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	495422	A. BUILDING _____ B. WING _____	C 07/13/2018

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/10/18 through 07/13/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/10/2018 through 07/13/2018. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 64 certified bed facility was 60 at the time of the survey. The survey sample consisted of 24 Resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		8/14/18

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

Electronically Signed | 08/01/2018

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to implement the abuse prevention policy for two Residents (Residents #1 and Resident #34) in a survey sample of 24 residents. Resident #1 willfully assaulted Resident #34. Resident #1 was a demented Resident, however, the act was not accidental. The victim was bed fast, and Resident #1 went to her, and struck her on the thigh and knee repeatedly while Resident #34 was in bed. The findings included: Resident #34 was admitted to the facility on 12-12-12. Diagnoses included; encephalopathy, epilepsy, anxiety, bipolar disorder, and dementia. Resident #34's most recent Minimum Data Set Assessment was a quarterly assessment with an assessment reference date of 5-25-18. She was coded with severe cognitive impairment. She required total assistance with all activities of daily living (ADLs), and was bed fast. A review of Resident #3's comprehensive care plan included an intervention under Resident #34's ADL Self Care Performance Deficit Plan related to her limited mobility, indicating the Resident was unable to defend herself against attackers. Nursing progress notes were reviewed for 3 month period, and no notes indicate any	F 600	1. Resident #1 was evaluated by psych on 7/19/2018 with medication adjustments. 1:1 activity 5 times a week. No documented resident to resident altercations at this time. Care plan reviewed and revised with specific redirection techniques. Resident #34 Head to Toe assessment was completed for any bruising or any other skin integrity concerns. Social Worker assessed resident for any signs of fear. 1:1 activity 5 times a week. Staff educated on observing resident and being aware of behaviors of other residents. Care plan reviewed and revised with current interventions. 2. All residents have the potential to be affected by this deficient practice. Current residents with documented behaviors will be reviewed by the Interdisciplinary Team for appropriate interventions to include specific redirection techniques. Review of current room placement with changes made if recommended. Care plans of current residents with documented behaviors will be reviewed for appropriate interventions, to include nonpharmacological. 3. Facility staff will be educated on the Abuse Policy and Procedure including resident to resident altercations by Administrator/designee.	

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F 600	Continued From page 2 behaviors for this Resident. Resident #1 was initially admitted to the facility on 3-15-18 with diagnoses including but not limited to; Chronic obstructive pulmonary disorder, Dementia, delusional disorders, hypertension, seizures, major depression, was anemic, weighed 89 pounds, Dysphagia oral phase, and had a history of falls. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed. The Full Admission Minimum Data Set Assessment (MDS) with an ARD (assessment reference date) of 3-23-18 coded Resident #1 as having a BIMS (brief interview of mental status) of "2" out of a possible 15, or severely cognitively impaired. Resident #1 was coded as needing extensive assistance with ADL's (activities of daily living) such as bathing and dressing from 1 staff member, and for eating required supervision and set up help. The most recent MDS with an ARD of 6-25-18 was a significant change full assessment, and coded the resident as requiring extensive assistance from one staff member. Review of the nursing progress notes revealed the Resident to be documented as physically and verbally abusive toward others upon admission, and was documented as such in the admission MDS. Prior to assaulting her room mate (the room mate was identified as Resident #34 and placed in the survey sample) Resident #1 was documented in the nursing progress notes as combative, aggressive, verbally and physically abusive with staff and Residents. This behavior	F 600	Facility staff will be provided Dementia Training to include supervision, protecting and preventing resident to resident altercations by Corporate Director of Social Services and Activities/designee. New employees will be provided Dementia Training by Social Services Director/designee. Licensed nurse will be educated on utilizing the behavior flow sheet. 4. DON/designee will review the 24 hour report/nursing documentation/behavior monitoring flow sheet five days a week for 12 weeks for residents with behaviors to ensure interventions are in place. Results of audits will be taken to the QAPI committee meeting monthly for three months for review and revision as needed.	

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was documented 8 times in 3 months, and 3 times on 5-26-18, the day of the assault. After the assault she was moved to another room on 5-26-18, and continued the abusive behaviors on 5-27-18, 5-30-18, 5-31-18, 6-1-18, 6-3-18, 6-6-18, 6-13-18 and 6-29-18. Supervision interventions for this Resident were not described. The Resident was moved on 7-2-18 back directly across the hall from the room mate she assaulted on 5-26-18. No indication why she was moved back in close proximity to her victim could be found.

The incident of assault occurred on 5-26-18, and was reported to the state agency timely. A synopsis of that event follows from the Nursing progress notes:

5-26-18 at 5:57 p.m. Resident (#1) sitting up at nursing station yelling out and cursing at other residents and visitors as they walk by. Staff attempted several times to redirect, but resident continued to curse and yell and attempted to hit staff. Resident (#1) verbally threatening other residents, throwing silverware across the room. Staff even attempted to remove resident from stimulated area at nursing station but resident continued to yell and curse at residents and staff who walked by. Redirection was not successful.

5-26-18 at 7:00 p.m. Staff walked in room and observed Resident (#1) sitting on floor next to (Resident #34's) bed. Resident was hitting room mate on left knee. (In Resident #34 nursing note account it stated she was being struck on the left knee and thigh area.) (resident #34 was in bed) Residents were separated and both were assessed for injuries. None were noted at that time. Resident #1 has hallucinations, combative

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behavior, yelling and cursing.

5-26-18 at 7:05 p.m. CNA walked by room and observed resident (#1) sitting on floor next to bed. Resident was asked what happened and Resident (#1) replied I don't know what happened stupid. Resident was assessed for injuries and none were noted at this time. While assessing resident for injuries resident attempted to hit staff in the face.

The notes indicate continued willful acts on the part of Resident #1, and that Resident #1 was back in the room with her victim, after an assault.

During the survey on 7-12-18 when exiting the building for lunch break Resident #1 was observed sitting in her wheel chair with the receptionist in the lobby at the front desk. The receptionist was trying to keep the Resident from removing her clothing and exposing herself to visitors who were present there. This continued for approximately 10 minutes while waiting for other surveyors to arrive. The Resident was striking out at the receptionist, and the receptionist kept repeating "No, don't do that, you can't take your shirt off here," and the Resident was yelling "I don't care who is here, cursing, and hitting the receptionist. The Receptionist did not try to remove the Resident and seemed not to know what to do, stating, "I can't do this". We asked if the receptionist was a nurse or CNA, and she stated, "no".

Review of Resident #1's plan of care was conducted and revealed the interventions below for Behaviors::

Behaviors - Under "Focus" "The Resident has

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depression related to admission, dementia, disease process (altered mental status". Interventions included; "Administer medications, monitor for side effects and effectiveness, arrange for psyche consult, follow up as indicated, encourage and provide opportunities for exercise, physical activity, encourage movement program, monitor /document/report signs of depression to nurse/doctor, monitor/record/report to doctor as needed risk for harming others." The Resident was documented by staff repeatedly as being at risk of, and attempting to harm others during her entire stay.

Another "Focus" for behavior included further interventions of "room change, provide for positive interaction, attention, stop and talk, discourage from scratching self, encourage expression of feelings appropriately, explain all procedures before starting and allow Resident to adjust to changes, approach and speak in calm manner, intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to alternate location as needed, praise improvement in behavior."

The following was added to the care plan on 3-22-18 "Referred to [facility area community services board] for psychiatry services on 3-21-18. They are unable to add another patient to his caseload at this time. Will refer to telemed psychiatry when available at facility." No projection date is given for "telemed psychiatry" availability. On 5-24-18 (2 months later) another revision was made which stated; "Left message for (name of group) psychiatry". It is unknown when the actual appointment was made, however, a revision was made to the care plan

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F 600	Continued From page 6 dated 6-11-18, and the Resident is now scheduled to see a psychiatrist doctor on 7-19-18. The Psyche consult was not attempted to be arranged for 2 months, during which time the Resident was abusive to Residents and staff. On 6-11-18 weeks after the Resident had physically assaulted a resident, a revision was documented, and stated an arranged appointment for 7-19-18. The Resident continued to be abusive and aggressive for 3 months before this intervention was implemented. No supervision was specified in the care plan for any of these areas. Who will supervise, when to supervise, and how to supervise this Resident have not been included and are not person centered or measurable indicating staff is unaware of Resident need and how to meet it. In conclusion, the facility failed to maintain adequate supervision of Resident #1, and provide a safe environment for Resident #34, and others. On 7-12-18, and 7-13-18 at 4:30 p.m., the facility failure was reviewed with the Administrator, and Director Of Nursing at the end of day meeting. No further information was provided.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		8/14/18

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F 656	Continued From page 7 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete, implement, or develop a comprehensive care	F 656	1. Resident #38 care plan reviewed for all fall interventions and revised to reflect current and appropriate interventions.	

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F 656	Continued From page 8 plan for 3 of 24 sampled residents. (Residents #38, #1, and #34) 1. For Resident # 38, the facility staff failed to complete a comprehensive care plan to include interventions that were measurable, and did not describe the intervention "redirect". 2. For Resident #1, the facility staff did not develop and implement a comprehensive care plan for a broken hip with surgery until 23 days after readmission, and failed to initiate a comprehensive diet and feeding careplan. 3. Resident #34 did not have a comprehensive care plan for oxygen saturation assessments, and oxygen administration. Findings included: Resident # 38 was an 82 year old female who was admitted to the facility on 7/14/2015 and readmitted on 3/22/2016 with diagnoses of but not limited to: Chronic Pain, Atherosclerotic Heart Disease, Hypertension, Vitamin D Deficiency, Alzheimer's Disease with late onset, Dementia,Psychosis and Major Depressive Disorder. The Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 5/29/2018. The MDS coded Resident # 38 with a BIMS (Brief Interview for Mental Status) of 3/15 indicating severe cognitive impairment; the resident was coded as independent with most activities of daily living (bed mobility, transfers, ambulation, locomotion, eating, and toileting) except required extensive assistance of two staff persons with Hygiene, Dressing and Bathing;	F 656	Resident #1 clinical record reviewed and order for regular diet was found dated 6/13/2018. A speech consult for clarification on 7/25/2018; order clarified as regular on 7/26/2018; communication to dietary and tray card adjusted. Care Plan reviewed and updated to reflect current diet. Fall care plan reviewed and interventions current and in place. Resident #34 had orders clarified; continuous oxygen discontinued care plan reviewed and revised to reflect changes. 2. All residents have the potential to be affected by this deficient practice. 100% audit of residents receiving oxygen therapy had care plans to ensure care plans are accurate and interventions in place. 100% review of residents with falls in last 30 days to ensure care plans are accurate and interventions in place. 100% review of residents with mechanically altered diet to ensure care plan is accurate and interventions in place. 3. The interdisciplinary team will be in-serviced on developing comprehensive care plans relating to resident assessment and orders on admission, quarterly, annually, and with significant change by Regional Reimbursement specialist/designee. Nursing staff educated on following care plans by DON/designee. 4. DON/designee will audit 24 hour	

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F 656	Continued From page 9 Resident # 38 was coded as always continent of bowel and bladder. Review of the Clinical Record was conducted on 7/11/2018. Review of the care plan revealed a focus of "Risk for falls r/t (related to) impaired cognition/judgment, poor vision and the use of psychotropic medication. At risk for fractures due to dx (diagnosis) of vitamin D deficiency. Does have tendency to sit in floor." Interventions included: "Place in supervised area during restlessness. Redirect toward nurses station." initiated 3/17/2018, revision on 3/23/2018 "Frequent checks when restless." initiated on 6/20/2018 Under the focus: The resident is an elopement risk/wanderer AEB (As evidenced by) impaired safety awareness Interventions included: "Resident frequently attempts to get into other resident's beds. Redirect as needed." initiated 11/16/17. There was no documentation of the meaning of redirect as needed. The intervention did not describe how the facility staff should redirect Resident # 38. There was no intervention included about supervision of resident. On 7/11/2018 at 10:30 AM, a Group Interview was conducted with 15 alert and cognitively intact residents. The group complained that Resident #	F 656	report/MD orders/new admission/readmission 5 times a week for 12 weeks to ensure care plans have been developed/revised to reflect residents plan of care. DON/designee will audit 5 residents weekly to ensure care plan interventions are present. Results of audits will be taken to the QAPI committee monthly for three months for review and revision as needed.	

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38 frequently wandered into other residents rooms and was often combative toward others. Several residents in the group stated the nursing staff members were unable to keep Resident # 38 from entering their rooms "especially because the facility was often short staffed."

On 7/12/2018 at 3:05 PM, an interview was conducted with the Director of Nursing (DON) who stated Resident # 38 had several unwitnessed falls and bruises. The DON also stated Resident # 38 continued to wander into other residents' rooms and had a history of physical aggression toward other residents.

Resident # 38 was observed wandering throughout the facility during the four days of survey. At times, staff members accompanied Resident # 38 while in the hallway, other times Resident # 38 was observed to be ambulating without staff members nearby.

On 7/13/2018 during the end of day debriefing, the facility administrator and Director of Nursing were informed of the lack of adequate supervision and numerous accidents/incidents involving Resident # 38. The Facility Administrator stated the facility was actively searching for a more appropriate placement in another facility "possibly one with a secure unit" for Resident # 38. The Administrator stated Resident # 38's daughter wanted to find a facility closer to where the daughter lived.

No further information was provided.

2. For Resident #1, the facility staff did not

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develop and implement a comprehensive care plan for a broken hip with surgery until 23 days after readmission, and failed to implement a comprehensive diet and feeding careplan.

Resident #1 was initially admitted to the facility on 3-15-18 with diagnoses including but not limited to; Chronic obstructive pulmonary disorder, Dementia, delusional disorders, hypertension, seizures, major depression, was anemic, weighed 89 pounds, Dysphagia oral phase, and had a history of falls. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed.

The Full Admission Minimum Data Set Assessment (MDS) with an ARD (assessment reference date) of 3-23-18 coded Resident #1 as having a BIMS (brief interview of mental status) of "2" out of a possible 15, or severely cognitively impaired. Resident #1 was coded as needing extensive assistance with ADL's (activities of daily living) such as bathing and dressing from 1 staff member, and for eating required supervision and set up help.

The most recent MDS with an ARD of 6-25-18 was a significant change full assessment, and coded the resident as requiring extensive assistance from one staff member, and now required extensive assistance from 1 staff member for eating.

Nursing progress notes were requested for three months and reviewed. The notes revealed that the Resident experienced 8 repeated falls in a 3 month period. They occurred on 4-17-18, 5-4-18, 5-26-18 twice, 6-4-18, and was hospitalized on 6-7-18 with a fractured hip from an unwitnessed

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fall, and was readmitted on 6-13-18.

Physician orders and Registered Dietician (RD) notes indicated that on admission 3-15-18 the Resident was ordered to have a "chopped meat - add sauce, gravy to meats regular diet" which was not discontinued by the physician. The RD documented on 6-1-18 reflects the same. On 6-25-18 the same RD documented regular diet but does not specify consistency. The physicians order was never discontinued. Nursing notes denote the Resident requires limited to total feeding, supervision or hands on assistance from 1 staff member to eat, in some notes, and states independent in others.

On 7-10-18 during initial tour and observation of the lunch meal, Resident #1 was observed in her room with a meal tray in front of her with a whole chicken patty on it. The meat was not chopped. The Resident was just looking at the food, however, not consuming it.

The Resident suffered from seizures, oral phase Dysphagia (difficulty eating), chronic obstructive lung disease, and was confused, putting the Resident at greater risk for aspiration. No staff were in the room to assist the Resident from 11:45 a.m., until tour and observations ended on this hall at 12:45. No 30 minute checks were conducted. The Resident had not been evaluated by Speech therapy ever during her 4 month stay.

Review of Resident #1's plan of care was conducted and revealed the interventions below for Falls and Diet:

Diet - Interventions for: "Encourage to dine in

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dining room as appropriate", "monitor intake, weight, provide diet order, review preferences, and monitor need for increased nutritional intervention." were all applied to the care plan originally on 3-25-18 on admission. The interventions added after that were; "Monitor for signs and symptoms of "Aspiration", and "Speech Therapy screens as needed, treat as ordered" were added to the care plan on 7-11-18 after survey was in progress under a focus for "At risk for Cardiac Respiratory status". Resident #1's diet order and assistance needed from staff to eat, was never documented on the care plan, and so staff would not know what to provide.

No interim comprehensive care plan was developed For Resident #1's surgery for hip fracture and readmission on 6-13-18, until 23 days later, on 7-6-18, and that care plan did not mention any surgical wound care.

On 7-12-18, and 7-13-18 at 4:30 p.m., the facility failure was reviewed with the Administrator, and Director Of Nursing at the end of day meeting. No further information was provided.

3. Resident #34 did not have a comprehensive care plan for oxygen saturation assessments, and oxygen administration.

Resident #34 was admitted to the facility on 12-12-12. Diagnoses included; encephalopathy, epilepsy, anxiety, bipolar disorder, and dementia.

Resident #34's most recent Minimum Data Set Assessment was a quarterly assessment with an assessment reference date of 5-25-18. She was coded with severe cognitive impairment. She

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required total assistance with all activities of daily living (ADLs).

Resident #34 was first observed on 7-10-18 during initial tour of the facility at approximately 11:45 a.m. in her room in a low bed. She did not respond to verbal stimulation. Resident #34 exhibited contractures of both hands, in which her fingers were closed inward toward the palm in a loose fist formation. She was not receiving oxygen at this time.

On 7-11-18 at 9:00 a.m., Resident #34 was observed again in her room and no oxygen was applied. The Resident was observed this day repeatedly at 10:00 a.m., 11:00 a.m., 1:00 p.m., and 2:00 p.m. and no oxygen was applied.

Review of Resident #34's clinical record revealed a current physician's order signed 6-19-18 for the administration of oxygen. Review of the "Physician's Order" sheet revealed the oxygen order was first implemented on 2-3-14. Further review of the record revealed Resident #34 was to receive the following;

2-3-14 - "Oxygen at 2Lpm (liters per minute) via nasal cannula as needed to keep oxygen sats (saturation) above 94% - Monitor oxygen sats every shift when oxygen in use."

Review of the Medication and Treatment Administration Records (MAR/TAR) for May, June, and July 2018 were reviewed and revealed the order was on the documents, with a place for nursing to initial as administered. Only one initial was documented for the 3 month period, and it had been scored through with a single line on 5-1-18.

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F 656	Continued From page 15 The current Nursing care plan was reviewed to ascertain the plan for Resident #34's oxygen saturation evaluations and when oxygen should be applied, and documentation should occur. There was no care plan for oxygen saturation assessments, and oxygen use for this Resident. The vital sign record was reviewed and revealed in the past 6 months, the Resident's oxygen saturation was only checked one day a month, except for the month of may, when it was checked 6 days. 1 day in January, 1 day in February, 1 day in March, 1 day in April, 6 days in May, 1 day in June, and 1 day in July. On 7-12-18 The Director of Nursing was interviewed at the end of day debrief, and asked how the staff knew what the Resident's oxygen saturation was, so that they would know when to administer oxygen. She replied They do it routinely with other vital signs. She was asked how staff evaluated if the Resident's oxygen saturation was at any time 94% or below. She did not answer. The Corporate Registered Nurse (Corp RN) and Administrator were both in attendance and the Corp RN stated "that order needs to be clarified." No further information was provided by the facility.	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	F 657		8/14/18

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F 657	Continued From page 16 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary 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, facility documentation review and clinical record review the facility staff failed to review and revise a diet care plan to prevent further weight loss for one resident (Resident #28) of 24 residents in the survey sample. For Resident #28 the facility staff did not revise the diet care plan during a significant weight loss. The findings included: Resident #28 was admitted to the facility on 5-2-17. Diagnoses included; diabetes, heart disease, chronic kidney disease, hypertension, depression and dementia.	F 657	1. Resident #28 reviewed by RD on 7/26/2018 and new order obtained for new eldertonic; new orders 8/2/2018 discontinue med pass and boost; began med pass sugar free 120cc three times a day; care plan reviewed and revised to reflect current changes. 2. All residents have the potential to be affected by this deficient practice. 100% audit of residents with weight loss in last 30 days will be reviewed by RD for recommendations. Care plans will be updated to reflect any new recommendations.	

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F 657	Continued From page 17 Resident #28's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5-16-18. She was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. She required extensive assistance to total dependence on staff for completion of activities of daily living. Section K, Swallowing/Nutritional Status, question K0300 asked "Loss of 5% or more in the last month or loss of 10% or more in the last 6 months." Resident #28 was coded as "2. Yes, not on a physician-prescribed weight-loss regimen." The Resident was coded as weighing 160 pounds in the assessment. Weight records for the Resident were reviewed, and revealed the following: Resident #28 weighed 183 pounds in January 2018. She weighed 172.2 pounds in February (10 pound loss in one month). She weighed 168 pounds in March 2018 (15 pound loss in 2 months). She weighed 162 pounds in April (21 pound loss in 3 months). During May, June, and July the Resident continued to loose another 11 pounds. The Resident weighed 151 pounds on 7-5-18, at the time of survey to reveal a 32 pound weight loss in 6 months without being on a weight reduction plan. Physician orders signed 7-5-18 were reviewed for Resident #28. The dietary orders and their dates of implementation included: Weigh every month (5-2-17).	F 657	3. The interdisciplinary team will be in-serviced on updating care plans with change of condition which may include new supplement orders by Regional Reimbursement specialist/designee. Licensed nurses will be in-serviced on updating care plans with change in conditions which may include new supplement orders by DON/designee. 4. DON/designee will audit residents with significant weight loss weekly times 12 weeks to ensure that care plans reflected are current and reflect RD and MD recommendations. DON/designee will audit physician orders 5 times a week for 12 weeks for changes/new diet, supplement orders and care plans have been revised to reflect changes as indicated. Results of audits will be taken to QAPI committee monthly x 3 for review and revision as needed.	

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Boost glucose controlled supplement by mouth every day at 10:00 a.m. (2-15-18).

Fortified foods program each meal secondary to weight loss (4-12-18).

Med pass 2.0 sugar free supplement 120 milliliters daily at 2:00 p.m., and 8:00 p.m., for weight loss (7-5-18).

Resident #28's lunch meal trays were observed on 7-10-18, and 7-12-18. Regular diet no concentrated sweets was observed. Licensed Practical Nurse D (LPN D) stated Resident #28 had always been on that diet.

The meal card on Resident #28's tray read that she was to receive the prescribed diet "Regular no added salt (NAS) no concentrated sweets (NCS) diet.

Nursing progress notes and Registered dietician (RD) notes were reviewed and revealed the following chronological event sequence:

January 2018 until 4-12-18, the Resident had a pressure ulcer on her coccyx, and was continuing to lose weight. At this time the Resident had lost 18 pounds, and was only receiving her regular NAS/NCS diet, and Boost supplement. The RD only documented a 3 pound weight loss over 30 days, and did not describe the 18 pound weight loss in 3 months since January 2018 (9.9% loss).

On 4-12-18 the RD recommended adding the fortified foods, and weekly weights on 4-12-18. The weekly weights were never added to physician orders, and so were missed at times as

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they were only completed on the following occasions after the RD recommended them on 4-12-18;

1 time in April, 3 times in may, 4 times in June, and on 7-5-18 in July prior to survey. On 4-12-18 fortified foods were added.

On 4-25-18 the RD documented continued weight loss and made no new additions to treat the Resident.

On 5-1-18 the Nursing progress notes indicated the Resident was dehydrated with a blood pressure of 101/50 and a pulse of 98 and blood sugar of 174. The doctor ordered "Hypodermocysis fluid infusion" and the Resident improved rapidly the same day.

On 5-9-18 the RD documents further weight loss that week, and orders no interventions.

On 5-15-18 the RD documents significant weight loss and now at 160 pounds, (23 pound weight loss) and Albumin blood test results reveal the Resident is low at 3.2, with 3.5 to 5.5 being normal.

On 6-7-18 continued weight loss, no intervention changes.

On 6-14-18 continued weight loss, no intervention changes.

On 7-5-18 continued weight loss, and the Resident weighs 151 pounds, and has lost 32 pounds (17.5% loss) in 6 months without changes in dietary interventions since 4-12-18, (3 months).

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On 7-5-18 the final RD note documents "noted with ongoing slow weight loss, now showing as a significant weight loss over 6 months. Supplements will be adjusted to SF (sugar free) med pass 2.0 supplement (tid) three times per day, and mighty shakes were discontinued. The note goes on to say intake variable from day to day - does refuse often. alternatives offered. None of the progress notes indicate the Resident refuses anything. There are no dietary notes to indicate preferences were checked during this time.

On 7-12-18 the Medication and Treatment Administration Records (MAR/TAR's) for May, June, and July 2018 were reviewed and revealed that the boost ordered in February was not administered on the following days: 5-2-18, 5-16-18, and 7-4-18.

The sugar free mighty shakes ordered twice per day were not administered on the following days: 5-2-18 twice, 5-10-18 once, 5-14-18 once, 5-15-18 once, 5-16-18 once, 5-17-18 once, 5-18-18 once, 5-19-18 once, 5-20-18 once, 6-5-18 once, and 7-4-18 once.

There were no notes to describe why these supplements were not administered.

The SF med pass 2.0 supplement that was ordered to be given 3 times per day by the RD on 7-5-18, had only been given twice per day since ordered, as the order had been transcribed incorrectly, omitting 7 doses since ordered.

On 7-12-18 the Residents care plan was reviewed and revealed that the fortified food program ordered on 4-12-18 was not added to

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F 657	Continued From page 21 the care plan until 5-26-18. After 5-26-18, none of the interventions that were changed or ordered had been added to the care plan at the time of survey. The care plan did not have measurable interventions, and did not denote significant weight loss. The care plan had not been revised appropriately. The failure of staff to recognize and intervene timely and revise the diet care plan was reviewed with the Administrator and Director of Nursing at the end of day meeting on 7-12-18, and 7-13-18. No further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for 2 residents (Resident's #62, 60) of the 24 residents in the survey sample. 1. For Resident #62, four documents were altered before or during survey, to include; Employee discipline record, Quality Assurance records, and Resident records. 2. For Resident # 60, the facility staff did not complete a Nurses Note upon discharge on 6/11/2018.	F 658	1. Resident #62 no longer resides in facility. Resident #62 discharged on 6/11/18. Administrator no longer employed at facility. Human Resources educated and counseled on altering documents. Resident #60 no longer resides in facility. 2. All residents have the potential to be affected by this deficient practice. 100% audit of residents discharged in past 30 days for physician discharge summary.	8/14/18

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F 658	Continued From page 22 Findings included: Resident #62 was originally admitted to the facility on 2-15-06, and expired in the facility on 6-12-18. Diagnoses included but were not limited to: Encephalopathy due to suicide attempt, schizoaffective disorder, epilepsy, Dysphagia oral phase, and dementia. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed. Resident #62's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3-12-18 was coded as a quarterly Assessment. The Resident was coded as having a BIMS score of 6 indicating moderate to severe cognitive impairment. The Resident was coded as having a poor appetite or overeating 2-6 days in the 7 day look back period. Resident #62 was coded as needing limited to extensive assistance of one staff person with activities of daily living, except for locomotion in a wheel chair which only required supervision, and eating, which coded the Resident as independent. Resident #62 was also coded as requiring a mechanically altered diet, always incontinent of bowel and bladder, and requiring a "wanderguard" elopement bracelet, for supervision, secondary to poor judgement. The following record were altered: 6-13-18 RD altered diet supervision Documents. 7-13-18 Unknown individual found to have altered Employee D's signature date on her disciplinary form. 7-13-18 HR Director altered staff disciplinary Document date. 7-13-18 Administrator altered QAPI Documents.	F 658	3. Facility staff will be educated on professional standard of documentation to include importance of not altering documents and that altering documents can result in disciplinary action which could include termination by DON/designee. Administrator, DON and Social Services Director will be educated on the discharge/transfer policy by Regional Director of Clinical Services/designee. Licensed nursing staff will be educated on discharge/transfer policy by DON/designee. Medical records staff will be educated on monitoring discharges for physician discharge summary. 4. DON/designee will audit clinical records of discharged residents five times a week for 12 weeks for appropriate components of discharge documentation. Medial Records/designee will audit discharge clinical records weekly times 12 weeks for physician discharge summary. Administrator/designee will audit disciplinary actions weekly for 12 weeks to ensure current documentation to include accuracy of dates. Results of audits will be taken to the QAPI committee monthly for three months for review and revisions as needed.	

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The Dining Services Manager (DSM) was interviewed on 7-12-18 at 11:30 a.m., and a Menu for 6-12-18, and a tray card were requested for Resident #62. She stated that she would print it from the computer program. The documents were reviewed and revealed that the Resident was on a "Regular/ground" diet for all three meals. The documents also reflect that changes were made to the computerized documents on 6-13-18, one day after the Resident died and was discharged, altering the record.

The document changes were made by a Registered Dietician (RD) with computer access known as HL7 interface (employee C). The DSM stated that this particular RD came in sometimes and updated resident records. Those old standing orders from the DSM documented on 11-20-17, and the new changes made by the RD on 6-13-18 after the Resident expired are below.

DSM 11-20-17 - Lunch main dining room, dinner main dining room, no hot dogs choking hazard, dislikes raw carrots - but likes cooked carrots. ice tea, allergic: Almonds, shell fish.

RD 6-13-18 - Lunch eats in room, dinner eats in room, no hot dogs choking hazard, No raw carrots or cooked carrots. ice tea, allergic: Almonds, carrot, shell fish. According to facility staff, after discharge, the computer system defaults to "eats in room."

On 7-13-18 the DSM was asked if she had any counseling or disciplinary forms for the cook (employee D) and she stated yes. She had 2, "one from back in March 2018" "when she didn't use the right serving utensils to do special diets right, and this one for not doing (Mr. name)

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Resident #62's diet right." She supplied the most recent form which was dated 7-12-18 at 6:00 p.m. The Dining Services Manager had originally written it on 6-13-18, and Employee D's signature date was written over and changed. It appeared to be signed on either 6-13, 6-15, 6-17, 6-19, or 7-13-18. She was asked why the Employee D signature date had been changed, and she stated she did not know, but the form was completed by her on 6-13-18, and signed by the employee on 7-13-18.
It is notable to mention, Employee D was observed in the kitchen on 7-13-18 at 4:30 p.m. preparing the dinner meal, and serving it.

On 7-13-18 at 10:00 a.m., Staff counseling forms for this incident, and Quality Assurance and Process Improvement (QAPI) monthly meeting topics and sign in sheets only were requested from the Administrator. The first document received was from the Human Resources Director (HRD) at approximately 10:15 a.m. The form was the counseling form first seen in the DSM office and was found to have the date altered from 7-12-18 to 6-12-18 from the identical document received earlier from the DSM. The HRD was asked if she altered the document, and she stated that she did. She was asked why it was altered, and she said "the date was wrong so she fixed it this morning." She was asked if she was involved in the counseling or had any part in completing the document, and she stated "no". she was asked why she would alter a document she did not complete and had no knowledge of the events involved in the counseling. She did not answer.

The second set of documents requested from the Administrator at 10:00 a.m., (QAPI) meeting

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topics and sign in sheets, were said to be in the Administrator's office. At 3:30 p.m, on 7-13-18 surveyors had still not received the documents requested, and so surveyors went across the hall to the Administrators office to retrieve them. The Administrator and Corporate Registered Nurse (Corp RN) were observed in the office shuffling papers on the desk, and the Administrator was hastily writing on a document. The Administrator was asked if those were the QAPI documents she was going to present to surveyors, and she stated yes. She was asked how old the documents were, and she stated 3 months. She was asked why she was altering 3 month old documents this morning, and she stated there are no dates on them. She was asked not to alter documents and to please present them as is. The documents had no dates on them and 2 of the 3 documents were neatly documented in corresponding columns to topic with discussion information in boxes. She stated those were April and May 2018. The third document which she had been writing on when surveyors approached the office, did not resemble the first 2. She stated that this was June 2018. There were no dates on any of the three documents, and no way to ascertain when they were produced, however, the last document was observed to be altered that morning.

The Administrator stated "Lippincott" was the professional standard for practice.

References from the Mosby, and Lippincott, Fundamentals of documentation for the National Council Licensure Examination (NCLEX) states; "Altering someone else's notes:" "Records are legal documents and entries must not be altered once recorded."

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On 7-13-18 at 4:30 p.m., the incident was reviewed again with the Administrator, Corp RN, Regional Vice President, and Director Of Nursing at the end of day meeting. No further information was provided.

Resident # 60 was a 68 year old male who was admitted to the facility on 3/27/2018 with diagnoses of but not limited to: Injury at C 3 Cervical Spine, Quadriplegia, Hypertension, Chronic Obstructive Pulmonary Disease, Long term use of Anticoagulants, Flaccid Neuropathic Bladder, Suprapubic Catheter and Autonomic Dysreflexia.

The Minimum Data Set (MDS) was an Admission assessment with an Assessment Reference Date (ARD) of 4/6/2018. The MDS coded Resident # 60 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident was coded as totally dependent on staff for activities of daily living.

On 7/12/2018 at 10 AM, an interview was conducted with the Medical Records staff who stated Resident # 60 was discharged on 6/11/2018.

Review of the closed clinical record was conducted on 7/12/2018.

Review of the Nurses Progress Notes revealed

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no documentation of Resident # 60's discharge from the facility on 6/11/2018.

Review of the clinical record revealed no documentation in the nurses notes of the Resident #60's discharge from the facility on 6/11/2018. There was no documentation of what information was given to the receiving hospital.

On 6/11/218 at 8:14 AM , a Progress note was a note written by the Social Worker who documented a referral was sent to the Home Health Agency on 6/8/18.

The next Progress Note was a Nurses Note dated 6/11/2018 at 6:09 AM and documented that Resident # 60 refused all of his morning medications.

There was no note from the nurses who discharged Resident # 60 from the facility on 6/11/2018. There was no documentation of Resident # 60's condition at discharge,how the resident was transported, where, with whom or what time.

Further review of the clinical record revealed no Discharge Summary in neither the electronic nor paper clinical record. There was a Discharge Instructions sheet "Effective date" 6/8/2018 13:05 (1:05 PM) that stated Resident # 60 would be discharged on 6/11/2018.

On 7/12/2018 at 3:30 PM during the end of day debriefing, the facility Administrator and Director of Nursing were informed there was no nursing note nor Discharge Summary in the clinical record. The Director of Nursing and the Administrator stated the facility staff should have

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F 658	Continued From page 28 written a nurses note upon discharge. Both stated the expectation was that nurses would document in the Nurses Notes anytime a resident left the facility. The Administrator cited Lippincott as its Nursing professional guidance used by the facility. On 7/13/2018 at 8:30 AM, the facility Administrator presented a copy of a Discharge Summary that was dated as Effective 6/11/2018 9:51 AM. The form had a section completed by the Social Worker and signed on 6/11/2018, Dietary Summary section was completed and signed on 6/14/2018, Activities Summary was not filled out and not signed, Nursing Summary was completed and signed on 6/28/2018, Therapy Summary was blank and not signed Summary Length of stay gave information of Discharge Date and Time 6/11/2018 9:50 AM, Section B was Blank where the Physician was supposed to write comments and sign. The Discharge Summary was incomplete and did not indicate the information had been given to the receiving hospital. There was no reconciliation of medications. The Administrator stated the nurses did not document upon Resident # 60's discharge. No further information was provided.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes,	F 661		8/14/18

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F 661	Continued From page 29 but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a discharge summary for one resident (Resident # 60) in a survey sample of 24 residents. For Resident # 60, the facility staff did not complete a Discharge Summary. Findings included: Resident # 60 was a 68 year old male who was	F 661	1. Resident #60 no longer resides in facility. Resident was discharged 6/11/2018. 2. All residents have the potential to be affected by this deficient practice. 3a. The licensed Nursing staff will be in serviced on discharge/transfer policy to include proper documentation for discharge by the DON/designee. 3b. 100% audit of discharged residents in	

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F 661	Continued From page 30 admitted to the facility on 3/27/2018 with diagnoses of but not limited to: Injury at C 3 Cervical Spine, Quadriplegia, Hypertension, Chronic Obstructive Pulmonary Disease, Long term use of Anticoagulants, Flaccid Neuropathic Bladder, Suprapubic Catheter and Autonomic Dysreflexia. The Minimum Data Set (MDS) was an Admission assessment with an Assessment Reference Date (ARD) of 4/6/2018. The MDS coded Resident # 60 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident was coded as totally dependent on staff for activities of daily living. On 7/12/2018 at 10 AM, an interview was conducted with the Medical Records staff who stated Resident # 60 was discharged on 6/11/2018. Review of the closed clinical record was conducted on 7/12/2018. Review of the Nurses Progress Notes revealed no documentation of Resident # 60's discharge from the facility on 6/11/2018. On 6/11/2018 at 8:14 AM, a Progress note was a note written by the Social Worker who documented a referral was sent to the Home Health Agency on 6/8/18. The next Progress Note was a Nurses Note dated 6/11/2018 at 6:09 AM and documented that Resident # 60 refused all of his morning medications. There was no note from the nurses who	F 661	the last 30 days to ensure discharge summary has been completed. 4a. The Social Service Director/designee will audit the 24 hour report and MD orders 5 times a week for 12 weeks to ensure discharge summaries are complete. 4b. Medial Records/designee will track discharge summaries for completion and physician signatures weekly x 12 weeks. Results of audits will be taken to the QAPI committee monthly for three months for review and revisions as needed.	

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F 661	Continued From page 31	F 661		

discharged Resident # 38 from the facility on 6/11/2018. There was no documentation of Resident # 60's condition at discharge,how the resident was transported, where, with whom or what time.

Further review of the clinical record revealed no Discharge Summary in neither the electronic nor paper clinical record. There was a Discharge Instructions sheet "Effective date" 6/8/2018 13:05 (1:05 PM) that stated Resident
60 would be discharged on 6/11/2018.

On 7/12/2018 at 3:30 PM during the end of day debriefing, the facility Administrator and Director of Nursing were informed there was no Discharge Summary in the clinical record. An interview was conducted with the Administrator who stated the facility staff should have prepared a Discharge Summary. The Administrator stated the facility staff would search for the document.

On 7/13/2018 at 8:30 AM, the facility staff presented a copy of a Discharge Summary that was dated as Effective 6/11/2018 9:51 AM. The form had a section completed by the Social Worker and signed on 6/11/2018,
Dietary Summary section was completed and signed on 6/14/2018,
Activities Summary was not filled out and not signed,
Nursing Summary was completed and signed on 6/28/2018,
Therapy Summary was blank and not signed
Summary Length of stay gave information of Discharge Date and Time 6/11/2018 9:50 AM,
Section B was Blank where the Physician was supposed to write comments and sign.

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F 661	Continued From page 32 The Discharge Summary was incomplete. There was no reconciliation of medications. No further information was provided.	F 661		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure a physician ordered palm guard/hand splint was implemented due to "limited mobility" per the facility care plan for one resident (Resident #34) of 24 residents in the survey sample. Resident #34 was observed on 6 occasions,and was found to be not wearing her left hand splint (palmer guard), and her left hand splint (palmar	F 688	1. Resident #34 was evaluated by Occupational Therapy with recommendations and care plan updated to reflect interventions. 2. Residents with splints have the potential to be affected by this deficient practice. Current residents with splint/brace orders care plans reviewed for appropriate interventions in place; residents were observed for appropriate	8/14/18

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F 688	Continued From page 33 guard) could not be found in her room. The findings included: Resident #34 was admitted to the facility on 12-12-12. Diagnoses included; encephalopathy, epilepsy, anxiety, bipolar disorder, and dementia. Resident #34's most recent Minimum Data Set Assessment was a quarterly assessment with an assessment reference date of 5-25-18. She was coded with severe cognitive impairment. She required total assistance with all activities of daily living (ADLs). Resident #34 was first observed on 7-10-18 during initial tour of the facility at approximately 11:45 a.m. in her room in a low bed. She did not respond to verbal stimulation. Resident #34 exhibited contractures of both hands, in which her fingers were closed inward toward the palm in a loose fist formation. She was not wearing a splint on either hand at this time. On 7-11-18 at 9:00 a.m., Resident #34 was observed again in her room and no hand splint was visible on the Resident. The Resident's bedside dresser and other storage areas were observed and no palmar guard could be located in the room. The Resident was observed this day repeatedly at 10:00 a.m., 11:00 a.m., 1:00 p.m., and 2:00 p.m. and the palmer guard was not on the Resident. A review of Resident #3's comprehensive care plan included an intervention under Resident #34's ADL Self Care Performance Deficit Plan related to her limited mobility that read, 8-4-16 - Palmer Guard as Ordered.	F 688	placement of splints/braces. 3. Licensed clinical staff in-serviced on following physician orders to include splints and following care plans by DON/designee. 4. DON/designee will audit residents with splints/braces five times a week for 12 weeks to ensure in place as ordered and accurate documentation. Results of audits taken to QAPI committee monthly for three months for review and revisions as needed.	

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Resident #34's most current signed physician orders were dated 6-19-18. "The orders included, "10-8-15, Wear (L) Palmer Guard At All Times Except for Bathing and Range of Motion.

Resident #34 was screened for Occupational Therapy (OT) during a Certification Period of 7-30-15 - 9-27-15. The OT notes read:

Long Term Goals - Patient will tolerate left hand palmer guard at all times except bathing and exercise with no redness, edema, or skin breakdown noted. (Target: 9/27/15)." The physician signed the OT Plan of Treatment on 10-8-15. This occurred when the device was ordered.

A review of Resident #34's Treatment Administration Record (TAR) revealed an entry for documenting the application and use of the Left Palmer Guard. Resident #34's May, June, and July TAR revealed the Left Palmer Guard was documented by nursing staff as not applied frequently. In May 2018 it was not applied 16 times, and in June 2018 it was not applied 17 times, and in July 2018 it was not applied on 3 occasions, other than the 2 days surveyors observed it as not applied. On the days for the 3 month period that the palmer guard was not applied, the reason for the omission, documented on the back of the TAR, was simply; "N/A", or "Not on". The specific reason for the omission was not given.

Nursing progress notes were reviewed for this 3 month period, and no notes indicate anything about the palmar guard.

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F 688	Continued From page 35 On 7-11-18 at 3:30 p.m., a CNA in the hallway by Resident #34's room was asked if she could find the Resident's palmar guard. She stated that she would, and did not return. On 7-11-18 at 4:30 p.m., during an end of day briefing, the Administrator and Director of Nursing were informed of the observations during which Resident #34 was not wearing the Palmer Guard, no comment or information was offered or provided by them. On 7-13-18 at 4:30 p.m., the administration was again informed of the findings. No additional information was provided.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide a supervised and safe environment for six residents (Residents #62, 1, 34, 38, 29, and 37) resulting in harm for Resident #62, in a survey sample of 24 residents. 1. For Resident #62, the facility staff failed to provide supervision to prevent a choking hazard,	F 689	1. Resident #62 no longer resides in facility. Resident #1 clinical record reviewed and order for regular diet was found 6/13/2018; A speech consult was completed on 7/25/2018, diet clarified and ordered as regular on 7/26/2018. Dietary notified and tray card updated. Care plan reviewed and revised with current dietary orders. Fall care plan reviewed and	8/14/18

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F 689	Continued From page 36 from an improper diet, resulting in death. 2. For Resident #1, the facility staff failed to provide adequate supervision to prevent this Resident from assaulting Resident #34, and failed to provide fall prevention supervision, the correct diet, and feeding services. 3. For Resident # 34, the facility staff failed to provide adequate supervision to prevent an assault/hazard perpetrated by Resident #1. 4. For Resident # 38, the facility staff failed to provide adequate supervision to prevent accidents. 5. Resident #29 was not supervised resulting in resident to resident altercations. 6. Resident #37 was found outside of the facility. He was not wearing his wanderguard. Findings included: 1. Resident #62 was originally admitted to the facility on 2-15-06, and expired in the facility on 6-12-18. Diagnoses included but were not limited to: Encephalopathy due to suicide attempt, schizoaffective disorder, epilepsy, Dysphagia oral phase, and dementia. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed. Resident #62's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3-12-18 was coded as a quarterly Assessment. The Resident was coded as having a BIMS score of 6 indicating moderate to severe cognitive	F 689	revised for current interventions. Care plan revised to reflect specific redirection techniques. Dietary manager was disciplined for failure to ensure #1 received correct diet. Cook was disciplined for failure to provide resident with correct diet. Resident #1 evaluated by psych on 7/19/2018 with medication adjustments; no documented resident to resident altercations at the time. 1:1 activity 5 times a week. Resident #34 Head To Toe assessment was completed for any bruising or any other skin integrity concerns. Social Worker assessed resident for any signs of fearful behavior. Staff educated on observing resident and being aware of behaviors of other residents. 1:1 activity program 5 times a weeks. Resident #38 care plan was reviewed and revised to reflect current fall interventions placement. Resident #29 no longer resides in facility. Resident #37 was assessed for placement and functionality of wanderguard. Care plan reviewed and currently reflects use of wanderguard. 2. All residents have the potential to be affected by this deficient practice. 100% residents with falls in 30 days care plans reviewed for appropriate interventions in place. Audit of residents with documented behaviors to ensure interventions in place and present. Audit of current residents and residents with history of elopement to ensure that assessments are current; interventions in	

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F 689	Continued From page 37 impairment. The Resident was coded as having a poor appetite or overeating 2-6 days in the 7 day look back period. Resident #62 was coded as needing limited to extensive assistance of one staff person with activities of daily living, except for locomotion in a wheel chair which only required supervision, and eating, which coded the Resident as independent. Resident #62 was also coded as requiring a mechanically altered diet, always incontinent of bowel and bladder, and requiring a "wanderguard" elopement bracelet, for supervision, secondary to poor judgement. Review of Resident #62's closed clinical record revealed the most recent "Dietary Quarterly Assessment" completed by the Registered Dietician (RD), dated 3-15-18, describing the "Current Diet order" as "Regular, ground texture no hot dogs - choking hazard." This order was never amended or discontinued. Occupational Therapy (OT) notes were reviewed, and revealed an evaluation and planning for therapy dated 6-7-18. The document revealed under "Functional assessment", "self feeding = Did not test (Pt at baseline)." on page 3 of the 4 page document. On page 4, the document goes on to say under "Self Care", "Eating independent, oral hygiene Partial/Moderate assistance." It is unknown how independence in eating was assumed as no actual testing was completed, and oral hygiene required moderate assistance. Speech Therapist (ST) notes were reviewed, and revealed the most recent evaluation and treatment for Resident #62 was from 12-7-16 to 1-5-17 when the Resident was discharged from	F 689	place, care plan current and if wanderguard utilized in place and functioning appropriately. 100% audit will be completed on all residents to ensure physician orders related to diets and supervision during meals for accuracy and consistency as well. 3. Facility staff educated on the Abuse Policy and Procedure including resident to resident altercations by Administrator/DON/designee. Facility staff will be educated on Dementia/Behavior Management by Corporate Director of Social Services and Activities. New employees will be educated on Dementia Training by Social Service Director/designee. Clinical staff will be educated on the facility fall prevention program DON/designee . Facility staff will be educated on the policy and procedure on elopement including Wanderguard placement Administrator/DON/designee. Dietary staff will be educated on following diet order per MD to include Mechanical Altered diets by RD/designee. Nursing staff will be educated on following physician orders related to diet orders to include mechanically altered diets by DON or designee. All new clinical staff will be educated during orientation on following physician orders related to diet orders and supervision during meals.	

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F 689	Continued From page 38 speech therapy services. The documents reveal that "patient (pt) was observed and noted in chart that patient coughs on some consistencies, including hot dogs. Pt often requires cues to increase accuracy. No choking in this visit, however, patient chart indicated history of choking." "Patient frequently requires verbal cues to decrease risk of aspiration, penetration."(choking). A second ST evaluation note revealed, "Patient visited while consuming regular ground meat trial. Patient demonstrated increased rate (of eating) and decreased mastication (chewing) while consuming meal. Patient somewhat stimulable to verbal cues (by staff) to reduce rate." "Patient requires verbal cues by staff on a regular basis to decrease risk of aspiration/penetration (inhaling food and choking). With cues (from staff) patient is able to reduce rate, and intake amount (smaller bites) as well as demonstrate increased mastication." "Patient demonstrated increased difficulty with regular bread at times due to increased rate and bite size. Patient currently on mechanical soft diet, however, has been receiving what is consistent with a regular/ground diet." "ST recommend upgrade patient to regular/ground due to patient is able to tolerate at this time." At the time of discharge from ST, all goals were not met and a final discharge document was produced dated 1-5-17 "end of care". The document read; "Due to periodic impulsive behavior, it is recommended patient continue to receive cues via staff during unsafe times with provisional supervision." "Patient periodically demonstrates impulsivity during PO (eating) that he favors (deserts, sandwiches, or when he is	F 689	4. All residents who require supervision will be audited to ensure staff are following supervision protocol every meal for two week then five meals a week for ten weeks by DON, Dietary Manager or designee. All residents who on mechanical altered diets will be audited to ensure meal served is correct every meal for two weeks then five times a week for ten additional weeks by Dietary Manager or designee. Diet orders will be reviewed for all new admissions and readmissions through the 24 hour report five times a wee k for 12 weeks by DON or designee. DON or designee will review the 24 hour report/nursing documentation five days a week for any residents with behaviors, falls and/or triggering for risk of elopement to ensure interventions for preventing falls, behaviors and elopement are in place. Two audits weekly to be completed on all residents with provider orders for a wanderguard bracelet to ensure placement and proper functioning for four weeks then one audit weekly for eight additional weeks. Residents with falls will be audited five times a week for 12 weeks to ensure interventions are in place by Administrator/designee. Results of audits will be taken to the QAPI meeting monthly for three months for review and revision as needed.	

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hungry) patient requires cues to practice safe swallowing and reduce rate and masticate and swallow all bolus (mouthful) prior to additional bites." "Regular/ground diet, at times patient demonstrates increased rate and decreased mastication when consuming by mouth. Impulsive behaviors at times." Patient demonstrates large bite sizes, increased rate and decreased mastication of bolus."

Physician orders were reviewed and revealed current diet orders signed by the physician on 6-12-18, "No hot dogs, choking hazard", first ordered 4-23-12, and "Regular, ground diet with supervision", first ordered 12-7-16.

Certified Nursing Aide (CNA) "Resident Care Card" care plan instructed staff to always set up and supervise this Resident's meal at lunch and dinner. It is unknown why breakfast was not included.

A copy of the current Nursing Care Plan, last revised on 3-28-18, was reviewed and revealed the following interventions; "Impaired safety awareness, the resident is independent with eating, the Resident requires supervision and cueing at times to eat (resolved 3-21-18), meals in room or dining room, no hot dogs, serve diet as ordered". The care plan did not specify what the Resident's diet order is, nor did it specify supervision while eating as the doctor's order mandates, and actually rescinds the doctor's supervision order.

The facility Care Plan policy was reviewed and revealed the following;
Policy: "An interdisciplinary plan of care will be established for every resident and updated in

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accordance with state and federal regulatory requirements and on an as needed basis."
A). The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and mental, and psychosocial needs that are identified in the comprehensive assessments."
D). "All staff must be familiar with each resident's care plan and all approaches must be implemented."
F). "The comprehensive care plan is reviewed and updated at least every 90 days by the interdisciplinary team."
U). There may be additional problem areas not triggered by the MDS, which will need to be addressed in the care plan."
Z). All direct care staff must always know, understand and follow their resident's care plan. If unable to implement any part of the plan, notify your charge nurse or MDS coordinator, so that this can be documented or the care plan changed if necessary."

The following nursing note dated 5-28-18 indicated; "Set up help only with eating." Another note dated 4-28-18 indicated; "Set up help only with eating." The same note is documented on 3-28-18. On 3-15-18 a quarterly dietary assessment is documented in the progress notes which stated "Current diet order Regular, ground texture - no hot dogs, choking hazard, continues with same diet order."

A 2-28-18 nursing note indicated; "Set up help only with eating." A 1-28-18 nursing note indicated; "No set up or physical help from staff with eating." The physician's order for supervision with meals occurred on 12-7-16, and

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on 12-5-17 through 1-5-17 the Speech therapy evaluation continued to document the need for supervision with meals, yet nursing did not follow or adhere to the orders, which never changed.

On 6-12-18 at 3:06 p.m. the nursing notes describe the Resident as "sitting up in wheel chair in room, denying pain or hurting in the last 5 days"

On 6-12-18 at 6:45 p.m. the nursing notes describe the following; 2 nurses were called to Resident #62's room by a CNA who was performing the "Heimlich Maneuver" unsuccessfully. The Resident was noted to have large amounts of chewed food in the mouth. A nurse then began the "Heimlich Maneuver" unsuccessfully, and the second nurse then tried to perform the maneuver, and was unsuccessful. The Resident was without respirations or pulse. The Resident was then placed on the floor and the visible food was removed from the Resident's mouth. The nurses were unable to suction the Resident due to large amounts of chewed food in the mouth. Emergency 911 was called, abdominal thrusts were attempted, and CPR (Cardio Pulmonary Resuscitation) was begun. An "Ambu bag" with oxygen was used to ventilate the Resident but had no effect as there was no air flow into the Resident's airway. The primary Care Physician was in the building, and arrived in the room and pronounced the Resident deceased at 6:20 p.m.

On 7-12-18 at 11:00 a.m. LPN D was interviewed and asked what she knew about the situation. She stated she was the charge nurse who responded to the Resident that night. She stated when CNA B called her she had been serving

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meal trays and feeding other residents on the unit, and she ran to the room and found CNA B applying the Heimlich maneuver and she took over for her. She stated a second nurse came and attempted the same maneuver with no success. LPN D stated that there was a third nurse on duty that evening, however, she was busy orienting a new nurse and was not involved. She stated that she and the second nurse laid the Resident on the floor, as he was found sitting in his wheel chair, and continued to sweep the food from his mouth, but it was lodged deeply in his throat and could not be removed. She went on to say they tried to use CPR, and the oxygen and ambu bag to ventilate the Resident, but too much food was in his throat and blocked the airway. She stated the doctor was in the facility doing rounds, and responded to their call, and he pronounced the Resident expired. She was asked who the CNA was, and she responded with a name (CNA B) and was asked to call the CNA so that she could be interviewed as well.

On 7-12-18 at 11:15 a.m. CNA B was contacted via telephone and interviewed. CNA B stated she had delivered the tray from the kitchen to Resident #62's room and "set it down and left" " it looked like a whole sandwich" and then "I went back to the dining room" to feed other residents. She stated she was already busy feeding and orienting a new CNA, and she was not responsible to supervise him.

She stated "we were already short staffed and with only 3 CNA's that is 20 residents each" to care for "and we had 2 new CNA's we were training as well. I couldn't stay with him." She further stated "I was just doing them a favor, because they refused his dinner tray, and a new

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one had to be sent down to the unit." Since I was in the dining room already I just took it." She went on to say when she was finished in the dining room around 6:00 she went down to the unit and started collecting trays from the rooms, and found Resident #62 slumped over in his chair, with lots of food in his mouth and one large piece (the size of a quarter) of uneaten chicken patty in front of him. She called for help and started the Heimlich maneuver.

The Primary Care Physician's discharge summary documented Resident #62's cause of death as "choking".

Staffing records were reviewed and revealed That indeed there were 3 CNA's on duty that evening and 2 new CNA orientees, and 1 new LPN orientee.

The Dining Services Manager (DSM) was interviewed on 7-12-18 at 11:30 a.m., and a Menu for 6-12-18, and a tray card were requested for Resident #62. She stated that she would print it from the computer program. The documents were reviewed and revealed that the Resident was on a "Regular/ground" diet for all three meals. The documents also reflect that changes were made to the computerized documents on 6-13-18, one day after the Resident died and was discharged, altering the record.

The document changes were made by a Registered Dietician (RD) with computer access known as HL7 interface (employee C). The DSM stated that this particular RD came in sometimes and updated resident records. Those old standing orders from the DSM documented on 11-20-17, and the new changes made by the RD

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on 6-13-18 after the Resident expired are below.

DSM 11-20-17 - Lunch main dining room, dinner main dining room, no hot dogs choking hazard, dislikes raw carrots - but likes cooked carrots. ice tea, allergic: Almonds, shell fish.

RD 6-13-18 - Lunch eats in room, dinner eats in room, no hot dogs choking hazard, No raw carrots or cooked carrots. ice tea, allergic: Almonds, carrot, shell fish. According to facility staff, after discharge, the computer system defaults to "eats in room."

The DSM was further interviewed and stated she was not present the evening of 6-12-18, however the cook who served the meal (Employee D) had reported to her the circumstances of the incident. Employee D was not in the building on 7-12-18. The DSM stated that the meal for dinner the evening of 6-12-18 was an omelet, and the nursing staff refused it saying eggs made the Resident have diarrhea, so a chicken patty sandwich was sent as the alternative, and it should have been ground and was not.

The facility Administrator and Director of Nursing were made aware of the failure of the facility to protect Resident #62 from accidents and hazards at the end of day debrief on 7-12-18 at 4:30 p.m.. They did not offer any comment or documentation in regard to the incident at that time.

On 7-13-18 the DSM was asked if she had any counseling or disciplinary forms for the cook (employee D) and she stated yes. She had 2, "one from back in March 2018" "when she didn't use the right serving utensils to do special diets right, and this one for not doing (Mr. name)

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Resident #62's diet right." She supplied the most recent form which was dated 7-12-18 at 6:00 p.m. The Dining Services Manager had originally written it on 6-13-18, and Employee D's signature date was written over and changed. It appeared to be signed on either 6-13, 6-15, 6-17, 6-19, or 7-13-18. She was asked why the Employee D signature date had been changed, and she stated she did not know, but the form was completed by her on 6-13-18, and signed by the employee on 7-13-18.

It is notable to mention, Employee D was observed in the kitchen on 7-13-18 at 4:30 p.m. preparing the dinner meal, and serving it.

On 7-13-18 at 10:00 a.m., The Facility Administrator stated she had 3 "Plans Of Correction" (POC), for the incident, and requested a finding of "Past Non-Compliance" (PNC). The facility Administrator insisted that the multiple failures involved in the death of Resident #62 had been self identified and corrected prior to this survey with a correction completion date of 6-18-18, and she supplied them. She went on to say Employee D "wrote in her statement that she had chopped the sandwich." The Admin then stated "it should have been ground, he had issues, he ate really fast or not at all."

Past non-compliance was not the case however, as another resident, Resident #1 had no CP for orders or diet and supervision with diet, and was not being tracked in Quality audits. This non-compliance can be found below in the second example of deficient practice for the 5 Residents contained in this citation. The non-compliance continued during survey.

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Quality audits to support the Plans of correction were given to surveyors and included a corrective action audit of "supervision during meals" audit form. The form listed the names of all residents included in the audit, with blank columns for each meal heading, which was for staff to sign if they supervised the resident listed during "Breakfast, lunch, and dinner" and each day's date. Resident #1 was not named on the document, and so was not being supervised, and was ordered by the physician on 3-15-18 to have a chopped meat diet add sauce and gravy to meats, which was also recommended by the RD on 6-1-18. This order was never discontinued. The Resident was documented in nursing progress notes often, and up until 3 days before survey to require one staff member assistance with eating. This indicated not all residents who had special diets or required supervision and assistance were included in the audit, voiding the validity of the corrective action.

The investigation review indicated the following;

Resident #62 had a consistent history of choking, aspiration, poor judgement, and eating so quickly he was unsafe to eat without supervision. His diet order was regular ground texture with supervision. Speech therapy documented the Resident would require verbal cues by staff on a regular basis to decrease his risk of aspiration and choking, The ST also indicated the Resident had trouble with regular bread as Resident #62 would eat it more quickly than other foods and take larger bites. Overall the ST stated at discharge from services that the Resident was impulsive, took large bites very quickly, and did not chew his food well. The CNA care card was incomplete. The nursing care plan was incorrect, and incomplete, and did not follow the facility

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policy. Nursing staff did not provide supervision as was ordered. On 6-12-18 the Resident was found alone in his room expired from choking, according to the physician, nurses, and CNAs. Staffing was insufficient to care for residents, train new staff, and provide this Resident with supervision while eating, according to all staff accounts. The Dining Services Manager, the Administrator, the Charge nurse, the CNA that delivered the meal, and the cook who prepared the meal all stated that the meal was incorrect for the Resident, and the Resident was left alone in his room to consume it. The cook who was negligent in preparing the special diet meal for Resident #62 on 6-12-18, had been counseled for this issue previously in March 2018, and was still preparing meals during survey. The Plan of correction audits did not include others found to be at risk while on survey, and the following documents related to the investigation were found and observed to be altered by facility staff during the survey:

On 7-13-18 at 4:30 p.m., the incident was reviewed again with the Administrator, Corp RN, Regional Vice President, and Director Of Nursing at the end of day meeting. No further information was provided.

COMPLAINT DEFICIENCY

2. For Resident #1, the facility staff failed to provide adequate supervision to prevent this Resident from assaulting Resident #34, and failed to provide fall prevention supervision, the correct diet, and feeding services.

Resident #1 was initially admitted to the facility on

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3-15-18 with diagnoses including but not limited to; Chronic obstructive pulmonary disorder, Dementia, delusional disorders, hypertension, seizures, major depression, was anemic, weighed 89 pounds, Dysphagia oral phase, and had a history of falls. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed.

The Full Admission Minimum Data Set Assessment (MDS) with an ARD (assessment reference date) of 3-23-18 coded Resident #1 as having a BIMS (brief interview of mental status) of "2" out of a possible 15, or severely cognitively impaired. Resident #1 was coded as needing extensive assistance with ADL's (activities of daily living) such as bathing and dressing from 1 staff member, and for eating required supervision and set up help.

The most recent MDS with an ARD of 6-25-18 was a significant change full assessment, and coded the resident as requiring extensive assistance from one staff member, and now required extensive assistance from 1 staff member for eating.

Nursing progress notes were requested for three months and reviewed. The notes revealed that the Resident experienced 8 repeated falls in a 3 month period. They occurred on 4-17-18, 5-4-18, 5-26-18 twice, 6-4-18, and was hospitalized on 6-7-18 with a fractured hip from an unwitnessed fall, and was readmitted on 6-13-18. The Resident had another fall on 6-19-18, and her final documented fall prior to survey, was on 6-28-17. There was no consistent time for these falls as they occurred approximately at 2:00 a.m., 6:00 a.m., 7:00 p.m., 9:00 p.m., and 10:00 p.m.

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Day shift appears to be the only time not documented as having falls. This is the time when the Resident is up and more active, with more supervision and staff.

Further review of the progress notes revealed the Resident to be documented as physically and verbally abusive toward others upon admission, and was documented as such in the admission MDS. Prior to assaulting her room mate (the room mate was identified as Resident #34 and placed in the survey sample) Resident #1 was documented in the nursing progress notes as combative, aggressive, verbally and physically abusive with staff and Residents. This behavior was documented 8 times in 3 months, and 3 times on 5-26-18, the day of the assault. After the assault she was moved to another room on 5-26-18, and continued the abusive behaviors on 5-27-18, 5-30-18, 5-31-18, 6-1-18, 6-3-18, 6-6-18, 6-13-18 and 6-29-18. Supervision interventions for this Resident were not described. No further documentation indicated Resident aggressive behavior continued after the Resident experienced her last fall on 6-28-18, except for the 6-29-18 incident with staff providing care. The Resident was moved on 7-2-18 back directly across the hall from the room mate she assaulted on 5-26-18. No indication why she was moved back in close proximity to her victim could be found.

Physician orders and Registered Dietician (RD) notes indicated that on admission 3-15-18 the Resident was ordered to have a "chopped meat - add sauce, gravy to meats regular diet" which was not discontinued by the physician. The RD documented on 6-1-18 reflects the same. On 6-25-18 the same RD documents regular diet but

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does not specify consistency. The physician's order was never discontinued. Nursing notes denote the Resident requires limited to total feeding, supervision or hands on assistance from 1 staff member to eat, in some notes, and states independent in others. Nursing staff documentation appears confused, and do not appear to know an agreed upon comprehensive plan of care.

On 7-10-18 during initial tour and observation of the lunch meal, Resident #1 was observed in her room with a meal tray in front of her with a whole chicken patty on it. The meat was not chopped. The Resident was just looking at the food, however, not consuming it. The Resident was noted to be edentulous, and would not be able to chew the patty sufficiently to swallow it, causing a choking hazard. The Resident suffered from seizures, oral phase Dysphagia (difficulty eating), chronic obstructive lung disease, and was confused, putting the Resident at greater risk for aspiration. No staff were in the room to assist the Resident from 11:45 a.m., until tour and observations ended on this hall at 12:45. No 30 minute checks were conducted. The Resident had not been evaluated by Speech therapy ever during her 4 month stay.

LPN D was interviewed on 7-12-18 and asked when 30 minute checks should be performed. She stated when the care plan says to, or when the Resident needs them. She was asked how they could tell if the Resident needed them, she stated that would be decided on an individual basis. She was asked under what circumstances 30 minute checks should be instituted, would be part of the care plan, and she responded "absolutely."

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On 7-12-18 when exiting the building for lunch break Resident #1 was observed sitting in her wheel chair with the receptionist in the lobby at the front desk. The receptionist was trying to keep the Resident from removing her clothing and exposing herself to visitors who were present there. This continued for approximately 10 minutes while waiting for other surveyors to arrive. The Resident was striking out at the receptionist, and the receptionist kept repeating "No, don't do that, you can't take your shirt off here," and the Resident was yelling "I don't care who is here, cursing, and hitting the receptionist. The Receptionist did not try to remove the Resident and seemed not to know what to do, stating, "I can't do this". We asked if the receptionist was a nurse or CNA, and she stated, "no".

Review of Resident #1's plan of care was conducted and revealed the interventions below for Falls with 30 min checks, Behaviors, and Diet:

Falls - All of the documented falls for the Resident are not documented on the care plan. Interventions include; Dycem to wheel chair seat, assist with transfers, assist with mobility, bed in lowest position, room change closer to nursing station, mat on floor, mats on both sides of bed, body pillow on bed, 30 minute checks on resident (not specified who, when, or how to complete), non-skid footwear, place in supervised area during restlessness.

30 minute checks - were never ordered by a doctor, and were not added to the care plan until 6-28-18. These checks were only documented in nursing progress notes as completed, on the

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following 13 days and times:

5-29-18 at 12:14 a.m., 5-31-18 at 12:45 a.m., 6-1-18 at 6:17 a.m., 6-2-18 at 6:30 p.m., 6-2-18 at 11:42 p.m., 6-3-18 at 11:19 p.m., 6-5-18 at 2:15 a.m., 6-6-18 at 12:06 p.m., 6-19-18 at 9:50 p.m., 6-20-18 at 4:43 a.m., 6-28-18 at 2:06 a.m., 7-4-18 at 1:12 a.m., and on 7-10-18 at 11:30 p.m. The 30 minute checks have no specific instructions in the clinical record as to why they will be conducted, when it is decided to conduct them, or who will be conducting them.

Behaviors - Under "Focus" "The Resident has depression related to admission, dementia, disease process (altered mental status". Interventions included; "Administer medications, monitor for side effects and effectiveness, arrange for psyche consult, follow up as indicated, encourage and provide opportunities for exercise, physical activity, encourage movement program, monitor /document/report signs of depression to nurse/doctor, monitor/record/report to doctor as needed risk for harming others." The Resident was documented by staff at different times as being at risk of harming others during her entire stay.

Another "Focus" for behavior included further interventions of "room change, provide for positive interaction, attention, stop and talk, discourage from scratching self, encourage expression of feelings appropriately, explain all procedures before starting and allow Resident to adjust to changes, approach and speak in calm manner, intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to alternate location as needed, praise improvement in

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behavior."

The following was added to the care plan on 3-22-18 "Referred to [facility area community services board] for psychiatry services on 3-21-18. They are unable to add another patient to his caseload at this time. Will refer to telemed psychiatry when available at facility." No projection date is given for "telemed psychiatry" availability. On 5-24-18 (2 months later) another revision was made which stated; "Left message for (name of group) psychiatry". It is unknown when the actual appointment was made, however, a revision was made to the care plan dated 6-11-18, and the Resident is now scheduled to see a psychiatrist doctor on 7-19-18.

The Psyche consult was not attempted to be arranged for 2 months, during which time the Resident was abusive to Residents and staff. On 6-11-18 weeks after the Resident had assaulted another resident a revision was documented an arranged appointment for 7-19-18. The Resident continued to be abusive and aggressive for 3 months before this intervention was implemented.

Diet - Interventions for: "Encourage to dine in dining room as appropriate", "monitor intake, weight, provide diet order, review preferences, and monitor need for increased nutritional intervention." were all applied to the care plan originally on 3-25-18 on admission. The interventions added after that were; "Monitor for signs and symptoms of "Aspiration", and "Speech Therapy screens as needed, treat as ordered" were added to the care plan on 7-11-18 after survey was in progress under a focus for "At risk for Cardiac Respiratory status". This revealed

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staff recognition at this point of vulnerability of this Resident who was not included in the POC for issues associated with Resident #62. Resident #1's diet order and assistance needed from staff to eat, was never documented on the care plan, and so staff would not know what to provide.

No supervision was specified in the care plan for any of these areas. Who will supervise, when to supervise, and how to supervise this Resident have not been included and are not person centered or measurable indicating staff is unaware of Resident need and how to meet it.

No interim comprehensive care plan was developed For Resident #1's surgery for hip fracture and readmission on 6-13-18, until 23 days later, on 7-6-18, and that care plan did not mention any surgical wound care.

Fall mats and 30 minute checks were never ordered by a physician, and 30 minute checks do not appear on the Medication Administration Record (MAR), nor on the Treatment Administration Record (TAR) for May/June/and July 2018. Fall mats do appear on the June and July 2018 TAR as having been applied. Fall mats were placed on the care plan as an intervention on 5-4-18, but not documented as implemented until 6-1-18, a month later. The 30 minute checks were not added to the care plan until 6-28-18, and were documented as implemented infrequently in nursing progress notes only, from 5-29-18 for a month before being placed on the care plan on 6-28-18.

The Director of nursing was asked when 30 minute checks were to be completed, and she stated "I will check." She never returned with an

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answer.

In conclusion, the facility failed to maintain adequate supervision of Resident #1, and they further failed to supervise and protect Resident #1 from a fracture caused by frequent falls, and failed to protect Resident #1 from a potential choking hazard.

On 7-12-18, and 7-13-18 at 4:30 p.m., the facility failure was reviewed with the Administrator, and Director Of Nursing at the end of day meeting. No further information was provided.

3. Resident #34 was admitted to the facility on 12-12-12. Diagnoses included; encephalopathy, epilepsy, anxiety, bipolar disorder, and dementia.

Resident #34's most recent Minimum Data Set Assessment was a quarterly assessment with an assessment reference date of 5-25-18. She was coded with severe cognitive impairment. She required total assistance with all activities of daily living (ADLs), and bed fast.

Resident #34 was first observed on 7-10-18 during initial tour of the facility at approximately 11:45 a.m. in her room in a low bed. She did not respond to verbal stimulation. Resident #34 exhibited contractures of both hands, in which her fingers were closed inward toward the palm in a loose fist formation.

This Resident was the victim of an assault by Resident #1. The incident of assault on this Resident by Resident #1 and the lack of safety provided for this Resident can be found described in this statement of deficiencies (SOD) report, at

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F 689	Continued From page 56 F-600 abuse. 4. For Resident # 38, the facility staff failed to provide adequate supervision to prevent accidents. Resident # 38 was an 82 year old female who was admitted to the facility on 7/14/2015 and readmitted on 3/22/2016 with diagnoses of but not limited to: Chronic Pain, Atherosclerotic Heart Disease, Hypertension, Vitamin D Deficiency, Alzheimer's Disease with late onset, Dementia, Psychosis and Major Depressive Disorder. The Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 5/29/2018. The MDS coded Resident # 38 with a BIMS (Brief Interview for Mental Status) of 3/15 indicating severe cognitive impairment; the resident was coded as independent with most activities of daily living (Bed Mobility, Transfers, Ambulation, Locomotion, Eating, and Toileting) except required extensive assistance of two staff persons with Hygiene, Dressing and Bathing; Resident # 38 was coded as always continent of bowel and bladder. On 7/10/2018 at 11:55 AM during initial tour, Resident # 38 was observed with a large bruise over the right eye and forehead. Resident # 38 was lying in bed. On 7/11/2018 at 9:45 AM, Resident # 38 was observed ambulating in the hallway. Review of the Clinical Record was conducted on 7/11/2018 at 10:00 AM.	F 689		

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Review of the Nurses Progress Notes revealed documentation of numerous incidents involving unwitnessed falls, skin tears,wandering into other residents rooms and physical aggression toward other residents.

Documentation included:

7/11/2018 8:00 AM-Head to toe eval.-Note to unwitnessed fall....."Resident frequently wandering this shift. Bruising to right forehead and eye remain visible. Noted periods of increased agitation.

7/10/2018 2:25 PM- ..."Noted bruising to right side of forehead to have extended surrounding right eye. Resident has declined to allow nursing staff to measure. Accepted medication this shift per order. No aggressive behaviors but with noted periods of increased agitation during attempts to redirect when wandering into other resident rooms."

7/9/2018 8:00 AM-"Resident found sitting on buttocks in front of her dresser rummaging through her sock drawer. Denies pain/discomfort. Noted redness to right forehead measuring 3 x 3 cm. Resident assisted to bed without difficulty."

7/3/2018 11:41 AM-Resident in Room 416 crawling on her knees-blood on right temple in hairline with small open area 1.4 cm (centimeter) by 0.1 cm, hematoma surrounding area 3.6 cm x 3.1. Assisted to Beauty Parlor to hair cleaned .

6/30/2018 11:08 PM-wandering in halls and into other residents rooms-combative

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6/30/2018 10:17 AM-skin tear right lower arm 1 cm x 1 cm

6/23/2018 10:10 AM- Skin assessment- Wound -location top of head

6/21/2018 3:29 AM-Called to Room 417-observed sitting in floor on buttocks with water noted on floor. Resident had picked up water pitcher and spilled in the floor, then fell

6/20/2018 12:12 AM-Every 30 minute checks continue, wandering at times into other resident's rooms, redirected with much encouragement

6/19/2018 1:17 AM-Observed sitting in floor in hallway-no injuries

6/16/2018 8:45 PM-Resident in Room 409 D called staff to room-told staff Resident pulled TV off into the floor and when she pulled it down, it struck her above the eye.

6/16/2018 11:18 Sitting on floor with back against the wall, knee bent

6/14/2018 1:25 PM- Fall-observed on floor in front of bed- Intervention-Bed change

6/8/2018 Swung at roommate- Hitting resident on right shoulder

5/27/2018 12:00 PM- follow up unwitnessed fall-skin tear

5/25/2018 12 midnight Head to toe eval-Called to room 408 by CNA (Certified Nursing Assistant)-Resident lying on right side on floor with feet on fall mat-skin tear to left forearm 7 x

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0.9 cm- Bruise to right hand 1.2 x 0.9 cm- Barefoot, refuses to place non-skid socks

5/25/2018 12 midnight-Bruise to back of left upper arm 8 cm x 8.5 cm

5/21/2018 2:21 PM- Reported by Housekeeping staff that resident noted to be on floor on buttocks in Room 409. ...Resident with noted confusion, no agitation noted but refused complete skin assessment and vital sign check. Resident has refused to allow staff to place non-skid footwear on this shift. Hipsters intact"

5/21/2018 11:00-"CNA (Certified Nursing Assistant) staff heard alarm sounding at front entrance doors-CNA staff noted resident to have wandered outside of main entrance doors while delivery driver was dropping off packages for the facility. Resident remained at front entrance for staff to assist her back within the doors without further incident."

5/20/2018 8:45 PM- Found lying on floor mat in another resident's room. lying on her right side with her hands under her head with her eyes closed. 2 x 2 cm bruise to right knee

5/19/2018 3:30 PM- Bruise to back of left upper arm-(no measurements were documented) Also- Bruise on left forearm 4 cm x 2 cm

5/16/2018 6:53 AM -"Resident found sitting on floor beside bed.

5/13/2018 3:16 PM-Went into another residents room when other resident told resident to leave out of her room, resident stated this is her room and she is not leaving. Resident then became

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angry, took her stuffed animal and hit resident on the arm. Resident then picked up the residents water at threw it at the resident..."

5/9/2018 9:00 AM "Resident's roommate that this resident had pulled television onto the floor overnight. No injury noted to resident at this time"

5/6/2018 10 PM-Nurse went to room to give medications, noted bruise on left outer foot-7 cm x 4 cm

4/25/2018 Unwitnessed fall-Resident noted sitting on buttocks beside her bed with her back against her bedside table. Assessed for injury none noted. Resident stated to nursing staff, "I slipped, I slipped."

3/17/2018 5:07 PM Resident sitting in floor of another resident's room. Assessed for injury. Resident refused every 15 minute vital signs.

3/16/2018 11:30 AM Bruise to right hand, wrist, forearm 10 cm x 8 cm. Resident unable to let staff know how bruising occurred. Order for X ray to right hand and forearm. Geri sleeves to be worn.

Review of the care plan revealed a focus of "Risk for falls r/t (related to) impaired cognition/judgment, poor vision and the use of psychotropic medication. At risk for fractures due to dx (diagnosis) of vitamin D deficiency. Does have tendency to sit in floor."

Interventions included:
"Place in supervised area during restlessness. Redirect toward nurses station." initiated 3/17/2018, revision on 3/23/2018

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"Frequent checks when restless." initiated on 6/20/2018

Under the focus: The resident is an elopement risk/wanderer AEB (As evidenced by) impaired safety awareness
Interventions included:

"Resident frequently attempts to get into other resident's beds. Redirect as needed." initiated 11/16/17.

There was no documentation of the meaning of redirect as needed. The intervention did not describe how the facility staff should redirect Resident # 38. There was no intervention included about supervision of resident.

On 7/11/2018 at 10:30 AM, a Group Interview was conducted with 15 alert and cognitively intact residents. The group complained that Resident # 38 frequently wandered into other residents rooms and was often combative toward others. Several residents in the group stated the nursing staff members were unable to keep Resident # 38 from entering their rooms "especially because the facility was often short staffed."

On 7/12/2018 at 3:05 PM, an interview was conducted with the Director of Nursing (DON) who stated Resident # 38 had several unwitnessed falls and bruises. The DON also stated Resident # 38 continued to wander into other residents' rooms and had a history of physical aggression toward other residents.

Resident # 38 was observed wandering throughout the facility during the four days of

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survey. At times, staff members accompanied Resident # 38 while in the hallway, other times Resident # 38 was observed to be ambulating without staff members nearby.

On 7/13/2018 during the end of day debriefing, the facility administrator and Director of Nursing were informed of the lack of adequate supervision and numerous accidents/incidents involving Resident # 38. The Facility Administrator stated the facility was actively searching for a more appropriate placement in another facility "possibly one with a secure unit" for Resident # 38. The Administrator stated Resident # 38's daughter wanted to find a facility closer to where the daughter lived.

No further information was provided.

5. Resident #29 was not supervised resulting in resident to resident altercations.

Resident #29, an 82 year old, was admitted to the facility on 2/9/18. Diagnoses included hypertension and Alzheimer's dementia with behavioral disturbances.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/18/18. Resident #29 was coded with a Brief Interview of Mental Status score of 2 indicating severe cognitive impairment and required extensive assistance with activities of daily living. She was coded to wander the facility on a daily basis.

Resident #29 was observed on 7/10/18 at 11:35

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a.m. wandering throughout the facility. At 12:20 p.m., staff seated Resident #29 in the main dining room at a table in the corner of the room. A visitor was seated to her right side and the wall was to her left. A chair blocked her path to get through the space between the end of the table and the wall. The resident stood and tried to remove the chair. Eventually a staff member let Resident #29 out from behind the table. From 12:30-12:45 p.m., staff walked with Resident #29 in the hallways outside of the kitchen.

At 12:45 p.m., Resident #29 was brought back to the dining room and was seated at a square table in the middle of the room with another resident. While unattended at the table, Resident #29 attempted to take food and drink from the other resident at the table, eventually taking away his half eaten bowl of beets.

Certified Nursing Assistant A (CNA A) eventually brought food to Resident #29. CNA A cleared the bowl of beets from the table. When asked why she was clearing the beets, CNA A stated that the beets did not belong to Resident #29 and Resident #29 had taken them from the other resident at the table.

A review of the Facility Reported Incidents (FRIs) revealed that Resident #29 had altercations with other residents. On 5/25/18, Resident #29 entered the room of Resident #21. Resident #29 began messing with Resident #21's wheel chair and then hit him on the head with a magazine. Resident #21 reported the incident to a CNA.

Another FRI revealed that Resident #29 had an altercation with Resident #51 on 6/16/18. It was documented in the FRI that Resident #29 twisted

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Resident #51's right arm while they were at the nursing station.

On 7/10/18 at 12:00 p.m., a velcro STOP sign was observed in the doorway to Resident #51's room. An interview was held with Resident #51. Resident #51 was asked why she had a STOP sign. She stated that there was a resident that wanders into the room an takes items. During the interview, Resident #29 walked up to the door and stopped at the sign. Resident #51's roommate yelled at Resident #29 to go away.

On 7/11/18 at 10:30 a.m., a group interview was held with cognitively intact residents. Residents at the group meeting issued concern that Resident #29 frequently wandered in and out of their rooms.

Resident #29's care plan was reviewed. The focus of elopement was dated 2/9/18. Interventions included calmly redirect resident, divert resident's attention, relocate resident to a different area and wanderguard placement. A second focus dated 2/12/18 addressed behaviors. The focus read "The resident has a behavior problem r/t (related to) disease process. Resident wanders throught (sic) facility, into others rooms, and towards exits. She refuses medications, becomes agitated, spit at staff, attempted to pour water on staff, and becomes verbally and physically abusive towards staff. Disrobes in facility common areas and when wandering into others' rooms. Has become agitated upon redirection, refuses to wear hipsters at times, likes to lie down/sleep on sofa/chair." Interventions included benadryl as needed for restlessness, ativan as needed for anxiety, Seroquel increase, frequent checks and

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redirection, anticipate needs, stop and talk to resident, explain procedures, maintain resident in a safe area and allow her time, intervene as necessary to protect the rights and safety of others, and provide activities of interest.

On 7/12/18 at 3:45 p.m., the Administrator and Director of Nursing were notified that there were concerns with the supervision of Resident #29. The Administrator stated that the facility was looking for placement for Resident #29 at a new facility.

6. Resident #37 was found outside of the facility. He was not wearing his wanderguard.

Resident #37, a 63 year old, was admitted to the facility on 10/24/07. His diagnoses included dementia, head injury with psychosis, diabetes, hypertension, reflux, and schizophrenia.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/29/18. He was coded with a Brief Interview of Mental Status score of 6 indicating severe cognitive impairment. He required extensive assistance with activities of daily living.

According to a Facility Reported Incident dated 3/5/18, Resident #37 was observed outside of the facility urinating on the sidewalk without supervision. The incident report read that Resident #37 had been assessed on 10/25/17 to be an elopement risk and a wanderguard was placed on him at that time. Resident #37 was not wearing the wanderguard on 3/5/18 when he was found outside of the facility.

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F 689	Continued From page 66 Resident #37's Treatment Administration Record (TAR) for March 2018 was reviewed. The wanderguard placement checks were documented as having been performed every shift. On 7/12/18 at 3:35 p.m. the wanderguard system was reviewed with the Maintenance Director. At this time, the wanderguard sensors were tested and functioning properly. The Maintenance Director stated that the sensors were tested weekly. Documentation was provided. On 7/13/18 in the afternoon, Licensed Practical Nurse B (LPN B) was asked if the function of wanderguard bracelets that the residents wore were ever tested. LPN B stated that the nurses tested the function every shift. On 7/12/18 at 3:45 p.m., the Administrator and Director of Nursing were notified that there was a concern that Resident #37 was found outside of the facility without his wanderguard. No further information was provided.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		8/14/18

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F 692	Continued From page 67 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review the facility staff failed to provide a physician ordered nutritional supplement, and failed to implement interventions for further weight loss for one resident (Resident #28) of 24 residents in the survey sample. For Resident #28 the facility staff did not provide supplements as ordered, and failed to intervene during a significant weight loss. The findings included: Resident #28 was admitted to the facility on 5-2-17. Diagnoses included; diabetes, heart disease, chronic kidney disease, hypertension, depression and dementia. Resident #28's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5-16-18. She was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. She required extensive assistance to total dependence on staff for completion of activities of	F 692	1. Resident #28 was reviewed by RD and recommendations made, orders changed and care plan updated to reflect current interventions. 2. All residents have the potential to be affected by this deficient practice. 100% audit of residents triggering for significant weight lost in 30, 60 and 90 days have had care plans reviewed for current interventions by Registered Dietician. 3. Nursing staff will be in-serviced on following care plans and physician orders regarding diets and supplements by DON/designee. The interdisciplinary team will be in-serviced on updating care plans with any diet/supplement orders by DON/designee. 4. The DON/designee will audit RD documentation, MD orders, care plans for ten residents to include delivery of ordered diet/supplements per week for 12	

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F 692	Continued From page 68 daily living. Section K, Swallowing/Nutritional Status, question K0300 asked "Loss of 5% or more in the last month or loss of 10% or more in the last 6 months." Resident #28 was coded as "2. Yes, not on a physician-prescribed weight-loss regimen." The Resident was coded as weighing 160 pounds in the assessment. Weight records for the Resident were reviewed, and revealed the following: Resident #28 weighed 183 pounds in January 2018. She weighed 172.2 pounds in February (10 pound loss in one month). She weighed 168 pounds in March 2018 (15 pound loss in 2 months). She weighed 162 pounds in April (21 pound loss in 3 months). During May, June, and July the Resident continued to loose another 11 pounds. The Resident weighed 151 pounds on 7-5-18, at the time of survey to reveal a 32 pound weight loss in 6 months without being on a weight reduction plan. Physician orders signed 7-5-18 were reviewed for Resident #28. The dietary orders and their dates of implementation included: Weigh every month (5-2-17). Boost glucose controlled supplement by mouth every day at 10:00 a.m. (2-15-18). Fortified foods program each meal secondary to weight loss (4-12-18). Med pass 2.0 sugar free supplement 120 milliliters daily at 2:00 p.m., and 8:00 p.m., for weight loss (7-5-18).	F 692	weeks for recommendation, orders and care plan revisions for weight loss/interventions. Results of audits will be taken to the QAPI committee meeting monthly for three months for review and revisions as needed.	

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Resident #28's lunch meal trays were observed on 7-10-18, and 7-12-18. Regular diet no concentrated sweets was observed. Licensed Practical Nurse D (LPN D) stated Resident #28 had always been on that diet.

The meal card on Resident #28's tray read that she was to receive the prescribed diet "Regular no added salt (NAS) no concentrated sweets (NCS) diet.

Nursing progress notes and Registered dietician (RD) notes were reviewed and revealed the following chronological event sequence:

January 2018 until 4-12-18, the Resident had a pressure ulcer on her coccyx, and was continuing to loose weight. At this time the Resident had lost 18 pounds, and was only receiving her regular NAS/NCS diet, and Boost supplement. The RD only documented a 3 pound weight loss over 30 days, and did not describe the 18 pound weight loss in 3 months since January 2018 (9.9% loss).

On 4-12-18 the RD recommended adding the fortified foods, and weekly weights on 4-12-18. The weekly weights were never added to physician orders, and so were missed at times as they were only completed on the following occasions after the RD recommended them on 4-12-18;

1 time in April, 3 times in may, 4 times in June, and on 7-5-18 in July prior to survey. On 4-12-18 fortified foods were added.

On 4-25-18 the RD documented continued weight loss and made no new additions to treat the

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Resident.

On 5-1-18 the Nursing progress notes indicated the Resident was dehydrated with a blood pressure of 101/50 and a pulse of 98 and blood sugar of 174. The doctor ordered "Hypodermocysis fluid infusion" and the Resident improved rapidly the same day.

On 5-9-18 the RD documents further weight loss that week, and orders no interventions.

On 5-15-18 the RD documents significant weight loss and now at 160 pounds, (23 pound weight loss) and Albumin blood test results reveal the Resident is low at 3.2, with 3.5 to 5.5 being normal.

On 6-7-18 continued weight loss, no intervention changes.

On 6-14-18 continued weight loss, no intervention changes.

On 7-5-18 continued weight loss, and the Resident weighs 151 pounds, and has lost 32 pounds (17.5% loss) in 6 months without changes in dietary interventions since 4-12-18, (3 months).

On 7-5-18 the final RD note documents "noted with ongoing slow weight loss, now showing as a significant weight loss over 6 months. Supplements will be adjusted to SF (sugar free) med pass 2.0 supplement (tid) three times per day, and mighty shakes were discontinued. The note goes on to say intake variable from day to day - does refuse often. alternatives offered. None of the progress notes indicate the Resident refuses anything. There are no dietary notes to

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indicate preferences were checked during this time.

On 7-12-18 the Medication and Treatment Administration Records (MAR/TAR's) for May, June, and July 2018 were reviewed and revealed that the boost ordered in February was not administered on the following days: 5-2-18, 5-16-18, and 7-4-18.

The sugar free mighty shakes ordered twice per day were not administered on the following days: 5-2-18 twice, 5-10-18 once, 5-14-18 once, 5-15-18 once, 5-16-18 once, 5-17-18 once, 5-18-18 once, 5-19-18 once, 5-20-18 once, 6-5-18 once, and 7-4-18 once.

There were no notes to describe why these supplements were not administered.

The SF med pass 2.0 supplement that was ordered to be given 3 times per day by the RD on 7-5-18, had only been given twice per day since ordered, as the order had been transcribed incorrectly, omitting 7 doses since ordered.

On 7-12-18 the Residents care plan was reviewed and revealed that the fortified food program ordered on 4-12-18 was not added to the care plan until 5-26-18. After 5-26-18 None of the interventions that were changed or ordered have been added to the care plan at the time of survey. The care plan does not have measurable interventions, and does not denote significant weight loss. The care plan has not been revised appropriately.

The failure of staff to recognize and intervene timely and revise the diet care plan was reviewed

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F 692	Continued From page 72 with the Administrator and Director of Nursing at the end of day meeting on 7-12-18, and 7-13-18. No further information was provided.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure oxygen orders and assessments for need were clarified for one Resident (Resident #34) in a survey sample of 24 Residents. Resident #34 was not receiving adequate oxygen saturation assessments to guide needed oxygen administration per a physician's order. The findings included: Resident #34 was admitted to the facility on 12-12-12. Diagnoses included; encephalopathy, epilepsy, anxiety, bipolar disorder, and dementia. Resident #34's most recent Minimum Data Set Assessment was a quarterly assessment with an assessment reference date of 5-25-18. She was coded with severe cognitive impairment. She required total assistance with all activities of daily	F 695	1. Resident #34 order reviewed by physician and was discontinued. 2. All residents have the potential to be affected by this deficient practice. 100% audit of current residents receiving oxygen therapy for appropriate orders and care plans revised as needed. 3. Licensed nurses will be in-serviced on following physician orders to include oxygen therapy by DON/designee. 4. The MDSC/designee will audit MARs/TARs and care plans of residents receiving oxygen therapy for appropriate documentation two times a week for 12 weeks. Results of audits will be taken to the QAPI committee monthly for three months for review and revision as needed.	8/14/18

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living (ADLs).

Resident #34 was first observed on 7-10-18 during initial tour of the facility at approximately 11:45 a.m. in her room in a low bed. She did not respond to verbal stimulation. Resident #34 exhibited contractures of both hands, in which her fingers were closed inward toward the palm in a loose fist formation. She was not receiving oxygen at this time.

On 7-11-18 at 9:00 a.m., Resident #34 was observed again in her room and no oxygen was applied. The Resident was observed this day at 10:00 a.m., 11:00 a.m., 1:00 p.m., and 2:00 p.m. and no oxygen was applied.

Review of Resident #34's clinical record revealed a current physician's order signed 6-19-18 for the administration of oxygen. Review of the "Physician's Order" sheet revealed the oxygen order was first implemented on 2-3-14. Further review of the record revealed Resident #34 was to receive the following;

2-3-14 - "Oxygen at 2Lpm (liters per minute) via nasal cannula as needed to keep oxygen sats (saturation) above 94% - Monitor oxygen sats every shift when oxygen in use."

The Medication and Treatment Administration Records (MAR/TAR) for May, June, and July 2018 were reviewed and revealed the order was on the documents, with a place for nursing to initial as administered. Only one initial was documented for the 3 month period, and it had been scored through with a single line on 5-1-18.

The current Nursing care plan was reviewed to

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F 695	Continued From page 74 ascertain the plan for Resident #34's oxygen saturation evaluations and when oxygen should be applied, and documentation should occur. There was no care plan for oxygen saturation assessments, and oxygen use for this Resident. The vital sign record was reviewed and revealed in the past 6 months, the Resident's oxygen saturation was only checked one day a month, except for the month of may, when it was checked 6 days. 1 day in January, 1 day in February, 1 day in March, 1 day in April, 6 days in May, 1 day in June, and 1 day in July. On 7-12-18 The Director of Nursing was interviewed at the end of day debrief, and asked how the staff knew what the Resident's oxygen saturation was, so that they would know when to administer oxygen. She replied They do it routinely with other vital signs. She was asked how staff evaluated if the Resident's oxygen saturation was at any time 94% or below. She did not answer. The Corporate Registered Nurse (Corp RN) and Administrator were both in attendance and the Corp RN stated "that order needs to be clarified." No further information was provided by the facility.	F 695		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;	F 711		8/14/18

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F 711	Continued From page 75 §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on clinical record review the facility staff failed to ensure physician orders were signed for 1 resident (Resident #29) of 24 residents in the survey sample. For Resident #29, the most recent signed physician order sheets was dated 2/11/18. The findings included: Resident #29, an 82 year old, was admitted to the facility on 2/9/18. Diagnoses included hypertension and Alzheimer's dementia with behavioral disturbances. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/18/18. Resident #29 was coded with a Brief Interview of Mental Status score of 2 indicating severe cognitive impairment and required extensive assistance with activities of daily living. She was coded to wander the facility on a daily basis. Resident #29's clinical record was reviewed. Included were physician order sheets for the months of February 2018 through June 2018. The February 2018 admitting orders were signed. The physician orders sheets from March	F 711	1. Resident #29 is no longer a resident at the facility. 2. All residents have the potential to be affected by this deficient practice. 100% audit of current residents clinical record for physician documentation to include signed physician orders. 3. Administrator/DON/Nurse Manager/Medical Records in-serviced on CMS guideline regarding timeliness of physician visits and documentation of visits by Regional Director of Clinical Services. Review of CMS guidelines regarding physician visits and documentation with Medical Director and attending physicians by Administrator/designee. 4. Medical Records/designee will audit ten clinical records a week for 12 weeks for physician visits. Results of audits will be taken to QAPI committee meeting monthly for three months for review and revision as needed.	

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F 711	Continued From page 76 2018-June 2018 were not signed. The Administrator and Director of Nursing were notified about the issue on 7/12/18 at 4:00 p.m. and 7/13/18 at 1:30 p.m. No further information was provided.	F 711		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced	F 741		8/14/18

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F 741	Continued From page 77 by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide sufficient competent staff for behavioral health needs for 1 resident (Residents #1) in a survey sample of 24 residents. For Resident #1, the facility staff failed to provide competent staff supervision to protect this Resident and prevent this Resident from assaulting Resident #34. The findings included; Resident #1 was initially admitted to the facility on 3-15-18 with diagnoses including but not limited to; Chronic obstructive pulmonary disorder, Dementia, delusional disorders, hypertension, seizures, major depression, was anemic, weighed 89 pounds, Dysphagia oral phase, and had a history of falls. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed. The Full Admission Minimum Data Set Assessment (MDS) with an ARD (assessment reference date) of 3-23-18 coded Resident #1 as having a BIMS (brief interview of mental status) of "2" out of a possible 15, or severely cognitively impaired. Resident #1 was coded as needing extensive assistance with ADL's (activities of daily living) such as bathing and dressing from 1 staff member, and for eating required supervision and set up help. The most recent MDS with an ARD of 6-25-18 was a significant change full assessment, and coded the resident as requiring extensive	F 741	1. Receptionist was educated on 7/26/2018 on Dementia/Behavior management relative to residents with behaviors utilizing hand to hand materials 7/26/2018. Resident #1 was evaluated by psych on 7/19/2018 with medication adjustments. 1:1 activities 5 times a week. Care plan reviewed and revised to reflect specific redirection techniques. No documented resident to resident altercation as of this time. Resident # 34 has head to toe assessment completed for any bruising or any other skin integrity concerns. Social Worker assessed resident for signs of fearfulness. 1:1 activities 5 times a week. Staff educated on observing resident and being aware of behaviors with other residents. Care plan reviewed and revised to reflect current needs. 2. All residents have the potential to be affected by this deficient practice. Audit of residents with documented behaviors to ensure care plans have current interventions to include specific redirection techniques and non pharmacological interventions. All current residents with documented behaviors will be reviewed by the interdisciplinary team for psychiatric referrals as needed. 3. All facility staff will be re-educated on Dementia Training to include supervision, protecting and preventing resident to resident altercations by corporate director of social services and activities. New	

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assistance from one staff member, and now required extensive assistance from 1 staff member for eating.

Further review of the progress notes revealed the Resident to be documented as physically and verbally abusive toward others upon admission, and was documented as such in the admission MDS. Prior to assaulting her room mate (the room mate was identified as Resident #34 and placed in the survey sample) Resident #1 was documented in the nursing progress notes as combative, aggressive, verbally and physically abusive with staff and Residents. This behavior was documented 8 times in 3 months, and 3 times on 5-26-18, the day of the assault. After the assault she was moved to another room on 5-26-18, and continued the abusive behaviors on 5-27-18, 5-30-18, 5-31-18, 6-1-18, 6-3-18, 6-6-18, 6-13-18 and 6-29-18. Supervision interventions for this Resident were not described. No further documentation indicated Resident aggressive behavior continued after the Resident experienced her last fall on 6-28-18, except for the 6-29-18 incident with staff providing care. The Resident was moved on 7-2-18 back directly across the hall from the room mate she assaulted on 5-26-18. No indication why she was moved back in close proximity to her victim could be found.

On 7-12-18 when exiting the building for lunch break Resident #1 was observed sitting in her wheel chair with the receptionist in the lobby at the front desk. The receptionist was trying to keep the Resident from removing her clothing and exposing herself to visitors who were present there. This continued for approximately 10 minutes while waiting for other surveyors to

employees will be educated on dementia training by Social Services Director/designee.

LPN/RN's will be educated on utilization of behavior monitoring flow sheets by DON/designee.

All facility staff will be educated on the Abuse policy and procedure to include resident to resident by Administrator/designee.

4. DON/designee will review the 24 hour report/nurse documentation/behavior flow sheets five times a week for any residents with behaviors to ensure interventions in place and are effective.

Audits will be taken to the QAPI committee meeting monthly for three months for review and revision as needed.

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arrive. The Resident was striking out at the receptionist, and the receptionist kept repeating "No, don't do that, you can't take your shirt off here," and the Resident was yelling "I don't care who is here, cursing, and hitting the receptionist. The Receptionist did not try to remove the Resident and seemed not to know what to do, stating, "I can't do this". We asked if the receptionist was a nurse or CNA, and she stated, "no".

Review of Resident #1's plan of care was conducted and revealed the interventions below Behaviors:

Under "Focus" "The Resident has depression related to admission, dementia, disease process (altered mental status". Interventions included; "Administer medications, monitor for side effects and effectiveness, arrange for psyche consult, follow up as indicated, encourage and provide opportunities for exercise, physical activity, encourage movement program, monitor /document/report signs of depression to nurse/doctor, monitor/record/report to doctor as needed risk for harming others." The Resident was documented by staff at different times as being at risk of harming others during her entire stay.

Another "Focus" for behavior included further interventions of "room change, provide for positive interaction, attention, stop and talk, discourage from scratching self, encourage expression of feelings appropriately, explain all procedures before starting and allow Resident to adjust to changes, approach and speak in calm manner, intervene as necessary to protect the rights and safety of others, divert attention,

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remove from situation and take to alternate location as needed, praise improvement in behavior."

The following was added to the care plan on 3-22-18 "Referred to [facility area community services board] for psychiatry services on 3-21-18. They are unable to add another patient to his caseload at this time. Will refer to telemed psychiatry when available at facility." No projection date is given for "telemed psychiatry" availability. On 5-24-18 (2 months later) another revision was made which stated; "Left message for (name of group) psychiatry". It is unknown when the actual appointment was made, however, a revision was made to the care plan dated 6-11-18, and the Resident is now scheduled to see a psychiatrist doctor on 7-19-18.

The Psych consult was not attempted to be arranged for 2 months, during which time the Resident was abusive to Residents and staff. On 6-11-18 weeks after the Resident had assaulted another resident a revision was documented an arranged appointment for 7-19-18. The Resident continued to be abusive and aggressive for 3 months before this intervention was implemented.

In conclusion, the facility failed to provide adequate supervision of a resident with mental and behavioral health needs, and provide a safe environment for Resident #1's room mate, and others.

On 7-12-18, and 7-13-18 at 4:30 p.m., the facility failure was reviewed with the Administrator, and Director Of Nursing at the end of day meeting. No further information was provided.

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to provide pharmaceutical services for one resident (Resident # 38) in survey of 24	F 755	1. Resident #38 medication was reviewed and scheduled narcotics are available for administration.	8/14/18

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F 755	Continued From page 82 residents. For Resident # 38, the facility staff failed to provide a scheduled pain management medication, Percocet, as ordered by the physician. Findings included: Resident # 38 was an 82 year old female who was admitted to the facility on 7/14/2015 and readmitted on 3/22/2016 with diagnoses of but not limited to: Chronic Pain, Atherosclerotic Heart Disease, Hypertension, Vitamin D Deficiency, Alzheimer's Disease with late onset, Dementia, Psychosis and Major Depressive Disorder The Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 5/29/2018. The MDS coded Resident # 38 with a BIMS (Brief Interview for Mental Status) of 3/15 indicating severe cognitive impairment; the resident was coded as independent with most activities of daily living (bed mobility, transfers, ambulation, locomotion, eating, and toileting) except required extensive assistance of two staff persons with Hygiene, Dressing and Bathing; Resident # 38 was coded as always continent of bowel and bladder. Review of the Clinical Record was conducted on 7/11/2018. Review of the Nurses Progress Notes revealed documentation that the medication, Percocet, was not available for administration as ordered by the physician on 4/11/2018 at 6 AM, 6/11/2018 at 2 PM, 6/26/2018 at 9:30 PM, 6/27/18 at midnight.	F 755	2. All residents have the potential to be affected by this deficient practice. 100% audit on all current residents pain medication. 3. The DON/designee will in-service nursing staff on polices regarding medication administration, stat box usage, following a physician's order and medication availability. 4. The DON/designee will audit availability of medications two times a week for 12 weeks and five random MARS for omissions for 12 weeks. Audit results/trends will be taken to the QAPI committee monthly for three months for review and revision as needed.	

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Review of the April 2018 MAR (Medication Administration Record) revealed documentation that the medication Oxycodone/APAP 5 milligrams/325 milligrams (Percocet) one tablet by mouth three times daily was not administered on 4/11/2018 at 0600 (6 AM) and 4/11/2018 at 10 PM due to medication not available.

Review of the May 2018 MAR revealed documentation that Percocet was not administered on 5/22/2018 at 6:00 AM with no reason documented on the back of the MAR.

Review of the June 2018 MAR revealed documentation that Percocet was not administered on 6/10/2018 at 10 PM and 6/26/2018 at 10 PM because the medication was not available.

Review of the facility policy on medication administration revealed statement that medication should be administered as ordered by the physician.

On 7/13/2018 at 12:15 PM, an interview was conducted with the Pharmacy Consultant (Admin H) who stated narcotics should have a hard script, the Pharmacy would send a card with 30 tablets and the facility staff would need to call for refills prior to dispensing the last of the 30 pills sent. The Pharmacist stated the Pharmacy did not want to send too many pills at a time because of the potential for pills to be wasted if the order changed and to reduce the risk of drug diversion. The Pharmacist stated the facility staff should call for refills in enough time for the residents to receive the medications as ordered by the physician.

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F 755	Continued From page 84 On 7/13/2018 at 12:45 PM, an interview was conducted with the medication nurse Licensed Practical Nurse (LPN) A who stated the facility staff was supposed to call the Pharmacy for a refill when there was a 5 day supply of the Narcotic left. LPN A stated the Pharmacy narcotic sheet had a label that let the staff know how many refills remain for the medication. On 7/13/2018 at 12:50 PM, an interview was conducted with the Director of Nursing (DON) who stated Medications should be available to be administered as ordered by the physician. The DON stated the Pharmacy required a hard script to dispense narcotics. On 7/13/2018 at 3:45 PM during the end of day debriefing, the facility Administrator, DON and Corporate Consultants were informed of the failure of the facility staff to provide the medication Percocet as ordered by the physician. No further information was provided.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		8/14/18

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F 757	Continued From page 85 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on facility records, clinical record review and staff interview the facility failed to keep resident free from unnecessary medications for 1 resident (Resident #49) in a survey sample of 24 residents. The facility failed to ensure the Resident #49 was not given duplicate drug therapy for "itching". The findings included: Resident #49 an 83 yr. old male was admitted on 7/31/17 with diagnoses of but not limited to Dementia, anemia, anxiety and depression. Resident #49's most recent MDS (Minimum Data Set) was coded as Quarterly and had an ARD date of 6/15/18. Resident #49 was coded as having a BIMS (Basic Interview of Mental Status) score of 6, indicating moderate cognitive impairment. A review of medication administration record (MAR) shows that Resident #49 had an order for Atarax (anti-itch medication) and also an order for Doxepin both dated 2/25/18. Both described as being for itching.	F 757	1. Resident #49 medication reviewed by attending physician. 2. All residents have the potential to be affected by this deficient practice. 100% audit of current residents physician orders for duplicate drug therapy and clarify as needed. 3. Licensed nurses will be educated on the use of Unnecessary medications to include residents receiving duplicate drug therapy by DON/designee. 4. DON/designee will audit the 24 hour report/physician orders five times a week for 12 weeks for duplicate drug therapy. Results of audits will be taken to the QAPI committee meeting monthly for three months for review and revision as needed.	

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Doxepin being prescribed at 25 (milligrams) mg capsule twice a day at 9 AM and 9 PM. and Atarax (hydroxyzine/ antihistamine) 25 mg every 8 hours PRN (as needed).

According to the Manufacture website and Mayo Clinic online :

"The tricyclic antidepressant Doxepin (Zonalon), used in cream form, can help relieve itching. This drug may cause dizziness and drowsiness. Topical Doxepin is used to relieve itching in patients with certain types of eczema. It appears to work by preventing the effects of histamine, which is a substance produced by the body that causes itching."

Doxepin (Oral) is recommended for the treatment of:

Psychoneurotic patients with depression and/or anxiety.
· Depression and/or anxiety associated with alcoholism (not to be taken concomitantly with alcohol).
· Depression and/or anxiety associated with organic disease (the possibility of drug interaction should be considered if the patient is receiving other drugs concomitantly).
· Psychotic depressive disorders with associated anxiety including involutional depression and manic-depressive disorders.
The target symptoms of psychoneurosis that respond particularly well to Doxepin include anxiety, tension, depression, somatic symptoms and concerns, sleep disturbances, guilt, lack of energy, fear, apprehension and worry.

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F 757	Continued From page 87 Resident #49 was given (by mouth) PO Doxepin 25 mg twice a day along with a PRN order for Atarax (antihistamine) 25 mg every 8 hrs as needed for itching. On 7/12/18 the director of nursing was interviewed and she stated that she was aware that Resident #49 was getting duplicate drug therapy for Itching. She also stated she knew that Doxepin was an antidepressant and was sometimes used for itching. She said she was not aware it was available in topical cream form. She stated Resident #49 already had a treatment order for Sarna (anti-itch lotion) but was non compliant with that. Administration was made aware on 7/12/18 and no further documentation was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		8/14/18

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F 758	Continued From page 88 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility failed to ensure 1 Resident (Resident #49) remain free from unnecessary antipsychotic medications in a survey sample of	F 758	1. Resident #49 medications were reviewed for appropriate diagnosis and medications discontinues as appropriate by physician.	

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F 758	Continued From page 89 24 Residents. 1a. For Resident #49 the facility failed to ensure the Resident's PRN (as needed) order for Ativan (anti-anxiety) was discontinued after 14 days. 1b. For Resident #49 the facility failed to ensure a the resident had a proper diagnosis that supports the use of antipsychotic medication 2. For Resident #15 the facility failed to ensure the resident had a proper diagnosis to support the use of antipsychotic medications. The findings included: 1a. For Resident #49 the facility failed to ensure the Resident's PRN (as needed) order for Ativan (anti-anxiety) was discontinued after 14 days. Resident #49 an 83 yr. old male was admitted on 7/31/17 with diagnoses of but not limited to Dementia, anemia, anxiety and depression. Resident # 49's most recent MDS (Minimum Data Set) was coded as Quarterly and had an ARD date of 6/15/18. Resident #49 was coded as having a BIMS (Basic Interview of Mental Status) score of 6, indicating moderate cognitive impairment. Resident was coded as independent with ADL's and continent of bowel and bladder. Resident #49 an 83 yr. old male was admitted on 7/31/17 with diagnoses of but not limited to Dementia, anemia, anxiety and depression. On 7/12/18 @ 1:15 PM review of clinical record showed that according to the MAR (medication	F 758	Resident #15 the PCP reviewed medications to include appropriate diagnosis. 2. All residents have the potential to be affected by this deficient practice. Residents receiving antipsychotic medications clinical records reviewed for appropriate diagnosis. 3. Licensed nurses will be in-serviced on use of Unnecessary medications, antipsychotics and appropriate diagnosis and use by DON/designee. DON and Unit Manager in-serviced on policy related to pharmacy medication review and timely follow up by Regional Director of Clinical Services. 4. The DON/designee will audit the Pharmacy tracking log weekly for 12 weeks for implementation or denial of pharmacy recommendations. Audit of physician orders five times a week for 12 weeks by DON/designee for antipsychotic medications to ensure appropriate time frame if indicated and appropriate diagnosis. Results of audits will be taken to QAPI committee monthly for three months for review and revision as needed.	

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administration record) on 3/7/18 Resident #49 was prescribed Ativan (Psychotropic-anti anxiety) 1 mg tablet every 4 hours PRN (as needed) for agitation this order had no end date.

The Resident also had an order for Ativan IM (intramuscular injection) 1 milligram (mg) every 4 hours as needed for agitation dated 5/16/18 this order had no end date.

On 7/12/18 during clinical record reviews the Pharmacy Reviews recommending the discontinuance of the Ativan orders both oral tablets and injections were never addressed. The reviews were as follows:

January 19, 2018 - Comments: Resident #49 has a PRN order for anxiolytic [anti-anxiety] which has been in place for greater than 14 days without a stop date. Lorazepam [trade name Ativan] 0.5 every 6 hrs for agitation.

Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy and the rationale for the extended time.

March 22, 2018 - Comments: Resident #49 has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date. Lorazepam 1 mg every 4 hrs for anxiety.

Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy and the rationale for the

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F 758	Continued From page 91 extended time. April 16 2018 -Comments: "REPEATED RECOMMENDATION from 3/22/2018". Please respond promptly to ensure facility compliance with FEDERAL REGULATIONS" Resident #49 has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date. Lorazepam 1 mg every 4 hrs for anxiety. Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy and the rationale for the extended time. May 21, 2018 - Comments- Resident #49 has a PRN order for an anxiolytic which has been in place for greater than 14 days without a stop date. Lorazepam tablet and injectable Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy please document a reevaluation date and the rationale for the extended time period. 1b. On 7/12/18 a review of clinical record was conducted and found that Resident #49 has psychiatric/ behavioral health notes that state the Residents diagnosis as Dementia with behavioral	F 758		

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disturbance. Resident has been receiving Seroquel with no GDR (gradual dose reduction) attempts made.

On 7/12/18 a review of clinical record shows the Pharmacy Reviews recommending the following with regards to Seroquel:

February 22, 2018 -Comment: Resident #49 receives Quetiapine Fumarate [Trade name Seroquel-an antipsychotic] a medication with may cause involuntary movements including tardive dyskinesia (TD) but an AIMS (Assessment for Involuntary Movement Screening) or (DISCUS Dyskinesia Identification System: Condensed User Scale - A screening tool for identifying side effect of prolonged antipsychotic use)

Please monitor for involuntary movements by using one of the available scales now and then again at lease every six months. It is recommended that monitoring frequency increase during dosage change. If symptoms appear it is recommended that a risk / benefit assessment be done.

June 1, 2018 - Comments- Resident #49 is on antipsychotic Quetiapine

Please clarify the following so the facility can assist in providing care while the resident receives Quetiapine.

1) Provide a clear indication for use 2) Provide specific target behaviors the antipsychotic is being prescribed to treat and define the desired outcome. The specific target behavior must represent a danger to himself or others. Indicate hat it is causing the resident distress of that it has

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been a resistant to multiple attempts at non drug interventions. 3) On going evaluation no less than quarterly for effacy and adverse effects. 40 Add older that ensure ongoing monitoring of weight fasting lipid and fasting glucose or A 1 C (baseline and annually) movement disorders via AIMS OR DISCUS 5) Regularly evaluate and document the ongoing need for the antipsychotic and if a gradual dose reduction is clinically appropriate.

Rationale for Recommendation : The FDA has issued a BOXED WARNING for antipsychotics posing and incareased risk of mortatluty in elderly individuals demtnia related psychosis. Additionally the are associated with potentially serious adverse effects including movement disorders metabolic abnormalities and Orthostatic Hypotension. Older adults are at increases risk of harm from these medication

The facility physician only signed one of the pharmacy reviews the one dated June 1, 2018 was signed and the only documentation or stated was " Pt has documented history of delusional disorder. He has behavioral problems."

Further review of the Residents chart shows his psychiatric evaluation from 6/1/18 states that Resident diagnosis is Dementia with behavioral disturbance.

Interview with Employee F (corporate regional Nurse) who stated that it is the expectation of the facility that the doctors look at and address each pharmacy recommendation. She also stated that the facility is aware of the 14 day limit for PRN psychotropic use.

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Employee F also stated she was a ware that Seroquel is not intended for use with elderly dementia patients due to the black box warnings and FDA recommendations.

The administrator was made aware of these findings on 7/13/18. No further information was provided.

2. For Resident #15 the facility failed to ensure the resident had a proper diagnosis to support the use of antipsychotic medications.

Resident #15 an 89 yr old female admitted to the facility on 9/1/15 with a diagnosis of but not limited to Alzheimer's Disease with late onset, CAD (coronary artery disease), and Dementia with behavioral disturbance, anxiety disorder.

Resident # 15's most recent MDS (Minimum Data Set) was coded as Quarterly and had an (assessment reference date) ARD date of 6/15/18. Resident #15 was coded as having a BIMS (Basic Interview of Mental Status) score of 4 indicating severe cognitive impairment. Resident was coded as extensive assistance of 2 or more staff with (activities of daily living) ADL care. Resident is in a wheelchair unable to walk, and is always incontinent of both bowel and bladder.

On 7/11/18 at 10:55 AM a review of clinical record was conducted and it was found that Resident #15 has an order to receive (an antipsychotic) Seroquel 50 mg twice daily . Upon further review of the clinical record it was discovered that a pharmacy review was conducted on May 21, 2018 and the pharmacy recommendations were

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as follows:

COMMENTS:
Resident #15 has received Quetiapine 50 mg (Generic for Seroquel) twice daily since dose increased 12/2017 for delusional disorder. Last noted psych evaluation 3/3/2018.

RECOMMENDATIONS:
Please attempt gradual dose reduction of Quetiapine. If clinically appropriate Thank you.

RATIONALE:
CMS requires that antipsychotics being used to treat a psychiatric disorder, be evaluated at least quarterly with documentation regarding continued clinical appropriateness and undergo GDR attempts in 2 separate quarters within the first year in which a resident is admitted or after the facility has initiate the medication and then annually unless contraindicated.

The Physician signed the Pharmacy review and checked the box that stated - "Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individuals function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder. as documented below":

"Please provide CMS REQUIRED patient specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual:

[Physician responded] - " Patient's behaviors are barely adequately controlled on current medications. Would not recommend dosage

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F 758	Continued From page 96 change at this time. Pt is delusional". Interview with Employee F (corporate regional) was conducted. She stated she was aware of Resident #15 being on Seroquel with an Alzheimers disease daiagnosis. She also stated that the facility is aware of the Resident also receiving Xanax (anti anxiety/ benzodiazepine) scheduled twice daily. Employee F also stated she was aware that Seroquel is not intended for use with elderly dementia patients due to the black box warnings and FDA recommendations. The administrator was made aware of these findings on 7/13/18. No further information was provided	F 758		
F 808 SS=G	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide a therapeutic diet for 2 residents (Residents #62, and #1) resulting in harm for Resident #62, in a survey sample of 24	F 808	1. #62 no longer is a resident in this facility. Resident #1 clinical record reviewed. Order of 6/13/2018 stated regular diet. For clarification speech consult was completed 7/27/2018 and diet order was	8/14/18

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F 808	Continued From page 97 residents. 1. For Resident #62, the facility staff failed to provide a ground regular diet resulting in death by choking. This is harm. 2. For Resident #1, the facility staff failed to provide the correct diet, and feeding services. Findings included: 1. Resident #62 was originally admitted to the facility on 2-15-06, and expired in the facility on 6-12-18. Diagnoses included but were not limited to: Encephalopathy due to suicide attempt, schizoaffective disorder, epilepsy, Dysphagia oral phase, and dementia. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed. Resident #62's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3-12-18 was coded as a quarterly Assessment. The Resident was coded as having a BIMS score of 6 indicating moderate to severe cognitive impairment. The Resident was coded as having a poor appetite or overeating 2-6 days in the 7 day look back period. Resident #62 was coded as needing limited to extensive assistance of one staff person with activities of daily living, except for locomotion in a wheel chair which only required supervision, and eating, which coded the Resident as independent. Resident #62 was also coded as requiring a mechanically altered diet, always incontinent of bowel and bladder, and requiring a "wanderguard" elopement bracelet, for supervision, secondary to poor judgement. Review of Resident #62's closed clinical record	F 808	confirmed for regular diet. Tray card was corrected in the system to reflect regular diet. Dietary Manager was disciplined for failure to ensure resident #1 received correct diet for lunch on 7/10/2018. The Cook that failed to ensure resident #1 received correct diet for lunch on 7/10/2018 was disciplined. 2. All residents have the potential to be affected by this deficient practice. 100% audit completed of current residents to ensure physician ordered diets, care plans and dietary tray cards are accurate and complete. 3. Dietary staff educated on following diet order per Medical Provider to include mechanical altered diets by RD/designee. Nursing staff educated on following physician orders related to diet orders to include mechanically altered diets by DON or designee. New clinical and dietary staff will be educated during orientation on following physician orders related to diet orders and supervision during meals by DON or designee. 4. All residents who require supervision will be audited to ensure staff are following supervision protocol every meal for two weeks then five meals a week for ten weeks by DON, Dietary Manager or designee. All residents who are on mechanical altered diets will be audited to ensure meal served is correct every meal for two	

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F 808	Continued From page 98 revealed the most recent "Dietary Quarterly Assessment" completed by the Registered Dietician (RD), dated 3-15-18, describing the "Current Diet order" as "Regular, ground texture no hot dogs - choking hazard." This order was never amended or discontinued. Occupational Therapy (OT) notes were reviewed, and revealed an evaluation and planning for therapy dated 6-7-18. The document revealed under "Functional assessment", "self feeding = Did not test (Pt at baseline)." on page 3 of the 4 page document. On page 4, the document goes on to say under "Self Care", "Eating independent, oral hygiene Partial/Moderate assistance." It is unknown how independence in eating was assumed as no actual testing was completed, and oral hygiene required moderate assistance. Speech Therapist (ST) notes were reviewed, and revealed the most recent evaluation and treatment for Resident #62 was from 12-7-16 to 1-5-17 when the Resident was discharged from speech therapy services. The documents reveal that "patient (pt) was observed and noted in chart that patient coughs on some consistencies, including hot dogs. Pt often requires cues to increase accuracy. No choking in this visit, however, patient chart indicated history of choking." "Patient frequently requires verbal cues to decrease risk of aspiration, penetration."(choking). A second ST evaluation note revealed, "Patient visited while consuming regular ground meat trial. Patient demonstrated increased rate (of eating) and decreased mastication (chewing) while consuming meal. Patient somewhat stimulable to verbal cues (by staff) to reduce rate." "Patient	F 808	weeks then five times a week for ten additional weeks by Dietary manager or designee. Diet orders will be reviewed for all new admissions and readmissions through the 24 hour report five times a week for 12 weeks by DON or designee. Results of audits will be taken to the QAPI committee monthly for three months for review and revision as needed.	

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requires verbal cues by staff on a regular basis to decrease risk of aspiration/penetration (inhaling food and choking). With cues (from staff) patient is able to reduce rate, and intake amount (smaller bites) as well as demonstrate increased mastication." "Patient demonstrated increased difficulty with regular bread at times due to increased rate and bite size. Patient currently on mechanical soft diet, however, has been receiving what is consistent with a regular/ground diet." "ST recommend upgrade patient to regular/ground due to patient is able to tolerate at this time."

At the time of discharge from ST, all goals were not met and a final discharge document was produced dated 1-5-17 "end of care". The document read; "Due to periodic impulsive behavior, it is recommended patient continue to receive cues via staff during unsafe times with provisional supervision." "Patient periodically demonstrates impulsivity during PO (eating) that he favors (deserts, sandwiches, or when he is hungry) patient requires cues to practice safe swallowing and reduce rate and masticate and swallow all bolus (mouthful) prior to additional bites." "Regular/ground diet, at times patient demonstrates increased rate and decreased mastication when consuming by mouth. Impulsive behaviors at times." Patient demonstrates large bite sizes, increased rate and decreased mastication of bolus."

Physician orders were reviewed and revealed current diet orders signed by the physician on 6-12-18, "No hot dogs, choking hazard", first ordered 4-23-12, and "Regular, ground diet with supervision", first ordered 12-7-16.

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Certified Nursing Aide (CNA) "Resident Care Card" care plan instructed staff to always set up and supervise this Resident's meal at lunch and dinner. It is unknown why breakfast is not included.

A copy of the current Nursing Care Plan, last revised on 3-28-18, was reviewed and revealed the following interventions; "Impaired safety awareness, the resident is independent with eating, the Resident requires supervision and cueing at times to eat (resolved 3-21-18), meals in room or dining room, no hot dogs, serve diet as ordered". The care plan does not specify what the Resident's diet order is, nor does it specify supervision while eating as the doctor's order mandates, and actually rescinds the doctor's supervision order.

The facility Care Plan policy was reviewed and revealed the following;
Policy: "An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis."
A). The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and mental, and psychosocial needs that are identified in the comprehensive assessments."
D). "All staff must be familiar with each resident's care plan and all approaches must be implemented."
F). "The comprehensive care plan is reviewed and updated at least every 90 days by the interdisciplinary team."
U). There may be additional problem areas not triggered by the MDS, which will need to be

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addressed in the care plan."
Z). All direct care staff must always know, understand and follow their resident's care plan. If unable to implement any part of the plan, notify your charge nurse or MDS coordinator, so that this can be documented or the care plan changed if necessary."

The following nursing note dated 5-28-18 indicated; "Set up help only with eating." Another note dated 4-28-18 indicated; "Set up help only with eating." The same note is documented on 3-28-18. On 3-15-18 a quarterly dietary assessment is documented in the progress notes which stated "Current diet order Regular, ground texture - no hot dogs, choking hazard, continues with same diet order." A 2-28-18 nursing note indicated; "Set up help only with eating." A 1-28-18 nursing note indicated; "No set up or physical help from staff with eating." The physician's order for supervision with meals occurred on 12-7-16, and on 12-5-17 through 1-5-17 the Speech therapy evaluation continued to document the need for supervision with meals, yet nursing did not follow or adhere to the orders, which never changed.

On 6-12-18 at 3:06 p.m. the nursing notes describe the Resident as "sitting up in wheel chair in room, denying pain or hurting in the last 5 days"

On 6-12-18 at 6:45 p.m. the nursing notes describe the following; 2 nurses were called to Resident #62's room by a CNA who was performing the "Heimlich Maneuver" unsuccessfully. The Resident was noted to have large amounts of chewed food in the mouth. A nurse then began the "Heimlich Maneuver"

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unsuccessfully, and the second nurse then tried to perform the maneuver, and was unsuccessful. The Resident was without respirations or pulse. The Resident was then placed on the floor and the visible food was removed from the Resident's mouth. The nurses were unable to suction the Resident due to large amounts of chewed food in the mouth. Emergency 911 was called, abdominal thrusts were attempted, and CPR (Cardio Pulmonary Resuscitation) was begun. An "Ambu bag" with oxygen was used to ventilate the Resident but had no effect as there was no air flow into the Resident's airway. The primary Care Physician was in the building, and arrived in the room and pronounced the Resident deceased at 6:20 p.m.

On 7-12-18 at 11:00 a.m. LPN D was interviewed and asked what she knew about the situation. She stated she was the charge nurse who responded to the Resident that night. She stated when CNA B called her she had been serving meal trays and feeding other residents on the unit, and she ran to the room and found CNA B applying the Heimlich maneuver and she took over for her. She stated a second nurse came and attempted the same maneuver with no success. LPN D stated that there was a third nurse on duty that evening, however, she was busy orienting a new nurse and was not involved. She stated that she and the second nurse laid the Resident on the floor, as he was found sitting in his wheel chair, and continued to sweep the food from his mouth, but it was lodged deeply in his throat and could not be removed. She went on to say they tried to use CPR, and the oxygen and ambu bag to ventilate the Resident, but too much food was in his throat and blocked the airway. She stated the doctor was in the facility doing

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rounds, and responded to their call, and he pronounced the Resident expired. She was asked who the CNA was, and she responded with a name (CNA B) and was asked to call the CNA so that she could be interviewed as well.

On 7-12-18 at 11:15 a.m. CNA B was contacted via telephone and interviewed. CNA B stated she had delivered the tray from the kitchen to Resident #62's room and "set it down and left" " it looked like a whole sandwich" and then "I went back to the dining room" to feed other residents. She stated she was already busy feeding and orienting a new CNA, and she was not responsible to supervise him. She stated "we were already short staffed and with only 3 CNA's that is 20 residents each" to care for "and we had 2 new CNA's we were training as well. I couldn't stay with him." She further stated "I was just doing them a favor, because they refused his dinner tray, and a new one had to be sent down to the unit." Since I was in the dining room already I just took it." She went on to say when she was finished in the dining room around 6:00 she went down to the unit and started collecting trays from the rooms, and found Resident #62 slumped over in his chair, with lots of food in his mouth and one large piece (the size of a quarter) of uneaten chicken patty in front of him. She called for help and started the Heimlich maneuver.

The Primary Care Physician's discharge summary documented Resident #62's cause of death as "choking".

Staffing records were reviewed and revealed That indeed there were 3 CNA's on duty that evening and 2 new CNA orientees, and 1 new LPN

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orientee.

The Dining Services Manager (DSM) was interviewed on 7-12-18 at 11:30 a.m., and a Menu for 6-12-18, and a tray card were requested for Resident #62. She stated that she would print it from the computer program. The documents were reviewed and revealed that the Resident was on a "Regular/ground" diet for all three meals. The documents also reflect that changes were made to the computerized documents on 6-13-18, one day after the Resident died and was discharged, altering the record.

The document changes were made by a Registered Dietician (RD) with computer access known as HL7 interface (employee C). The DSM stated that this particular RD came in sometimes and updated resident records. Those old standing orders from the DSM documented on 11-20-17, and the new changes made by the RD on 6-13-18 after the Resident expired are below.

DSM 11-20-17 - Lunch main dining room, dinner main dining room, no hot dogs choking hazard, dislikes raw carrots - but likes cooked carrots. ice tea, allergic: Almonds, shell fish.

RD 6-13-18 - Lunch eats in room, dinner eats in room, no hot dogs choking hazard, No raw carrots or cooked carrots. ice tea, allergic: Almonds, carrot, shell fish. According to facility staff, after discharge, the computer system defaults to "eats in room."

The DSM was further interviewed and stated she was not present the evening of 6-12-18, however the cook who served the meal (Employee D) had reported to her the circumstances of the incident.

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Employee D was not in the building on 7-12-18. The DSM stated that the meal for dinner the evening of 6-12-18 was an omelet, and the nursing staff refused it saying eggs made the Resident have diarrhea, so a chicken patty sandwich was sent as the alternative, and it should have been ground and was not.

The facility Administrator and Director of nursing were made aware of the failure of the facility to protect Resident #62 from accidents and hazards at the end of day debrief on 7-12-18 at 4:30 p.m.. They did not offer any comment or documentation in regard to the incident at that time.

On 7-13-18 the DSM was asked if she had any counseling or disciplinary forms for the cook (employee D) and she stated yes. She had 2, "one from back in March 2018" "when she didn't use the right serving utensils to do special diets right, and this one for not doing (Mr. name) Resident #62's diet right." She supplied the most recent form which was dated 7-12-18 at 6:00 p.m. The Dining Services Manager had originally written it on 6-13-18, and Employee D's signature date was written over and changed. It appeared to be signed on either 6-13, 6-15, 6-17, 6-19, or 7-13-18. She was asked why the Employee D signature date had been changed, and she stated she did not know, but the form was completed by her on 6-13-18, and signed by the employee on 7-13-18.

It is notable to mention, Employee D was observed in the kitchen on 7-13-18 at 4:30 p.m. preparing the dinner meal, and serving it.

On 7-13-18 at 10:00 a.m., The Facility Administrator stated she had 3 "Plans Of

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Correction" (POC), for the incident, and requested a finding of "Past Non-Compliance" (PNC). The facility Administrator insisted that the multiple failures involved in the death of Resident #62 had been self identified and corrected prior to this survey with a correction completion date of 6-18-18, and she supplied them. She went on to say Employee D "wrote in her statement that she had chopped the sandwich." The Admin then stated "it should have been ground, he had issues, he ate really fast or not at all."

Past non-compliance was not the case however, as another resident, Resident #1 had no CP for orders or diet and supervision with diet, and was not being tracked in Quality audits.

On 7-13-18 at 10:00 a.m., Staff counseling forms for this incident, and Quality Assurance and Process Improvement (QAPI) monthly meeting topics and sign in sheets only were requested from the Administrator. The first document received was from the Human Resources Director (HRD) at approximately 10:15 a.m. The form was the counseling form first seen in the DSM office and was found to have the date altered from 7-12-18 to 6-12-18 from the identical document received earlier from the DSM. The HRD was asked if she altered the document, and she stated that she did. She was asked why it was altered, and she said "the date was wrong so she fixed it this morning." She was asked if she was involved in the counseling or had any part in completing the document, and she stated "no". she was asked why she would alter a document she did not complete and had no knowledge of the events involved in the counseling. She did not answer.

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Quality audits to support the Plans of correction were given to surveyors and included a corrective action audit of "supervision during meals" audit form. The form listed the names of all residents included in the audit, with blank columns for each meal heading, which was for staff to sign if they supervised the resident listed during "Breakfast, lunch, and dinner" and each day's date. Resident #1 was not named on the document, and so was not being supervised, and was ordered by the physician on 3-15-18 to have a chopped meat diet add sauce and gravy to meats, which was also recommended by the RD on 6-1-18. This order was never discontinued. The Resident was documented in nursing progress notes often, and up until 3 days before survey to require one staff member assistance with eating. This indicated not all residents who had special diets or required supervision and assistance were included in the audit, voiding the validity of the corrective action.

The investigation review indicated the following;

Resident #62 had a consistent history of choking, aspiration, poor judgement, and eating so quickly he was unsafe to eat without supervision. His diet order was regular ground texture with supervision. Speech therapy documented the Resident would require verbal cues by staff on a regular basis to decrease his risk of aspiration and choking, The ST also indicated the Resident had trouble with regular bread as Resident #62 would eat it more quickly than other foods and take larger bites. Overall the ST stated at discharge from services that the Resident was impulsive, took large bites very quickly, and did not chew his food well. The CNA care card was incomplete. The nursing care plan was incorrect,

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and incomplete, and did not follow the facility policy. Nursing staff did not provide supervision as was ordered. On 6-12-18 the Resident was found alone in his room expired from choking, according to the physician, nurses, and CNAs. Staffing was insufficient to care for residents, train new staff, and provide this Resident with supervision while eating, according to all staff accounts. The Dining Services Manager, the Administrator, the Charge nurse, the CNA that delivered the meal, and the cook who prepared the meal all stated that the meal was incorrect for the Resident, and the Resident was left alone in his room to consume it. The cook who was negligent in preparing the special diet meal for Resident #62 on 6-12-18, had been counseled for this issue previously in March 2018, and was still preparing meals during survey. The Plan of correction audits did not include others found to be at risk while on survey, and the following documents related to the investigation were found and observed to be altered by facility staff during the survey:

On 7-13-18 at 4:30 p.m., the incident was reviewed again with the Administrator, Corp RN, Regional Vice President, and Director Of Nursing at the end of day meeting. No further information was provided.

COMPLAINT DEFICIENCY

2. For Resident #1, the facility staff failed to provide the correct diet. Resident #1 chicken was not chopped.

The findings included;

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Resident #1 was initially admitted to the facility on 3-15-18 with diagnoses including but not limited to; Chronic obstructive pulmonary disorder, Dementia, delusional disorders, hypertension, seizures, major depression, was anemic, weighed 89 pounds, Dysphagia oral phase, and had a history of falls. The Resident was a "Full Code" status, meaning that CPR was requested to be performed as needed.

The Full Admission Minimum Data Set Assessment (MDS) with an ARD (assessment reference date) of 3-23-18 coded Resident #1 as having a BIMS (brief interview of mental status) of "2" out of a possible 15, or severely cognitively impaired. Resident #1 was coded as needing extensive assistance with ADL's (activities of daily living) such as bathing and dressing from 1 staff member, and for eating required supervision and set up help.

The most recent MDS with an ARD of 6-25-18 was a significant change full assessment, and coded the resident as requiring extensive assistance from one staff member, and now required extensive assistance from 1 staff member for eating.

Physician orders and Registered Dietician (RD) notes indicated that on admission 3-15-18 the Resident was ordered to have a "chopped meat - add sauce, gravy to meats regular diet" which was not discontinued by the physician. The RD documented on 6-1-18 reflects the same. On 6-25-18 the same RD documents regular diet but does not specify consistency. The physicians order was never discontinued. Nursing notes denote the Resident requires limited to total

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feeding, supervision or hands on assistance from 1 staff member to eat, in some notes, and states independent in others.

On 7-10-18 during initial tour and observation of the lunch meal, Resident #1 was observed in her room with a meal tray in front of her with a whole chicken patty on it. The meat was not chopped. The Resident was just looking at the food, however, not consuming it. The Resident was noted to be edentulous, and would not be able to chew the patty sufficiently to swallow it, causing a choking hazard. The Resident suffered from seizures, oral phase Dysphagia (difficulty eating), chronic obstructive lung disease, and was confused, putting the Resident at greater risk for aspiration. No staff were in the room to assist the Resident from 11:45 a.m., until tour and observations ended on this hall at 12:45 p.m.

The Resident had not been evaluated by Speech therapy ever during her entire 4 month stay.

Review of Resident #1's plan of care was conducted and revealed the interventions below for Diet:

Diet - Interventions for: "Encourage to dine in dining room as appropriate", "monitor intake, weight, provide diet order, review preferences, and monitor need for increased nutritional intervention." were all applied to the care plan originally on 3-25-18 on admission.

The care plan interventions added after admission were; "Monitor for signs and symptoms of "Aspiration", and "Speech Therapy screens as needed, treat as ordered" were added to the care plan on 7-11-18 after survey was in

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F 808	Continued From page 111 progress under a focus for "At risk for Cardiac Respiratory status". Resident #1's diet order and assistance needed from staff to eat, was never documented on the care plan, and so staff would not know what to provide. On 7-12-18, and 7-13-18 at 4:30 p.m., the facility failure was reviewed with the Administrator, and Director Of Nursing at the end of day meeting. No further information was provided.	F 808		
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 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 documentation review, the facility staff failed to know how to sanitize dishes, and serving equipment on which to serve food.	F 812	1. No residents cited with this deficiency. 2. All residents have the potential to be affected by this deficient practice.	8/14/18

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	495422	A. BUILDING _____ B. WING _____	C 07/13/2018

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 812	Continued From page 112 The issue identified in the kitchen was an inability to sanitize dishes in the 3 compartment sink. The findings included: On 7-10-18 at 11:15 a.m., initial tour of the main kitchen began. The Dining Services Manage (DSM) Admin E was in the kitchen area near her office. She was asked to provide a tour with the surveyor. Tour was conducted and concluded at the 3 compartment sink where Admin E was asked to show how dishes and pots were sanitized in the sink. Admin E stated "we fill the sinks with these chemicals", and showed 2 dispensers on the wall behind the sink. Hoses were attached to the boxes, and traveled from the chemical boxes on the wall, into 2 of the three sinks. She was asked to do what she would normally do, when washing dishes, and she seemed to be confused as to which hose filled which sink. She moved the hoses into the sinks, changing them three times, and reading the boxes full of chemicals. She was asked which way the dishes would proceed through the 3 sinks, and she then said the first sink was for washing, the second sink was a clean water rinse, and the third sink was for sanitizing. She was instructed to fill them, as she would normally. She proceeded to fill all 3 of the sinks with hot water, each sink was one half full. She seemed unsure of when to turn the knob on the chemicals, to allow them to infuse the water flow. After each of the three the sinks were half full, she turned the water back on, and turned the	F 812	3. Dietary staff will be in-serviced on use of the three compartment sink which includes concentration of chemicals, to include a competency assessment by the RD/designee. 4. Two audits will be completed weekly for four weeks then one audit weekly for eight additional weeks on dietary staff on utilizing the three compartment sink by administrator/designee. Audits will be taken to the QAPI committee monthly for three months for review and revision as needed.	

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F 812	Continued From page 113	F 812		

knob, which allowed the chemicals to infuse.

When the sinks were three quarters full she turned off the water and chemical mixture. I asked her how she could tell if the sanitizing agent was at the proper strength, she stated "We use these test strips, and she dipped one in the sanitizer sink. The strip was a litmus type paper and would change colors to indicate chemical concentration.

The color key picture on the bottle, which held the strips, showed a different color for the amount of "parts per million" (ppm) chemical strength. The paper strip barely changed color, and did not register on the scale given in the color key. She dipped it in again, and swirled it in the water, and there was still no change. She threw the test strip away, turned the water and chemical mixture back on and continued filling the sink.

When the sink was almost overflowing, she turned the chemical water mixture off again and took out a new test strip and swirled it in the water mixture. It still did not reach sanitizing strength, and was well below 50 ppm. This was an unacceptable level.

She was asked what happened, and she said she did not know. I asked her if she had received training on use of the chemicals, and she stated she had, however, it had "been a long time, and I have forgotten." She was asked it the chemicals had been correct, how long would she have left the dishes in the sanitizer, in order for them to be sanitized, and she stated "20-30 seconds I think." The information for length of dwell time was written on the chemical boxes above the sink, and the manufacturer's stated dwell time for the

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F 812	Continued From page 114 dishes in the sanitizer liquid at the proper concentration was 70 seconds. This was shown to the DSM, so she would know where to find it again. The DSM was told she needed to find out what went wrong with the sanitizing chemical concentration, and get back to me. She stated she would. Tray line was then observed without deficient practice. The DSM approached the surveyor after tray line and stated she should have had the chemical turned on the whole time she was filling the sink, and not wait to turn it on. A list of facility infections was reviewed. There was no evidence of gastrointestinal outbreak at the facility. The Administrator and Director of Nursing were notified of the kitchen issues on 7-11-18 at 4:30 p.m. No further information was provided.	F 812		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, facility staff failed to ensure a homelike environment, and failed to prevent pervasive odor throughout the facility for 2 residents (Residents #28 and	F 921	1. Residents #28 and #34 rooms were cleaned on 07/13/2018. The carpet on the 400 hall was shampooed on 07/25/2018.	8/14/18

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F 921	Continued From page 115 #34) of the 24 residents in the survey sample. During the initial tour of the facility on 7-10-18 at 12:00 noon, foul odors were noted on the 400 hall Unit, and in the room of Residents #28, and #34. During the course of the survey, foul odors persisted on that hall. The findings included: During the initial tour of the facility on 7-10-18 at 12:00 noon, foul odors were noted on the 400 hall Unit, and in the room of Residents #28, and #34. During the course of the survey, foul odors persisted on that hall. On that same day, during the initial tour of the facility, several surveyors noticed foul odors on all of the halls. The halls were carpeted, and staff were questioned during the survey about the odors. The staff response was that accidents by Resident incontinence had soaked into the carpeting in the hallways and was irremovable. On 7-11-18 at 3:40 p.m., two surveyors were sitting at the only nurses station in the building, and a very pungent, foul urine smell was noted. An interview was conducted with the nurse, who stated there was a resident on the unit who often refused to bathe or shower and that she thought that might be the smell. The nurse stated she would ensure that resident was provided a shower. On 7-12-18, and 7-13-18 the foul odor was still pungent noticed on the halls. At no time during survey was the carpet cleaned, as an intervention to the pervasive odor in the	F 921	2. All resident rooms and carpeted areas have the potential to have a foul odor. Resident rooms and common areas were audited for any odors and cleanliness concerns. 3. Housekeeping staff were in-serviced on best practices for cleaning to include a check off list by Administrator/designee. Housekeeping director in-serviced on carpet shampoo schedule by Administrator/designee. 4. Audits of resident rooms and common area two times a week for 12 weeks by Administrator/designee for any odors or cleanliness concerns. Audits will be taken to the QAPI committee monthly for three months for review and revisions as needed.	

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F 921	Continued From page 116	F 921		

facility.

In the room of Residents #34, and #28, who were room mates, the shared bathroom was especially strong with the foul urine smell. The CNA assisting the Residents with ADL care stated both Residents were incontinent of bowel and bladder, and that Resident #28 had just been treated for a urinary tract infection.

The Nursing unit manager stated the Housekeeping Department utilized a schedule where rooms were cleaned regularly.

On 7-12-18 an interview was conducted with the Housekeeper working on the hallway who stated there were a couple of residents on the hall often refused to shower. The Housekeeper stated that the Housekeeping staff cleaned the rooms and halls daily, but the carpet was not cleaned by them.

A General Observations of the Facility Tour was conducted on 7-12-18 at approximately 2:00 p.m. During the Tour, foul odors of urine were noticed on all of the halls. Several housekeeping staff persons were observed to be cleaning rooms during the Facility Tour.

During the end of day debriefing on 7-12-18 at 4:30 p.m., the facility Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

No further information was provided.