that he made sure the resident was wearing her prevalon boots after looking at her orders.

An interview was conducted on 03/06/2019 at approximately 2:42 p.m. with LPN #2 (Licensed Practical Nurse) (MDS Coordinator). LPN #2 was asked who is responsible for developing and updating resident's care plan. LPN #2 stated, "MDS is responsible for developing and updating the care plans." LPN #2 was asked the purpose of the care plan. LPN #2 stated that the purpose of the care plan is to keep nursing staff informed of resident's plan of care.

On 03/06/2019 at approximately 12:30 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.

3b. The facility staff failed to develop a comprehensive care to address Resident # 98's sacral wound and the care required.

Resident #98's Minimum Data Set (MDS) with an Assessment Reference Date of 01/18/2019 coded Resident #98 in Section M Skin Conditions M0100 A., "Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device." Section M Skin Conditions M0150 Risk of Pressure Ulcers/Injuries coded, "Resident is at risk of developing pressure ulcers/injuries." Section M Skin Conditions M0300 F. coded Resident #98 as having 1 unstageable pressure ulcer/injury (1) that was present upon admission.

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On 03/06/2019, Resident #98's clinical record was reviewed. A physician order dated 02/04/19 documented, "Cleanse sacrum with dermal wound cleanser, pat dry, apply foam dressing every day and as needed." Resident #98 did not have a comprehensive care plan addressing her sacral wound and the care required.

An interview was conducted on 03/06/2019 at approximately 2:42 p.m. with LPN #2 (Licensed Practical Nurse) (MDS Coordinator). LPN #2 (MDS Coordinator) was asked who is responsible for developing and updating resident's care plan. LPN #2 stated, "MDS is responsible for developing and updating the care plans." LPN #2 (MDS Coordinator) was asked what is the purpose of the care plan. LPN #2 (MDS Coordinator) stated that the purpose of the care plan is to keep nursing staff informed of resident's plan of care. LPN #2 (MDS Coordinator) was made aware of Resident #98 not having a wound care plan to address the resident's sacral wound and the care required. LPN #2 (MDS Coordinator) reviewed Resident #98's care plan and validated that there was not a wound care plan in the comprehensive care plan and that Resident #98 did have a sacral wound.

On 03/06/2019 at approximately 12:30 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.

References:
(1) Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This

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reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency.patientinstructions/000147.htm

3c. The facility staff failed to implement Resident #98's comprehensive care plan for fall mats per physician order. On 3/5/19, separate observations revealed Resident #98 in bed with only one fall mat on the floor, on the left side of the resident's bed, instead of a fall mat to each side of the bed per the physician's order and comprehensive care plan.

On 03/05/2019 at approximately at 8:40 a.m., Resident #98 was observed lying in bed, on her right side, under a light green colored blanket with feet exposed. One fall mat was on the left side Resident #98's bed on the floor.

On 03/05/2019 at approximately 1:59 p.m., Resident #98 was observed lying in bed, on her back, under a light green colored blanket with feet exposed. One fall mat was on the left side Resident #98's bed on the floor.

On 03/05/2019, Resident #98's clinical record was reviewed. Resident #98's comprehensive care plan documented, "Fall mat times two to bedside for safety dated 03/22/2018." Resident # 98 had a physician order that documented, "Fall mat to each side of bed for safety dated 12/17/2018."

An interview was conducted on 03/06/2019 at approximately 10:23 a.m. with RN #1 (Registered Nurse) (Unit Manager). RN #1 was asked what

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F 656	Continued From page 67 the purpose of the resident's care plan is. RN #1 stated that the care plan is what's used to let nursing staff know what the resident needs are. RN #1 was asked who is responsible for developing the care plan. RN #1 stated that the MDS (Minimal Data Set) Coordinator is responsible for developing the care plan. RN #1 was asked who is responsible for implementing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 was asked how staff ensure care plan interventions are implemented and in place. RN #1 stated that rounds are made to ensure that care plan interventions are in place. RN #1 was made aware of Resident #98 not having a fall mat on both sides of the bed. RN #1 stated that he corrected the issue after reviewing the orders and care plan. On 03/06/2019 at approximately 12:30 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings. 4. The facility staff failed to develop Resident #138's a comprehensive care plan to address the residents pain and the care required to address the residents pain. Resident #138 was admitted to the facility on 9/14/16. Resident #138's diagnoses included but were not limited to high blood pressure, vitamin B12 deficiency and constipation. Resident #138's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 2/15/19, coded the resident's cognition as severely impaired. Section J coded Resident #138 as having received PRN (as needed) pain	F 656		

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medication and non-medication intervention during the last five days. Section J further coded Resident #138 reported having frequent pain during the last five days. Section V documented pain as a triggered care area and documented pain as being addressed in the care plan.

Review of Resident #138's clinical record revealed a physician's order dated 1/29/19 for Tylenol (1) 650 mg (milligrams) every six hours PRN for pain or a fever greater than 101. Review of Resident #138's February 2019 MAR (medication administration record) revealed the resident was administered PRN Tylenol on 2/4/19, 2/5/19, 2/6/19, 2/10/19, 2/11/19, 2/12/19, 2/14/19, 2/15/19 and 2/18/19. Review of Resident #138's comprehensive care plan dated 2/15/19 failed to reveal documentation regarding pain.

On 3/6/19 at 11:32 a.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse who administered PRN Tylenol to Resident #138 on all of the above dates except 2/10/19). LPN #5 confirmed she administered Tylenol to Resident #138 for pain. When asked if a resident who is receiving pain medication should have a pain care plan, LPN #5 stated, "Yes."

On 3/6/19 at 4:13 p.m., an interview was conducted with RN (registered nurse) #2 (the nurse responsible for developing care plans). RN #2 was made aware of the above concern. RN #2 confirmed Resident #2 should have had a pain care plan and stated she created one on this date.

On 3/6/19 at 4:50 p.m., ASM (administrative staff

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F 656	Continued From page 69 member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the regional vice president of operations) was made aware of the above concern. The facility policy titled, "Care Plans, Comprehensive Person-Centered" documented, "Policy Statement: A comprehensive, person-centered car plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment..." The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual documented: "SECTION V: CARE AREA ASSESSMENT (CAA) SUMMARY Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning. There are 20 CAAs in Version 3.0 of the RAI, which includes the addition of "Pain" and "Return	F 656		

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F 656	Continued From page 70 to the Community Referral." These CAAs cover the majority of care areas known to be problematic for nursing home residents. The Care Area Assessment (CAA) process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directs facility staff and health professionals to evaluate triggered care areas. The interdisciplinary team (IDT) then identifies relevant assessment information regarding the resident's status. After obtaining input from the resident, the resident's family, significant other, guardian, or legally authorized representative, the IDT decides whether or not to develop a care plan for triggered care areas." No further information was presented prior to exit. (1) Tylenol is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html	F 656		
F 657 SS=D	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.	F 657	**F657** **Corrective Action(s):** Resident #145's comprehensive care plan has been reviewed and revised to reflect specific interventions and approaches for Nebulizer treatment use for shortness of breath per physician order. A Risk Management Incident & Accident Form was completed for this incident.	

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F 657	Continued From page 71 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for 1 of 51 residents in the survey sample, Resident 145. The facility staff failed to revise Resident #145's care plan to address and include the 2/11/19 physician ordered nebulizer treatments as needed for shortness of breath. The findings include: Resident #145 was admitted to the facility on 02/17/2017. Diagnoses for Resident #145 included but were not limited to High Blood Pressure, Depression, and Anxiety Disorder. Resident #145's Annual Minimum Data Set (annual assessment) with an Assessment Reference Date of 02/12/2019 coded Resident #145 with moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #145 as requiring extensive assistance of one	F 657	**Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition.	

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F 657	Continued From page 72 staff member with activities of daily living and limited assistance of one staff person for eating. On 03/06/2019, Resident #145's clinical record was reviewed. A physician order dated 02/11/2019 documented, "Ipratropium Bromide/Albuterol Sulfate 0.5-3 (2.5) mg (milligrams)/3 ml (milliliters) (1) give nebulizer treatment every four hours as needed for shortness of breath." Resident #145's February 2019 medication administration record documented administration of "Ipratropium Bromide/Albuterol Sulfate 0.5-3 (2.5) mg (milligrams)/3 ml (milliliters) give nebulizer treatment every four hours as needed for shortness of breath" dated 02/11/2019. Resident #145's comprehensive care plan dated 02/12/2019 was reviewed and failed to evidence a revision to include the new physician treatment and intervention. On 03/05/2019 at approximately 8:40 a.m., Resident #145's nebulizer machine was observed on top of the dresser with an unbagged mask. On 03/05/2019 at approximately 1:59 p.m., Resident #145's nebulizer machine was observed on top of the dresser with an unbagged mask. An interview was conducted on 03/06/2019 at approximately 4:15 p.m. with RN (Registered Nurse) #2 (MDS Coordinator). RN #2 was asked if the physician ordered nebulizer treatment should be care planned. RN #2 stated that it should be care planned. RN #2 stated that Resident #145's care plan was recently updated and she did not carry the nebulizer treatment over because Resident #145 only used the nebulizer	F 657	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 657	Continued From page 73 machine one time and it was an as needed order. A copy of the facility policy regarding care planning was requested from ASM (Administrative Staff Member) #1 (Administrator) on 03/06/2019 at approximately 4:50 p.m. The facility policy titled, Care Plans, Comprehensive Person-Centered", documented "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly Minimal Data Set (MDS) assessment." On 03/06/2019 at approximately 6:00 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings. No further information was presented prior to exit. References: (1) A medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with diseases that affect the lung and airways. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html	F 657		

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F 658 F 658 SS=D	Continued From page 74 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 51 residents in the survey sample, Residents #145 and #25. 1. The facility staff failed to clarify Resident #145's physician order for oxygen regarding the flow rate parameters for titration of the oxygen. 2. The facility failed to clarify Resident #25's physician order for oxygen regarding the flow rate parameters for titration of the oxygen. The findings include: 1. The facility staff failed to clarify Resident #145's physician order for oxygen regarding the flow rate parameters for titration of the oxygen. Resident #145 was admitted to the facility on 3/4/19 with diagnoses that included but were not limited to: shortness of breath, diabetes, dementia, and interstitial lung disease [Interstitial lung disease is the name for a large group of diseases that inflame or scar the lungs. The inflammation and scarring make it hard to get enough oxygen (1)].	F 658 F 658	**F658** **Corrective Action(s):** Resident #145 & #25's attending physician has been notified that the facility staff failed to administer oxygen at the correct flow rate per the physician ordered titrated oxygen flow rate. Resident #145 & #25's Oxygen orders have been reviewed and clarified by the attending physician and their comprehensive care plans have been updated to reflect the current oxygen orders. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents with Oxygen orders may have been potentially affected. The DON or Unit Manager will conduct a 100% review of all resident's with Oxygen orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding.	

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F 658	Continued From page 75 There was no MDS (minimum data set) assessment completed as the resident was admitted on the first day of survey. The "Nursing Admission Assessment" dated 3/6/19, documented the resident as being alert and confused. The resident was documented as being dependent upon the staff for his activities of daily living. There was no documentation of oxygen use on this form. The nurse's note dated 3/4/19 at 11:08 p.m. documented in part, "O2 (oxygen) sat (saturation - the percentage of oxygen in the blood stream) 96% on 2 L/M (liters per minute) via NC (nasal cannula - a tube with two prongs that inserts into the nose). The physician order dated 3/5/19, documented, "O2 continuous @ (at) 2 L/M via nasal cannula. May Titrate to Maintain O2 sat 92%." The MAR (medication administration record) for March 2019 documented, "O2 continuous @ 2 L/M via nasal cannula. May titrate to maintain O2 sat 92%." The "Baseline Care Plan" dated 3/5/19 at 2:00 p.m. documented in part, "Special Treatments/Procedures: Oxygen was checked. Route: N/C (nasal cannula) LPM (liters per minute): 2. Frequency: continuous." An interview was conducted with LPN (licensed practical nurse) #1 on 3/6/19 at 11:29 a.m. The order above for oxygen was shown to LPN #1. When asked how she would follow that order, LPN #1 stated, "Normally we can go up to 4 liters. If the resident is on 2 liters then we can go up to 3	F 658	**Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include clarifying and verifying resident specific oxygen orders prior to administration and monitoring. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will review oxygen orders weekly in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 658	Continued From page 76	F 658		

liters and then check to see where the sat is." When asked how and when does the nurse go up in oxygen and down in the setting of the liter flow rate, LPN #1 stated, "According to this, you wound not know. I'd have to call the doctor. The doctor would have to say how high you can go up." LPN #1 stated, "That order would need clarification."

An interview was conducted with RN (registered nurse) #3, the unit manager; on 3/6/19 at 11:36 a.m., RN #3 was asked to review the order above for oxygen. When asked how to read the order, RN #3 stated, "It does not say how many liters to go up to." When asked about the meaning of the order for 'titrate,' RN #3 stated, "I would have to get clarification because we would need to know how high to go and at what increments." When asked if the order documents how, and when, to bring the oxygen flow rate down, RN #3 stated, "I would have to get this order clarified by the doctor."

The facility policy, "Medication and Treatment Orders" documented in part, "Orders for medications must include: a. Name and strength of the drug. b. Quantity or specific duration of therapy. c. Dosage and frequency of administration. d. route of administration. e. Reason or problem for which given."

According to Lippincott's "Fundamentals of Nursing, 5th edition, page 553 documents the following statement, "Always clarify with the prescriber any medication order that is unclear or seems in appropriate."

Administrative staff member (ASM) #1, the

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F 658	Continued From page 77 administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. On 3/6/19 at 8:15 p.m. ASM #2, the director of nursing, was asked which professional standard of practice the facility follows, ASM #2 stated they follow their policies and Lippincott." No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/interstitiallungdiseases.html 2. The facility failed to clarify Resident #25's physician order for oxygen regarding the flow rate parameters for titration of the oxygen. Resident #25 was admitted to the facility on 12/13/17 with the diagnoses of but not limited to Chronic Obstructive Pulmonary Disease, acute respiratory failure with hypoxia, diabetes type 2, transient cerebral ischemic attack, high blood pressure, and depression. Resident #25's Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 12/9/18, and coded Resident #25 as moderately cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for toilet use, eating, and transfers; total care for hygiene, bathing, and dressing; and as continent of bowel and bladder.	F 658		

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F 658	Continued From page 78 A review of the clinical record revealed a physician's order dated 2/28/18 that documented, "O2 (oxygen) at 2L/MIN (2 liters per minute) via NC (nasal cannula) PRN (as needed) for SOB (shortness of breath), may titrate to maintain sats > 92 (oxygen saturations greater than 92 %)." Further clinical record review revealed a standing physician's orders dated 7/19/18 that documented, "SOB: O2 at 2L/M via NC prn for SOB. May titrate to maintain O2 sat > 92%. Check O2 sat Qshift (every shift)." An interview was conducted on 3/6/19 at 11:29 a.m., with LPN #1 regarding Resident #25's physician order for O2. When asked how she would read the order, LPN #1 stated back the order as written and "you may titrate it up to make O2 sat > 92." When asked how the nurse would follow the order, LPN #1 stated, "We have a standing order for oxygen." She then presented the standing orders. When asked how high or how low the nurse can go with the oxygen rate, LPN #1 stated, "Normally you would not go over 4 liters (per minute). If (the resident is) on 2 (liters per minute) you can go up to 3 (liters per minute) and see where sat (oxygen saturation) is. According to this, you would not know. I'd have to call the doctor. The doctor would have to say how high you can go up." LPN #1 stated, "That order would need clarification." An interview was conducted on 3/5/19 at 11:36 a.m., with RN (registered nurse) #3 regarding Resident #25's physician order for oxygen. When asked how she would read the order, RN #3 stated, "It does not say how many liters to go up to. The titrate part, I would have to get clarification on, cause we would need to know	F 658		

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F 658	Continued From page 79 how high to go and at what increments. (The order) Does not say how or when to bring it down." RN #3 stated, "I would have to get this order clarified by the doctor." A review of the facility policy, "Oxygen Administration" documented the following: "Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." A review of the facility policy, "Administering Medications" documented the following: "5. If a dosage is believed to be inappropriate...for the resident...the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concern." On 3/7/19 at 6:26 p.m., AMS #1 (Administrative Staff Member - the Administrator) was made aware of the findings. No further information was provided by the end of the survey.	F 658		
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- (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	F 686	**F686** **Corrective Action(s):** Resident #53's attending physician was notified that the facility staff failed to assess, measure, monitor and track a sacral wound for resident #53. A facility Incident & Accident form was completed for this incident. Resident #98's attending physician was notified that the facility staff failed to apply physician ordered prevalon boots as ordered. A facility Incident & Accident form was completed for this incident.	

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F 686	Continued From page 80 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, staff interview, facility document review and clinical record review it was determined the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for two of 51 residents in the survey sample, Residents #53 and #98. 1. The facility staff failed to assess, measure, monitor and track Resident #53's sacral pressure sore. 2. The facility staff failed to implement the physician ordered Prevalon boots to off load pressure on Resident #98's feet. On 3/5/19, Resident #98 was observed in bed without the physician ordered Prevalon boots in place. The findings include: 1. The facility staff failed to assess, measure, monitor and track Resident #53's sacral pressure sore. Resident #53 was admitted to the facility on 2/24/17 with diagnoses that included but were not limited to: hypothyroid disease [decreased activity of the thyroid gland) (1)], rhabdomyolysis [is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage (2)], degenerative	F 686	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with wound care prevention and treatment orders may have potentially been affected. The DON, ADON, QA nurse and/or Unit Manager will conduct 100% skin audit and a 100% audit of all Pressure injury prevention orders to identify any residents at risk for alterations in skin integrity without proper monitoring, assessment and tracking and missing prevention items. Any negative findings will be corrected and the time of discovery and disciplinary action taken as indicated. A facility Incident and Accident form will be completed each negative finding. **Systemic Change(s):** The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The Wound Care nurse will receive 1:1 inservice training on the proper procedure for assessing, measuring, monitoring and tracking of pressure injuries and other skin integrity issues. All nursing staff will be inserviced by the Wound Care Nurse and/or the DON on the facility's Pressure Ulcer Treatment and Prevention Policy and Procedure. The training will include the review and application of physician ordered pressure relieving devices.	

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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 686	Continued From page 81 disc disease [disc disease is a common condition characterized by the breakdown [degeneration] of one or more of the discs that separate the bones of the spine (3)], and COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (4)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/18, coded the resident as scoring a "8" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as being completely dependent upon one or more staff members for all of her activities of daily living. In Section M - Skin Conditions, the resident was coded as not having any pressure injuries. During the entrance conference on 3/4/19 at approximately 6:30 p.m., a request was made for a list of all residents who had pressure injuries. A "Wound and Skin Status Report dated 3/4/19 at 11:56 a.m. was presented to this surveyor. Resident #53's name was documented on the form as having a pressure injury on her sacrum that was acquired on 2/20/19. She was not documented as having any other pressure injuries. The clinical record was reviewed. The nurse's note dated 2/6/19 at 4:27 p.m. documented in part, "Resident observed to have a 0.5 L (length) X (by) 0.5 W (width) X 0.5 D (depth) open area to her right buttocks. New tx (treatment) order written."	F 686	**Monitoring:** The DON is responsible for compliance. The DON, ADON and/or QA nurse will review all residents weekly skin inspection sheets to identify any residents with a potential skin alteration that requires assessment, measuring, tracking and monitoring. The DON, ADON and/or QA nurse will complete 3 random rounds weekly to monitor for physician ordered preventive pressure injury devices are in place. Any/all negative findings will be addressed at time of discovery and additional inservice training and/or disciplinary with will be administered at that time. The results of the audits will be sent to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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	495353	A. BUILDING _____ B. WING _____	C 03/06/2019

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Review of the Wound Specialist's notes dated 2/8/19, documented in part, "History of Present Illness: She has an unstageable (due to necrosis) of the right buttock of at least 1 days duration. There is moderate serosanguinous exudate...Unstageable (Due to necrosis) of the right buttock. Etiology: Pressure; Wound size: 1.6 x 1.3 x not measurable. Slough: 100%."

The Wound Specialist's notes dated 2/22/19, documented in part, "Unstageable (Due to Necrosis) of the right buttock. Etiology: pressure, Wound size: 1.6 x 1.3 x not measurable, Slough (including biofilm) 100%."

The care plan did not document a date under "Problem onset." The "Problem/Need: Potential for skin breakdown due to incontinence." Under "Approaches" was documented in part, "Assess skin for signs or symptoms of redness or break downs document and report to md (medical doctor) as needed. Air mattress to bed as ordered. Treatments as orders per physician." Dated 2/7/19, "Tx (treatment) to right buttock."

A request was made on 3/6/19 at approximately 3:00 p.m., to ASM (administrative staff member) #1, the administrator, and ASM #3, the regional nurse consultant, for any measurements and documentation of the wound on the resident's right buttock. No further documents were provided.

An interview was conducted with LPN (licensed practical nurse) #10, the wound nurse, on 3/6/19 at approximately 4:30 p.m. When asked about the location in the clinical record for the assessment, measurements and tracking documentation,of the pressure injury on Resident

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#53's right buttocks, LPN #10 stated, "It was an oversight. I didn't see that documented in (name of wound doctor's) notes. It's an oversight." A request was made to see the wound of Resident #53.

An observation of Resident #53 was conducted with LPN #10 and RN (registered nurse) #3, the unit manager on 3/6/19 at 4:58 p.m. The right buttock was observed. The wound was noted to be healed. At this time LPN #10 stated, "It was an oversight on my part (for not tracking and measuring the wound). It was my mistake."

An interview was conducted on 3/6/19 at 5:50 p.m. with ASM #6, the wound care specialist. When asked to describe her involvement with Resident #53's wounds, ASM #6 stated that she only sees the resident every three to four weeks unless she has a new area. She is on hospice care. She stated that this resident has very fragile skin. She and the facility have tried as much as we can to prevent and heal her wounds. With everything they try, she still breaks down. She stated that the resident and responsible party has refused debridement of the wounds. They have tried nutritional interventions and she refuses them and she still breaks down. When asked when she was first aware of the right buttock wound, ASM #6 stated, "According to my notes, it was 2/8/19. I saw her again on 2/22/19 because she had a new wound on her sacrum. I looked at the right buttock at the same time."

The facility policy, "Pressure Ulcers/Skin Breakdown - Clinical Protocol" documented in part, "2. In addition, the nurse shall assess and document/report the following: b. Full assessment of pressure sore including location, stage , length

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F 686	Continued From page 84 , width and depth, presence of exudates or necrotic tissue." The policy presented by the facility, did not address the tracking, monitoring and measuring of the wounds, once found. Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. On 3/6/19 at 8:15 p.m. ASM #2, the director of nursing, was asked which professional standard of practice the facility follows, ASM #2 stated they follow their policies and Lippincott." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 286. (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000473.htm (3) This information was obtained from the following website: https://ghr.nlm.nih.gov/condition/intervertebral-disc-disease. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 2. The facility staff failed to implement the physician ordered Prevalon boots to off load pressure on Resident #98's feet. On 3/5/19, Resident #98 was observed in bed without the physician ordered Prevalon boots in place.	F 686		

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Resident #98 was admitted to the facility on 12/17/2018. Diagnoses for Resident #98 included but were not limited to Heart Failure, High Blood Pressure, and Depression. Resident #98's Minimum Data Set (significant change in status) with an Assessment Reference Date of 01/18/2019 coded Resident #98 with severe cognitive impairment. In addition, the Minimum Data Set coded Resident #98 as requiring total assistance of one staff member with activities of daily living and total dependence for eating (tube feeding).

On 03/05/2019 at approximately at 8:40 a.m., Resident #98 was observed lying in bed, on her right side, under a light green colored blanket with feet exposed. Resident #98 had on gray socks and both feet were propped up on a pillow.

On 03/05/2019 at approximately 1:59 p.m., Resident #98 was observed lying in bed, on her back, under a light green colored blanket with feet exposed. Resident #98 had on gray socks and both feet were observed propped up on a pillow.

On 03/05/2019, Resident #98's clinical record was reviewed. Resident #98's care plan documented, "Prevalon boots to bilateral lower extremities at all times" dated 01/18/2019. Resident #98's physician order documented, "Prevalon boots to bilateral lower extremities at all time" dated 01/18/2019. Resident #98's Braden Risk Assessment Report (1) documented resident "Risk score 11 and risk level high" dated 01/18/2019. Resident #98 did not have prevalon boots on when observed at approximately 8:40 a.m. and at 1:59 p.m.

On 03/05/2019 at approximately 3:51 p.m.,

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F 686	Continued From page 86	F 686		

Resident 98 was observed lying in bed, on her back, under a light green colored blanket with feet covered. LPN #4 (Licensed Practical Nurse) was asked to remove Resident #98's blanket to reveal both feet. Resident #98's feet were observed propped up on a pillow and the resident was not wearing prevalon boots. LPN #4 asked Resident #98, "Where are your prevalon boots?" Resident # 98 did not respond. LPN #4 then located the resident's prevalon boots behind the television and placed the boots on Resident #98's feet.

An interview was conducted on 03/06/2019 at approximately 10:23 a.m. with RN (Registered Nurse) #1 (Unit Manager). RN #1 was asked what the purpose of physician orders. RN #1 stated that the purpose of physician orders was to ensure resident gets the care needed. RN #1 was asked how staff ensure physician orders are being followed. RN #1 stated that he reviews the orders and make rounds to ensure things are in in place or are being done. RN #1 was made aware of Resident #98 not wearing prevalon boots as ordered. RN #1 was asked the purpose of prevalon boots. RN #1 stated to prevent pressure. RN #1 stated that he made sure the resident was wearing her prevalon boots after looking at her orders.

On 03/06/2019 at approximately 12:30 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.
No further information was presented prior to exit.

References:
(1) A risk assessment scale used in identifying the risk of developing pressure sores. This

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F 686	Continued From page 87 information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/25608538	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to implement interventions to prevent accidents per the physician order for one of 51 residents in the survey sample, Resident #98 The facility staff failed to implement fall mat(s) on each side of Resident #98's bed for fall prevention per the comprehensive care plan and physician order on 03/05/2019. The findings include: Resident #98 was admitted to the facility on 12/17/2018. Diagnoses for Resident #98 included but were not limited to Heart Failure, High Blood Pressure, and Depression. Resident #98's Minimum Data Set (MDS) with an Assessment Reference Date of 01/18/2019 coded Resident #98 with severe cognitive impairment. In addition, the Minimum Data Set coded Resident #98 as requiring total assistance of one staff member with activities of daily living and total dependence	F 689	**F689** **Corrective Action(s):** Resident #98's attending physician has been notified that facility staff failed to ensure a physician ordered fall mat was in place on both sides of the bed as ordered. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered fall mats or other preventive devices to prevent falls and injury may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of all residents with physician ordered fall mats and fall prevention devices to identify residents at risk for inconsistent application of the equipment. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all Licensed Nursing staff regarding proper use of and application of fall prevention equipments to include fall mats and wheelchair and bed alarms to prevent falls.	

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F 689	Continued From page 88 for eating (tube feeding). On 03/05/2019 at approximately at 8:40 a.m., Resident #98 was observed lying in bed, on her right side, under a light green colored blanket with feet exposed. One fall mat was observed on the left side of Resident #98's bed on the floor. On 03/05/2019 at approximately 1:59 p.m., Resident #98 was observed lying in bed, on her back, under a light green colored blanket with feet exposed. One fall mat was observed on the left side of Resident #98's bed on the floor. On 03/05/2019, Resident #98's clinical record was reviewed. Resident #98's care plan dated 03/22/18 documented, "Fall mat times two to bedside for safety." and Resident #98's physician order dated 12/17/2018 documented, "Fall mat to each side of bed for safety." Resident #98's fall risk assessment dated 02/11/2019 documented a total score of 12. The fall risk assessment dated 02/11/2019 stated a score of 10 or higher indicates HIGH RISK for which a prevention protocol should be initiated immediately and documented on the care plan. An interview was conducted on 03/06/2019 at approximately 10:23 a.m. with RN (Registered Nurse) #1 (Unit Manager). RN #1 was asked about the purpose of fall mats. RN #1 stated that the purpose of fall mats are fall interventions put in place to help with falls. RN #1 was asked how staff ensure fall mats are in place. RN #1 stated that rounds are made to ensure that fall mats are in place. RN #1 was made aware of Resident #98 not having a fall mat on both sides of the bed. RN #1 stated that he corrected the issue after	F 689	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will perform daily inspections of all residents with physician order fall prevention devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 689	Continued From page 89 reviewing the orders and care plan. On 03/06/2019 at approximately 12:30 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690	**F690** **Corrective Action(s):** Resident #45's catheter drainage bag is now anchored per policy and procedure to ensure the catheter collection bag and collection tubing is off the floor to prevent infection and injury. The resident's care plan has been revised to reflect accurate Suprapubic catheter care to include proper placement of the drainage bag and tubing. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a Foley or Supra pubic catheter may have been potentially affected. The DON, ADON and or Unit Manager will conduct a 100% review of all residents with a Foley and/or Suprapubic catheter to identify residents at risk. Residents identified will be corrected at time of discovery and disciplinary action with be taken as warranted. a Facility Incident & Accident Form will be for each negative finding.	

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F 690	Continued From page 90 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide care and services for a suprapubic catheter to prevent urinary tract infections for one of 51 residents in the survey sample, Residents # 45. The facility staff failed to ensure Resident # 45's catheter collection bag and tubing were not resting on the floor. The findings include: Resident # 45 was admitted to the facility on 07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to: retention of urine, urinary tract infection (1), benign prostatic hyperplasia (2), diabetes mellitus (3) and hypertension (4). Resident # 45's most recent MDS (minimum data set), a 30-day assessment with an ARD (assessment reference date) of 12/19/18, coded Resident # 45 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 45 was coded as being totally dependent of one staff member for activities of daily living. Section H "Bladder and Bowel" Resident # 45 was coded	F 690	**Systemic Change(s):** The facility Policy and Procedure for Foley/Suprapubic Catheter usage and Foley/Suprapubic Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON on the policy and procedures for proper Foley/Suprapubic Catheter care to include the proper anchoring of catheter tubing and proper placement of the drainage bag to prevent infection and injury. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or Unit Manager will make daily random audits of all Foley/Suprapubic Catheter's to ensure compliance with anchoring of tubing and proper placement of drainage bags to monitor compliance. All negative findings will be corrected at time of discovery. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 690	Continued From page 91 as "A. Indwelling catheter (including suprapubic catheter [5] and nephrostomy tube)." On 03/05/19 at 10:27 a.m., an observation of Resident # 45 revealed the resident lying in bed. Observation of the catheter collection bag revealed it was hanging off the right side of the bed. Further observation of the catheter collection bag and tubing revealed the collection bag and a section of the tubing was resting directly on the floor. On 03/05/19 at 10:49 a.m., an interview was conducted with Resident # 45. Before this surveyor entered Resident # 45's room, a nurse stated she had just administered Resident # 45's medication. After entering the room Resident # 45 was observed sitting up in bed. Observation of the catheter collection bag revealed it was hanging off the right side of the bed. Further observation of the catheter collection bag and tubing revealed the collection bag and a section of the tubing was resting directly on the floor. On 03/06/19 at 8:59 a.m., an observation of Resident # 45 revealed the resident lying in bed. Observation of the catheter collection bag revealed it was hanging off the right side of the bed. Further observation of the catheter collection bag and tubing revealed the collection bag and a section of the tubing was resting directly on the floor. The POS (physician's order sheet) for Resident # 45 dated "March 2019" documented, "Foley catheter care and check catheter anchor placement Q (every) shift. Order Date: 02/15/19."	F 690		

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F 690	Continued From page 92	F 690		

The comprehensive care plan for Resident # 45 dated 06/08/2015 documented, "Problem/Need: Colostomy and indwelling urinary catheter." Under "Approaches" it documented, "Change Foley catheter / Foley bag as ordered."

On 03/06/19 at 9:05 a.m., an observation and interview of Resident # 45's catheter collection bag and tubing was conducted with RN (registered nurse) # 3. RN # 3 accompanied this surveyor into Resident # 45's room to observe the placement of Resident # 45's catheter collection bag and catheter tubing. Upon observing the 45's catheter collection bag and catheter tubing RN # 3 raised Resident # 45's bed until the catheter collection bag and catheter tubing was off the floor. RN # 3 stated, "It should not be touching the floor." When asked why the catheter collection bag and catheter tubing should be off the floor, RN # 3 stated, "To prevent infection." When asked how the facility ensures the catheter collection bag and catheter tubing are kept off the floor, RN # 3 stated, "You do education for the placement of the bag and tubing so it doesn't touch the floor." When asked how often the catheter collection bag and catheter tubing is checked for placement, RN # 3 stated, "It should checked whenever CNAs (certified nursing assistants) and nurses are checking on patient."

The facility's policy "Catheter Care, Urinary" documented, "Infection Control. 2. Maintain clean technique when handling or manipulating the catheter, tubing or drainage bag. b. Be sure the catheter tubing and drainage bag are kept off the floor."

On 03/26/19 at approximately 3:30 p.m. ASM (administrative staff member) # 1, the

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F 690	Continued From page 93 administrator and ASM # 3, regional nurse consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm. (2) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to	F 693	**F693** **Corrective Action(s):** Residents #151's attending physician has been notified that facility staff did not properly label resident #151's tube feeding with name, rate of feeding, date and time the tube feeding was started. A facility Incident & Accident form has been completed for this incident.	

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F 693	Continued From page 94 eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide appropriate treatment and services to prevent complications of enteral feeding for one of 51 residents in the survey sample, Residents # 151. The facility staff failed to label Resident # 151's G-tube (1) feeding with Resident # 151's name, rate of feeding, Resident # 151's identification number, and the date and time, the feeding was started. The findings include: The facility staff failed to label Resident # 151's G-tube (1) feeding with the Resident # 151's name, rate of feeding, Resident # 151's identification number, and the date and time, the feeding was started. Resident # 151 was admitted to the facility on 01/26/04, with a re-admission on 01/15/18, with diagnoses that included but were not limited to:	F 693	**Identification of Deficient Practice(s) & Corrective Action(s):** All other tube-feeding residents may have been potentially affected. A 100% review of all tube-feeding residents was performed to identify those at risk. Any negative findings will be corrected at the time of discovery and a facility Incident & Accident form will be completed for any/all negative findings. **Systemic Change(s):** The facility Policy and Procedure was reviewed and no changes are warranted at this time. All licensed staff will be inserviced by the DON and/or the Regional Nurse Consultant on the facility policy and procedure for labeling, administering and the changing and of physician ordered tube-feedings, as well as proper documentation for tube-feedings. **Monitoring:** The DON is responsible for compliance. The DON and/or Unit Managers will perform 2 random tube feeding audits weekly to monitor for compliance. All negative findings identified during the audit will be corrected at time of discovery and appropriate disciplinary action taken. Detailed findings of these reviews will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 693	Continued From page 95 dysphagia (2), cerebral palsy (3), anemia (4) and gastrostomy (5). Resident # 151's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/22/19, coded Resident # 151 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 151 was coded as being totally dependent of one staff member for activities of daily living. Section K "Swallowing/Nutritional Status" coded Resident # 151 as having a "Feeding tube. While a resident." On 03/05/19 at 10:07 a.m., an observation of Resident # 151 revealed she was in bed, the head of the bed was elevated and the resident was observed receiving a tube feeding. Observation of Resident # 151's room revealed a 1000-milliliter bag of "Fibersource (6)" hanging on a pole next to the bed, being infused through a G-tube, to Resident # 151 at 45 milliliters per hour. Observation of the Fibersource bag failed to evidence Resident # 151's name, rate of feeding, Resident # 151's identification number, and the date and time the feeding was started. On 03/05/19 at 11:00 a.m., an observation of Resident # 151 revealed she was in bed, the head of the bed was elevated and the resident was observed receiving a tube feeding. Observation of Resident # 151's room revealed a 1000-milliliter bag of "Fibersource" hanging on a pole next to the bed, being infused through a G-tube, to Resident # 151 at 45 milliliters per hour. Observation of the Fibersource bag failed to evidence Resident # 151's name, rate of	F 693		

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F 693	Continued From page 96 feeding, Resident # 151's identification number, and the date and time the feeding was started. On 03/05/19 at 12:50 p.m., an observation of Resident # 151's tube feeding revealed the bag of Fibersource was taken down. The POS (physician's order sheet) dated "March 2019" documented, "Fibersource 1.2 CAL (calories) Liquid, 45 cc (cubic centimeters)/ hr (hour) via peg X (times) 20 hours. On at 1600 (4:00 p.m.) and off 1200 (12:00 p.m.). Start Date 1/15/18." On 03/05/19 at 12:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 6. When asked about Resident # 151's bag of Fibersource, LPN # 6 stated she had taken it down and placed it in the trash container on the medication cart. LPN # 6 was asked to remove the feeding bag from the trash container so it could be examined. LPN # 6 put on a pair of plastic gloves and removed it from the trash container. An observation of the bag of Fibersource feeding was conducted with LPN # 6. The observation revealed that the label on the bag of Fibersource was filled in with Resident # 151's name, rate of feeding, Resident # 151's identification number, and the date and time the feeding was started. When asked who filled in the label on the bag of Fibersource feeding, LPN # 6 stated, "After I did the flush at about 11:30 I put the information on the bag." When asked to describe the procedure of documenting on a resident's bag of tube feeding, LPN # 6 stated, "It should have the resident's name, room number, bed, date and order for the infusion." When asked about the time for Resident # 151's tube	F 693		

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feeding, LPN # 6 stated, "It's started at 4 p.m. (4:00 p.m.) and it is cut off (stopped) at 12 (12:00 p.m., noon) each day." When asked when the label on Resident # 151's bag of tube feeding should have been filled in, LPN # 6 stated, "Yesterday at 4 p.m." LPN # 6 further stated that LPN # 7 would have started the new bag of tube feeding for Resident # 151 on 03/04/19 at 4:00 p.m.

On 03/05/19 at 3:37 p.m., an interview was conducted with LPN # 7. When asked to describe the process for starting a resident's tube feeding, LPN # 7 stated, "Check the orders to make sure it is the right feeding for the resident. Spike it and prime it through the pump to push the air out of the tubing and make sure it is filled with feeding, check placement with stethoscope, flush with water, complete the label provided with patient's name, date time and rate of feeding, attach tubing to g-tube, clear volume and check settings and start the feeding." When asked how often the process she described is completed LPN # 7 stated, "The process is done each time a new bag is hung." When asked why the label needs to be filled out, LPN # 7 stated, "To make sure the resident is getting the proper feeding at the proper time at the proper rate and it is the right patient." When asked about Resident # 151's feeding, LPN # 7 stated, "I hung her bag last night (03/04/19)" When asked if she remembered putting the label on the bag and completing it, LPN # 7 stated, "I would hope I did." When informed of the observations of Resident # 151's label on the tube-feeding bag being blank, LPN # 7 did not have a comment.

The facility's policy "Enteral Feedings - Safety Precautions" documented, "Preventing errors in

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administration. 2. On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order."

On 03/05/19 at approximately 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

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

(5) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and

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F 693	Continued From page 99 the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm. (6) Nutritionally complete, fiber-containing tube feeding formula for normal or elevated calorie and/or protein requirements. This information was obtained from the website: https://www.nestlehealthscience.us/brands/fibersource/fibersource-hn-hcp+	F 693		
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 observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to respiratory care and services for five of 51 residents in the survey sample, Residents #53, #119, #145, #117, and #90. 1. The facility staff failed to administer oxygen per the physician order for Resident #53. On 3/5/19, Resident #53 was observed on separate occasions without her physician ordered continuous oxygen in place. The clinical record did not document staff reapplied the residents	F 695	**F695** **Corrective Action(s)** Resident #53's attending physician has been notified that the facility failed to ensure oxygen was administered at all times as ordered by the physician. A Facility Incident & Accident form was completed for this incident. Resident #119, #145 and #90's attending physicians have been notified that the facility failed to properly store their Nebulizer masks when not in use. The Nebulizer Masks and tubing has been replaced with a new one and all were dated and stored in a clear plastic bag when not in use. A facility Incident & Accident form was completed for this incident. Resident #117 has had their oxygen concentrators thoroughly cleaned to include the air filter. A facility Incident and Accident form was completed for this incident.	

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F 695	Continued From page 100 oxygen or any resident noncompliance with wearing the oxygen and notification to the physician.. 2. The facility staff failed to store a nebulizer mask in a sanitary manner, Resident #119's nebulizer mask was observed sitting on a chair next to the resident's bed on top of a plastic bag uncovered during multiple observations. 3. The facility staff failed to ensure proper storage Resident #145's nebulizer mask after use. On 3/5/19 during separate observations, Resident #145's nebulizer mask was observed on top of the residents dresser not stored in a bag. 4. The facility staff failed to maintain a clean filter in Resident #117's oxygen concentrator. Observations of Resident #117's oxygen concentrator filter revealed the filter was covered in a light gray, dusty residue. 5. The facility staff failed to store Resident # 90's nebulizer mask in a sanitary manner. During multiple observations the resident's nebulizer mask sitting on top of the nebulizer machine uncovered. The findings include: 1. The facility staff failed to administer oxygen per the physician order for Resident #53. On 3/5/19, Resident #53 was observed on separate occasions without her physician ordered continuous oxygen in place. The clinical record did not document staff reapplied the residents oxygen or any resident noncompliance with wearing the oxygen and notification to the	F 695	**Identification of Deficient Practice & Corrective Action(s):** All other resident receiving physician ordered oxygen may have potentially been affected. A 100% review of all residents with physician ordered oxygen was conducted to identify any/all residents at risk. Any negative findings were corrected at time of discovery and new oxygen equipment was obtained and dated and stored correctly as needed. As well as all concentrators were inspected for cleanliness. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing staff will be inserviced by the DON on the proper procedure for administering oxygen per physician order as well as proper cleaning, changing and storing of Oxygen equipment to include cleaning concentrators and storage of nasal cannulas and nebulizer tubing and masks when not in use. **Monitoring:** The DON and/or Unit Manager is responsible for maintaining compliance. The DON or Unit Manager will make weekly rounds to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action	

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F 695	Continued From page 101 physician. Resident #53 was admitted to the facility on 2/24/17 with diagnoses that included but were not limited to: hypothyroid disease (decreased activity of the thyroid gland) (1), rhabdomyolysis (is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage) (2), degenerative disc disease (disc disease is a common condition characterized by the breakdown (degeneration).of one or more of the discs that separate the bones of the spine) (3), and COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (4). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/18, coded the resident as scoring a "8" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as being completely dependent upon one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs the resident was coded as using oxygen while a resident in the facility. Resident #53 was observed on 3/5/19 at 9:05 a.m. The resident was in her bed, drinking some water. The oxygen tubing was not on the resident. The tubing was observed hanging over the end of the tubing closest to the concentrator. The tubing was not touching the ground. The oxygen concentrator was running.	F 695	will be taken as warranted. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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A second observation was made of Resident #53 on 3/5/19 at 12:33 p.m. The resident was in bed asleep. The oxygen concentrator was running and the tubing was still hanging off the tubing, not on the resident.

The third observation of Resident #53 on 3/5/19 at 3:42 p.m. revealed the resident receiving her oxygen via a nasal cannula (a tubing with two prongs that insert into the nose).

The physician order dated 6/22/18, documented, "O2 (oxygen) at 2L/min (liters per minute) continuous."

The comprehensive care plan reviewed on 12/21/18, documented in part, "Problem: Per staff Resident is non-compliant with O2 at times, takes O2 off." The "Approaches" documented in part, "Encourage O2 use as ordered. Educate resident about being non-compliant with O2 use. Document and report to MD (medical doctor) and RP (responsible party) as needed. Replace O2 when noticed off."

Review of the nurse's notes for 3/5/19 failed to evidence documentation of noncompliance by the resident with wearing her oxygen, or notification to the physician.

An interview was conducted with LPN (licensed practical nurse) #9 on 3/6/19 at 3:28 p.m. When asked if oxygen was ordered for Resident #53, LPN #9 stated, "Yes, at 2 L/min." When asked if she cared for Resident #53 on 3/4/19, LPN #9 acknowledged that she had. When asked how often she checked on her oxygen, LPN #9 stated, "I check it while I am on med (medication) pass or whenever I am in the room." LPN #9 further

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stated, "She does take it off. She claims she can't eat or drink with it on. Yesterday was the most I've seen it on her." The observations above were shared with LPN #9. LPN #9 stated, "The hospice aide must not have put it on her after care. She has to have her oxygen on. When she doesn't have it on, her sats (oxygen saturation levels in her blood) can drop to 89 - 90%. When she's sitting in her room she is normally 90-91%."

An interview was conducted with RN (registered nurse) #3 on 3/6/19. When asked oxygen is ordered for Resident #53, RN #3 stated, "Yes, and I believe it's at 2L/min." When asked if the oxygen should be on at all times, RN #3 stated, "Yes, if that's the doctor's order."

The facility policy, "Oxygen Administration" documented in part, "7. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated."

According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription. Policies and standing orders often permit the nurse to administer oxygen in emergency situations if the physician is not immediately available to write an order. Although oxygen is generally safe when used properly, certain precautions must be observed. As with all drugs, the potential exists for causing harm with misuse." On page 852, Procedure 36-5, "3. Identify client and proceed with 5 rights of medication administration...Rationale: Oxygen is a drug and administering using the 5 rights avoids potential errors....11. Document procedure and observations. Rationale: Maintains legal record and communicates with healthcare team

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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 695	Continued From page 104 members." Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. On 3/6/19 at 8:15 p.m. ASM #2, the director of nursing, was asked which professional standard of practice the facility follows, ASM #2 stated they follow their policies and Lippincott." No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 286. (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000473.htm (3) This information was obtained from the following website: https://ghr.nlm.nih.gov/condition/intervertebral-disc-disease. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 2. The facility staff failed to store a nebulizer mask in a sanitary manner, Resident #119's nebulizer mask was observed sitting on a chair next to the resident's bed on top of a plastic bag uncovered during multiple observations. Resident #119 was admitted to the facility on 1/30/19 with diagnoses that included but were not	F 695		

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F 695	Continued From page 105 limited to: depression, alcohol use, pneumonia, lung cancer, shortness of breath and COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)]. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 2/27/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one staff member for her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident not coded for any respiratory services. An observation was made of Resident #119's room on 3/4/19 at 6:36 p.m. The nebulizer machine and mask were sitting on a chair next to the bed. The mask was sitting on top of a plastic bag. When asked when was the last time it was used, Resident #119 stated she had had her treatment at 6:00 p.m. An observation was made of Resident #119's room on 3/5/19 at 8:52 a.m. The nebulizer mask was still noted to be sitting on the plastic bag on the chair. When asked when it was used last, Resident #119 stated, "Last night." An observation was made of the nebulizer mask in Resident #119's room on 3/5/19 at 10:12 a.m. An interview was conducted with Resident #119 at this time. When asked if the staff puts the nebulizer mask in the bag, Resident #119 stated, "Sometimes they do and sometimes they don't."	F 695		

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F 695	Continued From page 106 An observation was made of the nebulizer mask in Resident #119's room on 3/5/19 at 3:40 p.m. The nebulizer mask was in the bag. Resident #119 stated that she put it in the bag, not the staff. The physician order dated, 1/30/19, documented, "Albuteral Sul (solution) 1.25 MG/ML (milligrams/milliliters) sol (solution) (Albuterol is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease [COPD]) (2) - inhale 1 unit dose via jet neb (nebulizer) Q (every) 6 hours while awake." The comprehensive care plan dated, 1/30/19 and revised on 2/6/19, failed to evidence documentation regarding the use of nebulizers for the treatment of the resident's COPD. An interview was conducted with LPN (licensed practical nurse) #1 on 3/6/19 at 1:31 p.m. When asked how a nebulizer mask should be stored when not in use, LPN #1 stated it should be stored in a plastic bag when not in use. When asked why that is done, LPN #1 stated, "It's for sanitation reasons." An interview was conducted with RN (registered nurse) #3 on 3/6/19 at 1:33 p.m. When asked how a nebulizer mask should be stored when not in use, RN #3 stated, "It should be stored in a plastic bag with the resident's name and date it was changed." When asked why it should be stored in a plastic bag, "It's to keep it clean." The facility policy, "Oxygen Admiration"	F 695		

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F 695	Continued From page 107 documented in part, "10. Oxygen tubing, cannula/mask should be stored in a clear plastic bag when not in use." Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. At this time, ASM #3 informed this surveyor that the policy for the storage of nebulizers is the same for the oxygen storage. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682145.html 3. The facility staff failed to ensure proper storage Resident #145's nebulizer mask after use. On 3/5/19 during separate observations, Resident #145's nebulizer mask was observed on top of the residents dresser not stored in a bag. Resident #145 was admitted to the facility on 02/17/2017. Diagnoses for Resident #145 included but were not limited to High Blood Pressure, Depression, and Anxiety Disorder. Resident #145's Minimum Data Set (annual assessment) with an Assessment Reference Date of 02/12/2019 coded Resident #145 with moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #145 as requiring extensive assistance of one staff member with activities of daily living and limited	F 695		

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F 695	Continued From page 108 assistance of one staff person for eating. On 03/05/2019 at approximately 8:40 a.m., Resident #145's nebulizer machine was observed on top of the dresser, with the mask not stored in a bag. On 03/05/2019 at approximately 1:59 p.m., Resident #145's nebulizer machine was observed on top of the dresser, with the mask not stored in a bag. On 03/06/2019, Resident #145's clinical record was reviewed. A physician order dated 02/11/2019 documented, "Ipratropium Bromide/Albuterol Sulfate 0.5-3 (2.5) mg (milligrams)/3 ml (milliliters) (1) give nebulizer treatment every four hours as needed for shortness of breath." Resident #145's comprehensive care plan date 02/12/2019 failed to document information regarding a nebulizer mask. An interview was conducted on 03/06/2019 at approximately 10:23 a.m. with RN #1 (Registered Nurse) (Unit Manager). RN #1 was asked what the protocol was for oxygen and nebulizer equipment storage. RN #1 stated that the nasal cannula or mask should be bagged and put away when not in use. RN #1 was made aware of observations above of the nebulizer mask on top of the resident's dresser, not stored in a bag. A copy of the facility policy regarding oxygen and nebulizer storage was requested from ASM (Administrative Staff Member) #1 (Administrator) on 03/06/2019 at approximately 4:50 p.m. The facility policy titled, "Oxygen Administration", documented, "Oxygen tubing, cannula/mask	F 695		

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F 695	Continued From page 109 should be stored in a clean, clear plastic bag when not in use." On 03/06/2019 at approximately 6:00 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings. No further information was presented prior to exit. References: (1) A medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with diseases that affect the lung and airways. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html 4. The facility staff failed to maintain a clean filter in Resident #117's oxygen concentrator. Observations of Resident #117's oxygen concentrator filter revealed the filter was covered in a light gray, dusty residue. Resident #117 was admitted to the facility on 12/17/18. Resident #117's diagnoses included but were not limited to chronic kidney disease, heart failure and dehydration. Resident #117's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD (assessment reference date) of 2/11/19, coded the resident as being cognitively intact. Section O documented Resident #117 as receiving oxygen therapy. Review of Resident #117's clinical record revealed a physician's order dated 12/23/18, for continuous oxygen at two liters per minute.	F 695		

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F 695	Continued From page 110 Further review of physician's orders failed to reveal any orders regarding the oxygen concentrator filter. Resident #117's comprehensive care plan dated 12/24/18, failed to reveal documentation regarding the oxygen concentrator filter. On 3/5/19 at 8:30 a.m., 3/5/19 at 2:00 p.m., and 3/6/19 at 8:30 a.m., observations of Resident #117's oxygen concentrator filter were conducted. The filter was covered in a light gray, dusty residue. On 3/6/19 at 10:28 a.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse caring for Resident #117) and RN (registered nurse) #1 (the unit manager). LPN #4 and RN #1 were asked the facility process for cleaning oxygen concentrator filters. LPN #4 stated, "I know that when I see that they are starting to get lint on the filter I take them off, rinse them out, clean, dry and put back on." LPN #4 and RN #1 were made aware of the above concern. LPN #4 stated she had not noticed the dirty filter. LPN #4 stated Resident #117 often sits in a chair near the oxygen concentrator and she (LPN #4) can't get to the filter on the concentrator. RN #1 was asked to observe the filter. On 2/6/19 at 3:41 p.m., another interview was conducted with RN #1. RN #1 stated, "I cleaned it (the filter). It was rough." RN #1 stated the oxygen concentrator vendor is supposed to clean the filter each month. On 3/6/19 at 4:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the	F 695		

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F 695	Continued From page 111 regional vice president of operations) was made aware of the above concern. The facility policy titled, "Oxygen Administration" failed to document information regarding the facility process for cleaning the concentrator filter. No further information was presented prior to exit. 5. The facility staff failed to store Resident # 90's nebulizer mask in a sanitary manner. During multiple observations the resident's nebulizer mask sitting on top of the nebulizer machine uncovered. Resident # 90 was admitted to the facility on 9/10/15, and re-admitted on 4/29/16 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), bronchiectasis (2), and hypertension (3). Resident # 90's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/19, coded Resident # 90 as scoring a 8 on the brief interview for mental status (BIMS) of a score of 0 - 15, 8 - being moderately impaired of cognition for making daily decisions. Resident # 90 was coded as requiring limited to extensive assistance with activity of daily living of one staff member and was coded as being totally dependent of one staff member for toileting. On 3/04/19 at 6:57 p.m., an observation of Resident # 90's room revealed Resident # 90 was sitting next to her bed. The nebulizer machine was observed on the bed with the nebulizer mask laying on the top of the nebulizer machine uncovered.	F 695		

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F 695	Continued From page 112 On 3/05/19 at 9:50 a.m., an observation of Resident# 90's room revealed Resident # 90 was sitting in a chair next to her bed. Observation of the nebulizer machine revealed it was on the bed and the nebulizer mask was sitting on top of the nebulizer machine uncovered. On 3/05/19 at 10:33 a.m., an observation of the Resident # 90's room revealed the Resident # 90 was sitting on a chair next to the door with the nebulizer machine on her bed. Observation of the nebulizer machine revealed the nebulizer mask was on top off the nebulizer machine uncovered. On 3/6/19 at approximately 10:15 a.m., an interview conducted with LPN (license practical nurse) # 1. When asked a nebulizer mask should be stored when not in use, LPN # 1 stated, "It should be kept in a plastic bag with the resident's name and the date when the mask and the tubing were changed, this is done once a week usually on Sundays." When asked why it is important to cover the nebulizer mask after the resident has used it, LPN # 1 stated, "To keep the nebulizer mask clean and free from germs." On 3/6/19 at approximately 3:30 p.m., ASM (administrative staff member) # 1, administrator and ASM # 3, regional corporate nurse consultant, RN (registered nurse) were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 1 stated, "We follow the facility's policies. No further information was provided prior to exit. References:	F 695		

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F 695	Continued From page 113 1. Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. A chronic condition where the walls of the bronchi are thickened from inflammation and infection. People with bronchiectasis have periodic flare-ups of breathing difficulties, called exacerbations. This information was obtained from the website: https://www.lung.org/lung-health-and-diseases/lung-disease-lookup/bronchiectasis/ 3. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure pain management consistent with professional standards of practice, for one of 51 residents in the survey sample, Resident #148. The facility staff failed to clarify physician's orders	F 697	**F697** **Corrective Action(s):** Resident #148's attending physicians was notified that the facility staff failed to clarify the pain medication orders for resident #148 to indicate what type of pain medication is to be administered based on pain scale score. A facility Incident and Accident form was completed for this incident.	

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F 697	Continued From page 114 for two as needed pain medications to determine which, as needed pain medication should be administered to Resident #148 based on pain parameters. The findings include: Resident #148 was admitted to the facility on 12/11/17 with a readmission on 1/24/19, with diagnoses that included but were not limited to: diabetes, high blood pressure, chronic kidney disease dependent on hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine (1)], COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)], and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 2/21/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section J - Health Conditions, the resident was coded as having occasional pain with a pain level of "5" on a scale of 1 - 10, 10 being the worse pain they have ever been in. The physician order dated, 1/24/19 documented, "Acetaminophen (Tylenol) [used to treat mild pain and fevers (3)], 325 MG (milligrams) Tablet, give two tabs (tablets) po (by mouth) q (every) 4 hours prn (as needed) for pain/fever >(greater than)	F 697	**Identification of Deficient Practices/Corrective Action(s):** All other residents receiving pain medications may have been potentially affected. The DON, ADON, and/or Unit Manager will conduct a 100% audit of all resident's receiving PRN pain medications to identify resident at risk for inaccurate pain medication orders or pain medication orders that require clarification. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24-Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication orders & treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as administering the appropriate prn pain medications based on pain scale score.	

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F 697	Continued From page 115 101." A second physician order dated 1/24/19 documented, "Norco 5-325 Tablet [used to treat moderate to severe pain (4)] - Norco 5/325 mg take 1/2 tab po q4hours prn for pain." The January 2019 MAR (medication administration record) documented the above medication orders. The MAR documented the administration of the Acetaminophen on the following dates, times, with pain levels as follows: 1/17/19 at 1:23 a.m. for a pain level of 7 1/19/19 at 7:54 p.m. for a pain level of 4 1/22/19 at 12:49 a.m. for a pain level of 4 1/22/19 at 4:53 p.m. for a pain level of 6. 1/29/19 at 8:11 p.m. for a pain level of 4 1/30/19 at 10:22 p.m. for a pain level of 4 1/31/19 at 10:53 a.m. for a pain level of 4. The January 2019 MAR documented the above medication orders. The MAR documented the administration of the Norco on the following dates, times with pain levels as follows: 1/1/19 at 5:26 p.m. for a pain level of 4 1/2/19 at 6:13 p.m. for a pain level of 5 1/3/19 at 5:49 p.m. for a pain level of 6 1/6/19 at 6:12 p.m. for a pain level of 5. 1/7/19 at 6:11 p.m. for a pain level of 0 1/8/19 at 5:33 p.m. for a pain level of 5 1/11/19 at 4:04 p.m. for a pain level of 0 1/17/19 at 5:50 a.m. for a pain level of 7 1/24/19 at 8:39 p.m. for a pain level of 5 1/25/19 at 8:28 a.m. for a pain level of 5 1/25/19 at 3:46 p.m. for a pain level of 0 1/26/19 at 8:33 a.m. for a pain level of 5 1/26/19 at 6:03 p.m. for a pain level of 5 1/26/19 at 10:32 p.m. for a pain level of 5 1/28/19 at 8:54 p.m. for a pain level of 6. The February 2019 MAR (medication	F 697	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 697	Continued From page 116 administration record) documented the above medication orders. The MAR documented the administration of the Acetaminophen on the following dates, times, with pain levels as follows: 2/1/19 at 8:05 a.m. for a pain level of 4 2/5/19 at 8:24 a.m. for a pain level of 5 2/5/19 at 11:43 a.m. for a pain level of 5 2/8/19 at 5:17 a.m. for a pain level of 4 2/21/19 at 9:51 a.m. for a pain level of 5 2/22/19 at 7:53 a.m. for a pain level of 5 2/23/19 at 9:42 a.m. for a pain level of 5 2/25/19 at 1:12 a.m. for a pain level of 4 2/26/19 at 9:01 a.m. for a pain level of 5. The February 2019 MAR documented the above medication orders. The MAR documented the administration of the Norco on the following dates, times with pain levels as follows: 2/1/19 at 5:00 a.m. for a pain level of 7 2/1/19 at 6:26 p.m. for a pain level of 3 2/2/19 at 11:55 p.m. for a pain level of 4 2/3/19 at 10:01 p.m. for a pain level of 5 2/4/19 at 6:21 p.m. for a pain level of 4 2/5/19 at 1:39 p.m. for a pain level of 6 2/6/19 at 8:33 a.m. for a pain level of 5 2/6/19 at 11:38 p.m. for a pain level of 6 2/7/19 at 11:09 p.m. for a pain level of 4 2/8/19 at 10:54 p.m. for a pain level of 9 2/9/19 at 11:53 p.m. for a pain level of 8 2/10/19 at 8:51 a.m. for a pain level of 5 2/10/19 at 10:34 p.m. for a pain level of 8 2/11/19 at 11:03 a.m. for a pain level of 5 2/13/19 at 8:58 a.m. for a pain level of 6 2/14/19 at 8:12 a.m. for a pain level of 5 2/15/19 at 8:55 a.m. for a pain level of 5 2/15/19 at 6:01 p.m. for a pain level of 4 2/17/19 at 1:21 a.m. for a pain level of 4 2/19/19 at 8:58 a.m. for a pain level of 5 2/19/19 at 6:41 p.m. for a pain level of 4	F 697		

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F 697	Continued From page 117 2/21/19 at 11:50 p.m. for a pain level of 4 2/25/19 at 7:54 a.m. for a pain level of 10. The March 2019 MAR documented the above medication oders. The MAR documented the administration of the Acetaminophen was administered on 3/3/19 at 6:08 a.m. for a pain level not documented. The March 2019 MAR documented the above medication orders. The MAR documented the administration of the Norco on the following dates, times with pain levels as follows: 3/1/19 at 12:41 a.m. for a pain level of 5 3/1/19 at 9:42 p.m. for a pain level of 5 3/3/19 at 12:09 a.m. for a pain level of 4 3/3/19 at 7:42 p.m. for a pain level of 5 3/6/19 at 9:36 a.m. for a pain level of 5. The comprehensive care plan dated as reviewed on 1/31/19, documented in part, "Problem/Need: Potential for pain." The "Approaches" documented, "Provide pain meds (medications) as ordered. Assess pain med effectiveness document and report to MD (medical doctor) as needed. Assess for signs and symptoms of break thru pain document and report to MD as needed. Assist with turning and repositioning for comfort." An interview was conducted with LPN (licensed practical nurse) #1 on 3/6/19 at 11:44 a.m. LPN #1 was asked to review the above physician orders for Acetaminophen and Norco. Once reviewed, LPN #1 was asked how the staff knows which medication to give the resident when they complain of pain, LPN #1 stated, "I start with the lesser of the medications, then go up if that doesn't work, if needed. I will tell you with this	F 697		

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F 697	Continued From page 118	F 697		

resident she is alert and oriented and does ask for a specific medications." LPN #1 stated, "I have seen orders that tell the nurse if they have pain from 1-4 you give, normally, some Tylenol, and if the pain is 5-10 on a pain scale you give them the stronger medication." When asked if she is capable of making the decision what to give, LPN #1 stated, "Yes, I would give them the Norco if their pain was from 5-10 and Tylenol if their pain was 1-4."

An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/6/19 at 11:50 a.m. RN #3 was asked to review the above orders for pain medications. Once reviewed, RN #3 was asked how the nurses' know which medication to give, RN #3 stated, "We need clarification of those orders. The pain level needs to be added to the orders."

The facility policy, "Administering Pain Medications" documented in part, "6. Administer pain medications as ordered."

According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

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F 697	Continued From page 119 Administrative staff member (ASM) #1, the administrator, ASM #3, the regional nurse consultant, and ASM #4, the regional vice president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m. On 3/6/19 at 8:15 p.m. ASM #2, the director of nursing, was asked which professional standard of practice the facility follows, ASM #2 stated they follow their policies and Lippincott." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html (4) This information was obtained from the following website: https://medlineplus.gov/ency/article/002670.htm	F 697		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812	**F812** **Corrective Action(s):** The opened Pimento Spread identified during the kitchen tour with no "opened dated or use by date was immediately removed and disposed of. A facility Incident and Accident form was completed for this incident.	

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F 812	Continued From page 120 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner in the facility's kitchen. The facility staff failed to ensure an opened five-pound container of pimento spread available for use had an open date and a use-by-date. The findings include: On 03/04/19 at 6:30 p.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 1, cook. An observation of the single door reach-in refrigerator revealed a five-pound container of "Pimento Spread" with approximately two-thirds remaining and available for use. Observation of the "Pimento Spread" container failed to evidence an open date and a use-by-date. Further observation of the container revealed a black stamped date on the side of the container. Observation of the black stamp revealed it was blurred and unreadable. After looking at the black stamp and examining the container of "Pimento Spread" OSM # 1 stated, "I can't read the use-by-date." When asked if there	F 812	**Identification of Deficient Practices & Corrective Action(s):** All other food items in the kitchen may have been potentially affected. The Food Service Manager will inspect the kitchen dry storage areas, the walk-in freezer, reach in freezers and refrigerators to identify any negative findings. All negative findings will be corrected at time of discovery and appropriate disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The Dietary manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy for proper food storage to include proper labeling and dating. **Monitoring:** The Dietary Manager is responsible for maintaining compliance. The Administrator and/or Food service manager will complete the Kitchen audit tool weekly for monitoring and maintaining compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 812	Continued From page 121 was, an open date posted on the container, OSM # 1 stated, "No." When asked to describe the procedure for storing open food items in the kitchen, OSM # 1 stated, "It should be dated when it was opened and a use-by-date." The facility's policy "Covering, Labeling, Dating Food" documented, "Good storage guidelines include date labeling food correctly to determine when a food is no longer safe to consume and should be discarded. Food labeling is also a component of proper food storage to easily identify foods, especially when the food has been removed from the original packaging." Under "Refrigeration storage" it documented, "All foods must be covered, labeled and dated with a date label. All food should be monitored each day to be assured that the foods will be used, consumed or discarded by the use-by-date or expired date." On 03/05/19 at approximately 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 3, regional nurse consultant, were made aware of the findings. No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842	**F842** **Corrective Action(s):** Resident #9's attending physician has been notified that the facility staff failed to document the non-pharmacological interventions attempted prior to the administration of a PRN pain medication. A facility incident and accident form has been completed for this incident.	

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F 842	Continued From page 122 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842	**Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all residents receiving routine or PRN pain medication orders and MAR's, will be conducted by the DON and/or Unit Manager to identify residents at risk for inappropriate documentation of non-pharmacological interventions. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This inservice will include the standards for proper documentation for interventions both pharmacological and non-pharmacological implemented when administering routine or PRN pain medications.	

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F 842	Continued From page 123 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 51 residents in the survey sample, Resident #138. The facility staff failed to document non-pharmacological interventions that were provided for Resident #138 in addition to administering as needed Tylenol (1) on multiple dates in February 2019. The findings include: Resident #138 was admitted to the facility on 9/14/16. Resident #138's diagnoses included but were not limited to high blood pressure, vitamin B12 deficiency and constipation. Resident #138's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 2/15/19,	F 842	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

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F 842	Continued From page 124	F 842		

coded the resident's cognition as severely impaired. Section J coded Resident #138 as having received PRN (as needed) pain medication and non-medication intervention during the last five days. Section J further coded Resident #138 reported having frequent pain during the last five days.

Review of Resident #138's clinical record revealed a physician's order dated 1/29/19, for Tylenol 650 mg (milligrams) every six hours PRN (as needed) for pain or a fever greater than 101. Review of Resident #138's February 2019 MAR (medication administration record) revealed the resident was administered PRN Tylenol on 2/4/19, 2/5/19, 2/6/19, 2/10/19, 2/11/19, 2/12/19, 2/14/19, 2/15/19 and 2/18/19. Further review of Resident #138's MAR, MAR notes and nurses' notes failed to reveal documentation that Resident #138 was offered non-pharmacological interventions prior to or in addition to the administration of PRN Tylenol on all the above dates. Review of Resident #138's comprehensive care plan dated 2/15/19 failed to reveal documentation regarding pain.

On 3/6/19 at 11:32 a.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse who administered PRN Tylenol to Resident #138 on all of the above dates except 2/10/19). LPN #5 confirmed she administered Tylenol to Resident #138 for pain. LPN #5 was asked what should be done prior to or in addition to administering PRN pain medication to a resident. LPN #5 stated, "Well, see if you can reposition them, if there is something else non-pharmaceutical you can do." When asked if she documents the non-pharmacological interventions she provides, LPN #5 stated, "Most

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F 842	Continued From page 125 of the time, yes." When asked if non-pharmacological interventions should be documented each time they are offered, LPN #5 stated, "You should." When asked why, LPN #5 stated, "Just to show that you didn't just give them a pill; that you tried something else to relieve their discomfort." LPN #5 stated she provided repositioning to Resident #138 each time she administered PRN Tylenol. When asked where she documented this non-pharmacological intervention, LPN #5 stated she really could not say where she documented this information but some residents' MARs have a drop down box containing a list where nurses can select the provided non-pharmacological intervention. LPN #5 stated she thought this process was generated by a certain way the orders are put into the computer system. When asked if she could recall if Resident #138's MAR had this option, LPN #5 stated she was not sure. Further review of Resident #138's MAR failed to reveal this option. On 3/6/19 at 4:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the regional vice president of operations) was made aware of the above concern. The facility policy regarding pain medication administration documented, "5. Evaluate and document the effectiveness of non-pharmacological interventions..." No further information was presented prior to exit. (1) Tylenol is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.h	F 842		

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F 842	Continued From page 126 tml	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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	F 880	**F880** **Corrective Action(s):** C.N.A. #4 that was assisting resident #108 with their meal has been inserviced on proper handwashing procedures to be followed when assisting other residents while in the dining room assisting residents with their meals. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents may have the potential to be affected by improper infection control techniques related to improper handwashing and feeding practices. The DON, ADON or designee will perform 3 dining room meal audits to observe for proper infection control practices during the meal service and while feeding residents. Any/all negative findings will be corrected at time of discovery and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All facility staff will be inserviced on the facility policy and procedure for maintaining proper infection control practices. The inservice training will include proper hand washing and feeding procedures to be followed during all meal services by the DON and/or Regional Nurse Consultant.	

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F 880	Continued From page 127 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain infection control practices for one of 51 residents in the survey sample, Residents #108. The facility staff failed to wash or sanitize their	F 880	**Monitoring:** The DON will be responsible for monitoring compliance. The DON, ADON, and/or designee will perform 3 random weekly Dining room adutis during meal times to monitor for proper infection control practices and hand washing during resident mela times and while assisting with feeding resident to maintain compliance. Any/all negative findings will be corrected at time of discovery and one-on-one inservice training will be completed with staff member. Detailed findings of the audits will be reported to the Quality Assurance Committee for review, analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 17, 2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 128	F 880		

hands after assisting other residents in the Cottage dining room and returning to feed Resident #108.

The findings include:

Resident #108 was admitted to the facility on 8/1/16 with the diagnoses of but not limited to Dysphagia, Schizophrenia, Alzheimer's disease, high blood pressure, sleep apnea, osteoporosis, depression with psychotic symptoms, and metabolic encephalopathy. Resident #108's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/26/19. The resident was coded as requiring total assistance for all areas of activities of daily living.

On 3/5/19 at approximately 1:30 p.m. to 1:50 p.m., observations were made in the Cottage dining room for the lunch meal. The following was observed:

On 3/5/19 at approximately 1:30 p.m., CNA #4 (Certified Nursing Assistant) was sitting down at the table feeding Resident #108.

On 3/5/19 at approximately 1:33 p.m., while feeding Resident #108, CNA #4 got up to assist another resident who was leaving the dining room and touched the personal wheelchair of another resident. CNA #4 then returned to the table to feed Resident #108, without washing or sanitizing her hands.

On 3/5/19 at approximately 1:35 p.m., CNA #4 was observed standing up from feeding Resident # 108, to speak with another resident and was observed patting the resident on the back as the

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F 880	Continued From page 129 resident was leaving the dining room. CNA #4 then returned to the table to feed Resident #108 without washing or sanitizing her hands. On 3/5/19 at approximately 1:44 p.m., CNA #4 was observed standing up from feeding Resident # 108, to help another resident place her tray onto the tray cart. CNA #4 then returned to the table to feed Resident #108 without washing or sanitizing her hands. On 3/5/19 at approximately 1:45 p.m., CNA #4 was observed reaching across the table to assist another resident with his tray. CNA #4 then returned to feeding Resident #108 without washing or sanitizing her hands. On 3/05/19 at 3:44 p.m., in an interview with CNA #4, when asked what protocols the facility follows to maintain infection control in the dining room, CNA #4 stated, "I should wash or sanitize my hands when I do other things before returning to feed a resident." When asked about the observations of assisting multiple residents back and forth and not washing or sanitizing her hands between them, CNA #4 stated, "We do not have any sanitizers in the dining room, just the wipes (which were kept in a locked cabinet). I should have washed or sanitized my hands before feeding a resident again." A review of the facility policy, "Handwashing/Hand Hygiene" documented, "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other ...residents .... Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations ...before and	F 880		

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F 880	Continued From page 130 after direct contact with residents ...before and after assisting a resident with meals." A review of the facility policy, "Infection Control Guidelines for All Nursing Procedures" documented, "Employees must wash their hands ...before and after direct resident contact ...before and after assisting a resident with meals ...." On 3/5/19 at 5:15 p.m., the Administrator (ASM #1 - Administrative Staff Member) were made aware of the findings. No further information as provided. In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 655. "The nurse follows certain principles and procedures, including standard precautions, to prevent and control infection and its spread. During daily routine care the nurse uses basic medical aseptic techniques to break the infection chain. A major component of client and worker protection is hand hygiene. Contaminated hands of health care workers are a primary source of infection transmission in health care settings."	F 880		