STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495358		C 04/05/2019

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/2/19 through 4/5/19. Complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 90 at the time of the survey. The survey sample consisted of 43 current resident reviews and four closed resident reviews.	F 000	The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegations in the 2567. The facility is completing the allegation of compliance because it is required by State and Federal law. The the alleged deficiencies as stated and the scope and severity at which they are cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the alleged deficiencies. This includes, but is not limited to, the alleged content / summary of interviews, the timing / chronological sequence of events and contact with health care professionals, and the description of the care provided to the residents. The facility reserves its right to continue disputing, appealing and contesting these alleged deficiencies and taking any action related to or arising therefrom in any other forum as needed.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550	F 550 It is the practice of this facility to treat residents with dignity and serve food in a dignified manner.	5-9-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roger Frank, LNHA
TITLE: ADMINISTRATOR
(X6) DATE: 4/26/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, it was determined that the facility staff failed to serve food in a dignified manner in two of one facility dining rooms, (main dinning room); and for three of 45 sampled residents, (Resident #501, #39 and #50). 1. During a meal observation in the main facility dining room on 4/2/19 residents were observed being served and eating the lunch meal on trays cafeteria style and not in a homelike dining manner. 2. The facility staff failed to ensure a dignified dining experience during the lunch meal on 4/2/19. Resident #501 was observed seated at a table waiting approximately eleven minutes for her lunch meal to be served, while her tablemate's and other residents were eating their lunch meal.	F 550	I Past non-compliance cannot be corrected. II The seating chart for the assisted dining room was updated by the Dietary Manager. Residents served in the restorative dining area will be served meals directly on the table and not on trays as in cafeteria style. Residents seated at the same table will be served at the same time. Residents who require feeding and are seated at the same table will have meals fed at that table before proceeding to the next table. Employees working with residents during meals will maintain conversation with the resident to engage the residents during the dining experience.	

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F 550	Continued From page 2 3. During a meal observation in the assisted dining room on 4/2/19, Resident #39, was not provided her meal and fed by CNA #7 (Certified Nursing Assistant) until 12:55 p.m., approximately 15 minutes after her tablemate began eating his meal. Resident #50's tablemate finished eating at 1:04 p.m., and approximately 31 minutes elapsed before staff attempted to feed Resident #50. Staff feeding residents were observed talking amongst themselves and not interacting with the residents they were assisting. The findings include: 1. On 4/2/19 at approximately 12:39 p.m., an observation was made of the first floor's main dining room. Eight residents sitting around four different tables located near the left side of the dining room were served their meals on plates placed on cafeteria style trays by OSM (other staff member) # 3. She then placed the trays on the table without removing the plates, cups, and utensils from the trays. The residents then ate their food from the trays cafeteria style and not in a homelike dining manner. Two out of eight resident had a BIMS (brief interview for mental status) score of 13 out of 15, 13 indicating that they were cognitively intact for daily decision making. These two residents didn't mind having their food served on the tray. However six of eight resident that were cognitively impaired (they were not interviewable) for daily decision making were not served in a dignified manner. On 04/04/19 8:17 a.m., an interview was conducted with CNA # 1. When asked about the	F 550	III On or before May 4, 2019, the Director of Nursing, QA Nurse, Unit Managers or designee will complete an educational review for facility nursing staff and current agency staff on: • F 550 regulation as it pertains to respect and dignity • Serving resident food off the tray and placing it directly on to the table • Serving residents seated at the same table, at the same time. • Assisting residents that need to be fed, when seated at the same table. • Talking with residents during the meal to promote a dining experience • If in dining room, each nursing staff member can assist with tray delivery and feeding as needed. Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift.	

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F 550	Continued From page 3 process of serving food to the residents, CNA # 1 stated, "We serve the resident from the big tray cart. Remove the plates from the tray before placing the food plate on the table in front of the residents. Each resident is served individually by their ticket number." When asked if residents should be served their food on food trays which are kept there throughout their dining experience, CNA # 1 stated, "They shouldn't be served their food on the trays. We are supposed to remove the plates from the tray and place them on the table." When asked what should have been done, CNA # 1 stated, "We received training from name of OSM [other staff member # 1, the facility dietary manager] how to serve all residents even if they are assisted dinners." On 4/4/19 at 03:19 p.m., an interview was conducted with OSM # 1, regarding the observations above. When asked if residents eating in the dining room should be served their food on the cafeteria style food trays, OSM # 1 stated, "No, you are right, all residents should be served in the same manner, and food should be off the tray before serving it to the residents." When asked why this should have been done, OSM # 1 stated, "We are working on providing residents a fine dining experience as all other residents." A review of the facility's policy on "Privacy-Dignity" documented as followed: "1. All residents shall be treated with dignity and respect at all times." "2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth." On 04/03/19 at approximately 6:01 p.m., ASM	F 550	IV Beginning 5/6/19 the Director of Nursing (DON), Unit Managers or Staff Development Coordinator or designee will conduct audits during meal service to ensure that dignity is maintained in relation to: • tray delivery (one table at a time and food being removed off trays and placed on the table, in the dining room) • Assisting residents at the same table at the same time • staff interaction with residents during meals • all nursing staff present in the dining room are to assist with either meal delivery or assisting with feeding residents as indicated This audit will be conducted 5 days per week for 2 weeks, then 2 days per week for 2 weeks, then weekly X 4 weeks, then monthly. Any discrepancy noted during the audit will be corrected at that time.	

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F 550	Continued From page 4 (administrative staff member) # 1, the administrator, ASM # 2, director of nursing, and ASM # 3, regional vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to ensure a dignified dining experience during the lunch meal on 4/2/19. Resident #501 was observed seated at a table waiting approximately eleven minutes for her lunch meal to be served, while her tablemate's and other residents were eating their lunch meal. Resident #501 was admitted to the facility on 12/19/18 with the diagnoses of but not limited to metabolic encephalopathy (1), Type 2 Diabetes Mellitus, high blood pressure, legal blindness, gastro-esophageal reflux disease, and osteoarthritis. Resident #501 Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 12/26/18, coded Resident #501 as moderately cognitively impaired in her ability to make daily life decisions. The resident was coded as requiring setup assistance for eating. On 4/2/19 between 12:33 to 1:15 p.m., an observation was made of the main dining room. One resident, Resident #501 was sitting at a table with three other residents. On 4/2/19 at 1:06 p.m., it was observed that two people at the table with Resident #501 were served their food. At that time another resident was brought into the dining room and seated at another table behind the table Resident #501 was sitting at. The new resident received her food.	F 550	Results of the audits will be submitted by the DON monthly to the Quality Assessment Performance Improvement (QAPI) committee for its review and recommendation. The QAPI committee consists of the facility Administrator, Director of Nursing, Unit Manager, MDS nurse, Business Office Manager, Activity Director and the Medical Director, who attends at least quarterly.	

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F 550	Continued From page 5 On 4/2/19 at 1:14 p.m., it was observed the third resident at the table with Resident #501 was served their food. Another resident was brought into the dining room and seated at another table behind the table Resident #501 was sitting at. The new resident received her food. On 4/2/19 at 1:15 p.m., Resident #501 received her food. On 4/4/19, multiple attempts were made to interview Resident #501. However, Resident #501 was not available. On 4/4/19 at 8:17 a.m., an interview was conducted with CNA (certified nursing assistant) #1 regarding the process for serving residents seated at the same table, CNA #1 stated, "You don't serve the food until the entire table's food is ready." When CNA #1 was asked if some of the residents at a table were served their food and some had not would you serve food to another table, CNA #1 stated, "You should not serve the food until all are there and you should not have served another table until all are served at the first table." A review of the facility's policy "Privacy - Dignity documented in part, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality ...1. Residents shall be treated with dignity ...at all times. 2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth." On 4/4/19 at 4:15 p.m., ASM (Administrated Staff Member) #1, the administrator and ASM #2, the	F 550		

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F 550	Continued From page 6 DON (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. (1) Metabolic encephalopathy: Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. This information was retrieved from https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page 3. During a meal observation in the assisted dining room on 4/2/19, Resident #39, was not provided her meal and fed by CNA #7 (Certified Nursing Assistant) until 12:55 p.m., approximately 15 minutes after her tablemate began eating his meal. Resident #50's tablemate finished eating at 1:04 p.m., and approximately 31 minutes elapsed before staff attempted to feed Resident #50. Staff feeding residents were observed talking amongst themselves and not interacting with the residents they were assisting. Resident #39 was admitted to the facility on 10/26/17 with the diagnoses of but not limited to dementia, high blood pressure, bipolar disorder, depression, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/1/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. Resident #50 was admitted to the facility on 1/27/17 with the diagnoses of but not limited to stroke, skin cancer, cardiomyopathy, dementia,	F 550		

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F 550	Continued From page 7 congestive heart failure, glaucoma, atrial fibrillation, acute kidney failure, aphasia, and degenerative disease of the nervous system. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 2/5/19. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, eating, dressing, and transfers. On 4/2/19 from 12:15 p.m. to 1:40 p.m., an observation was made of the assisted care dining room. At 12:30 p.m., a resident was observed being brought into the dining room by staff and seated at table 6 by himself. At 12:33 p.m., Resident #39 was brought into the dining room and seated at table 5. At 12:34 p.m., another resident was observed being brought into the dining room by staff and placed at table 5 with Resident #39. At 12:38 p.m., staff was observed brining Resident #50 into the dining room and placing the resident at table 4. At 12:40 p.m., another resident was brought in by staff and seated at table 4 with Resident #50. At table 5, the resident brought in at 12:34 p.m., was provided his tray at 12:40 p.m. Resident #39, who arrived to the dining room at 12:33 p.m., was not provided her meal and fed by CNA #7 (Certified Nursing Assistant) until 12:55 p.m.. This was approximately 15 minutes after her tablemate began eating his meal. At table 4, the resident seated at the table with Resident #50, was provided her meal at 12:44 p.m., and CNA (certified nursing assistant) #6 sat down to feed her. This resident was done with	F 550		

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her meal at 1:04 p.m. CNA #6 then went to table 6 and began feeding the resident seated there at 1:05 p.m. The staff did not attempt to feed Resident #50 at this time. At 1:35 p.m., approximately 57 minutes after being brought to the dining room and approximately 31 minutes after her tablemate finished eating; CNA #7 was observed attempting to feed Resident #50. At this time, Resident #50 was observed in a deep sleep and was not aroused to by CNA #7 to be fed. CNA #7 closed Resident #50's uneaten tray, and was observed taking Resident #50 and the resident's meal tray out of the dining room. This was resident observed awake at times early during dining and could have been fed by a separate staff member while her tablemate was being fed.

At 1:05 p.m., LPN #7 (Licensed Practical Nurse), the MDS nurse, came into the dining room and sat down in a chair near the window next to table 6 where a resident was being fed by CNA #6. LPN #7 sat there for the remainder of the lunch service (until at least 12:40 p.m.), talking to the staff who were feeding residents, and was not doing anything to assist residents who still needed to be fed. CNA #6 and CNA #7 were engaged in talking to LPN #7 and observed having minimal interaction with the residents they were feeding.

On 4/3/19 at 11:07 a.m., an interview with LPN #7, she stated that she was there "to monitor for choking." When informed it was noted that the residents who were in the dining room for supervision only were all seated on the opposite side of the dining room from where LPN #7 was sitting, LPN #7 had no comment. When asked if

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F 550	Continued From page 9 she, as an LPN was trained and able to assist with feeding residents, LPN #7 stated she could have. LPN #7 further stated, "We need to be more mindful in how we place the residents at the tables, who needs to be fed and who is just supervision. Both residents at a given table should be fed at the same time." When asked about engaging the staff who were feeding residents in unrelated conversation rather than the staff engaging with the residents, LPN #7 stated she did not realize she was doing that. On 4/3/19 at 10:47 a.m., in an interview with CNA #7, she stated that residents at the same table should be fed at the same time, that it is a dignity issue. CAN #7 further stated that staff should be interacting with the residents and not each other; and that staff who are not assisting should not be hanging out in the dining room during the meal. On 4/4/19 at 8:24 a.m., in an interview with CNA #1, she stated that all the residents at the table should be served at the same time. CNA #1 stated that if there are two people at a table that require feeding, the residents should be fed at the same time by two different staff. CNA #1 stated that if one resident at the table eats independently or requires supervision only, and the other resident at the table requires feeding by staff, that staff should feed the resident that requires feeding at the same time the independent eater gets their meal. After feeding one at the table, then staff should feed the next one at the same table if no one else was available to feed them at the same time, before moving to another table. CNA #1 stated you should concentrate on the resident being fed and interact with them, not the other staff in the dining room.	F 550		

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F 550	Continued From page 10 On 4/5/19 at 9:47 a.m., in an interview with CNA #6, when asked about the observation of feeding the resident seated at table 5 with Resident #50 and then leaving the table to feed the resident at table 6 without attempting to feed Resident #50, CNA #6 stated, "That was wrong, I should have done the same table. I feel there should be 2 staff feeding both residents at the same time." CNA #6 further stated that if there is a table where one resident eats independently and one requires staff to feed them, the resident requiring staff to feed them should be fed at the same time as the independent eater. CNA #6 stated, "There should be someone there to help her at the same time at the same table. It is a dignity and respect issue for the resident." When asked about interacting with other staff and not the residents being assisted with the meal, CNA #6 stated, "Interacting with staff during resident meal, instead of the resident is not treating the resident with dignity." On 4/4/19 at 4:30 p.m., ASM #1 and ASM #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558	**F 558** It is the practice of this facility that residents receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	5-9-19

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F 558	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure accommodation of resident needs and preferences for one of 47 residents in the survey sample, Resident #64. The air mattress box located on the footboard of Resident #64's prevented Resident #64 from independently accessing her nightstand and bathroom. The findings include: Resident #64 was admitted to the facility on 9/1/15 with diagnoses that included but were not limited to: high blood pressure, anxiety disorder, peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (1)], and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 3/2/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. The resident was coded as needing only supervision for locomotion on the unit and off the unit. A resident interview was conducted with Resident #64 on 4/2/19 at 2:51 p.m. Resident #64 was	F 558	I Prior to survey exit, Resident # 64, was asked to allow staff to rearrange her room to allow unhampered access to the entire room and her personal items. She refused the offer. The mattress pump was arranged, by nursing staff, so that it does not interfere with her navigating past the bed to access her nightstand and bathroom. The maintenance director removed the bumper pads from the wall at the head of her bed and placed a sheet of plexi glass there to allow her additional room to navigate past the bed. II On 4/25/19 the Director of Nursing completed a walk-through of each resident room to identify if there were any obstacles in rooms to prevent resident unhampered access to their personal belongings. There were no equipment issues noted to be blocking resident access to personal belongings.	

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F 558	Continued From page 12 asked if her room was set up so that she could function in the room. Resident #64 stated, "I can't get past the end of the bed to get to the bathroom to wash my hands when I want. I also can't get to my things on my night stand on that side of the bed." Two bibles and a music device were observed on the resident's nightstand. Observation of Resident #64's room revealed, the head of the bed was placed against the left wall. Behind the bed, attached to the wall, appeared to be handicapped rails placed approximately 1 foot apart. The rails prevented the bed from being flush up against the wall. The dresser was placed on the wall to the left as you enter the room. The nightstand was located on the far side of the bed, against the left wall. The bathroom door was on the right wall of the room, near the window. A "box" that controlled the air mattress, on the resident's bed, was observed on the footboard of the bed. The distance from the end of the footboard, not including the air mattress box, was two and approximately 1/3 of a square tile length (each tile is 12 inches square) from the wall. The average width of a wheelchair is 24.5 inches. (2) An interview was conducted with CNA (certified nursing assistant) #4 on 4/3/19 at 2:12 p.m. CNA #4 was shown Resident #64's room. When asked how the resident reached the bathroom or her side of the room where the nightstand was located with her Bible or music device, CNA #4 stated, "She asks us to move the box on the end of the bed and then she can squeeze through." At this time, CNA #4 shoved the bed up against the handicap handrails attached to the wall and there was a little more room but the air mattress	F 558	III On or before May 4, 2019 the DON, or unit managers/designees will complete educational reviews for nursing staff and current agency staff regarding: • F 558-- Accommodation of needs and preferences to create an individualized homelike environment to ensure that residents have access to their personal belongings Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 558	Continued From page 13 box still had to be removed from the foot of the bed to allow the resident to pass in a wheelchair. CNA #4 stated that Resident #64 likes to be independent. Observation of Resident #64 prior to this interview revealed the resident self-propelling her wheelchair in the hallway. Resident #64 demonstrated how she goes through the space, once she removes the box for the air mattress from the footboard of the bed. Resident #64 barely had enough room to get through the space to reach her nightstand and bathroom. On 4/3/19 at 2:26 p.m., an interview was conducted with administrative staff member (ASM) #1, the administrator. ASM #1 was shown Resident #64's room. The resident told ASM #1 at this time that she can't get to the other side of her room to reach her Bible and can't get to the bathroom to wash her hands. She informed the ASM #1 that she has to pick up the box, on the footboard of the bed, and place it on the bed, to get by and that is still tight for her. When asked if this was okay, ASM #1 stated the resident should have access to her things. ASM #1, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services, were made aware of the above concern on 4/3/19 at 6:02 p.m. On 4/5/19 at 1:05 p.m., a request for the facility policy on accommodation of resident needs for the resident's room was made to ASM #3. At 3:13 p.m., ASM #3 informed the survey team that the facility did not have a policy on the accommodation of needs for the resident's room. No further information was obtained prior to exit.	F 558	**IV** Beginning 5/6/19 the DON, Unit Managers, Administrator or designees, will conduct an audit of resident physical environment to ensure that resident needs and preferences for a homelike environment and accommodation of the environment is met. This audit will take place weekly X 4 weeks, then monthly for 2 months. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted monthly by the DON to the QAPI committee for its review and recommendations.	

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F 558	Continued From page 14 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447 (2) This information was obtained from the following website: thoroughlyreviewed.com/health-beauty/best-wheel-chair/	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583	**F 583** It is the practice of this facility to maintain the residents right(s) to privacy and confidentiality of his/her personal and medical records and to ensure residents have prompt delivery of postal mail. **I** During survey the Activity Director met with resident council. The council voted that it would be okay with them, to continue without mail being delivered on Saturdays. However, on April 9, 2019 the facility Activity Director reached out to the Postmaster at the local post office and requested that mail delivery begin again at the facility. Saturday mail delivery began on April 13, 2019. Past non-compliance for private information protection cannot be corrected for Resident # 23 or # 73.	5-9-19

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F 583	Continued From page 15 federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and facility document review it was determined that the facility staff failed to provide prompt delivery of the resident's postal mail and the facility staff failed to protect the resident's private information for two of six residents in the medication observation, Resident #73 and Resident #23. 1. The facility staff failed to maintain postal mail delivery for the residents on Saturdays. During the Group Resident meeting, residents stated they did not receive mail on Saturdays. 2. The facility staff failed to protect Resident #73's private information during medication administration. LPN (licensed practical nurse) #1 left a box of medication on the top of the medication cart unattended with Resident #73's name on the label, visible to anyone who may have passed by the medication cart. 3. The facility staff failed to protect Resident #23's private information during medication administration. LPN #2 was observed leaving the computer screen on the medication cart open with Resident #23's information exposed to the hallway, visible to the surveyor and easily read when walking by the medication cart. The findings include:	F 583	II On 4/4/19 the facility Administrator purchased a locked mail box which was mounted to the wall in the facility lobby by the facility maintenance staff on 4/8/19. The local mail carrier was provided with education on April 12, 2019 regarding the facility internal mail drop box for mail delivery on Saturdays. On April 13, 2019 following US Postal Service mail delivery, a member of the activity staff began Saturday mail delivery to residents who received mail. Licensed nurses will maintain resident privacy and confidentiality by closing the computer screen, when it is not in use, and securing all resident personal information when it is on top of the medication cart so that it is not visible to anyone passing by.	

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F 583	Continued From page 16 1. A group interview was conducted with four residents, who were cognitively intact, on 4/3/19 at 2:30 p.m. When asked if they received mail on Saturdays, the residents stated that they only get mail Monday through Friday because there is not enough office help to hand it out on Saturdays. An interview as conducted on 4/3/19 at 3:16 p.m., with other staff member (OSM) #5, the business office assistant. OSM #5 was asked when mail is delivered to the residents. OSM #5 stated the mail comes Monday through Friday around 11:00 a.m. The mail is received in the front office and then put in the boxes (mailboxes) for the staff members. The resident's mail is put in the activities box and they separate it and distribute it to the residents. An interview was conducted on 4/3/19 at 3:20 p.m. with OSM #6, the business office manager. When asked about the process for mail delivery to residents', OSM #6 stated that the mail is received from the post office and anything with a resident's name on it goes into the activities box. They then distribute it to the residents. When asked about mail delivery to residents' on Saturdays, OSM #6 stated, "We don't get mail on Saturday and Sundays. It's been set up that way for a long time. We don't have an actual mail box outside." When asked if the residents had access to receive mail on Saturdays, OSM #6 stated, "No, Ma'am." An interview was conducted with administrative staff member (ASM) #1, the administrator, on 4/3/19 at 3:25 p.m. regarding residents receiving mail at the facility. ASM #1 stated would have to get back with this surveyor. ASM #1 was asked at this time for a policy on mail delivery to residents.	F 583	III On April 10, 2019 the Activity Director provided education to the Activity staff on: • The location of the internal mailbox, how to unlock the mailbox and delivery of mail on Saturdays to residents who receive mail. Newly hired activity staff will receive this education during orientation. The Activity department does not employ agency personnel.	

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F 583	Continued From page 17 On 4/4/19 at 9:34 a.m., ASM #1 stated the facility did not have a written policy on mail delivery. ASM #1 stated, "After talking to my staff, based on a history of 15 -20 years ago, they requested the post office not to deliver mail on Saturdays, because it was in those big plastic bins and it was available for everyone to see. There is no one in the admissions office to receive it. Any mail collected on the weekends is brought to the facility on Monday mornings." When asked if this is following the regulations, ASM #1 stated, "I'd have to check the regulations." ASM #1 was made aware of the above concern for no delivery of mail to residents on Saturdays. No further information was provided prior to exit. 2. The facility staff failed to protect Resident #73's private information during medication administration. LPN (licensed practical nurse) #1 left a box of medication on the top of the medication cart unattended with Resident #73's name on the label, visible to anyone who may have passed by the medication cart. Resident #73 was admitted to the facility on 1/11/19 with the diagnoses of but not limited to stroke, heart failure chronic obstructive pulmonary disease (1), respiratory failure, and type 2 diabetes mellitus. Resident #73's Minimum Data Set (MDS) an admission assessment with an Assessment Reference Date (ARD) of 1/18/19 coded Resident #73 as having no cognitive impairment in her ability to make daily life decisions. The resident was coded as requiring setup assistance for eating; limited assistance for hygiene; extensive assistance for dressing, transfers, and toileting; total care for	F 583	On or before May 4, 2019 the DON, Unit Managers or designee(s) will conduct an educational review for current licensed staff as well as current agency staff regarding: • F 583: Privacy and confidentiality of resident personal and medical records • Keeping the computer screen closed during medication pass • Use of the 'walk away' button or minimizing the screen before walking away from the computer screen • Keeping resident personal / confidential information secure and not on top of or to the side of the medication carts where it can be visualized by anyone. Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 583	Continued From page 18 bathing; and as occasionally incontinent of bladder and continent of bowel. On 4/3/19 at 8:05 a.m., to 8:16 a.m., an observation of medication administration was performed. LPN (Licensed Practical Nurse) #1 was observed administering medications during this time to one resident. On 4/3/19 at 8:05 a.m., LPN #1 was observed leaving a box of Resident #73's Anoro Ellipta (2) medication on the cart with the label facing outward. The label contained Resident #73's name was visible and easily to read by this surveyor when walking by the medication cart. LPN #1 was observed walking away from the cart in the hallway to administer Resident #73's medication in her room. However, the Anora Ellipta medication remained on the top of the medication cart unattended with Resident #73's name on the label visible to anyone who may have passed by the medication cart. No one was observed to walking past the medication cart at this time. On 4/4/19 at 12:25 p.m., an interview was conducted with LPN #1. LPN #1 was asked about the process for administering medication. LPN #1 stated, "I pop the pills, check the orders in the eMAR (electronic mediation administration record). I don't check them off yet, in case the resident does not take them. Then I close the computer down so you can't see the screen and lock the cart. I knock on the door and greet them. I stay with them while they take their medication. I then wash my hands as I leave or use sanitizer." When asked about not closing or lowering a computer screen on the medication cart, LPN#1 stated, "It would be a HIPAA (Health Insurance	F 583	**IV** Beginning 4/13/14, the Activity Director will complete a weekly audit of resident mail delivery to ensure that residents, who receive mail, have it delivered to them on Saturdays. This audit will be conducted by the Activity Director weekly X 4 weeks to ensure that the process is flowing smoothly. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted monthly, by the Activity Director, to the QAPI committee for its review and recommendations. Beginning 5/6/19, the DON, Unit managers or designee will conduct audits of resident personal information to ensure privacy and verify that : • Computer screens are not left up during medication pass if the nurse walks away from the cart • Medication and treatment cart tops do not contain resident information which is private	

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F 583	Continued From page 19 Portability and Accountability Act) violation if I did that." When asked about leaving items on the top of the medication cart, LPN#1 stated, "You should have the top cleared off so no one can see any resident information, and keep the cart locked." When asked about leaving a medication box with patient label visible to anyone walking by LPN#1 stated, "It should not be left on the cart." A review of the facility's policy "Confidentiality of Information" documented in part, "Our facility shall treat all resident information confidentially...1. The facility will safeguard all resident records ...to protect the confidentiality of the information." A review of the facility's policy "Administration of Medications" documented in part, "All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis ...Wash hands before and after each administration of medication or hand sanitizer as appropriate ...Medication cart is not to be left open and unattended. Computer screen is not to be up with the Resident information when the cart is unattended." On 4/4/19 at 4:15 PM, ASM (Administrated Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. (1) Chronic Obstructive Pulmonary Disease makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs.	F 583	This audit will be completed across all 3 shifts and be conducted 5 days per week for 2 weeks, then 2 days per week for 2 weeks then weekly X 8 weeks. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted, by the DON, monthly to the QAPI committee for its review and recommendations.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 583	Continued From page 20 This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=copd&_ga=2.160000441.566140716.1522143307-139120270.1477942321 (2) Anoro Ellipta: used long term to treat chronic obstructive pulmonary disease (COPD), including chronic bronchitis, emphysema, or both, for better breathing. ANORO is not used to treat sudden COPD symptoms and won't replace a rescue inhaler. ANORO is not for asthma. This information was obtained from the website: https://www.anoro.com/ 3. The facility staff failed to protect Resident #23's private information during medication administration. LPN #2 was observed leaving the computer screen on the medication cart open with Resident #23's information exposed to the hallway, visible to the surveyor and easily read when walking by the medication cart. Resident #23 was admitted to the facility on 1/4/19 with the diagnoses of but not limited to chronic obstructive pulmonary disease (1), high blood pressure, solidary pulmonary nodule (2) and gastro-esophageal reflux disease. Resident #23's Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 1/11/19, coded Resident #23 as having no cognitive impairment in his ability to make daily life decisions. On 4/3/19 at 8:21to 8:40 a.m., an observation of	F 583		

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F 583	Continued From page 21 medication administration was performed. LPN (Licensed Practical Nurse) #2 was observed administering medications during this time to one resident. On 4/3/19 at 8:21 a.m., LPN #2 was observed leaving the computer screen on the medication cart open with Resident #23's information exposed to the hallway, visible to the surveyor and easily read when walking by the medication cart. LPN #2 was observed walking away from the cart in the hallway to administer Resident #23's medication in her room. However, the computer screen with Resident #23's information remained visible to anyone who may have walked past the medication cart. No one was observed to walking past the medication cart at this time. On 4/4/19 at12:38 p.m., an interview was conducted with LPN #2 about the process for administering medication. LPN #2 stated, "I do the rights: time, route, resident, dosage, you know all five. I ensure privacy and knock before I enter a resident's room. I introduce myself. I state why I am there. I check all identifiers; armband, room, and the resident's picture on the computer screen." When asked about not closing or lowering a computer screen on the medication cart, LPN #2 stated, "When I leave the cart, my screen is down and the cart is locked. Everything is turned over so no one could see." When informed of the above observation and asked if it was a problem to leave the computer screen open, LPN #2 stated, "Oh yes! HIPAA (Health Insurance Portability and Accountability Act). People could see the resident's name. I should not have left the screen up."	F 583		

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F 583	Continued From page 22 On 4/4/19 at 4:15 PM, ASM (Administrated Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. (1) Chronic Obstructive Pulmonary Disease makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=copd&_ga=2.160000441.566140716.1522143307-139120270.1477942321 (2) Solidary Pulmonary Nodule: is an isolated, single lesion in a round or oval shape with a diameter of ?3 cm (centimeters) in lung parenchyma (the portion of the lung involved in gas transfer), surrounded entirely by gas-containing lung tissue. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3886703/	F 583		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607	**F 607** It is the practice of this facility to maintain written policies and procedures which provide protections for the health, welfare and rights of each resident residing in the facility and to implement the abuse policies for reporting allegations of abuse	5-9-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495358		C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 23 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement the abuse policies for reporting allegations of abuse for four of 47 residents in the survey sample, Residents #63, #146, #53 and #16. 1. The facility staff failed to implement their policies for reporting Resident #63's allegation of abuse within 2 hours to the state agency and other required agencies. On 12/28/18, Resident #63 informed the facility staff of the allegation of abuse, and the facility staff failed to report the allegation to the state agency until 1/2/19. 2. The facility staff failed to implement their abuse policies and procedures for a resident-to-resident incident between Resident #146 and Resident #53. The facility staff submitted a FRI (facility reported incident) on 10/26/19 for the incident but failed to conduct an investigation and failed to submit a final report to the State Agency within five working days. 3. The facility staff failed to implement the policies for immediately reporting an allegation abuse to the administrator for Resident #16 that occurred on 10/21/18. An employee did not report the allegation to the administrator until 10/29/18, eight days after incident occurred	F 607	I Past non-compliance of reporting an allegation of abuse timely, completing an investigation or submitting results of an investigation within 5 working days for Resident's #16, #53, # 63 & # 146, cannot be corrected. Resident #146 no longer resides in the facility. Employee LPN # 11 no longer works at the facility. Employee OSM #8 no longer works at the facility II Facility staff will follow policy and procedure to immediately notify the Administrator of allegations of abuse, neglect and exploitation of residents and misappropriation of resident property. Such allegations will be reported to state officials per regulations and if an allegation of abuse, within 2 hours. Allegations will be investigated, and results of the investigation(s) submitted to the State Agency within 5 working days.	

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F 607	Continued From page 24 The findings include: 1. The facility staff failed to implement their policies for reporting Resident #63's allegation of abuse within 2 hours to the state agency and other required agencies. On 12/28/18, Resident #63 informed the facility staff of the allegation of abuse, and the facility staff failed to report the allegation to the state agency until 1/2/19. Resident #63 was admitted to the facility to the facility on 1/12/18, with a recent readmission on 2/1/19 with diagnoses that included but were not limited to: morbid obesity, diabetes, high blood pressure, and congestive heart failure [abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)]. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 3/1/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Resident #63 was coded as having rejected care daily during the look back period. The resident was coded as requiring extensive assistance of two staff members for most of her activities of daily living, including transfers. The resident was coded as being able to feed herself once set up assistance was provided. A Facility Reported Incident (FRI) dated 1/2/19, documented, "Report date: 1/2/19. Incident Date 12/12/18." The report further documented, "Resident noted on 12/12/18 to have a fall. On 12/28/18, Resident reported to have arm and	F 607	An audit was conducted by Social services / designee on 4/24/19 & 4/25/19 for Residents with BIMs of 8 & above to determine if there were any residents with concerns that they wish to report. No concerns related to abuse were reported. On 4/24/19 .& 4/25/19 the DON, Unit Managers or licensed nurses conducted skin assessments on residents with BIMS 7 & below to determine if there were any issues identified which would indicate abuse. There were no negative findings. III On or before May 4, 2019 the DON, Unit Managers or designee willconducted an educational review for facility staff on: • F 607- as it pertains to recognition, prevention and reporting abuse and neglect immediately to the Administrator. • Update and location of department head and facility Administrator phone numbers to ensure timely notification of alleged violations	

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F 607	Continued From page 25 wrist pain and stated that the injury occurred when resident was helped up off of floor. Investigation initiated." The name of an employee was documented under "Name of Employee involved." The "Final Report" dated, 1/7/19, documented, "On 1/2/19 you were contacted regarding an injury for Resident (#63). Resident reported that she did not injure her left arm when she fell but that the nurse (LPN - licensed practical nurse- #11) pulled on her arm to get her off the floor. This nurse was not informed of this until 12/28/18 when the resident came to express her concern." Under, "If applicable, date notification provided to: Responsible party - 12/12/2018; Physician - 12/12/18." There was no documented notification to APS (adult protective services), DHP (department of health professionals) or Law Enforcement. This FRI was completed by ASM #2. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, the one who completed the FRI reporting, on 4/4/19 at 3:33 p.m. When asked why she waited to report the FRI on 1/2/19 when she had knowledge of the allegation on 12/28/18, ASM #2 stated, "At my last facility, I thought we had five days to get it in. Since then I've been told the requirements for reporting within two hours." ASM #2 was asked about the requirements for reporting suspected abuse, neglect or misappropriation of resident property according to the facility policy, ASM #2 stated, "We need to send it to the ombudsman, (state agency), department of social services and depending on the outcome, to the board of nursing." When asked who is responsible for reporting to the state agency, ASM #2 stated, "Either (Name of administrator) or myself. If we are not here, the	F 607	Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift On or before May 4, 2019 either the Regional Director of Operations or Regional VP Clinical Services will conduct an educational review for the facility Administrator and Director of Nursing regarding: • F 607 as it pertains to reporting abuse within 2 hours to the state agency and other required agencies, completing an investigation and submitting a final report to the State Agency within 5 working days Newly hired department directors will receive this education during orientation. Any current management staff on FMLA, LOA or vacation will receive this training prior to returning to work.	

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F 607	Continued From page 26 nurse on the floor is responsible to send it in the two hour time frame." An interview was conducted with ASM #1, the administrator, on 4/4/19 at 3:45 p.m. When asked about the process for reporting allegations of abuse or mistreatment, ASM #1 stated as soon as it is reported to any staff in the building, it is to be reported to myself or (Name of ASM #2). Once we determine that it should be reported we have a two-hour window. If it's involving a staff member, it should be reported to all entities. For the final report, I have five working days to get it completed. When asked if an action plan was initiated for this, ASM #1 stated, "No, I gave (ASM #2) a copy of the fax cover sheets for all four entities so she would have them for future use. She and I talked about the two hour window." The facility policy, "Abuse" documented in part, "4. Identification: b. Staff are encouraged to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member...5. Investigation: Designated staff will immediately review and investigate all allegations or observations of abuse. a. The results of all investigation are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 2 hours of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. 6. Protection: a. In the event of an allegation or observation of abuse,	F 607	IV Beginning 4/29/19 the facility Administrator will maintain an audit sheet for allegations of abuse to track the timeliness of staff reporting to the Administrator, timeliness of reporting abuse allegations to the State Agency within 2 hours, completion of the investigation, protection of other residents during the investigation and submission of the investigation within 5 working days to the State Agency. Any discrepancy noted during the audit will be corrected at that time. The audit will take place 5 days per week for 8 weeks. The facility Administrator will submit results of the audit monthly, and as necessary via ad hoc, to the QAPI committee for its review and recommendations	

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F 607	Continued From page 27 the facility will immediately assess the resident, notify the physician and resident representative and protect the resident and other residents from further harm or incident. d. When specific staff is identified as being allegedly involved in the abuse allegation, the staff may be re-assigned or suspended during the investigation 7. Reporting: a. The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. 2. The facility staff failed to implement their abuse policies and procedures for a resident-to-resident incident between Resident #146 and Resident #53. The facility staff submitted a FRI (facility reported incident) on 10/26/19 for the incident but failed to conduct an investigation and failed to submit a final report to the State Agency within five working days. Resident #146 was admitted to the facility on 2/1/18 with diagnoses that included but were not	F 607		

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F 607	Continued From page 28 limited to: dementia, depression and insomnia [a condition characterized by difficulty falling asleep or staying asleep (1)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon staff for her activities of daily living. Resident #53 was admitted to the facility on 10/16/09 with diagnoses that included but were not limited to: high blood pressure, kidney stones, and intellectually disabled [persons whose general intelligence is significantly below average, and they have difficulty adapting to their environment (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/8/19, coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. The FRI (facility reported incident) dated 10/26/18, documented in part, "Date of report 10/26/18. Incident date: 10/26/18. Describe Incident: (Resident #53) was kicked in left shin by (Resident #146). No injury assessed. Residents separated. Employee action initiated or taken: Resident separated and 1:1 (one to one) provided." An interview was conducted with ASM	F 607		

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F 607	Continued From page 29 (administrative staff member) #1, the administrator, on 4/4/19 at 3:45 p.m., regarding the process for reporting allegations of abuse or mistreatment. ASM #1 stated as soon as it is reported to any staff in the building, it is to be reported to myself or (Name of ASM #2, the director of nursing). Once we determine that it should be reported we have a two-hour window. If it's involving a staff member, it should be reported to all entities. For the final report, I have five working days to get it completed. A copy of the facilities internal investigation of the 10/26/18 incident between Resident #53 and Resident #146 was requested on 4/3/19 at approximately 5:00 p.m. At 5:32 p.m. on 4/4/19, ASM (administrative staff member) #1, the administrator, informed this surveyor he could not locate an investigation on this FRI and stated there was no final report submitted to his knowledge. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 300. (2) This information was obtained from the following website: https://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/Outlook-for-Children-with-Intellectual-Disabilities.	F 607		

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F 607	Continued From page 30 aspx 3. The facility staff failed to implement the policies for immediately reporting an allegation abuse to the administrator for Resident #16 that occurred on 10/21/18. An employee did not report the allegation to the administrator until 10/29/18, eight days after incident occurred. Resident #16 was admitted to the facility on 4/18/13 with diagnoses that included but were not limited to: high blood pressure, heart failure, atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)] and unspecified conduct disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/10/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The FRI (facility reported incident) documented, "Report date: 29OCT2018. Incident Date: 21OCT2018. Describe the incident, including location and action taken: It was reported to Administrator on 29OCT2018 from dietary employee, name of [other staff member (OSM) #7] that dietary employee [Name of OSM #8, the dietary employee] intentionally did not take resident (Resident #16)'s meal order on Sunday 21OCT 2018 in the main dining room. It was reported that (OSM #8) took everyone else's order except for (Resident #16). Administrator (ASM - administrative staff member #1) was out	F 607		

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F 607	Continued From page 31 on medical leave 22-26OCT2018, and this is why (OSM #7) decided to wait to report it to the Administrator." An interview was conducted with ASM #1, the administrator, on 4/4/19 at 3:45 p.m., regarding the process for reporting allegations of abuse or mistreatment. ASM #1 stated as soon as it is reported to any staff in the building, it is to be reported to myself or (Name of ASM #2). Once we determine that it should be reported we have a two-hour window. If it's involving a staff member, it should be reported to all entities. For the final report, I have five working days to get it completed. When asked if an action plan was initiated for this, ASM #1 stated, "No, I gave (ASM #2) a copy of the fax cover sheets for all four entities so she would have them for future use. She and I talked about the two hour window." On 4/5/19 at 8:15 a.m., ASM #1 presented education on timely reporting documentation, dated 3/7/19. Review of the education revealed the documented signatures of the interdisciplinary team. When asked if the rest of the staff has been educated in timely reporting of abuse allegations, ASM #1 stated they have not taught them that as of this date. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the	F 607		

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F 607	Continued From page 32 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to report	F 609	**F 609** It is the practice of this facility that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of resident property are reported immediately, to the Administrator of the facility and to other officials in accordance with State law. **I** Past non-compliance of reporting timely or completing an investigation or submitting results of an investigation within 5 working days for Resident's #16, #53, #63 & # 146, cannot be corrected. Resident # 146 no longer resides in the facility.	5-9-19

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F 609	Continued From page 33 allegations of abuse immediately, but not later than 2 hours and/or failed to report to the state agency the final findings of an investigation for four residents in the survey sample, Residents #63, #146, #16, #53 and #2. 1. The facility staff failed to immediately (or within 2 hours) report, Resident #63's allegation of abuse to the state agency and to other officials in accordance with State law through established procedures. On 12/28/18, Resident #63 informed the facility staff of the allegation of abuse, and the facility staff failed to report the allegation to the state agency until 1/2/19. 2. The facility staff submitted a FRI (facility reported incident) on 10/26/19 for a resident-to-resident incident between Resident #146 and Resident #53, but failed to complete an investigation and report the results to the State Agency and to other officials within five working days. 3. The facility staff failed to report immediately an allegation abuse for Resident #16 that occurred on 10/21/18 to the state agency and to other officials in accordance with State law through established procedures. The allegation was not reported until 10/29/18 (eight days after the incident occurred) and was not reported to adult protective services. The findings include: 1. The facility staff failed to immediately (or within 2 hours) report, Resident #63's allegation of abuse to the state agency and to other officials in accordance with State law through established	F 609	II Department head telephone lists have been updated, and placed into the unit communication books, to ensure timely notification to the facility Administrator of an alleged violation. Facility staff will follow policy and procedure to immediately notify the Administrator of allegations of abuse, neglect and exploitation of residents and misappropriation of resident property. Such allegations will be reported to state officials per regulations and if an allegation of abuse, within 2 hours. Allegations will be investigated, and results of the investigation(s) submitted to the State Agency within 5 working days. An audit was conducted by Social Services/designee on 4/24/19 & 4/25/19 for Residents with BIMs of 8 & above to determine if there were any residents with concerns that they wish to report. No concerns related to abuse were reported.	

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	495358		C 04/05/2019

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F 609	Continued From page 34 procedures. On 12/28/18, Resident #63 informed the facility staff of the allegation of abuse, and the facility staff failed to report the allegation to the state agency until 1/2/19. Resident #63 was admitted to the facility to the facility on 1/12/18, with a recent readmission on 2/1/19 with diagnoses that included but were not limited to: morbid obesity, diabetes, high blood pressure, and congestive heart failure [abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)]. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 3/1/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Resident #63 was coded as having rejected care daily during the look back period. The resident was coded as requiring extensive assistance of two staff members for most of her activities of daily living, including transfers. The resident was coded as being able to feed herself once set up assistance was provided. A Facility Reported Incident (FRI) dated 1/2/19, documented, "Report date: 1/2/19. Incident Date 12/12/18." The report further documented, "Resident noted on 12/12/18 to have a fall. On 12/28/18, Resident reported to have arm and wrist pain and stated that the injury occurred when resident was helped up off of floor. Investigation initiated." The name of an employee was documented under "Name of Employee involved." The "Final Report" dated, 1/7/19, documented, "On 1/2/19 you were contacted	F 609	On 4/24/19 & 4/25/19 the DON, Unit Managers or licensed nurses conducted skin assessments on residents with BIMS 7 & below to determine if there were any issues identified which would indicate abuse. There were no negative findings. III On or before May 4, 2019 the DON, Unit Managers or designee will conduct an educational review for facility staff on: • F 609 -- as it pertains to reporting alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of resident property timely • A review of the location of the recently updated department head and facility Administrator phone numbers to ensure timely notification of alleged violations	

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F 609	Continued From page 35 regarding an injury for Resident (#63). Resident reported that she did not injure her left arm when she fell but that the nurse (LPN - licensed practical nurse- #11) pulled on her arm to get her off the floor. This nurse was not informed of this until 12/28/18 when the resident came to express her concern." Under, "If applicable, date notification provided to: Responsible party - 12/12/2018; Physician - 12/12/18." There was no documented notification to APS (adult protective services), DHP (department of health professionals) or Law Enforcement. This FRI was completed by ASM #2. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, the one who completed the FRI reporting, on 4/4/19 at 3:33 p.m. When asked why she waited to report the FRI on 1/2/19 when she had knowledge of the allegation on 12/28/18, ASM #2 stated, "At my last facility, I thought we had five days to get it in. Since then I've been told the requirements for reporting within two hours." ASM #2 was asked about the requirements for reporting suspected abuse, neglect or misappropriation of resident property according to the facility policy, ASM #2 stated, "We need to send it to the ombudsman, (state agency), department of social services and depending on the outcome, to the board of nursing." When asked who is responsible for reporting to the state agency, ASM #2 stated, "Either (Name of administrator) or myself. If we are not here, the nurse on the floor is responsible to send it in the two hour time frame." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical	F 609	Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift IV Beginning 4/29/19 the facility Administrator will maintain an audit sheet for allegations of abuse to track the timeliness of staff reporting to the Administrator, timeliness of reporting allegations of abuse to the State Agency within 2 hours, completion of the investigation, protection of other residents during the investigation and submission of the investigation within 5 working days to the State Agency. Any discrepancy noted during the audit will be corrected at that time. The audit will take place 5 days per week for 8 weeks. The facility Administrator will submit results of the audit monthly, and as necessary via ad hoc, to the QAPI committee for its review and recommendations	

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F 609	Continued From page 36 services, were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. 2. The facility staff submitted a FRI (facility reported incident) on 10/26/19 for a resident-to-resident incident between Resident #146 and Resident #53, but failed to complete an investigation and report the results to the State Agency and to other officials within five working days. Resident #146 was admitted to the facility on 2/1/18 with diagnoses that included but were not limited to: dementia, depression and insomnia [a condition characterized by difficulty falling asleep or staying asleep (1)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon staff for her activities of daily living. Resident #53 was admitted to the facility on 10/16/09 with diagnoses that included but were not limited to: high blood pressure, kidney stones, and intellectually disabled [persons whose general intelligence is significantly below average, and they have difficulty adapting to their	F 609		

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F 609	Continued From page 37 environment (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/8/19, coded the resident as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. The FRI (facility reported incident) dated 10/26/18, documented in part, "Date of report 10/26/18. Incident date: 10/26/18. Describe Incident: (Resident #53) was kicked in left shin by (Resident #146). No injury assessed. Residents separated. Employee action initiated or taken: Resident separated and 1:1 (one to one) provided." An interview was conducted with ASM (administrative staff member) #1, the administrator, on 4/4/19 at 3:45 p.m., regarding the process for reporting allegations of abuse or mistreatment. ASM #1 stated as soon as it is reported to any staff in the building, it is to be reported to myself or (Name of ASM #2, the director of nursing). Once we determine that it should be reported we have a two-hour window. If it's involving a staff member, it should be reported to all entities. For the final report, I have five working days to get it completed. A copy of the facilities internal investigation of the 10/26/18 incident between Resident #53 and Resident #146 was requested on 4/3/19 at approximately 5:00 p.m. At 5:32 p.m. on 4/4/19, ASM (administrative staff member) #1, the administrator, informed this surveyor he could not locate an investigation on this FRI and stated	F 609		

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F 609	Continued From page 38	F 609		

there was no final report submitted to his knowledge.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 4/4/19 at 6:48 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 300.
(2) This information was obtained from the following website:
https://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/Outlook-for-Children-with-Intellectual-Disabilities.aspx

3. The facility staff failed to report immediately an allegation abuse for Resident #16 that occurred on 10/21/18 to the state agency and to other officials in accordance with State law through established procedures. The allegation was not reported until 10/29/18 (eight days after the incident occurred) and was not reported to adult protective services.

Resident #16 was admitted to the facility on 4/18/13 with diagnoses that included but were not limited to: high blood pressure, heart failure, atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)] and unspecified

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F 609	Continued From page 39 conduct disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/10/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The FRI (facility reported incident) documented, "Report date: 29OCT2018. Incident Date: 21OCT2018. Describe the incident, including location and action taken: It was reported to Administrator on 29OCT2018 from dietary employee, name of [other staff member (OSM) #7] that dietary employee [Name of OSM #8, the dietary employee] intentionally did not take resident (Resident #16)'s meal order on Sunday 21OCT 2018 in the main dining room. It was reported that (OSM #8) took everyone else's order except for (Resident #16). Administrator (ASM - administrative staff member #1) was out on medical leave 22-26OCT2018, and this is why (OSM #7) decided to wait to report it to the Administrator." An interview was conducted with ASM #1, the administrator, on 4/4/19 at 3:45 p.m., regarding the process for reporting allegations of abuse or mistreatment. ASM #1 stated as soon as it is reported to any staff in the building, it is to be reported to myself or (Name of ASM #2). Once we determine that it should be reported we have a two-hour window. If it's involving a staff member, it should be reported to all entities. For the final report, I have five working days to get it completed. When asked if an action plan was initiated for this, ASM #1 stated, "No, I gave (ASM #2) a copy of the fax cover sheets for all four	F 609		

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F 609	Continued From page 40 entities so she would have them for future use. She and I talked about the two hour window." On 4/5/19 at 8:15 a.m., ASM #1 presented education on timely reporting documentation, dated 3/7/19. Review of the education revealed the documented signatures of the interdisciplinary team. When asked if the rest of the staff has been educated in timely reporting of abuse allegations, ASM #1 stated they have not taught them that as of this date. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610	**F 610** It is the practice of this facility to thoroughly investigate all alleged violations and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. **I** Past non-compliance in the alleged deficient practice for Resident's #53, #63 & #146 cannot be corrected. Resident # 146 no longer resides at the facility. Employee LPN # 11 no longer works at the facility	5-9-19

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F 610	Continued From page 41 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review ad clinical record review, it was determined the facility staff failed investigate an allegation of abuse and failed to protect residents during an investigation for three of 47 residents in the survey sample, Residents #63, #146 and #53. 1. The facility staff failed to ensure Resident #63 and other residents were protected during the investigation of Resident #63's allegation of abuse. The employee, LPN (licensed practical nurse) #11 named in the allegation was not suspend, and worked on 12/31/18, during the investigation. 2. The facility staff failed to investigate an allegation of abuse between Resident #146 and Resident #53. The findings include: 1. The facility staff failed to ensure Resident #63 and other residents were protected during the investigation of Resident #63's allegation of abuse. The employee, LPN (licensed practical nurse) #11 named in the allegation was not suspend, and worked on 12/31/18, during the investigation. Resident #63 was admitted to the facility to the	F 610	II An audit was conducted by Social Services/designee on 4/24/19 & 4/25/19 for Residents with BIMs of 8 & above to determine if there were any residents with concerns that they wish to report. No concerns related to abuse were reported. On 4/24/19 & 4/25/19 the DON, Unit Managers or licensed nurses conducted skin assessments on residents with BIMS 7 & below to determine if there were any issues identified which would indicate abuse. There were no negative findings. The facility will take appropriate actions in response to an alleged violation and thoroughly investigate, prevent further potential abuse while the alleged violation is being investigated and take appropriate corrective action, as a result of the investigation findings. The facility Administrator and DON will follow an investigation checklist to ensure that all aspects of abuse investigation, prevention, and protection of residents during an investigation are followed.	

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F 610	Continued From page 42 facility on 1/12/18, with a recent readmission on 2/1/19 with diagnoses that included but were not limited to: morbid obesity, diabetes, high blood pressure, and congestive heart failure [abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)]. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 3/1/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Resident #63 was coded as having rejected care daily during the look back period. The resident was coded as requiring extensive assistance of two staff members for most of her activities of daily living, including transfers. The resident was coded as being able to feed herself once set up assistance was provided. A Facility Reported Incident (FRI) dated 1/2/19, documented, "Report date: 1/2/19. Incident Date 12/12/18." The report further documented, "Resident noted on 12/12/18 to have a fall. On 12/28/18, Resident reported to have arm and wrist pain and stated that the injury occurred when resident was helped up off of floor. Investigation initiated." The name of an employee was documented under "Name of Employee involved." The "Final Report" dated, 1/7/19, documented, "On 1/2/19 you were contacted regarding an injury for Resident (#63). Resident reported that she did not injure her left arm when she fell but that the nurse (LPN - licensed practical nurse- #11) pulled on her arm to get her off the floor. This nurse was not informed of this until 12/28/18 when the resident came to express	F 610	**III** On or before, 5/4/19 either the Regional Director of Operations or the Regional VP Clinical Services will complete an educational review for the facility administrator, and Director of Nursing regarding: • F 610 as it relates to preventing, investigating and correcting alleged violations • Requirement to thoroughly investigate allegations to include gathering evidence to support such investigation • Requirement to prevent further abuse while the alleged violation is being investigated to include suspension, or removal, of the alleged perpetrator Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 610	Continued From page 43 her concern." Under, "If applicable, date notification provided to: Responsible party - 12/12/2018; Physician - 12/12/18." There was no documented notification to APS (adult protective services), DHP (department of health professionals) or Law Enforcement. This FRI was completed by ASM #2. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, the one who completed the FRI reporting, on 4/4/19 at 3:33 p.m. When asked why she waited to report the FRI on 1/2/19 when she had knowledge of the allegation on 12/28/18, ASM #2 stated, "At my last facility, I thought we had five days to get it in. Since then I've been told the requirements for reporting within two hours." ASM #2 was asked about the requirements for reporting suspected abuse, neglect or misappropriation of resident property according to the facility policy, ASM #2 stated, "We need to send it to the ombudsman, (state agency), department of social services and depending on the outcome, to the board of nursing." When asked who is responsible for reporting to the state agency, ASM #2 stated, "Either (Name of administrator) or myself. If we are not here, the nurse on the floor is responsible to send it in the two hour time frame." ASM #2 was asked to check to see if LPN #11 was suspended during the investigation. An interview was conducted with ASM #1, the administrator, on 4/4/19 at 3:45 p.m. When asked the process for reporting allegations of abuse or mistreatment, ASM #1 stated as soon as it is reported to any staff in the building, it is to be reported to myself or (Name of ASM #2). Once we determine that it should be reported we have	F 610	IV Beginning 4/29/19 the facility Administrator will maintain an audit sheet for allegations of abuse to track the timeliness of staff reporting to the Administrator, timeliness of reporting allegations of abuse to the State Agency within 2 hours, completion of the investigation, protection of other residents during the investigation and submission of the investigation within 5 working days to the State Agency. Any discrepancy noted during the audit will be corrected at that time. The audit will take place 5 days per week for 8 weeks. The facility Administrator will submit results of the audit monthly, and as necessary via ad hoc, to the QAPI committee for its review and recommendations	

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F 610	Continued From page 44 a two hour window. If it's involving a staff member, it should be reported to all entities. For the final report I have five working days to get it completed. When asked if an action plan was initiated for this, ASM #1 stated, "No, I gave (ASM #2) a copy of the fax cover sheets for all four entities so she would have them for future use. She and I talked about the two hour window." The facility policy, "Abuse" documented in part, "6. Protection: a. In the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative and protect the resident and other residents from further harm or incident. d. When specific staff is identified as being allegedly involved in the abuse allegation, the staff may be re-assigned or suspended during the investigation." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 4/4/19 at 6:48 p.m. On 4/4/19 at 7:09 p.m. ASM #2 informed this surveyor that the LPN #11 worked on 12/31/18, during the investigation, but was not assigned to Resident #63. . No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138 2. The facility staff failed to investigate an allegation of abuse between Resident #146 and	F 610		

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F 610	Continued From page 45 Resident #53. Resident #146 was admitted to the facility on 2/1/18 with diagnoses that included but were not limited to: dementia, depression and insomnia [a condition characterized by difficulty falling asleep or staying asleep (1)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon staff for her activities of daily living. Resident #53 was admitted to the facility on 10/16/09 with diagnoses that included but were not limited to: high blood pressure, kidney stones, and intellectually disabled [persons whose general intelligence is significantly below average, and they have difficulty adapting to their environment (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/8/19, coded the resident as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. The FRI (facility reported incident) dated 10/26/18, documented in part, "Date of report 10/26/18. Incident date: 10/26/18. Describe Incident: (Resident #53) was kicked in left shin by (Resident #146). No injury assessed. Residents separated. Employee action initiated or taken:	F 610		

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F 610	Continued From page 46 Resident separated and 1:1 (one to one) provided." An interview was conducted with ASM (administrative staff member) #1, the administrator, on 4/4/19 at 3:45 p.m., regarding the process for reporting allegations of abuse or mistreatment. ASM #1 stated as soon as it is reported to any staff in the building, it is to be reported to myself or (Name of ASM #2, the director of nursing). Once we determine that it should be reported we have a two-hour window. If it's involving a staff member, it should be reported to all entities. For the final report, I have five working days to get it completed. A copy of the facilities internal investigation of the 10/26/18 incident between Resident #53 and Resident #146 was requested on 4/3/19 at approximately 5:00 p.m. At 5:32 p.m. on 4/4/19, ASM (administrative staff member) #1, the administrator, informed this surveyor he could not locate an investigation on this FRI and stated there was no final report submitted to his knowledge. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 300. (2) This information was obtained from the	F 610		

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F 610	Continued From page 47 following website: https://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/Outlook-for-Children-with-Intellectual-Disabilities.aspx	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate.	F 622	**F 622** It is the practice of this facility to communicate with and provide the receiving health care institution or provider with care plan goals **I** Past alleged non-compliance related to required documentation being sent on transfer with Residents #2, #3, 10, #29, #33, #36, #60, #63, #67, #71 & #76 cannot be corrected. Resident # 36 no longer resides in the facility. **II** Facility licensed nurses will provide the receiving health care institution with necessary & required documentation regarding the resident when a resident transfers and proof of that transfer of information will be maintained in the resident record. On 4/24/19, the Resident transfer checklist was revised to include sending copies of the care plan and goals.	5-9-19

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F 622	Continued From page 48 (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider	F 622	**III** On or before May 4, 2019 the DON or Unit Manager(s) or designee will provide an in-service education for licensed nurses regarding: • F 622- as it relates to discharge documentation requirements • the revised transfer checklist • following the checklist for transfer paperwork to include a copy of the care plan and care plan goals • notification internally of all transfers out of the facility to include ER visits, hospital admissions using the internal movement notification form • Facility requirement to notify the Ombudsman of facility-initiated transfers and discharges Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 622	Continued From page 49 must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the required documentation was provided to the receiving facility at the time of a transfer for eleven of 47 residents in the survey sample, Resident's # 3, # 33, # 71, # 29, # 2, # 36, # 67, # 10, # 60 # 76 and # 63. 1. The facility staff failed to evidence Resident # 3's comprehensive care plan goals were sent with the resident to the hospital for the facility-initiated transfers to the hospital on 12/08/18 and 12/21/18. 2. The facility staff failed to provide the receiving facility with Resident # 33's comprehensive care plan goals upon a hospital transfer that occurred on 01/11/19. 3. The facility staff failed to evidence what, if any of the required documentation was provided to the hospital when Resident #71 was transferred	F 622	IV Beginning 4/29/19 the facility Admissions Director will complete an audit of all residents with transfers or discharges to ensure that documentation requirements are met with proof of such being sent and that the checklist for transfers /discharges is followed to validate that the care plan and care plan goals were sent with the resident, and that the Ombudsman is notified per regulation of the transfer/discharge. Any discrepancy found during the audit will be corrected at that time by sending the necessary paperwork to the hospital. This audit will take place 5 days per week for 2 weeks, then weekly for 6 weeks, then monthly for 1 month. Results of the audit will be submitted, by the Admissions Director, monthly to the QAPI committee for its review and recommendations.	

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F 622	Continued From page 50 to the hospital on 2/7/19. 4. The facility staff failed to evidence what, if any of the required documentation was provided to the hospital when Resident #29 was transferred to the hospital on 12/13/18. 5. The facility staff failed to evidence what, if any of the required documentation was provided to the hospital when Resident #2 was transferred to the hospital on 12/26/18. 6. The facility staff failed to evidence that Resident # 36's comprehensive care plan goals were sent with the resident to the hospital for the transfer dated 12/31/18. 7. The facility staff failed to ensure the comprehensive care plan goals were provided to the receiving facility when Resident #67 was transferred to the hospital on 1/26/19, 1/28/19, 2/3/19, 2/5/19, 2/12/19, 2/28/19, and 3/2/19. 8. The facility staff failed to evidence the documentation of the comprehensive care plan goals being sent to the receiving facility for a transfer of Resident #10 to the hospital on 12/27/18 and 3/27/19. 9. The facility staff failed to evidence the documentation of the comprehensive care plan goals being sent to the receiving facility for a transfer of Resident #76 to the hospital on 2/12/19 and 3/18/19. 10. The facility staff failed to evidence the comprehensive care plan goals were provided to the receiving facility for a transfer of Resident # 63 to the hospital on 1/17/19.	F 622		

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F 622	Continued From page 51 11. The facility staff failed to evidence the comprehensive care plan goals were provided to the receiving facility for a transfer of Resident # 64 to the hospital on 1/21/19 and 2/1/19. The findings include: 1. The facility staff failed to evidence Resident # 3's comprehensive care plan goals were sent with the resident to the hospital for the facility-initiated transfers to the hospital on 12/08/18 and 12/21/18. Resident # 3 was admitted to the facility on 08/22/2018 with diagnoses that included but were not limited to respiratory failure (1), bipolar disorder (2), and spondylolysis (3). Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/19/18, coded Resident # 3 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The nurse's "Progress Notes," dated 12/08/2018 for Resident # 3 documented, "12:10 p.m., Late Entry: This RN (registered nurse) was notified by Staff [sic] by at 6:00 a.m., that the resident was non-compliant with staying in her room under isolation precautions for RSV (Respiratory syncytial (sin-SISH-uhl) virus) [4]. Resident refusing to go back to her room and even ate breakfast in the dining room. Resident not responding to staff. Patient to be ECO'd (emergency court ordered) due to noncompliance and possible infection of other residents. Lithium levels not known at this time. Sheriff's office was notified. Magister petitioned to have Resident	F 622		

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F 622	Continued From page 52 removed from facility due to noncompliance. Facility unable to give adequate care. Resident removed from facility via (by) ambulance and taken to (Name of Hospital) to be evaluated at this time." The nurse's "Progress Notes," dated 12/21/2018 for Resident # 3 documented, "3:01 PM (p.m.) Staff notified that resident found in bedroom around 230pm (2:30 p.m.) with bloody drainage on right side of shoulder and floor from fall. Resident is A&Ox3 (alert and oriented times three, person place and time), T (temperature) 98.3, BP (blood pressure 156/78 (one hundred fifty-six over seventy-eight), p (pulse) 86, RR (respiration) 20, O2 (oxygen) 69% (percent) RA (on room air), c/o (complaint of) pain to head. Resident noted with small lump near back of R (right) side of head with skin tear in center. Moderate amount of bright red blood stabilized with gauze and compression gauze. ROM (range of motion) wnl (within normal limits), prn (as needed) Tylenol; 650 mg (milligram) po (by mouth) at 246pm (2:46 p.m.). No shoes or socks to feet. Resident was able to reach out and use call bell to notify staff, Supervisor, RP (responsible party), MD (medical doctor) notified. Resident has been sent to (Name of Hospital) ER (emergency room) for treatment. Left with EMT (emergency medical technician) out the facility via (by) stretcher at 256pm (2:56 p.m.). RP stated he would not hold bed if resident admitted to hospital." Review of the facility's "Transfer To Hospital Checklist" form dated 12/08/18 and 12/21/18 for Resident # 3 failed evidence documentation that the comprehensive care plan goals were sent to (Name of Hospital) for the transfers of Resident #	F 622		

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F 622	Continued From page 53 3 to the hospital. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." On 04/03/19 at approximately 6:00 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing and ASM # 3, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 622		

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F 622	Continued From page 54 (3) A condition in which a bone (vertebra) in the spine moves forward out of the proper position onto the bone below it. This information was obtained from the website: https://medlineplus.gov/ency/article/001260.htm. (4) A common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious, especially for infants and older adults. In fact, RSV is the most common cause of bronchiolitis (inflammation of the small airways in the lung) and pneumonia (infection of the lungs) in children younger than 1 year of age in the United States. It is also a significant cause of respiratory illness in older adults. This information was obtained from the website: https://www.cdc.gov/rsv/index.html. 2. The facility staff failed to provide the receiving facility with Resident # 33's comprehensive care plan goals upon a hospital transfer that occurred on 01/11/19. Resident # 33 was admitted to the facility on 09/25/17 with diagnoses that included but were not limited to: heart failure (1), peripheral vascular disease (2), chronic kidney disease (3) and hypertension (4). Resident # 33's most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 01/23/19, coded Resident # 33 as scoring a 6 (six) on the brief interview for mental status (BIMS) of a score of 0 - 15, 6 (six) - being severely impaired of cognition for making daily decisions.	F 622		

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F 622	Continued From page 55 The nurse's "Progress Notes," for Resident # 33 dated 01/11/19 at 3:21 p.m., documented the resident was transferred to a local hospital for evaluation after complaining of numbness and tingling in hands and legs. The note documented in part, "Resident had to purplish lips, call MD (medical doctor) gave order to send out for evaluation at hospital call RP (responsible party) states he is not a bed hold will continue to monitor." Review of the facility's "Transfer To Hospital Checklist" form dated 01/11/19 for Resident # 33 failed evidence documentation that the comprehensive care plan goals were sent to (Name of Hospital) upon the transfers of Resident # 3. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." On 04/04/19 at approximately 6:45 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing and ASM # 3, vice president of clinical services, were made aware of the findings.	F 622		

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F 622	Continued From page 56 No further information was provided prior to exit. References: (1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. (3) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. The facility staff failed to evidence what, if any of the required documentation was provided to the hospital when Resident #71 was transferred to the hospital on 2/7/19. Resident #71 was admitted to the facility on	F 622		

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F 622	Continued From page 57 2/4/19 with the diagnoses of but not limited to osteoarthritis, heart failure, diabetes, high blood pressure, and chronic kidney disease. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 2/19/19. The resident was coded as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 2/7/19 at 3:48 p.m., that documented Resident #71 was sent to a local hospital for evaluation due to wheezing in bilateral lungs and a fever. The note documented in part, "...writer called to inform MD about change in status. MD states she had 2 neb [nebulizer] tx [treatments] and was not effective, then send her out for evaluation. RP (responsible party) is resident and also grandson was called and told of this change and he wanted her back in the hospital because he says she never be this bad with her breathing. Writer called 911 and EMT (emergency medical technician) arrived at 10:50 AM and got resident and she was taken to (name of hospital, name of town) will call to check on status..." Further review of the clinical record failed to reveal any evidence of what, if any, required documentation was provided to the hospital for Resident #71's transfer to the hospital on 2/7/19. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance	F 622		

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F 622	Continued From page 58 card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." On 4/5/19 at 10:33 a.m., in an interview with RN (registered nurse) #1, a unit manager, she provided a blank copy of the transfer form. RN #1 stated, "This is the form we typically use. Care plan goals is not on the form. What all is sent should be in the progress notes. We keep a copy of the form." When asked what it meant if there was no note documenting what was sent to the hospital, and there was no copy of the completed form / checklist of what was sent to the hospital, RN #1 stated, "There is no evidence of what was sent to the hospital." On 4/5/19 at 9:30 a.m., ASM #1 (Administrative Staff Member, the Administrator stated) that the transfer form for this hospitalization of Resident #71 could not be located. No further information was provided. (1) Tylenol is used "to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever." Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	F 622		

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F 622	Continued From page 59 4. The facility staff failed to evidence what, if any of the required documentation was provided to the hospital when Resident #29 was transferred to the hospital on 12/13/18. Resident #29 was admitted to the facility on 10/29/18 with the diagnoses of but not limited to pressure ulcer, depression, Herpes Zoster with post herpetic nervous system involvement, trigeminal neuralgia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/23/19. The resident was coded as mildly impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 12/13/18 at 9:46 a.m., which documented, "Resident alert to self, remains confused to place/time/environment and emotional by crying and calling out for her mother. Resident given first dose of ABT (antibiotic) for UTI (urinary tract infection) this AM PO (by mouth)...MD (medical doctor) notified with change of condition with VS (vital signs) T (temperature) 97.4, 143/84 (blood pressure), p (pulse) 80, RR (respiratory rate) 18, unlabored, 02 (oxygen) 94% RA (on room air). New order from MD to send to (name of hospital) per RP (responsible party) request. Report given to (name of hospital) and resident transported via stretcher by EMT (emergency medical technician) and left facility at 9:20 (AM)." Further review of the clinical record failed to reveal any evidence of what, if any, required documentation was provided to the hospital for Resident #29's transfer on 12/13/18.	F 622		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 622	Continued From page 60 On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." On 4/5/19 at 10:33 a.m., in an interview with RN (registered nurse) #1, a unit manager, she provided a blank copy of the transfer form. RN #1 stated, "This is the form we typically use. Care plan goals is not on the form. What all is sent should be in the progress notes. We keep a copy of the form." When asked what it meant if there was no note documenting what was sent to the hospital, and there was no copy of the completed form / checklist of what was sent to the hospital, RN #1 stated, "There is no evidence of what was sent to the hospital." On 4/5/19 at 9:30 AM ASM #1 (Administrative Staff Member, the Administrator stated) that the transfer form for this hospitalization for this resident could not be located. No further information was provided. 5. The facility staff failed to evidence what, if any	F 622		

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F 622	Continued From page 61 of the required documentation was provided to the hospital when Resident #2 was transferred to the hospital on 12/26/18. Resident #2 was admitted to the facility on 6/28/13 with the diagnoses of but not limited to left above knee amputation, epilepsy, multiple sclerosis, gangrene of left amputation site, osteoporosis, acute respiratory failure, high blood pressure, aphasia, stroke, right femur fracture, and syphilitic heart involvement. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note date 12/26/18 at 7:47 AM that documented, "0655 (6:55 AM) CNA (certified nursing assistant) entered room and observed resident with seizure like activity. Magnet obtained and swiped over left chest VNS therapy system without improvement to seizure activity. Rectal Diazepam (1) administered as ordered at 0705 (7:05 AM) with no improvement. Multiple attempts to obtain Vitals unsuccessful d/t (due to) significant seizure activity. After Diazepam administered attempted VNS magnet swipe again without improvement. Call placed to (name of medical doctor) and updated. (Name of doctor) in facility and evaluated. Ordered to send to ER (emergency room) for evaluation and treatment. Call placed to 911 at 0715 (7:15 AM). While fellow LPN (licensed practical nurse) called Daughter and RP (responsible party) (name of daughter) as well as report called to (name of ER facility).... (Name of county) rescue squad arrived, report given and resident transferred to stretcher	F 622		

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F 622	Continued From page 62 as seizure activity continued...." Further review of the clinical record failed to reveal any evidence of what, if any, required documentation was provided to the hospital, when Resident #2 was transferred to the hospital on 12/26/18. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." On 4/5/19 at 10:33 a.m., in an interview with RN (registered nurse) #1, a unit manager, she provided a blank copy of the transfer form. RN #1 stated, "This is the form we typically use. Care plan goals is not on the form. What all is sent should be in the progress notes. We keep a copy of the form." When asked what it meant if there was no note documenting what was sent to the hospital, and there was no copy of the completed form / checklist of what was sent to the hospital, RN #1 stated, "There is no evidence of what was sent to the hospital." On 4/5/19 at 9:30 AM ASM #1 (Administrative Staff Member, the Administrator stated) that the	F 622		

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F 622	Continued From page 63 transfer form for this hospitalization for this resident could not be located. No further information was provided. (1) Diazepam rectal gel is used in emergency situations to stop cluster seizures (episodes of increased seizure activity) in people who are taking other medications to treat epilepsy (seizures). Information obtained from https://medlineplus.gov/druginfo/meds/a605033.html 6. The facility staff failed to evidence that Resident # 36's comprehensive care plan goals were sent with the resident to the hospital for the transfer dated 12/31/18. Resident # 36 was admitted to the facility on 10/05/17 with the most recent readmission date of 01/03/19. His diagnoses included but were not limited to acute bronchitis (1), hypertension (2), and umbilical (belly button area) hernia (3). Resident # 36's most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 02/01/19. The Brief Interview for Mental Status (BIMS) coded Resident # 36 as scoring a 11 on BIMS of a score of 0 - 15, 11 - indicating moderately impaired for making daily decisions. A review of Resident # 36's clinical record was conducted on 04/04/19. A nurse's note dated 1/03/19 at 5:29 p.m., documented Resident # 36 had been sent to the hospital for surgical hernia repair. The nurse's note did not document if comprehensive care plan goals were sent along	F 622		

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F 622	Continued From page 64 with the resident to the hospital. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." On 3/20/19 at approximately 5:30 p.m., ASM (administrative staff member) # 1, the Administrator, and ASM # 2, The Director of Nursing, and ASM # 3, regional vice president of clinical services, were made aware of the findings. No further information was provided. References: 1. Acute bronchitis is swelling and inflamed tissue in the main passages that carry air to the lungs. This information was obtained from the website: https://medlineplus.gov/ency/article/001087:htm - Medical Encyclopedia 2. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html	F 622		

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F 622	Continued From page 65 3. An umbilical hernia is an outward bulging (protrusion) of the lining of the abdomen or part of the abdominal organ(s) through the area around the belly button. This information was obtained from the website: https://medlineplus.gov/ency/article/000987.htm. 7. The facility staff failed to ensure the comprehensive care plan goals were provided to the receiving facility when Resident #67 was transferred to the hospital on 1/26/19, 1/28/19, 2/3/19, 2/5/19, 2/12/19, 2/28/19, and 3/2/19. Resident #67 was admitted to the facility on 1/25/19 with the diagnoses of but not limited to urinary tract infection, retention of urine, iron deficiency anemia, high blood pressure, heart failure, and chronic obstructive pulmonary disease. Resident #67's Minimum Data Set (MDS) was an admission assessment, with an Assessment Reference Date (ARD) of 2/5/19, coded Resident #67 as having no cognitive impairment in his ability to make daily life decisions. A review of the clinical record revealed physician orders dated 1/26/19 that documented, "send to ER (emergency room) for evaluation of possible fx (fracture)." A review of the clinical record revealed nurse's notes dated 1/26/19 at 3:41 p.m., that documented, "left facility at 1540 (3:40 PM), via stretcher to (name of facility) ER (emergency room). Bed hold sent with him, RP (Responsible Person) aware." A review of the clinical record revealed physician orders dated 2/3/19 that documented, "send	F 622		

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F 622	Continued From page 66 resident hospital for evaluation due to critical labs [laboratory] severe anemia." A review of the clinical record revealed nurse's notes dated 2/3/19 at 1:07 p.m., that documented in part, "received call from (name of lab) with critical lab results on resident at 11:15 a.m., ...all results called to (name of physician) he gave new orders to send to ER for evaluation of severe anemia ...Notified POA (power of attorney) will decide about bed hold policy if resident is admitted ..." A review of the clinical record revealed physician orders dated 2/12/19 that documented "send resident out to (name of hospital) ER for evaluation." A review of the clinical record revealed nurse's notes dated 2/12/19 at 11:01 p.m., that documented, "resident admitted to (name of hospital) with diagnosis of hypothermia, low blood pressure, and sepsis." A nurse's note dated 2/12/19 at 5:52 p.m., documented "bed hold agreement sent with resident." A review of the clinical record revealed physician orders dated 2/28/19 that documented, "send resident out to (name of hospital) ER for evaluation." A review of the clinical record revealed nurse's notes dated 2/28/19 at 9:38 p.m., that documented in part, "Resident sent out to (name of hospital) ER for evaluation at 7:45 p.m., via 911 on stretcher ...MD (medical doctor) and RP aware. No bed hold per family request." A review of the clinical record revealed nurse's	F 622		

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F 622	Continued From page 67 notes dated 3/2/19 at 3:00 p.m., that documented in part, "resident wheeled himself outside the front door ...stating he was going to wheel himself to the ER, complaining of shortness of breath ...information forwarded to MD and RP. 911 was called to transport resident to (name of hospital) ER for evaluation. Per RP resident is no bed hold." A review of the clinical record documented that written notice of the bed hold policy was mailed to the RP on the following dates: 1/26/19, 2/3/19, 2/12/19, 2/28/19, and 3/2/19. A review of the clinical record failed to reveal any evidence that care plan goals were sent with the resident upon transfer to the hospital on 1/26/19, 2/3/19, 2/12/19, 2/28/19, and 3/2/19. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." On 4/4/19 at 4:15 p.m., ASM (Administrated Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing), were made aware of the findings. No further information was provided	F 622		

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F 622	Continued From page 68 by the end of the survey. 8. The facility staff failed to evidence the documentation of the comprehensive care plan goals being sent to the receiving facility for a transfer of Resident #10 to the hospital on 12/27/18 and 3/27/19. Resident #10 was admitted to the facility on 7/11/18 with diagnoses that included but were not limited to: stroke, diabetes, encephalopathy [any disease or disorder of the brain (1)], and pneumonitis [inflammation of the lung caused by virus or allergic reaction, or foreign material (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/8/19 coded the resident as being severely impaired to make daily cognitive decisions. A nurse's note dated, 12/27/18 at 11:15 p.m. documented in part, "Resident sitting up in w/c (wheelchair) bedside bed, private sitter reported to staff that res (Resident) 'felt hot,' Temp (temperature) 102.7, writer observed that res had brownish phlegm during mouth care, prior to admin (administration) prn (as needed) Tylenol (used to treat fever and mild pain) for increased temp, res' residual feeding was 260 ml (milliliters), during care RP (responsible party), spouse in facility, writer telephoned MD (medical doctor) at 1645 (4:45 p.m.) and made aware of all findings, gave order to send to ER (emergency room), telephoned 911 (emergency medical services)...Out of facility via stretcher at 1715 (5:15 p.m.)." A nurse's note dated, 3/27/19 at 9:55 a.m. documented in part, "MD in house, observed	F 622		

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F 622	Continued From page 69 resident to monitor, noted that resident coughed some thick green sputum up and is desaturating (sic) at times in the 84% range, MD ordered to send resident out to the hospital to be evaluated." The review of the clinical record failed to evidence documentation that the comprehensive care plan goals were sent with the resident to the hospital for each of the above transfers. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 192 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 622		

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F 622	Continued From page 70 Chapman, page 464. 9. The facility staff failed to evidence the documentation of the comprehensive care plan goals being sent to the receiving facility for a transfer of Resident #76 to the hospital on 2/12/19 and 3/18/19. Resident #76 was admitted to the facility on 11/1/13 with a recent readmission on 3/5/19, with diagnoses that included but were not limited to: high blood pressure, diabetes, stroke and dementia. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 3/12/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. A nurse's note dated, 2/12/19 at 1:15 a.m. documented in part, "(Name of doctor) was called and informed of the resident's status. (Name of Doctor) ordered that the resident be sent to the ER (emergency room) for evaluation. 911 (emergency medical services) was called." The nurse's note dated, 3/18/19, documented in part, "MD (medical doctor) notified of resident's AMS (altered mental status) at 0515 am (5:15 a.m.) order received to send pt (patient) out to ED (emergency department) for AMS. POA (power of attorney) was called, but no answer at 5:15 a.m., message left on voicemail regarding plan to send to ED. 911 (emergency services) called at 5:30 a.m., report given to dispatcher. 6 am (6:00 a.m.) ambulance arrived to take resident to ED,	F 622		

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F 622	Continued From page 71 report given to ambulance crew." The review of the clinical record failed to evidence documentation that the comprehensive care plan goals were sent with the resident to the hospital for each of the above transfers. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. 10. The facility staff failed to evidence the comprehensive care plan goals were provided to the receiving facility for a transfer of Resident # 63 to the hospital on 1/17/19. Resident #63 was admitted to the facility to the facility on 1/12/18 with a recent readmission on	F 622		

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F 622	Continued From page 72 2/1/19 with diagnoses that included but were not limited to: morbid obesity, diabetes, high blood pressure, and congestive heart failure [abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)]. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 3/1/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The nurse's note dated, 1/18/19 at 12:02 a.m. documented in part, "..... While nurse was walking down hallway, returning to resident's room, resident began yelling out and nurse entered room to observe resident on the floor face down between her heater and the L (left) side of her bed. Side rails were in place on the bed; resident appears to have attempted standing alone. 911 was called by writer and operator advised staff not to mover resident. Resident slid herself around on the floor, repeatedly stated, 'get me up.' Ambulance arrived to facility @ 2200 (10:00 p.m.). Ambulance attendees sat resident up in (sic) the floor. Resident has a large swollen area form on her forehead. She then began to vomit repeatedly. Resident was transferred to stretcher via Hoyer lift. She was able to tell ambulance attendees her age and age. OOF (out of facility) at 2205 (10:05 p.m.)." The review of the clinical record failed to evidence documentation that the comprehensive care plan goals were sent with the resident to the hospital for the above transfer.	F 622		

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F 622	Continued From page 73 On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. 11. The facility staff failed to evidence the comprehensive care plan goals were provided to the receiving facility for a transfer of Resident # 64 to the hospital on 1/21/19 and 2/1/19. Resident #64 was admitted to the facility on 9/1/15 with diagnoses that included but were not limited to: high blood pressure, anxiety disorder, peripheral vascular disease - [any abnormal condition, including atherosclerosis, affecting	F 622		

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F 622	Continued From page 74 blood vessels outside the heart (1)], and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 3/2/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The nurse's notes dated 1/21/19 at 9:39 a.m. documented in part, "RP (responsible party) called and notified of resident calling 911 (emergency medical services) requesting to go to the hospital for her foot and that the MD (medical doctor) had seen her, per RP okay if that is what she wants. (Name of town) rescue squad here picking resident up to take to (name of hospital). RP is aware that they are here." The nurse's note dated 2/1/19 as a late entry, documented, "Resident was transferred to (name of) ER (emergency room)." The review of the clinical record failed to evidence documentation that the comprehensive care plan goals were sent with the resident to the hospital for each of the above transfers. On 04/03/19 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. LPN #3 was asked to describe the paperwork that is provided to the receiving facility at the time of a resident's transfer to a hospital. LPN # 3 stated, "We send a copy of the facesheet, list of medications, progress notes (nurse's notes), recent laboratory and/or x-rays, copy of insurance card, the bed hold agreement paper and the	F 622		

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F 622	Continued From page 75 resident's code status, contact information and notification to the responsible party and it is documented in the nurse's notes." When asked if they send a copy of the resident's comprehensive care plan goals at the time of transfer LPN # 3 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services were made aware of the above concern on 4/4/19 at 6:48 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623	**F 623** It is the practice of this facility to notify the Office of the State Long-Term Care Ombudsman of facility-initiated transfers and discharges. I On 4/24/19 the social services/ admissions staff updated the Ombudsman regarding the prior transfer of Resident #3 on 12/21/18 to the ER.	5-9-19

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F 623	Continued From page 76 and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how	F 623	II Facility licensed staff will complete internal movement notification forms on Residents to ensure communication between departments regarding resident movement out of the facility as a transfer or discharge. The Social Services Director will provide a monthly update to the Ombudsman for residents on the facility-initiated transfer list. III On or before May 4, 2019 the DON or Unit Manager(s) or designee will provide an in-service education for licensed nurses regarding: • F 623- as it relates to facility-initiated transfers or discharges and notification requirements • Completion of the facility-internal movement notification form with all transfers to the ER and hospital admissions. • Completion of the nightly census detail paperwork • Facility requirement to notify the Ombudsman of facility- initiated transfers and discharges	

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F 623	Continued From page 77 to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate	F 623	Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift IV Beginning 4/29/19 the Admissions Director/designee will monitor the facility internal movement notification forms and daily census detail, to identify any resident that has been sent to the ER or transferred out to a hospital. The Admissions team will provide the Ombudsman with a monthly list of facility-initiated transfers and discharges. Beginning 4/29/19 the facility Administrator will complete an audit of the facility-initiated transfer or discharge list being provided to the state Ombudsman to validate its accuracy. This audit will be conducted weekly for 4 weeks, then monthly for 2 months. Any discrepancy in the audit will be corrected at that time. The facility Administrator will submit results of the audit to the QAPI committee monthly for its review and recommendations	

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F 623	Continued From page 78 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the ombudsman of a facility initiated transfer for one of 47 residents in the survey sample, Residents # 3. The facility staff failed to notify the ombudsman when Resident # 3 was transferred to the hospital on 12/21/18. The findings include: Resident # 3 was admitted to the facility on 08/22/2018 with diagnoses that included but were not limited to respiratory failure (1), bipolar disorder (2), and spondylolysis (3). Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/19/18, coded Resident # 3 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The nurse's "Progress Notes," dated 12/21/2018 for Resident # 3 documented, "3:01 PM (p.m.) Staff notified that resident found in bedroom around 230pm (2:30 p.m.) with bloody drainage on right side of shoulder and floor from fall. Resident is A&Ox3 (alert and oriented times three, person place and time), T (temperature) 98.3, BP (blood pressure 156/78 (one hundred fifty-six over seventy-eight), p (pulse) 86, RR	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 79 (respiration) 20, O2 (oxygen) 69% (percent) RA (on room air), c/o (complaint of) pain to head,. Resident noted with small lump near back of R (right) side of head with skin tear in center. Moderate amount of bright red blood stabilized with gauze and compression gauze. ROM (range of motion) wnl (within normal limits), prn (as needed) Tylenol; 650 mg (milligram) po (by mouth) at 246pm (2:46 p.m.). No shoes or socks to feet. Resident was able to reach out and use call bell to notify staff, Supervisor, RP (responsible party), MD (medical doctor) notified. Resident has been sent to (Name of Hospital) ER (emergency room) for treatment. Left with EMT (emergency medical technician) out the facility via (by) stretcher at 256pm (2:56 p.m.). RP stated he would not hold bed if resident admitted to hospital." On 04/03/19 at 5:15 p.m., an interview was conducted with OSM (other staff member) #2, the social worker and admissions director. When asked to describe the procedure to notify the ombudsman of a facility initiated transfer for a resident, OSM # 2 stated, "We fax a list to the ombudsman at the beginning of each month." OSM # 2 was asked to provide evidence that the ombudsman was notified of Resident # 3's transfer to the hospital on 12/21/18. On 04/04/19 at 8:00 a.m., an interview was conducted with OSM # 2, social worker and admissions director. When asked about the notification to the ombudsman for Resident # 3's transfer to the hospital on 12/21/18, OSM # 2 stated, "When asked, went out the admissions and business was not notified she went out and returned therefore the ombudsman was not notified."	F 623		

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F 623	Continued From page 80 On 04/04/19 at approximately 6:45 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing and ASM # 3, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (3) A condition in which a bone (vertebra) in the spine moves forward out of the proper position onto the bone below it. This information was obtained from the website: https://medlineplus.gov/ency/article/001260.htm. (4) A common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious, especially for infants and older adults. In fact, RSV is the most common cause of bronchiolitis (inflammation of the small airways in the lung) and pneumonia (infection of the lungs) in children younger than 1 year of age in the United States. It is also a significant cause of respiratory illness in older adults. This	F 623		

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F 623	Continued From page 81	F 623		
	information was obtained from the website: https://www.cdc.gov/rsv/index.html.			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 47 residents in the survey sample, Resident # 34. The facility staff failed to accurately code Resident # 34's 14-Day MDS (minimum data set), assessment with an ARD (assessment reference date) of 03/23/19, for a pressure ulcer. The findings include: Resident # 34 was admitted to the facility on 10/22/2018 with diagnoses that included but were not limited to respiratory failure (1), diabetes mellitus (2), and major depressive disorder (3). Resident # 34's most recent MDS (minimum data set), a 14-day assessment with an ARD (assessment reference date) of 03/23/19, coded Resident # 34 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 34 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. Section M0210	F 641	**F 641** It is the practice of this facility that the resident assessment accurately reflects the resident's assessment. **I** On 4/25/19 the MDS coordinator completed a modified MDS for Resident # 34 and submitted it. **II** On or before 5/4/19 the MDS coordinators will complete an audit of current resident's with pressure ulcers against their most recent assessments to validate that the coding is accurate for section M-skin. Any discrepancy noted during the audit was corrected at that time, if needed, with MDS modification and submission.	5-9-19

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F 641	Continued From page 82 "Unhealed Pressure Ulcers/Injuries. Does the resident have one or more unhealed pressure ulcers/injuries?" coded Resident # 34 as "zero, No." The facility's "Progress Notes" for Resident # 34 dated 03/14/19 documented, "5:31 p.m. Area on bottom 0.5 x 0.75 (0.5 by 0.75 centimeters) on sacrum [4]. Existing order for triad (5). MD (medical doctor) aware. RP (responsible party) called and awaiting phone call back." The facility's "Pressure Injury Investigation" for Resident # 34 dated 3/14/19 documented, "Location of Ulcer: Sacrum. Stage and/or description of ulcer at time of discovery 0.5 x 0.75 open area." The comprehensive care plan for Resident # 34 dated 03/09/19 documented, "Problem. Category: Pressure Ulcer. 3/14/19 Sacrum open area. 3/26/19 resolved." On 04/05/19 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) # 7, MDS coordinator. After LPN #7 was asked to review section "M" of the MDS for Resident # 34 with the ARD of 03/23/19, the progress note dated 03/14/19 and the "Pressure Injury Investigation" dated 03/14/19 . After the review, LPN # 7 stated that the MDS should have coded Resident # 34 with a pressure ulcer. When asked to describe the process for coding the MDS for a pressure ulcer, LPN # 7 stated, "I look at documentation, nurse's notes, wound doctor notes and communicate with the nurses." LPN # 7 further stated that they follow the RAI (resident assessment instrument) manual.	F 641	III On or before 5/4/19 the DON / designee will complete an educational review for the MDS nurse's regarding: • Completion of the MDS following Section M, per the RAI manual for coding pressure ulcers under Section M Newly hired licensed MDS staff and will receive this education during orientation. The facility does not employ agency MDS nurses. IV Beginning 5/6/19, the lead MDS nurse/coordinator will conduct a review and audit, of MDS's submitted the prior week, for coding accuracy of Section M. This audit will be completed on 20% of the submitted MDS's weekly for 2 weeks, then 10% weekly for 2 weeks, then 20% monthly. Any discrepancy noted during the audit will be addressed at that time with completion and submission of a corrected MDS. The lead MDS nurse/coordinator will submit results of the audit to the QAPI committee monthly for its review and recommendations.	

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F 641	Continued From page 83 Review of "CMS's (Centers for Medicare/Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual CH (chapter) 3: MDS Item M0210: Unhealed Pressure Ulcers/Injuries documented, " Steps for Assessment 1. Review the medical record, including skin care flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any skin ulcers/injuries are present. Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries. Without a full body skin assessment, a pressure ulcer/injury can be missed. Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage. 4. Identify any known or likely unstageable pressure ulcers/injuries." On 04/05/19 at approximately 6:45 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing and ASM # 3, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfa	F 641		

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F 641	Continued From page 84 ilure.html. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) A shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis. Joined at the very end of the sacrum are two to four tiny, partially fused vertebrae known as the coccyx or "tail bone". The coccyx provides slight support for the pelvic organs but actually is a bone of little use. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm (5) A hydrophilic paste that contains zinc-oxide. It is usually used for managing light-to-moderate levels of wound exudates. Coloplast triad paste absorbs excess exudate and it gently sticks to moist wound beds. Coloplast Triad Dressing provides an optimal wound healing environment that facilitates natural autolytic debridement. This information was obtained from the website:	F 641		

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F 641	Continued From page 85 https://www.healthproductsforyou.com/p-coloplast-triad-hydrophilic-dressing.html?gclid=EAIaIQobChMII9X8yIXB4QIVD8DICh2u7QrSEAAYASAAEgIh1PD_BwE	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656	**F 656** It is the practice of this facility that each resident has a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals, which addresses the resident's medical, physical, mental and psychosocial needs. **I** Past alleged non compliance for developing or implementing the comprehensive care plan for Residents #45, #60 & #83 cannot be corrected. Resident # 83 no longer resides in the facility. **II** Licensed staff will complete dressing changes per MD order and per the care plan. Nursing staff will follow the care plan and implement interventions identified on the care plan for residents with behaviors Nursing staff will implement and follow the care plan for administration of oxygen	5-9-19

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F 656	Continued From page 86 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for three of 47 residents in the survey sample, Residents #2, #60, #45, and #83. 1. The facility staff failed to implement the comprehensive care plan for a physician ordered treatment for Resident #60. 2. The facility staff failed to implement the care plan for when a resident has behaviors for Resident #45. On 12/8/18 the facility staff only attempted the intervention of redirection and failed to implement other intervention identified on the care plan for her behaviors 3. The facility staff failed to implement Resident # 83's comprehensive care plan for the administration of oxygen to the resident as ordered. The findings include: 1. The facility staff failed to implement the comprehensive care plan for a physician ordered	F 656	III On or before 5/4/19, the DON, Unit Managers or designee will conduct in-service education for nursing staff regarding: • Implementation of a comprehensive care plan • Following a comprehensive care plan to include interventions for behaviors, completion of dressing changes and administration of oxygen • Completion of dressing changes per MD order • Documentation of behaviors, interventions that have been tried and failed or tried and were successful. Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 656	Continued From page 87 treatment for Resident #60. Resident #60 was admitted to the facility on 11/25/14 with diagnoses that included but were not limited to: stroke, diabetes, and peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (1)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/1/19, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she is capable of making daily cognitive decisions. Resident #60 was coded as requiring limited to extensive assistance of one staff member for most of her activities of daily living. Observation was made of Resident #60 on 4/2/19 at 4:03 p.m. the resident was sitting in her wheelchair in her room. There was noted to be a dressing on her left lower leg on the shin and handwritten on the dressing, "3/31/19." The comprehensive care plan dated, 3/5/19, documented in part, "Tx (treatment) to area on L (left) LE (lower extremity) per orders; see eTAR (skin tears)." The "Approach" documented in part, "Treatments as ordered; refer to wound DR (doctor) as indicated." The physician orders dated, 3/5/19, documented, "Cleanse left lower leg with NS (normal saline) cover with dry dressing and Kerlix, once a day." Review of the eTAR (electronic treatment administration record) for April 2019 documented the above order. The treatment was scheduled	F 656	IV Beginning 5/6/19 the DON or Unit Managers, or designee will complete audits of the completion of dressings, per physician order and the care plan. This audit will take place 5 days per week, to encompass all 3 shifts and weekends Any discrepancy noted during the audit will be corrected at that time. Beginning 5/6/19 the DON or Unit Managers, or designee will complete audits of residents with new orders or changes in orders for psychotropic medications to verify that the care plan interventions were implemented and new order for psychotropic medication was not obtained without implementation of the behavior interventions. This audit will take place daily, 5 days per week, as part of the AM clinical meeting. Any discrepancy noted during the audit will be corrected at that time.	

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F 656	Continued From page 88 for the 7:00 a.m. to 3:00 p.m. shift. On 4/1/19 it was initialed as being completed by RN (registered nurse) #4. Under the "Comments" section it was documented, "Charted late." An interview was conducted with LPN (licensed practical nurse) #1 on 4/4/19 at 11:59 a.m. When asked the purpose of the care plan, LPN #1 stated, "It gives you set goals and a way to get there." When asked if a physician ordered treatment is on the care plan and it's not completed, is that following the care plan, LPN #1 stated, "No, Ma'am." An interview was conducted with RN (registered nurse) #4 on 4/4/19 at 5:06 p.m. When asked if the care plan documents that a treatment should be completed as ordered by the physician and it's not completed, is that following the care plan, RN #4 stated, "No, Ma'am." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern. On 4/5/19 at 1:00 p.m., a request was made of ASM #3 for a policy related to following the comprehensive care plan. At 3:13 p.m. ASM #3 informed the survey team the facility didn't have a policy on following the care plan that it is a standard of practice. When asked which standard of practice the facility follows, ASM #3 stated, "Lippincott." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team	F 656	Beginning 5/6/19 the DON, Unit Managers, / designee will complete an audit of the administration of oxygen to validate that oxygen is administered per MD order and care plan. This audit will take place covering all 3 shifts, 5 days per week for 1 week then 2 times per week for 1 week, then weekly for 8 weeks. Any discrepancy noted during the audit will be addressed at that time. Results of the above audits will be submitted by the DON, to the QAPI committee, monthly, for its review and recommendations.	

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F 656	Continued From page 89	F 656		

members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.

2. The facility staff failed to implement the care plan for when a resident has behaviors for Resident #45. On 12/8/18 the facility staff only attempted the intervention of redirection and failed to implement other intervention identified on the care plan for her behaviors

Resident #45 was admitted to the facility on 4/2/12 with diagnoses that included but were not limited to: anxiety disorder, dementia, and high blood pressure.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/15/19, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as having disorganized thinking and physical behavior directed towards others on one-three days of the look back period. Resident #45 was coded as requiring extensive assistance of one or more

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F 656	Continued From page 90	F 656		

staff members for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antipsychotic and an antidepressant.

The comprehensive care plan dated, 11/19/18, documented in part, "Problem: Anxiety, received psychotropic daily. Seroquel (an antipsychotic medication used to treat schizophrenia, bipolar depression and in conjunction with other medication for depression) (1) d/c during review for GDR (gradual dose reduction); mood appears to remain stable most times. Can be combative and curse staff at times when performing care, continues to sleep in chair while up and doesn't like to be bothered likely associated with advancing dementia. Melatonin added for insomnia." Added on 12/8/18, "Seroquel per orders d/t (due to) increased agitation." The "Approaches" documented in part, "Attempt gradual dose reduction. monitor and record (Resident #45)'s behavior when combative to determine the need for medication adjustments. Monitor (Resident #45) for increased anxiety during care and attempt to redirect behavior by talking to her, providing music or leaving her alone and coming back later to try again. Offer snack before bedtime or when resident awakens during night. Provide comfortable environment to promote sleep (e.g., clean bedding, comfortable bed clothing, incontinence care, comfortable temperature, ventilation). When resident awakens during the night, provide comfort measures (e.g., back rub, repositioning, incontinence care, snack)."

The nurse's note in December 2018 documented, "12/8/18 at 2:41 a.m. - Res (Resident)awake at beginning of shift, noted with increased

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F 656	Continued From page 91 confusion, stating 'I need to call my husband and let him know where I am,' 1:1 given with positive effect. 12/8/18 at 6:10 a.m. - Res awake all shift talking outloud (sic) to self. Res up in dayroom at this time, stating 'I have to go home,' 1:1 ineffective." There were no further notes for 12/8/18. The next note related to behavior was on 12/12/18 at 8:17 a.m. - No behavior issues noted through the night. An interview was conducted with AMS (administrative staff member) #2, the director of nursing, on 4/5/19 at 12:44 p.m. The nurses' notes and the care plan were reviewed with ASM #2. When asked if the staff were implementing the care plan on 12/8/18, ASM #2 stated, "No, they only attempted redirection where there were other things on the care plan to try for her behaviors." ASM #2 was made aware of the above concern at this time. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.html 3. The facility staff failed to implement Resident # 83's comprehensive care plan for the administration of oxygen to the resident as ordered. Resident # 83 was admitted to the facility on 03/13/2019 with diagnoses that included but were not limited to: pneumonia (1), chronic obstructive pulmonary disease (2), and acute respiratory failure (3) with hypoxia (4). Resident # 83's most recent MDS (minimum data	F 656		

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F 656	Continued From page 92	F 656		

set), a quarterly assessment with an ARD (assessment reference date) of 03/27/2019, coded Resident # 83 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being no cognitive impairment for making daily decisions. Resident # 83 was coded as requiring extensive assistance of one staff member for activities of daily living and supervision of one staff member for eating. Under section "O. Special Treatment, Procedures and Programs", Resident # 83 was coded for "C. Oxygen therapy."

On 04/02/19 at 12:16 p.m., an observation of Resident # 83 revealed she was sitting up in her wheelchair at the dining table waiting for her meal. Resident # 83 appeared to be drowsy and occasionally nodding off. Further observation revealed Resident # 83 was wearing a nasal cannula connected to a portable oxygen tank. Observation of the oxygen flow meter on the oxygen tank revealed the oxygen flow rate knob was set on the off position. At 12: 33 p.m., approximately 17 minutes later, RN # 3 was observed setting Resident # 83's oxygen flow rate at two liters per minute.

The POS (physician's order sheet) for Resident # 83 dated 03/13/2019 documented, "O2 (oxygen) at 2 L (two liters) via (by) NC (nasal cannula) continuously, [chronic obstructive pulmonary disease]. Every shift; day shift, evening shift, night shift] Order Date: 03/13/2019."

The comprehensive care plan for Resident # 83 dated 03/22/2019 documented under "goals", "Resident will not exhibit signs of hypoxia (cyanosis (5), tachypnea(6), dyspnea (7), confusion, restlessness, nasal flaring (8),

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F 656	Continued From page 93 elevated blood pressure, increased respirations, and increased pulse)." Under "approach" it documented, "Oxygen via (by) N/C (nasal cannula) as ordered. Start Date: 03/22/2019." On 04/04/19 at 1:23 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked to look at the Resident # 83's care plan and determine if the care plan was followed, LPN # 1 stated, "No, the care plan was not followed." A review of the facility policy titled, "Oxygen Administration" documented as follows: 1. Oxygen is administer to the resident only upon written order of a licensed physician. According to "Lippincott Manual of Nursing Practice", Seventh Edition: by Lippincott Williams & Wilkins, pg. 276 read: "The plan of nursing care (patient care plan) is the written guide that directs the efforts of the nursing team as nurses work with patients to meet their health goals ...Is responsive to the individual characteristics and needs of the patient." On 04/04/19 at approximately 4:52 p.m., ASM (administrative staff member) # 1, administrator, was made aware of the findings. No further information was provided prior to exit. Reference: 1. An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.	F 656		

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F 656	Continued From page 94 2. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 3. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 4. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia. 5. A bluish color to the skin or mucous membrane is usually due to a lack of oxygen in the blood. The medical term is cyanosis. This information was obtained from: ttps://medlineplus.gov/ency/article/003215.htm 6. Breathing - rapid and shallow; Fast shallow breathing. https://medlineplus.gov/ency/article/007198.htm - Medical Encyclopedia 7. When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This	F 656		

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F 656	Continued From page 95 information was obtained from the website: https://medlineplus.gov/breathingproblems.html. 8. Occurs when the nostrils widen while breathing. It is often a sign of trouble breathing. This information was obtained from the website: https://medlineplus.gov/ency/article/003055.htm - Medical Encyclopedia	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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.	F 657	**F 657** It is the practice of this facility to review or revise resident care plans periodically and the services provided or arranged are consistent with each resident's written plan of care. **I** The care plan for Resident # 3 was re-reviewed and the intervention for the fall of 3/8/19 was noted to be under the problem section. The care plan interventions were updated, by the MDS nurse to reflect the new intervention which was put into place post fall of 3/8/19. **II** The Interdisciplinary team (IDT) will review resident changes in condition to include falls, during the AM clinical meeting, 5 days per week, to validate that care plans are updated post fall with new interventions.	5-9-19

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F 657	Continued From page 96 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to review or revise the care plan for one of 47 residents in the survey sample, Resident # 3. The facility staff failed to update Resident # 3's comprehensive care plan concerning a fall on 03/08/19. The findings include: The facility staff failed to update Resident # 3's comprehensive care plan concerning a fall on 03/08/19. Resident # 3 was admitted to the facility on 08/22/2018 with diagnoses that included but were not limited to respiratory failure (1), bipolar disorder (2), and spondylolysis (3). Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/19/18, coded Resident # 3 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The facility's "Progress Notes" dated "03/08/2019" for Resident # 3 documented, "Resident was found on the floor in her bathroom @ (at) 930pm (9:30 p.m.) unable to explain how she fell on the floor. Range of motion and assessment done denies pain no injury @ this time RP (responsible party) daughter [sic] inlaw notified and MD (medical doctor (Name of	F 657	The DON and/or Unit Managers/ designee will complete a review of residents with falls retro to January 1, 2019 to validate that care plans for residents with falls were reviewed and revised as indicated post fall. Any discrepancy, if noted was addressed at that time with the intervention which was put into place at the time of the fall being placed on the current care plan if applicable to the residents' current condition. III On or before, 5/4/19 the DON or Unit Managers, or designee will conduct an in-service education for license nurses on: • F 657—Care plan Timing and Revision to include reviewing for update the care plan post fall to decrease risk of additional falls Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 657	Continued From page 97 Doctor) made aware will continue to monitor." The comprehensive care plan dated 12/26/18 with a target date of 03/26/19 for Resident # 3 was reviewed. Under "Need" it documented, "Category: Falls. (Resident # 3) is at a low risk for falling r/t (related to) psychotropic meds (medications), incontinence and generalized muscle weakness, balance issues, alert and oriented X (times 0) 3 (three) and available and able to make needs known." Further review of the care plan failed to evidence documentation that the comprehensive care plan was reviewed or revised following Resident # 3's fall on 03/08/19. On 04/04/19 at 1:46 p.m., an interview was conducted with LPN (licensed practical nurse) # 7, MDS assistant coordinator about updating or revising the care plan for Resident # 3's fall on 3/8/19. After reviewing the care plan for Resident # 3 dated 12/26/18 with a target date of 03/26/19, LPN # 7 stated, "It was not on the care plan because it was not reported me." When asked to describe the process: for updating the care plan LPN # 7 stated, "They are updated on a daily basis by the MDS office if there is a change or issue. The nurse's on the floor can always add to care plan when there is a change because the plans are on the floor at the nurse's station." LPN # 7 stated, "We are notified during our morning meeting, by pulling up the facility report on the computer which is every 24 hours and/or communication with the unit manager or the nurses on the floor." The RAI (Resident Assessment Instrument) 3.0 User's Manual Version 1.16 dated October 2018 documented, "4.7 The RAI and Care Planning As	F 657	**IV** Beginning 5/6/19 the DON or designee will review resident falls in the AM clinical meeting, 5 days per week, to validate that the care plans for residents with changes in condition or falls, were updated. Any discrepancy noted during the audit will be addressed a that time. This audit will take place 5 days per week on an ongoing basis. Results of the audit will be submitted monthly, by the DON, to the QAPI committee for its review and recommendations.	

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F 657	Continued From page 98 required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care." On 04/04/19 at approximately 6:45 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing and ASM # 3, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (3) A condition in which a bone (vertebra) in the spine moves forward out of the proper position onto the bone below it. This information was obtained from the website: https://medlineplus.gov/ency/article/001260.htm	F 657		

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F 684 F 684 SS=D	Continued From page 99 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one resident (Resident #60) of 47 sampled residents, received the care and services in accordance with professional standards and the comprehensive care plan. The facility staff failed to administer a treatment to Resident #60 per the physician orders. The findings include: Resident #60 was admitted to the facility on 11/25/14 with diagnoses that included but were not limited to: stroke, diabetes, and peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (1)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/1/19, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she	F 684 F 684	**F 684** It is the practice of this facility to provide care and services to facility residents that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that meet each residents physical, mental and psychosocial needs **I** Past non-compliance for Resident # 60 cannot be corrected. There was no negative outcome as a result of the alleged deficient practice. The dressing for Resident # 60 was changed on 4/2/19 per MD orders. The Unit Manager provided 1:1 education for registered nurse #4 on regarding not just signing off a 'red' on the computer screen but to alert the Unit Manager or RN supervisor that the 'red' for a dressing change is noted.	5-9-19

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F 684	Continued From page 100 is capable of making daily cognitive decisions. Resident #60 was coded as requiring limited to extensive assistance of one staff member for most of her activities of daily living. Observation was made of Resident #60 on 4/2/19 at 4:03 p.m. the resident was sitting in her wheelchair in her room. A dressing was observed on her left lower leg, on the shin. The date "3/31/19" was handwritten on the dressing. The physician orders dated, 3/5/19, documented, "Cleanse left lower leg with NS (normal saline) cover with dry dressing and Kerlix, once a day." Review of the eTAR (electronic treatment administration record) for April 2019 documented the above physician's order. The treatment was scheduled for the 7:00 a.m. to 3:00 p.m. shift. On 4/1/19, it was initialed as being completed by RN (registered nurse) #4. Under the "Comments" section, "Charted late" was documented. The comprehensive care plan dated, 3/5/19, documented in part, "Tx (treatment) to area on L (left) LE (lower extremity) per orders; see eTAR (skin tears)." The "Approach" documented in part, "Treatments as ordered; refer to wound DR (doctor) as indicated." An interview was conducted with LPN (licensed practical nurse) #1 on 4/4/19 at 11:59 a.m. When asked if she was working on 4/1/19, LPN #1 stated she was off that day. When asked if she performed the dressing to Resident #60's left lower leg on 4/2/19, LPN #1 state yes. When asked what date she saw on the dressing on 4/2/19, LPN #1 stated, "3/31/19." When asked if the physician order is for a daily dressing change,	F 684	II A list of residents with dressing change orders was compiled to audit MD orders and the completion of dressings per MD order. Any discrepancy note during the audit was addressed at that time on the day of the audit. Licensed nurses will complete dressing changes per MD orders per professional standards of practice. III On or before 5/4/19 the DON, Unit Managers or designee will conduct an in-service for facility licensed nurses to include current agency nurses regarding: • F 684 as it relates to professional standards of practice, person centered care plan and resident choices. • Completion of dressing changes per MD order • Following the plan of care related to completion of dressing changes	

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F 684	Continued From page 101 LPN #1 stated, "It's do be done no matter what. It's once a day so it really doesn't matter which shift but has to be completed once a day. If it is late, then you have to notify the doctor and chart in the record that it was late." When asked if staff followed the physician orders since the dressing wasn't completed on 4/1/19, LPN #1 stated, "No." An interview was conducted with RN #4 on 4/4/19 at 5:06 p.m. The above information was reviewed with RN #4. When asked if he signed off the treatment on 4/1/19, RN #4 stated, "Yes." When asked if he completed the dressing ordered by the physician to the resident left lower leg, RN #4 stated, "No, the system keeps popping up a red window that it's not completed so I just signed it off." When asked if a physician order for a treatment, should be followed, RN #4 stated, "Yes, Ma'am." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern. On 4/5/19 at 1:00 p.m., a request was made of ASM #3 for a policy related to following physician orders. On 4/5/19 at 3:13 p.m., ASM #3 informed the survey team the facility did not have a policy on following physician orders; it's a professional standard of practice. When asked which standard of practice they follow, ASM ## stated, "Lippincott." The Potter-Perry Fundamentals of Nursing, 6th edition, was used as a reference related to documentation. In a table describing the Legal Guidelines for Recording, the following was noted; "Chart only for yourself." "Records need to	F 684	Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift IV Beginning 5/6/19 the DON or Unit Managers / designee will audit the completion of dressing changes to validate that they are completed per MD order. This audit will take place 5 days per week for 1 week on 20% of the residents with dressing changes orders, then 2 days per week for 1 week on 20% then weekly on 20% for 4 weeks. Any discrepancy noted during the audit will be corrected at that time. Results of the audits will be submitted by the DON, to the QAPI committee, monthly, for its review and recommendations.	

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F 684	Continued From page 102 reflect accountability during the time frame of the entry, which is best accomplished when nurses chart only their own observations and actions." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined that the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote the healing pressure ulcers for one of 47 residents in the survey sample, Resident #83. The facility staff failed to ensure weekly measurements were completed to assess and	F 686	**F 686** It is the practice of this facility that the resident receive care, consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable and a resident with a pressure ulcer receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections and prevent new ulcers from developing **I** Past non-compliance cannot be corrected for Resident # 83	5-9-19

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F 686	Continued From page 103 monitor the healing of Resident #83's multiple pressure ulcers. The findings include: The facility staff failed to complete weekly assessments including measurements and wound description to determine wound healing or decline, to evaluate / monitor the healing of Resident #83's sore. Resident # 83 was admitted to the facility on 03/13/2019 with diagnoses that included but were not limited to: malignant neoplasm (1) of brain (2), epilepsy (3), and chronic obstructive pulmonary disease (4). Resident # 83's most recent MDS (minimum data set), a 14-day assessment with an ARD (assessment reference date) of 03/27/19, coded Resident # 83 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 83 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. Section M0210 "Unhealed Pressure Ulcers/Injuries. Does the resident have one or more unhealed pressure ulcers/injuries?" coded Resident # 34 as "One, Yes." During the entrance conference on 04/02/19 at approximately 11:30 a.m., a request was made for a list of all residents who had pressure injuries. The facility's pressure ulcer list documented Resident # 83 with an acquired stage II pressure ulcer on her buttocks.	F 686	II On 4/24/19 & 4/25/19 the DON and Unit Managers completed a skin sweep on all facility residents to identify any skin issues of which the facility was not aware. There were no new skin issues noted. The wounds were measured on 4/25/19. The Unit Managers and DON/ designee completed tracking tools for residents with current pressure ulcers. Nursing management /designee will complete weekly wound rounds to include measurements and track wound progress weekly.	

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F 686	Continued From page 104 The facility's "Pressure Injury Investigation" for Resident # 83 dated 3/15/19 documented, "Location of Ulcer: Buttocks. Stage and/or description of ulcer at time of discovery: Stg (stage) 2 (two)." Further review of the "Pressure Injury Investigation" failed to document any measurements. The facility's "Weekly Skin Assessment" for Resident # 83 dated "3/15/19" documented a picture outline of a human body with three short horizontal lines on the left buttocks and was labeled "Open." The facility's "Progress Notes" for Resident # 83 dated 03/15/2019 documented in part, "ADMITT (admission) (Name of Physician) in to see resident for admit and NNO (no new orders). MD (medical doctor) aware of open areas to resident's buttocks. Advised to continue current Tx (treatment) at this time ..." The comprehensive care plan for Resident # 83 dated 03/22/2019 documented, "Category: Pressure Ulcer. Potential for skin breakdown (Resident # 83) is a new admit (admission) with recent hospitalization for UTI (urinary tract infection)? sepsis. She has edema (swelling) to her BLE (bilateral [both sides] lower extremities). Had previous injury to LLE (left lower extremity) and was receiving wound care from (Name of Doctor). Resident has 2 (two) stage 2 (two) pressure ulcers on each of her buttocks that is being treated with triad paste." Under "Approach", it documented several interventions and treatments for the pressure ulcer. Further review of the comprehensive care plan failed to evidence documentation of wound	F 686	III On or before, 5/4/19 the DON or Unit Managers /designee will provide an in-service education for current licensed nurses and agency staff nurses regarding: • Facility wound protocol • Wound measuring • Documentation of wounds on identification to include measurements, wound bed, location, surrounding tissue • notification to the MD and RP • following and completing treatment orders • Infection prevention • following the care plan and MD orders Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 686	Continued From page 105 measurements. The facility's TAR (treatment administration record) for Resident # 83 dated "03/01/2019 - 03/31/2019" documented, "Skin Assessment." Further review of the TAR revealed skin assessments conducted on 03/19/19 that documented, "No new skin areas" and on 03/26/19 that documented, "No new abnormalities." The facility's TAR for Resident # 83 dated "04/01/2019 - 04/04/2019" documented, "Skin Assessment." Further review of the TAR revealed staff initials on 04/02/19 at 3:00 p.m. - 11:00 p.m. indicating a skin assessment was completed. Under "Results" it documented, "n/a (not applicable)." The facility's "Progress Notes" for Resident # 83 dated 03/18/2019 documented, "5:30 p.m., Per discussion with RP (responsible party) on 3/15/19 when RP notified of order changes to resident's sacrum. RP advised that the blister / open area cycle has been an ongoing problem with resident that is why she has had A&D ointment in place. RP made aware of new order of Traid at that time. Thanked writer for updating. Further update given at this time of continuing tx." The facility's "Progress Notes" for Resident # 83 dated 03/26/2019 documented, "9:05 a.m. After observation of resident peri area and sacrum. Open area approximately 1/8" (one-eighth inch) x (by) 0.25" (one-fourth inch) with no drainage and pink wound bed noted on left buttocks with surrounding skin intact and [sic] non reddened. Right buttocks [sic] nonreddened and healing area of previous skin peeling noted. MD (medical	F 686	IV Beginning 4/25/19 the treatment nurse or Unit Managers / designee will monitor completion of wound measurements and begin tracking wound progress, on a weekly basis. The DON / designee will then audit the completion of wound measurements and validate tracking of the wound progress. Any discrepancy noted with the audit will be corrected at that time. Results of the audit will be submitted by the DON to the QAPI committee monthly for its review and recommendations.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 106 doctor) aware. Attempted to contact RP, awaiting call back at this time." Further review of the facility's progress notes for Resident # 83 dated 03/15/19 through 03/25/04/19 and 03/27/19 through 04/04/19 failed to evidence assessment, measurements, tracking and monitoring of Resident # 83's pressure ulcer. On 4/4/19 at 6:50 p.m., during the end of day meeting with ASM #1, ASM #2, and ASM #3 (Administrative Staff Members; the Administrator, Director of Nursing, and Regional Vice President of Clinical Services) were made aware of the findings. At this time a request was made to observe Resident # 83's wound on 4/5/19. The facility staff did not provide this opportunity. On 04/05/19 at 11:17 a.m., an interview was conducted with RN (registered nurse) # 3. After reviewing the facility's "Pressure Injury Investigation" for Resident # 83 dated 3/15/19, RN # 3 agreed the wound was a stage II and was discovered on 0 3/15/19. RN #3 stated, she (Resident #83) had an order for A&D ointment and I followed the order. When asked if weekly skin assessment for Resident # 83 were completed, RN # 3 stated, "Weekly skin assessments are completed for all residents." When asked if wound assessments including measurements are taken weekly for residents with pressure ulcers, RN # 3 stated, "They should be." After reviewing Resident # 83's TARs dated for March and April 2019 and the progress notes, RN # 3 was asked if the assessments and measurements of Resident # 83's wound were being documented. RN # 3 stated, "I don't see any." When asked if there was tracking and trending for Resident # 83's pressure ulcer, RN #	F 686		

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F 686	Continued From page 107 83 stated, "Not done appropriately" When asked why is was important to assess, measure, track and monitor a pressure ulcer, RN # 3 stated, "We need to know the condition of the resident so we can treat appropriately." A review of the facility policy, "Wound Protocol" which was undated, documented: "It is the intent of the facility to complete a weekly assessment of all wounds. Many of the wounds are assessed weekly by the wound care physician with documentation provided to facility and scanned into the clinical record. That physician also provides a weekly wound report of the status of each of the wounds he treats. This report is utilized by the facility as the weekly wound report. There are also wounds which that physician does not assess and treat on a weekly basis. The facility nurses are responsible for assessing and documenting the assessment in the clinical record. It is further the intent that the facility will be knowledgeable of the status / progress of each wound in facility. Process: 1. All wounds are to be treated daily by the nurse who is responsible for the care of that resident. 2. Each Thursday, the nurse will assess, measure and document on the status of each wound not being followed by the wound physician. 3. Documentation will be completed on the Weekly Pressure Ulcer and Non-Pressure Skin Condition forms. 4. The assessment will include the following: a. resident room number and name. b. identify if the wound is admitted and the date of admission. c. identify if the wound is in-house acquired and the date of onset. d. site of area of impairment. e. stage (if pressure). f. if not pressure, identify	F 686		

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F 686	Continued From page 108 the type of wounds (venous, arterial, skin tear, etc.) g. measurements (length x width x depth). h. description of wound bed. i. peri wound tissue. j. exudate (type and amount). k. odor. l. drainage - type/amount. m. pain. n. status of the wound (improving/declining/no change); also include devices. 5. The nurse is to complete the assessment and document every Thursday. This will ensure all wounds existing in facility are assessed on the same day each week (wound physician in facility on Thursdays). 6. The wound documentation forms will be placed on the MD board on each unit for the unit manager on Friday morning. The unit manager will ensure notification to physician. 7. Unit manager will use information from the documentation to complete the wound report. 8. The wound report is to be completed by the unit manager each week and submitted to the DON by the end of the workday on Friday. While completing the report, the unit manager is validating that the assessment of the wounds has been completed and documented per protocol. 9. If wound physician does not come, then the facility nurse is responsible for documenting and reporting on each wound, including those the wound physician generally assesses and treats. 10. Identification of a new wound must be included on the shift 24-hour report form. 11. Nurse is expected to contact physician for new orders upon identification of a new wound. 12. Weekly report to be submitted to DON, ADON, Infection Control Nurse, MDS nurses, and Administrator." The Pressure Ulcer Treatment Quick Reference Guide by NPUAP (National Pressure Ulcer Advisory Panel) states on page 8 concerning	F 686		

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F 686	Continued From page 109 pressure ulcer assessment, "Asses the pressure ulcer initially and re-assess it at least weekly, documenting findings. On 04/04/19 at approximately 6:45 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing and ASM # 3, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. (2) A brain tumor is a growth of abnormal cells in the tissues of the brain. Brain tumors can be benign, with no cancer cells, or malignant, with cancer cells that grow quickly. Some are primary brain tumors, which start in the brain. Others are metastatic, and they start somewhere else in the body and move to the brain. This information was obtained from the website: https: https://medlineplus.gov/braintumors.html. (3) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain	F 686		

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F 686	Continued From page 110 send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. (4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a FRI (facility reported incident) investigation, it was determined that the facility staff failed to ensure an environment free of accidents and hazards for three of 47 residents in the survey sample; Residents #2, and #17. 1. The facility staff failed to use the proper transfer method and bathing device (shower stretcher) for Resident #2. On 6/14/18, the facility staff failed to use a Hoyer lift to transfer Resident #2, into a shower chair and failed to ensure the residents lower extremities were properly	F 689	**F 689** It is the practice of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. **I** Resident # 2 complaint of pain was evaluated by nursing staff, her physician was notified, an X ray was obtained, and she was sent to the hospital where she received treatment for the fracture. She returned to the facility post treatment and her care plan was updated to reflect her current status. Resident # 2 has had no further incidents related to transfers. Resident # 17 was evaluated at the ER and returned to the facility. Resident # 17 has had no further incidents related to use of a mechanical lift.	5-9-19

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F 689	Continued From page 111 supported in the shower chair during transport to the shower room, resulting in a fracture of the right distal femoral metaphysis (1) [femur bone with the fracture located just above the knee joint], and harm to the resident. 2. While using a Hoyer lift (1) to transfer Resident # 17, the facility staff failed to follow the recommended procedures, Resident # 17 fell from the lift and sustaining a head injury (hematoma), and was sent to a local hospital. The findings include: 1. The facility staff failed to use the proper transfer method and bathing device (shower stretcher) for Resident #2. On 6/14/18, the facility staff failed to use a Hoyer lift to transfer Resident #2, into a shower chair and failed to ensure the residents lower extremities were properly supported in the shower chair during transport to the shower room, resulting in a fracture of the right distal femoral metaphysis (1) [femur bone with the fracture located just above the knee joint], and harm to the resident. Resident #2 was admitted to the facility on 6/28/13 and had the diagnoses of but not limited to left leg above the knee amputation, gangrene of left leg amputation site, epilepsy, multiple sclerosis, post surgical wound of the right thigh, abscess of tendon sheath of the right lower leg, bilateral lower extremities deep vein thrombosis, osteoporosis, acute respiratory failure with hypoxia, stroke, cataract, high blood pressure, aphasia, and syphilitic heart involvement. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD	F 689	II The DON and/or Unit managers compiled a list of current residents which currently utilize mechanical lifts for transfers and placed it in the transfer book respective to each unit, where G.N.A.'s and licensed nurses have access to review. New hires receive education regarding use of a mechanical lift during orientation to include: 2-person operation of any lift. Nursing staff will follow policy to utilize 2 persons when operating a mechanical lift. Staff will follow protocol to transport residents to the shower room via their usual mode of transportation and transfer the resident in the shower room to a shower chair if able to use a shower chair. Shower chairs are not used for transport of residents. There have been no further incidents related to shower chairs.	

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F 689	Continued From page 112 (Assessment Reference Date) of 12/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for transfers, dressing, eating, toileting, hygiene, and bathing. A review of the nurse's notes revealed the following: A note dated 6/14/18 at 12:15 PM: "Resident up for shower this AM and was complaining she was in pain. Upon assessment of charge nurse resident noted with swelling and pain to the right knee upon palpation and movement. Charge nurse notified writer of assessment data and writer in to eval (evaluate) right knee. Right knee swollen, not warm/hot to touch. No injury noted. Upon ROM clicking noted to posterior knee with pain reported per resident. Dr. (doctor) (name of the doctor) (ASM #4 - Administrative Staff Member) made aware of above assessment data and ordered xray of the right knee this shift and Ibuprofen (3) 600 mg (milligrams) Q8H (every eight hours) x (for) 3 days for right knee pain. Attempted x1 (once) to contact RP (responsible party) with update in resident status and new orders this shift with no success noted. Message left, awaiting call back. Charge nurse aware of new orders. (Mobile xray company) phoned for mobile image and awaiting their arrival currently." A note dated 6/14/18 at 4:52 PM: "At approximately 1430 (2:30 PM) (name of mobile xray company) tech in to perform xray of the right knee Immediately after performing xray, tech notified writer of possible impacted femur fracture	F 689	III On or before, 5/4/19 the DON, Unit Managers or designee will complete an educational review for facility nursing staff and current agency staff regarding: • Updated list of residents who use a mechanical lift • shower chair use and not using the shower chair to transport residents, • shower bed use • Mechanical lift use with 2 or more persons A post test will be utilized to validate staff understanding of the material presented. Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 689	Continued From page 113 of the right distal femur. (ASM #4) phoned by writer and made aware of preliminary reports of fracture to distal femur of right leg. New order written and noted to send resident to (name of hospital) for eval (evaluation) r/t (related to) fracture of right femur. ADON (Assistant Director of Nursing), Administrator, and Admissions department made aware of possible impacted distal right femur fracture. Attempted x1 to contact RP with information regarding status of resident and transfer of resident to (name of hospital) with no success noted. Unsure of bed hold status as unable to currently reach RP (responsible party). Message left and awaiting call back. Writer contacted 2nd contact (name of contact) and made her aware of status of resident and xrays results as well as impending transfer to (name of hospital) for eval. Writer and ADON in to further assess resident prior to transfer to (name of hospital) and resident is noted with faint positive pedal pulse to right LE (lower extremity). After exiting room for assessment of resident writer spoke on phoned (sic) with (name of mother) resident's mother and updated her on resident status and impending transfer to (name of hospital). (Name of transport company) unavailable to transport resident to (name of hospital) so charge nurse was instructed to contact 911 (emergency services) for transport. (Name of county emergency ambulance) into facility at around 1445 (2:45 PM) and receive report on resident condition from charge nurse and further information as provided to them by writer. Resident bed hold policy sent with resident to ER in transfer packet. Resident transported out of facility via stretcher accompanied by 2 EMTs (emergency medical technicians) to (name of hospital) at 1500 (3:00 PM) for further eval of femur fracture."	F 689	IV Beginning 5/6/19 the DON, Unit Managers or designee will audit the use of shower chairs to validate that the shower chairs are not being used to transport residents. This audit will encompass 10% of the showers provided during the week and will take place, 5 days per week, for 1 week, then 2 days per week for 1 week then weekly X 8. The audit will encompass all 3 shifts. Any discrepancy noted during the audit will be addressed at that time. Beginning 5/6/19 the DON, Unit Managers or designee will audit the use of mechanical lifts to ensure that the lift is being operated with 2 staff persons per facility protocol. The audit will encompass 10% of randomly chosen residents using mechanical lifts, 5 days per week for 1 week, then 2 days per week for 1 week then weekly X 8. Any discrepancy noted during the audit will be addressed at that time. Results of the above listed audits will be submitted by the DON, monthly, to the QAPI committee for its review and recommendations.	

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F 689	Continued From page 114	F 689		

A note dated 6/14/18 at 7:26 PM: "Resident admitted to (name of hospital) for fractured femur per (hospital) nurse; RP (name of RP) was notified and verbalized understanding and stated that she had just spoken to the physician from hospital."

A note dated 6/15/18 at 11:24 AM: "Spoke with resident RP (name of RP) this a.m. about her concerns about her mothers condition. I assured her that we were doing a thorough investigation with the staff and would keep her updated. I ask how her mother was doing and she said they were doing some pre-op testing to see if her mother could tolerate the procedure a (sic) she would keep us updated during her hospital stay."

A review of the hospital record revealed the following:

A History and Physical dated 6/14/18, documented, "....Here in the ER (emergency room) her x-ray shows oblique fracture of the distal femoral metaphysis extending from lateral distal to medial proximal with angular deformity. She also has osteoporosis. Other imagings (Sic.) including CT cervical spine, Ct head, x-ray of hip and pelvis, x-ray of right knee all negative for any acute injuries....The patient denies any other pains besides right leg....Assessment/Plan: 1. Right femur fracture. We will keep the patient n.p.o. (nothing by mouth) for possible surgical intervention...."

The hospital Discharge Note, dated 6/27/18, documented, "....Discharge diagnoses: S/P

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F 689	Continued From page 115 (status post) right distal femur ORIF (2) (6/16/18) for acute fracture due to fall...." Therapy: A review of the Physical Therapy Discharge Summary for services provided 4/11/18 to 5/4/18 documented, "....Discharge Status and Recommendations....Functional Outcomes....Transfers - Total...." A review of the Occupational Therapy Evaluation and Treatment Plan" dated 4/10/18 to 5/7/18, documented, "....Prior Level(s)....Bathing = Total....Functional Skills Assessment - Activities of Daily Living / Self Care....Bathing = Total...." On 4/5/19 at 12:27 PM in an interview with OSM #4 (Other Staff Member - the Director of Rehabilitation), OSM #4 stated, "We picked her up a month prior to the incident to try to improve transfer status because she was not total Hoyer lift. We saw her for a month and was not successful so she remained a Hoyer lift. We saw her after the incident as well because she returned to skilled services." Upon review of the therapy documents, when asked where it indicated that the resident was a Hoyer lift, OSM #4 stated that it was documented that the resident was "Total assist which means use a Hoyer." When asked how this information is communicated to the floor staff, OSM #4 stated, "We educate nursing and CNA's upon discharge from therapy. They have this documentation in their charts as well." Regarding the resident's shower status (use of a shower chair vs a shower bed/stretcher), OSM #4 stated that the resident	F 689		

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F 689	Continued From page 116 was dependent for bathing and it was documented in therapy notes as such, and that when it is documented that a resident is "total" for bathing, this "equates to the use of a shower stretcher. Total assist would mean resident was a Hoyer lift and total care for a shower stretcher." A review of the care plan for Resident #2 revealed the following: A care plan dated 3/4 /18, for "ADL (Activities of Daily Living) Functional / Rehabilitation Potential: (Resident #2) requires extensive to total assist of one or two with ADLS..." This care plan documented the intervention, "Hoyer lift used for transfers with 2 person assist as needed." This intervention was dated 3/14/18 and was a current care plan intervention in place at the time of the incident. A care plan for "Falls: (Resident #2) is at risk for falls r/t (related to) dx (diagnoses) of seizure d/o (disorder), CVA (stroke) and MS (multiple sclerosis). Needs extensive to total assist with all ADLS...." This care plan was dated 3/14/18, and was revised on 4/10/18. This care plan included the intervention, "Use 2 staff as needed with transfers as well as hoyer lift." This intervention was dated 3/14/18 and was a current care plan in place at the time of the incident. A care plan for "Pain: (Resident #2) has dx: MS, chronic pain; left hip pain; osteopenia to right knee; potential for pain..." This care plan was dated 3/14/18, and was revised on 4/10/18. This care plan included an intervention for "Monitor and record swelling and discoloration to right leg."	F 689		

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F 689	Continued From page 117 This intervention was dated 3/14/18 and was a current care plan in place at the time of the incident. Further review of the care plan that was in place at the time of the incident failed to reveal any interventions regarding what method of showering was to be used with Resident #2 (shower chair vs. the shower bed/stretcher). A review of the facility FRI (Facility Reported Incident) form dated 6/14/18 revealed the following: The initial FRI dated 6/14/18 documented, "Describe incident, including location, and action taken: Resident (name of Resident #2) complained of right leg pain while finishing up with shower. C.N.A. (Certified Nursing Assistant) noted the pain and some swelling; she notified charge nurse. Charge nurse noted swelling and severe pain to right knee area; she notified unit manager of right knee and pain during ROM (range of motion) to right knee. (ASM #4) notified of assessment findings. New orders were written, and noted for an x-ray of right knee on June 14, 2018. Preliminary x-ray results showed distal femur fracture at approximately 1430 hours. The final report, dated 6/21/18 documented, "FINAL: Staff were interviewed and statements were reviewed. Resident was interviewed, but couldn't properly verbalize the incident due to medical condition. The investigation showed that while the resident was being pushed to the shower room the resident put their right leg down. We believe this is most likely when the injury	F 689		

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F 689	Continued From page 118 occurred. The x-ray showed acute fracture to distal femur above right knee. Resident diagnosed with osteopenia from 10/2015. The investigation showed no signs of a fall, abuse, or neglect. A 100% in service is being conducted on resident transfers to the shower room." Review of an APS (Adult Protective Services) report dated 8/15/18 documented, "....staff consistently reported that when (Resident #2) was transferred from her bed to the shower chair/shower room, (names of CNA #9 and CNA #1) did not use a hoyer lift to complete the transfer. (CNA #9 and CNA #1) noted that they were both aware that (Resident #2) required a hoyer lift when transferring because she is a total care resident; however, they completed the transfer with a two-person assist...." Interviews: On 4/4/19 at 7:59 AM in an interview with CNA #1, she stated, "I was on the floor and (CNA #9) asked me to help transfer her (Resident #2) from the bed to the shower chair. We sat the resident on the side of the bed, and we each got under an arm, lifted her up, and put her in the (shower) chair. When we got her in the shower chair, I left. When she (CNA #9) brought her (Resident #2) out the room, she was rolling her forward, and I told her (CNA #9) 'you need to turn her around and push her backwards. When you roll her forward, her legs need to be lifted up and supported because she can't do it herself.' So she (CNA #9) turned her (Resident #2) around and pushed her backwards, then I left. Then when she (Resident #2) was in the shower, she was complaining about her leg. I don't know if it	F 689		

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F 689	Continued From page 119	F 689		

got hung under the chair when being pushed forward." When asked about what method of lifting was required for Resident #2, CNA #1stated, "She is a Hoyer lift." When asked how the resident was usually lifted, CNA #1 stated, "Two person lift is what they usually do because she does not weigh that much." When asked what the purpose of a Hoyer lift is, CNA #1 stated, "The purpose of a Hoyer lift is when they are total care and can't do anything for themselves." When asked why staff would choose not to use a Hoyer lift, if Resident #2 was supposed to be transferred with a Hoyer lift, CNA #1 stated, "Because they used the shower chair and not a shower bed. That is something; I should have questioned but did not, I should have caught that." When asked how staff know the kind of transfer status of a resident, CNA #1 stated, "It's in their chart." When asked if CNA's typically go in the charts to find out the transfer status, CNA #1 stated, "Sometimes we do and sometimes the nurse just tells us." CNA #1 stated, "After this, me and (CNA #9) went to Social Services (of the county) and talked to them and explained what happened. Then the Administrator talked to us. He just wanted to know what happened. He was saying we should have followed the procedure and used the shower bed and the Hoyer to put her (Resident #2) in it and we didn't do that. I did it (failure to use the Hoyer lift and shower bed) because that is the way they were doing it before and I just helped her (CNA #9). I should have caught that."

On 4/5/19 at 9:53 AM, in an interview with CNA #6, when asked how she knows how to transfer a resident, she stated, "I go by their care plans. We have care plan slips for the CNAs we use that

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F 689	Continued From page 120 is located in the closet, I can ask another staff member also. I look first to find out the correct transfer method for the resident." When asked if for showers, if a resident a shower needs chair or shower stretcher, she stated, "I go by the care plan card in the closet and ask other staff also. We also have care plan books at the nurse's station also that we can look at." On 4/4/19 at 8:54 AM in an interview with RN #5 (Registered Nurse) who was the unit manager at the time of the incident, she stated, "The charge nurse came to me and told me the resident was in shower and complained to the CNA of right lower extremity pain. The charge nurse assessed the situation and notified me and I called the doctor to get orders for an xray and pain medication. After that, we went back into the room and put her on the bed so I could assess the situation. She (Resident #2) had pain upon movement and clicking in the knee area. The xray was ordered and we were awaiting for the xray company at the time. I attempted to call the RP who did not answer so I left a message to call the facility back. Then mid-afternoon was when xray arrived. Once they arrived, the xray tech performed the xray with her (Resident #2) in the bed and after the xray was completed, he notified me of the results that she had a right femur distal impacted fracture. After that, I immediately notified the Administrator and ADON (Assistant Director of Nursing) (no longer at the facility) and the doctor, and got an order to send the resident to the ER (emergency room). After the order, we called a transportation company who could not take her so we called 911. We assessed her pulses in that foot and they were very faint but present pedal pulses and the ADON was with me.	F 689		

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F 689	Continued From page 121 Once we got hospital paperwork taken care of and transport taken care of, we attempted to call the RP back who did not answer again, so I called the second RP and notified her of the transfer. At that point, her mom had phoned and I updated her on the situation. After that, EMS (emergency medical services) got here, report was given to them, hospital paperwork was given to them and they took her to the hospital. Later that evening she (Resident #2) was admitted to the hospital for a femur fracture. She required surgery for repair of it." When asked about how the injury occurred, RN #5 stated, "At the time that we noted she had pain we did not know how the injury occurred. We investigated after. From the conclusion I got from the staff is she was put in a shower chair and her leg possibly was pushed backwards when pushing the shower chair down the hall. The aids were supposed to use a Hoyer lift and should have used a shower bed instead of the shower chair and they were educated on that. She was a Hoyer lift at the time and was total care and nursing judgement would be to use a shower bed." When asked how the staff know what transfer status a resident is, RN #5 stated, "The nurses provide information on level of assistance needed and how a resident should be transferred. Care plans are kept on the unit and the aids can look at that as well." When asked if the electronic clinical record system provides aids with transfer status information, RN #5 stated, "I don't know. I can't see it from a CNA perspective." When asked if it identifies how to take care of a person, RN #5 stated, "I'm not sure what it looks like to them and if they can see that information. The staff here, are told they may access the care plans (which were on paper in notebooks on the unit). If they are uncertain they should go back to the charge nurse and ask."	F 689		

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F 689	Continued From page 122 When asked how a resident's transfer status is determined in the first place, RN #5 stated, "It is a nursing judgement to use a Hoyer or a recommendation by the therapy department. It is not a doctor's order in this facility. The use of a Hoyer was a nursing judgement and the use of a shower bed versus a shower chair was a nursing judgement. At the time there was nothing in place that dictated which had to be done for a given resident." On 4/5/19 at 1:14 PM, in an interview with RN #3, a unit manager, when asked how the facility determines a resident's shower method (shower chair vs shower bed), RN #3 stated, "I have used nursing judgement as unit manager or therapy directive. If a resident is Hoyer lifted, a shower chair may limit access to cleaning. I tend to recommend the staff use a stretcher if the resident is a Hoyer transfer. I have meetings with my staff on a regular basis, we discuss concerns, and they assist me in some of the processes. If they note a decline, they make sure this is communicated, and if therapy is not involved it would be nursing judgement. CNA's have access to the care plans to review for the CNA level." On 4/5/19 at 1:26 PM, in an interview with RN #1, a unit manager, when asked who decides a resident's transfer status, RN #1 stated, "preferably therapy. When in doubt, I would get a consult. I wouldn't get anyone up without knowing their current status." When asked once this information is decided, how is information communicated to the floor staff, RN #1 stated, "We have weekly huddles to discuss all our residents and their needs and if any of their	F 689		

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F 689	Continued From page 123 status changes." When asked how a resident's shower method (shower chair vs shower bed) is determined, RN #1stated, "Based on therapy recommendations or an RN assessment. Anything that deals with safety would preferably be an RN / Unit Manager that assesses that. Generally, if they are using a Hoyer, you will want to use the long shower stretcher because when you transfer them from a bed to a shower bed it is safer than transferring to a chair. She (Resident #2) has an AKA (above knee amputation) so her stability is not what it should be. Her (Resident #2) AKA was in the fall of 2018." When asked if the care plan was implemented and followed regarding, the resident's transfer status, RN #1 stated, "No it was not. At the time, all the communication books about the residents were properly labeled and available to the staff." On 4/4/19 at 11:04 AM, ASM #1 (Administrative Staff Member) (the Administrator), ASM #2 (the Director of Nursing - DON), and ASM #3 (Regional Vice President of Clinical Services) were made aware of the concern for harm for Resident #2. At this time, a request was made for the facility to provide any further information they had regarding the concern. On 4/4/19 at 4:30 PM, ASM #1, ASM #2, and ASM #3 were reminded no further information had yet been provided. No further information was provided. References: (1) Distal Femoral Metaphysis - The distal femur	F 689		

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F 689	Continued From page 124 is the area of the leg just above the knee joint. Information obtained from https://orthoinfo.aaos.org/en/diseases–conditions /distal-femur-thighbone-fractures-of-the-knee/ (2) ORIF - Open Reduction and Internal Fixation - a type of surgery used to fix broken bones. Information obtained from https://hcahealthcare.com/hl/?/539804/Open-Reduction-and-Internal-Fixation-Surgery (3) Ibuprofen - used to relieve pain, tenderness, swelling and stiffness...." Information obtained from https://medlineplus.gov/druginfo/meds/a682159.html 2. While using a Hoyer lift (1) to transfer Resident # 17, the facility staff failed to follow the recommended procedures, Resident # 17 fell from the lift and sustaining a head injury, and was sent to a local hospital. Resident # 17 was admitted to the facility on 03/19/2012 with diagnoses that included but were not limited to dementia (2), diabetes mellitus (3), and cerebral infarction (4). Resident # 17's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/07/18, coded Resident # 17 as scoring a 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being moderately impaired of cognition for making daily decisions. Resident # 17 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating, totally dependent of two staff members for transfers. Under G0400 "Functional Limitation in Range of Motion"	F 689		

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F 689	Continued From page 125 Resident # 17 coded as "2 (two) - impairment on both sides under "Lower Extremities (hip, knee, ankle, foot)." The comprehensive care plan for Resident # 17 dated 09/11/2018 documented, "Category: ADL (activities of daily living) Functional / Rehabilitation Potential. (Resident # 17) is [sic] 63 female. She requires extensive assist (assistance) of one with ADLs; Subacute CVA (cerebral vascular accident) with left sided hemiplegia, H/O (history of) CVA with hemiplegia to right side but not as weak as the left-she is able to use her right arm/hand effective; Hoyer lift for transfers with 2 (two) person assist. Family has asked for comfort care. OOB (out of bed) daily in G/C (Geri chair) as tolerated; alert and oriented x2 (times two) with confusion; hearing adequate. RNP (restorative nursing program) for ROM (range of motion) and putting her brace on her left arm/elbow-use palm roll in left hand to prevent further contracture. Start Date: 09/11/2018." The facility's progress notes for Resident # 17 dated 09/14/2018 documented, "At 1800 (6:00 p.m.), I was sitting at the nurse's station when screaming was heard. I immediately responded to determine the source. Upon going down the hall, the screaming was noted to be coming from resident's room. Upon entering room, resident was noted to be lying on the floor. Assessment reveals no immediate injuries to resident. A further detailed assessment found a small hematoma (5) to the right occipital (6) region of the resident's head. Resident c/o (complaint of) hurting all over but especially her head. No loss of consciousness was noted. V/S (vital signs) were noted to be: 98.1 (temperature), 74 (pulse),	F 689		

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F 689	Continued From page 126 18 (respiration), 97/68 (ninety-seven over sixty-eight blood pressure), 96% (oxygen saturation). Administrator, Unit manager, Assistant DON (director of nursing) (Name of Physician) and resident's RP (responsible party) - (Name of Responsible Party) were all notified. Received order from (Name of Physician) to send resident to ER (emergency room) for evaluation." Further review of the progress note revealed it was written by, LPN (licensed practical nurse) # 12. The facility's incident report for Resident # 17 dated 9/14/18 documented, "Brief Description: Resident was being transferred via (by) Hoyer lift and fell out of lift. Small hematoma noted to R (right) occipital area." Under witness it documented, "(CNA [certified nursing assistant] # 8." The facility's "Fall Investigation" dated 09/14/2018 for Resident # 17 documented, "Environmental/Situational Conditions: Inappropriate use of assistive device." Under "Impact from Fall" it documented, "Head injury requiring neuro (neurological) check, Injury requiring diagnostic evaluation" and "Bruise/hematoma." The facility's FRI (Facility Reported Incident) dated 09/14/2018 for Resident # 17 documented, "Allegation of neglect." Under "Describe incident, including location and action taken: CNA (Name of CNA) attempted to transfer resident (Resident # 17) into bed with Hoyer lift without assistance in room (Room Number) on North unit. CNA stated resident thrashed herself out of the Hoyer Lift pad and resident landed on her head. Resident will be sent to local ER. MD (medical doctor) and RP	F 689		

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F 689	Continued From page 127 (responsible party) notified." Under "Employee action initiated or taken: "CNA (Name of CNA) suspended 5 (five) work days during investigation." The "(Name of Hospital) ED (emergency department) Report" dated 09/14/2018 for Resident # 17 documented, "Exams: CT [computerized tomography (CT) scan [7]] HEAD WO (without) IV (intravenous) CON (contrast). INDICATION: Fall with head trauma. IMPRESSION: No acute process or significant interval change." The "(Name of Hospital) Discharge Summary" dated 09/14/2018 at 9:14 p.m., for Resident # 17 documented, "Your Discharge Instructions/Diagnoses: Contusions. Head Injury." The facility's "Clinical Orientation Checklist for Nurses Aides" for "CNA # 8 documented, "X. Safety: 3. b. Mechanical Lift (Hoyer Lift)." Further review of item number 3b, "Mechanical Lift (Hoyer Lift)" revealed the initials of a staff member next to mechanical lift. The facility's in-service sheet dated 06/21/2018 documented, "1. Topic To Be Discussed: Transferring residents facility policies." Under "2. Objectives: CNAs will know and understand the facility transfer policy and procedure." Under "4. Personnel Attending Inservice" documented (Name of CNA # 8). Further review of the in-service training material documented in part, "If a resident is a hoyer lift, which requires two people, or is a two person assist without the hoyer lift, you must transfer the resident as such, do not do it by yourself."	F 689		

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F 689	Continued From page 128 The facility's FRI for the internal investigation dated 09/21/2018 for Resident # 17 documented, "Final: Interviews completed and witness statements reviewed. Resident was interviewed, but couldn't properly verbalize the incident due to medical condition. Evidence exists that CNA (Name of CNA) failed to follow the resident's care plan for a two-person Hoyer Lift. CNA (Name of CNA) attempted to transfer resident by herself with a Hoyer Lift; the resident thrashed and fell out of the Hoyer Lift sling to the floor on her head which caused a minor hematoma. Resident was transported to ER; CT (computerized tomography) scan negative. CNA (Name of CNA's) actions violates this [sic] facilities policy and procedures for transferring a resident with Hoyer Lift. In-service on the proper method of transfer with Hoyer Lift will be conducted." Under "Employee action initiated or taken: "CNA (Name of CNA) terminated on 21Sept2018 (September 21, 2018)." During the days of the survey an attempt to interview LPN # 12 was unsuccessful due to her being out on sick leave. On 04/04/19 at 11:01 p.m. ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing, were informed that there was a concern for harm. On 04/04/19 at 12:45 p.m. ASM (administrative staff member) # 1, administrator stated that he was unable to locate an action plan related to Resident # 17's fall and injury. On 04/04/19 at 2:11 p.m., an interview was conducted with CNA (certified nursing assistant) #	F 689		

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F 689	Continued From page 129 1. When asked where she would obtain information on how to transfer a resident, CNA # 1 stated, "I would ask the nurse and/or check the care plan if the nurse was not available." When asked to describe the procedure for using a Hoyer lift to transfer a resident, CNA # 1 stated, "When using the Hoyer lift it is always at least a two person procedure." When asked how or where she obtained that information, CNA # 1 stated, "It was presented in training." On 04/04/19 at 2:24 p.m., an interview was conducted with CNA # 6 When asked where she would obtain information on how to transfer a resident, CNA # 6 stated, "The information is posted on the inside of the resident's closet door. It's a care card." When asked to describe the procedure for using a Hoyer lift to transfer a resident, CNA # 1 stated, "It is always two persons." When asked how or where she obtained that information, CNA # 6 stated, "In training." On 04/04/19 at 2:36 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked where a CNA would obtain information on how to transfer a resident, LPN # 1 stated, "The CNA would ask their nurse or one of the other CNAs." When asked to describe the procedure for using a Hoyer lift to transfer a resident, LPN # 1 stated, "When using the Hoyer lift there is always a minimum of two staff. We are instructed on that in our orientation and annual education/in-service." On 04/04/19 at 3:06 p.m., an interview was conducted with RN (registered nurse) # 3, unit manager. When asked where a CNA would obtain information on how to transfer a resident,	F 689		

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F 689	Continued From page 130 RN # 3 stated, "There is a transfer book at each unit, the book contains all the information for each resident to transfer them safely or the care plan or the direction of the charge nurse." When asked to describe the procedure for using a Hoyer lift to transfer a resident, RN #3 stated, "Use of a Hoyer lift is always two persons, it is part of the staff's orientation." On 04/05/19 at 12:15 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After reviewing, the facility's "Clinical Orientation Checklist for Nurses Aides" ASM # 2 was asked to describe the purpose of the initials after "Mechanical lift (Hoyer Lift)". ASM # 2 stated, "The initials indicate the CNA demonstrated competency with the hoyer lift." On 04/04/19 at approximately 6:45 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing and ASM # 3, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. Reference: (1) Used for transfers when a person requires 90-100% assistance to get into and out of bed. A pad fits under the person's body in the bed and connects with chains to the Hoyer lift frame. A hydraulic pump is used to lift the person off the bed surface. This information was obtained from the website:http://www.free-foundation.org/hoyer-lifts (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language,	F 689		

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F 689	Continued From page 131 judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (5) Hematoma is a mass of usually clotted blood that forms in a tissue, organ, or body space as a result of a broken blood vessel . This information was obtained from the website: https://www.merriam-webster.com/dictionary/hematoma (6) The occipital bone is the trapezoidal-shaped bone found at the lower-back area of the cranium. The occipital is cupped like a saucer in order to house the back part of the brain. It is one of seven bones that fuse together to form the skull and is directly next to five of the cranium bones. This information was obtained from the website: https://www.healthline.com/human-body-maps/occipital-bone#1. (7) A computerized tomography (CT) scan combines a series of X-ray images taken from	F 689		

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F 689	Continued From page 132 different angles around your body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside your body. CT scan images provide more-detailed information than plain X-rays do. This information was obtained from the website:https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.	F 689		
F 695	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policies review, and clinical record review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan for one of 47 residents in the survey sample, Resident # 83. The facility staff failed to administer Resident # 83's oxygen according to the physician's orders. The findings include: Resident # 83 was admitted to the facility on	F 695	**F 695** It is the practice of this facility to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan. **I** As stated in the statement of deficiency report, and during survey, RN #3 adjusted the oxygen flow rate at 2 liters per minute following MD orders. Resident # 83 had no negative outcome. **II** On 4/3/19 an audit of all residents with oxygen was completed, to verify that the oxygen was turned on and that the O2 gage(s) were working properly. Any discrepancy noted with the audit was corrected at that time. There was no negative outcome as a result of the audit.	5-9-19

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F 695	Continued From page 133 03/13/2019 with diagnoses that included but were not limited to: pneumonia (1), chronic obstructive pulmonary disease (2), and acute respiratory failure (3) with hypoxia (4). Resident # 83's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/27/2019, coded Resident # 83 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being no cognitive impairment for making daily decisions. Resident # 83 was coded as requiring extensive assistance of one staff member for activities of daily living and supervision of one staff member for eating. Under section "O. Special Treatment, Procedures and Programs" Resident # 83 was coded for "C. Oxygen therapy." On 04/02/19 at 12:16 p.m., an observation of Resident # 83 revealed she was sitting up in her wheelchair at the dining table waiting for her meal. Resident # 83 appeared to be drowsy and occasionally nodding off. Further observation revealed Resident # 83 was wearing a nasal cannula connected to a portable oxygen tank. Observation of the oxygen flow meter on the oxygen tank revealed the oxygen flow- rate knob was set on the off position. At 12: 33 p.m., approximately 17 minutes later, RN # 3 was observed setting Resident # 83's oxygen flow rate at two litters per minute. On 04/03/19 at 9:27 a.m., an observation of Resident # 83 revealed she was lying in bed receiving oxygen by nasal cannula. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate at two liters per minute.	F 695	**III** On or before, 5/4/19 the DON, Unit Managers or designee will complete an in-service education for licensed nurses regarding: • Oxygen services: including the verification that the oxygen is being delivered per MD order and maintenance of O2 - gages to ensure they are working properly Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 695	Continued From page 134 The POS (physician's order sheet) for Resident # 83 dated 03/13/2019, documented, "O2 (oxygen) at 2 L (two liters) via (by) NC (nasal cannula) continuously, [chronic obstructive pulmonary disease]. Every shift; day shift, evening shift, night shift] Order Date: 03/13/2019." The comprehensive care plan for Resident # 83 dated 03/22/2019 documented under "goals", "Resident will not exhibit signs of hypoxia (cyanosis (5), tachypnea(6), dyspnea (7), confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, and increased pulse)." Under "approach" it documented, "Oxygen via (by) N/C (nasal cannula) as ordered. Start Date: 03/22/2019." On 04/04/19 at 1:23 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked how staff determine how much oxygen a resident is receiving, LPN # 1 stated, "I check the physician's order and I check the resident pulse oximetry (8)." When asked what the physician's order documented for Resident # 83's oxygen, LPN # 1 stated "Two liters." When asked if the physician's order for oxygen is being followed, if Resident #83's oxygen flow- rate knob is turned to the off position. LPN # 1 stated, "No, the physician's orders were not followed." A review of the facility policy titled, "oxygen administration" documented in part, "1. Oxygen is administered to the resident only upon written order of a licensed physician." On 04/04/19 at approximately 4:52 p.m., ASM (administrative staff member) # 1, the administrator, was made aware of the findings.	F 695	**IV** Beginning 5/4/19 the DON, Unit Managers or designee will conduct audits of residents on oxygen to validate that the oxygen is being delivered per MD orders. This audit will take place on 20% of the residents with oxygen, 5 days per week for 1 week, then 2 times per week for 1 week then weekly for 8 weeks. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted, by the DON, monthly, to the QAPI committee for its review and recommendations	

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F 695	Continued From page 135 No further information was provided prior to exit. Reference: 1. An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html. 2. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 3. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 4. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia. 5. A bluish color to the skin or mucous membrane is usually due to a lack of oxygen in the blood. The medical term is cyanosis. https://medlineplus.gov/ency/article/003215.htm	F 695		

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F 695	Continued From page 136 6. Breathing - rapid and shallow; Fast shallow breathing. https://medlineplus.gov/ency/article/007198.htm - Medical Encyclopedia 7. When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This information was obtained from the website: https://medlineplus.gov/breathingproblems.html. 8. Most people need an oxygen saturation level of at least 89% to keep their cells healthy. Having an oxygen level lower than this for a short time is not believed to cause damage. However, your cells can be strained or damaged if low oxygen levels happen many times. If your oxygen level is low on room air, you may be asked to use supplemental (extra) oxygen. The oximeter can be used to help see how much oxygen you need and when you may need it. This information was obtained from the website: file:///C:/Users/mth39879/Downloads/pulse-oximetry.pdf	F 695		
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	F 758	**F 758** It is the practice of this facility that 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	5-9-19

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F 758	Continued From page 137 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended 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	F 758	**I** The MD for Resident # 45 was contacted, and additional GDR for Seraquel medication was begun on 4/6/19 through 4/20/19 and is now discontinued. **II** Licensed nurses will provide interventions per the care plan for resident behaviors. The Unit managers/designee compiled a list of residents with new orders for psychotropic medications, retro to January 1, 2019, to determine if any other resident had recent addition of psychotropic medications. Any new or increased psychotropic medication noted during the audit will be brought to the attention of the physician for review.	

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	495358		C 04/05/2019

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F 758	Continued From page 138 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, facility document review and clinical record review, it was determined the facility staff failed to ensure one resident (Resident #45) of 47 sampled residents were free of unnecessary psychotropic medications. The facility staff restarted an antipsychotic medication without proper indications for Resident #45. The findings included: Resident #45 was admitted to the facility on 4/2/12 with diagnoses that included but were not limited to: anxiety disorder, dementia, and high blood pressure. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/15/19, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as having disorganized thinking and physical behavior directed towards others on one-three days of the look back period. Resident #45 was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antipsychotic and an antidepressant. The pharmacy "Consultant Report" dated,	F 758	**III** On or before May 8, 2019 the DON, Unit Managers or designee will complete in-service education for licensed nurses and agency nurses regarding: • F 758 - Un-necessary psychotropic medications and PRN use. • Use of non-pharmalogical interventions before psychotropic medications • Documenting care plan interventions • Following the care plan for non-pharmalogical interventions. Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 758	Continued From page 139 9/13/18 documented in part, "DC (discontinue) Seroquel [an antipsychotic medication used to treat schizophrenia, bipolar depression and in conjunction with other medication for depression) (1). Lexapro (used to treat depression and general anxiety disorder (2)] 5 mg (milligrams) daily." A physician telephone order dated, 12/8/18, documented, "Seroquel 25 mg, amt (amount) 0.5 (half a tablet) tab (tablet) daily." This order was received by LPN (licensed practical nurse) #10. The physician progress note dated, 12/5/18, documented in part, "a/p (approach/plan) - 4. dementia w/ (with) behaviors - severe - on Seroquel...6. Anxiety - on Lexapro." The physician progress note dated, 2/1/19, documented in part, "a/p - 4. dementia w/ behaviors - severe - on Seroquel...6. Anxiety - on Lexapro." Review of the physician order summaries for October and November 2018 failed to evidence a physician order for Seroquel. The nurse's notes for September 2018 were reviewed. The following was documented: 9/1/18 at 6:49 a.m. - No behavior issues noted at this time: 9/2/18 at 11:02 a.m. - No behavior issues noted at this time: 9/4/18 at 6:34 a.m. - No behavior issues noted at this time: 9/4/18 at 12:56 p.m. - No behavior issues noted at this time: 9/5/18 at 6:00 a.m. - No behavior issues noted at this time:	F 758	**IV** Beginning 5/6/19 the DON, Unit Managers or designee will conduct an audit of newly prescribed psychotropic medications to ensure that the care plan for non pharmalogical interventions is being followed and documented before an order for a psychotropic medication is obtained. Any discrepancy noted during the audit will be addressed at that time with notification to the attending MD. Results of the audits will be submitted monthly, by the DON, to the QAPI committee for its review and recommendations.	

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F 758	Continued From page 140 9/6/18 at 6:19 a.m. - No behavior issues noted at this time: 9/6/18 at 1:28 p.m. - No behavior issues noted at this time: 9/7/18 ar 12:52 p.m. - No behavior issues noted at this time: 9/9/18 at 5:51 a.m. -No behavior issues noted at this time: 9/10/18 at 6:28 a.m. - No behavior issues noted at this time: 9/10/18 at 12:36 p.m. - No behavior issues noted at this time: 9/11/18 at 12:46 p.m. - No behavior issues noted at this time: 9/12/18 at 8:00 a.m. - No behavior issues noted at this time: 9/12/18 at 1:45 p.m. - No behavior issues noted at this time: 9/13/18 at 1:11 p.m. - No behavior issues noted at this time: 9/14/18 at 7:34 a.m. - No behavior issues noted at this time: 9/15/18 at 5:43 a.m. - No behavior issues noted at this time: 9/16/18 at 2:32 p.m. - No behavior issues noted at this time: 9/17/18 at 1:20 p.m. - No behavior issues noted at this time: 9/18/18 at 3:03 p.m. - No behavior issues noted at this time: 9/19/19 at 8:46 a.m. - No behavior issues noted at this time: 9/20/19 at 2:15 p.m. - No behavior issues noted at this time: 9/21/18 at 11:41 a.m. - No behavior issues noted at this time: 9/23/18 at 5:50 a.m. - No behavior issues noted at this time: 9/24/18 at 6:17 a.m. - No behavior issues noted	F 758		

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F 758	Continued From page 141 at this time: 9/24/18 at 2:01 p.m. - No behavior issues noted at this time: 9/24/18 at 2:49 p.m. - New order noted by (name of doctor) to DC Seroquel and decrease Lexapro to 5 mg daily at this time. 9/27/18 at 2:26 p.m. - No behavior issues noted at this time: 9/28/18 at 6:23 a.m. - No behavior issues noted at this time: The October nurse's notes documented the following: 10/1/18 at 3:04 p.m. - resident combative towards aides during continence care, one on one given by writer and resident accepted. No further behavior issues noted at this time. 10/2/18 at 8:44 a.m. - No behavior issues noted at this time: 10/2/18 at 12:23 p.m. - No behavior issues noted at this time: 10/3/18 at 6:21 a.m. - No behavior issues noted at this time: 10/4/18 at 9:37 a.m. - No behavior issues noted through the night 10/4/18 at 12:26 p.m. - No behavior issues noted at this time: 10/5/18 at 4:28 a.m. - No behavior issues noted at this time: 10/7/18 at 12:07 p.m. - No behavior issues noted at this time: 10/8/18 at 6:54 a.m. - No behavior issues noted at this time: 10/8/18 at 3:32p.m. - No behavior issues noted throughout day shift. 10/9/18 at 12:35 p.m. - No behavior issues noted at this time: 10/11/18 at 2:33 p.m. - No behavior issues noted at this time:	F 758		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 142 10/13/18 at 6:03 a.m. - No behavior issues noted at this time: 10/16/18 at 7:01 a.m. - No behavior issues noted at this time: 10/16/18 at 8:27 a.m. - Res (resident) noted confused, thinks she is at home, 1:1 (one to one) given without effect. 10/17/18 at 6:13 a.m. - No behavior issues noted at this time: 10/18/18 at 8:02 a.m. - No behavior issues noted through the night 10/21/18 at 10:57 a.m. - Resident noted with confusion still this shift continually asking for help and having to be redirected multiple times which was noted somewhat effective altering behavior. 10/21/18 at 9:30 p.m. - Resident noted with increased confusion this shift aeb (as exhibited by) multiple attempts to exits seeking trying to find 'the care outside,' 1:1 rendered somewhat effective in altering behaviors. 10/23/18 at 3:12 p.m. - No behavior issues noted. 10/24/18 at 5:43 a.m. - No behavior issues noted at this time: 10/24/18 at 4:28 p.m. - No behavior issues noted throughout day shift. 10/25/18 at 7:44 a.m. - No behavior issues noted at this time: 10/25/18 at 3:06 p.m. - No behavior issues noted throughout day shift 10/26/18 at 5:30 a.m. - No behavior issues noted at this time: 10/27/18 at 5:37 a.m. - No behavior issues noted at this time: 10/27/18 at 12:59 p.m. - No behavior issues noted at this time: 10/28/18 at 2:24 p.m. - No behavior issues noted at this time: 10/29/18 at 11:40 a.m. - No behavior issues noted at this time:	F 758		

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F 758	Continued From page 143 10/30/18 at 6:49 a.m. - No behavior issues noted at this time: 10/30/18 at 10:33 a.m. - Resident resistive & (and) combative during am (morning) care, writer given one to one encouragement and resident accepted redirection easily....No further behavior issues noted at this time. 10/31/18 at 7:23 a.m. - No behavior issues noted through the night The November nurses notes documented the following: 11/1/18 at 5:25 a.m. - Res with increased confusion, thinking she was at home, noted awake most of the shift talking outloud (sic). 11/1/18 at 2:39 p.m. - No behavior issues noted at this time: 11/2/18 at 6:08 a.m. - No behavior issues noted at this time: 11/4/18 at 6:10 a.m. - No behavior issues noted this shift 11/5/18 at 10:16 a.m. - No behavior issues noted through the night 11/6/18 at 4:25 p.m. - No behavior issues noted throughout day shift 11/8/18 at 6:40 a.m. - No behavior issues noted at this time: 11/10/18 at 5:50 a.m. - No behavior issues noted at this time: 11/13/18 at 6:35 a.m. - No behavior issues noted at this time: 11/15/18 at 6:01 a.m. - No behavior issues noted at this time: 11/19/18 at 6:58 a.m. - No behavior issues noted at this time: 11/19/18 at 10:42 a.m. - resident combative during adl (activities of daily living), one on one given and resident accepted redirection, no further behavior issues noted at this time.	F 758		

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F 758	Continued From page 144 11/21/18 at 5:59 a.m. - No behavior issues noted at this time: 11/22/18 at 6:04 a.m. - No behavior issues noted at this time: 11/24/18 at 6:07 a.m. - No behavior issues noted at this time: 11/27/18 at 6:47 a.m. - No behavior issues noted at this time: 11/28/18 at 7:37 a.m. - No behavior issues noted at this time: 11/30/18 at 5:36 a.m. - No behavior issues noted at this time: 11/30/18 at 5:46 p.m. - Often times, resident requests staff to call daughters and husband to come take her home. The December 2018 nurse's notes documented the following: 12/2/18 at 6:10 a.m. - No behavior issues noted at this time: 12/2/18 at 8:04 a.m. - Res refused nail care. 12/5/18 at 8:42 a.m. - No behavior issues noted through the night 12/6/18 at 7:28 a.m. - No behavior issues noted at this time: 12/7/18 at 8:23 a.m. - No behavior issues noted through the night 12/8/18 at 2:41 a.m. - Res awake at beginning of shift, noted with increased confusion, stating 'I need to call my husband and let him know where I am,' 1:1 given with positive effect. 12/8/18 at 6:10 a.m. - Res awake all shift talking outloud (sic) to self. Res up in dayroom at this time, stating 'I have to go home,' 1:1 ineffective." There were no further notes for 12/8/18. The next note related to behavior was on 12/12/18 at 8:17 a.m. - No behavior issues noted through the night.	F 758		

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F 758	Continued From page 145 The comprehensive care plan dated, 11/19/18, documented in part, "Problem: Anxiety, received psychotropic daily. Seroquel d/c during review for GDR (gradual dose reduction); mood appears to remain stable most times. Can be combative and curse staff at times when performing care, continues to sleep in chair while up and doesn't like to be bothered likely associated with advancing dementia. Melatonin added for insomnia." Added on 12/8/18, "Seroquel per orders d/t (due to) increased agitation." The "Approaches" documented in part, "Attempt gradual dose reduction. monitor and record (Resident #45)'s behavior when combative to determine the need for medication adjustments. Monitor (Resident #45) for increased anxiety during care and attempt to redirect behavior by talking to her, providing music or leaving her alone and coming back later to try again. Offer snack before bedtime or when resident awakens during night. Provide comfortable environment to promote sleep (e.g., clean bedding, comfortable bed clothing, incontinence care, comfortable temperature, ventilation). When resident awakens during the night, provide comfort measures (e.g., back rub, repositioning, incontinence care, snack)." An interview was conducted with administrative staff member (ASM) # 4, the attending physician, on 4/5/19 at 11:52 a.m. The pharmacy consultant report of 9/13/18 was reviewed with ASM #4. The new physician order dated 12/8/18 was reviewed with ASM #4. ASM #4 was asked to review the nurse's notes of 12/8/18. When asked where about the location of his documentation regarding the reason why the Seroquel was restarted on 12/8/18, ASM #4 reviewed his progress notes and stated, "I don't see any documentation as to	F 758		

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F 758	Continued From page 146	F 758		

why it was restarted. It had to be some reason, that's an omission on my part, it should be documented."

An interview was conducted with RN (registered nurse) #3 on 4/5/18 at 12:16 p.m. When asked why Resident #45 was restarted on the Seroquel on 12/8/18, RN #3 stated, "I know there was a note on `12/8/18 that she had behaviors." When asked if the resident had two documented behaviors in one shift, is that a reason to restart the Seroquel, RN #3 did not respond.

A second interview was conducted with ASM #4 on 4/5/18 at 12:36 p.m. When asked if one episode of behavior on one shift was an appropriate reason to restart the Seroquel, ASM #4 stated, "I would say no." When asked if the documentation revealed that she was a danger to herself or others, ASM #4 stated, "No. It's my bad because I didn't document why it was restarted and if the behaviors were that bad, I would have expected the nurse to write a more descriptive note."

An interview was conducted with ASM #2, the director of nursing; on 4/5/18 at 12:44 p.m., ASM #2 was asked to review the nurse's notes of 12/8/18. Once reviewed, ASM #2 was asked if the behaviors documented on the one shift on 12/8/18 would be reason to restart Seroquel, ASM #2 stated, "No, I don't think so." ASM #2 was asked if the LPN who wrote the order for Seroquel was available for interview, ASM #2 stated that the employee was no longer employed at the facility.

The facility policy, "Psychotropic Drugs" documented in part, "Standard: The facility will

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F 758	Continued From page 147 develop and maintain a system for assuring proper use and monitoring of psychoactive agents. Psychoactive agents can only be used on receipt of physician's order to eliminate or reduce identified behavioral symptoms or to treat a specific diagnosis....Procedure: 1. Initiation of Psychoactive drug therapy: a. The resident's chart must contain an appropriate diagnosis for the use and the diagnosis should also be entered onto the Physician's Order Sheet and on the Medication Administration Record. b. Non-Drug interventions have been attempted and documented as ineffective...2. Monitoring Routine Use of Psychoactive Drugs:..2. Define and document specific behavioral problems within the nursing notes. 3. Set reasonable and measurable objectives and reflect this in the resident's care plan...5. Charting of occurrence will be reflected as follows: Each occurrence, or lack of occurrence, will be noted for each day and shift. 6. Physician will routinely comment on progress of resident in medical progress notes." ASM (administrative staff member) #1, the administrator and ASM #3, the vice president of clinical services were made aware of the above concern on 4/5/19 at 1:45 p.m. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.html (2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=lexapro	F 758		

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F 761	Continued From page 148	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure expired medications were not available for use in two of two medication carts, (South Back Unit medication cart and the facility's North Front Unit medication cart). The facility staff failed to ensure four expired	F 761	**F 761** It is the practice of this facility that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable. **I** There were no specific residents identified for this citation. As noted in the statement of deficiencies, LPN #8 removed the Advair and Flovent from the South wing medication cart. The expired medications were removed from the North wing medication cart.	5-9-19

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F 761	Continued From page 149 inhalers, three Advairs (1) and one Flovent (2) were not available for use on two of two medication carts. The findings include: On 04/05/19 at approximately 2:00 p.m., an observation of the facility's South Back Unit medication cart was conducted with LPN (licensed practical nurse) # 8. Observation of the bottom drawer of the medication cart revealed the following: Advair 100/50 mcg (microgram) with an open date documented on the inhaler of 12/16/18. One Advair 500/50 mcg, open without an open date documented on the Advair box or inhaler and Flovent 100 mcg open without an open date documented on the Flovent box or inhaler. On 04/05/19 at approximately 2:20 p.m., an interview was conducted with LPN # 8. When asked how long the Advair 100/50 mcg with the open dated of 12/16/18 was good for and how long the Advair 500/50 mcg and Flovent 100 mcg had been, opened, LPN # 8 stated that she did know. A review of the manufacturer's instructions and description of the Advair and Flovent with LPN # 8 failed to evidence documentation of how long the inhalers were good for after being opened. LPN # 8 stated she would call the pharmacist. LPN # 8 immediately telephoned the pharmacist in the presence of this surveyor. During the telephone conversation with the pharmacist, they stated that Advair and Flovent were expired after 30 days from the open date. A request was then made by LPN # 8 during the telephone conversation with the pharmacist in the presence of this surveyor to send the information regarding the inhalers by facsimile to the facility.	F 761	II Licensed nurses will follow accepted professional principles to ensure that multi-dose vials of medication, to include respiratory medication, are dated when opened. The Unit managers / designee conducted an audit of medication carts to validate that multi-dose vials, including respiratory medications, were dated when opened. Any discrepancy noted during the audits, if any, were addressed at that time with removal of the unlabeled or outdated medication and newly opened and labeled medication in its place.	

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F 761	Continued From page 150 LPN # 8 was asked about the Advair 11/50 mcg with the open date of 12/16/18. LPN # 8 stated, "It's expired." When asked about the Advair 500/50 mcg and Flovent 100 mcg both without open dates LPN # 8 stated that without the open date she didn't know how long they had been opened and removed them from the medication cart. When asked to describe the procedure to ensure expired medication are not available for use, LPN # 8 stated, "They should be checked before administering them." On 04/05/19 at approximately 2:25 p.m., an observation of the facility's North Front Unit medication cart was conducted with LPN (licensed practical nurse) # 9. Observation of the bottom drawer of the medication cart revealed the following: Advair 250/50 mcg with an open date documented on the inhaler of 02/22/19. LPN # 9 agreed that it was expired. When asked to describe the procedure to ensure expired medication are available for use LPN # 8 stated, "They should be checked before administering them." The facility's policy "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "4. Facility should ensure that medications and biologicals: 4.1 Have an expiration date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines; or, 4.3 Have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier." "Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads "0" (after all blisters have been used), whichever comes	F 761	**III** On or before 5/4/19 the DON, Unit Managers or designee will conduct an in-service education for facility licensed nurses and agency nurses regarding: • F 761- Labeling/Storage of Drugs and biologicals. Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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F 761	Continued From page 151 first." This information was obtained from the following website:https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=4eeb5f6a-593f-4a9e-9692-adefa2caf8fc "Fluticasone Oral Inhalation (Flovent): What should I know about storage and disposal of this medication? Store your fluticasone aerosol inhaler with the mouthpiece pointing down. Store it out of reach of children, at room temperature and away from excess heat and moisture (not in the bathroom). .. If you are using the fluticasone powder for inhalation 100 mcg or 250 mcg, you must dispose of the inhaler 2 months after opening the foil pouch." This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601056.html On 04/05/19 at approximately 3:15 p.m. ASM (administrative staff member) # 3, the vice president of clinical services, was made aware of the findings. No further information was provided prior to exit. References: (1) The combination of fluticasone and salmeterol (Advair Diskus, Advair HFA) is used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma. The combination of fluticasone and salmeterol (Advair Diskus) is also used to prevent and treat wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease (COPD; a group of lung diseases that includes chronic bronchitis and	F 761	**IV** Beginning 5/6/19 the DON, Unit Managers or designee will conduct audits of medication carts to verify that each multi dose vial or package is dated when opened and not past the recommended use date. This audit will take place weekly for 8 weeks and encompass each medication cart. Any discrepancy noted during the audit will be corrected at that time. Results of the audit will be submitted, monthly, by the DON, to the QAPI committee for it review and recommendations.	

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F 761	Continued From page 152 emphysema). The combination of fluticasone and salmeterol (Advair Diskus) is used in adults and children 4 years of age and older. The combination of fluticasone and salmeterol (Advair HFA) is used in children 12 years of age and older. Fluticasone is in a class of medications called steroids. It works by reducing swelling in the airways. Salmeterol is in a class of medications called long-acting beta-agonists (LABAs). It works by relaxing and opening air passages in the lungs, making it easier to breathe. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a699063.html. (2) Fluticasone oral inhalation is used to prevent difficulty breathing, chest tightness, wheezing, and coughing caused by asthma in adults and children 4 years of age and older. It is in a class of medications called corticosteroids. Fluticasone works by decreasing swelling and irritation in the airways to allow for easier breathing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601056.html.	F 761		
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.	F 812	**F 812** It is the practice of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety.	5-9-19

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F 812	Continued From page 153 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store and serve food in a sanitary manner in one of one facility kitchen. 1. An unopened three pound bag of an unlabeled item reported to be 'ginger liver' by OSM (other staff member) #1 was observed stored in the freezer without manufacturer expiration date, or use-by-date and no labeling of the contents on the bag. 2. The facility staff failed to maintain the food mixer in a sanitary manner in the facility kitchen. The findings include: On 04/02/19 at approximately 11:21 a.m., observation of the kitchen was conducted with OSM (other staff member) #1, dietary manager. Observation of the walk in freezer revealed an unopened three-pound bag of frozen item. OSM #1 stated the bag contained ginger liver. The ginger liver bag was missing any indication of when it was received in the facility, when it was stored in the freezer, the manufacturer expiration date, the use-by-date, and the name of the item	F 812	I On April 2, 2019 the dietary manager removed and discarded the items that were not dated or labeled and had the mixer recleaned and verified its readiness for use. There were no specific residents listed in the statement of deficiencies for this citation. II The dietary staff will label and date foods in accordance with accepted standards of practice. During survey, the DM conducted an audit of the kitchen refrigerators and found no other foods not labeled or dated. The mixer was cleaned and re-covered, ready for use.	

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F 812	Continued From page 154 in the bag. When OSM # 1 was asked how he knew when the item was put in storage and when it was going to expire, OSM # 1 stated, "I have no idea when the item is going to expire and the item should have a label indicating the expiration date or the use-by-date." Observation of the food mixer revealed it assembled, sitting on the food preparation table and covered with a plastic bag. When asked if the food mixer was cleaned and ready for use, OSM # 1 stated, "Yes." OSM # 1 then removed the bag covering the food mixer. Further observation of the food mixer revealed debris on the inside surface and on and around the handle area the of the food mixer. OSM # 1 was asked to observe the debris on the food mixer. When asked if the debris was food debris, OSM # 1 stated yes and agreed the food mixer was not clean. When asked how often the food mixer should be cleaned, OSM # 1 stated, "After each use, with soap and water and rinse with warm water until all debris are gone." The facility policy "CLEANING" documented, "[WARNING] unplug machine power cord before beginning any cleaning procedure. The mixer should be thoroughly cleaned daily. [DO NOT] use hose to clean mixer; it should washed with a clean, damp cloth. The facility staff was ask for the kitchen foods storage policies but no additional information was provided. On 04/03/19 at approximately 6:01 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, director of nursing, and ASM # 3, clinical regional vice president, were	F 812	**III** On or before, 5/4/19 the Dietary Manager or designee will complete education for dietary staff regarding: • F 812—Food safety and labeling requirements • Maintaining cleanliness of equipment • Kitchen sanitation Newly hired dietary staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift **IV** Beginning 4/29/19 the DM will conduct audits of the labeling and dating of food in the kitchen and audit the cleanliness of kitchen equipment. This audit will be conducted 5 days per week for 2 weeks, then weekly for 8 weeks. Any discrepancy noted during the audit will be corrected at that time and re-education provided to dietary staff as indicated. The dietary manager will submit results of the audits to the QAPI committee monthly for its review and recommendations.	

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F 812	Continued From page 155 made aware of the findings. No further information was provided prior to exit.	F 812	**F 814** **I** There were no residents identified as being affected by the alleged deficient practice. The Dietary Manager corrected the alleged deficient practice by removing the glove that was found on the ground behind the dumpster	5-9-19
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster area in a sanitary manner. The findings include: One pair of used plastic gloves was found lying on the ground around the facility's trash compactor. On 04/03/19 at 12:47 p.m., an observation of the facility's trash compactor and garbage dumpster was conducted with OSM, (other staff member), # 1, dietary manager. The facility's trash compactor was located approximately 50 feet from the back of the facility. Observation of the trash compactor area revealed that there was a compactor and a metal dumpster on the ground with no fence around them. Further observation of the trash compactor area revealed one pair of used plastic gloves lying on the ground around the trash compactor. When asked who was responsible for keeping the trash compactor and the dumpster area cleaned and picked up, OSM # 1 stated, "It is a joint responsibility between the kitchen staff, the maintenance crew, and the housekeeping staff." When asked how often the trash compactor and dumpster area was cleaned up, OSM # 1 stated, "I believe maintenance crew	F 814	**II** The area surrounding the dumpster will be maintained without trash on the ground surrounding the dumpster. **III** On or before 5/4/19 the Dietary Manager will complete in-service education for dietary staff regarding: • F 814-Dispose of garbage and refuse properly Newly hired dietary staff will receive this education during orientation. Any PRN staff or those on FMLA, LOA or vacation will receive this training prior to returning to work. The dietary department does not employ agency personnel	

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F 814	Continued From page 156 cleans the area daily and the kitchen staff clean as we go." When asked if there should be used gloves around the dumpster and the trash compactor, OSM # 1 stated, "No, there should not be any trash around the dumpster area and I am getting rid of it now." When asked why it was important to keep the trash compactor and the dumpster area cleaned and picked up, OSM # 1 stated, "To prevent contamination." Facility was asked to provide their policies regarding the facility's cleaning of the garbage and the refuse area but no additional information was provided. On 04/03/19 at approximately 6:01 p.m., ASM, (administrative staff member), # 1, the administrator, ASM # 2, director of nursing, and ASM # 3, regional vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	F 814	On or before 5/4/19 the Housekeeping Manager will complete in-service education for housekeeping staff regarding: • F 814-Dispose of garbage and refuse properly Newly hired housekeeping staff will receive this education during orientation. Any staff on FMLA, LOA or vacation will receive this training prior to returning to work. The housekeeping department does not employ agency personnel **IV**	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	Beginning 5/6/19 the dietary manager and the housekeeping supervisor will conduct separate audits of the dumpster area to ensure that it is maintained in a sanitary manner. Any discrepancy noted during the audit will be corrected at that time. Results of each audit will be submitted by the respective department manager, monthly, to the QAPI committee for its review and recommendations.	5-9-19

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F 814	Continued From page 156 cleans the area daily and the kitchen staff clean as we go." When asked if there should be used gloves around the dumpster and the trash compactor, OSM # 1 stated, "No, there should not be any trash around the dumpster area and I am getting rid of it now." When asked why it was important to keep the trash compactor and the dumpster area cleaned and picked up, OSM # 1 stated, "To prevent contamination." Facility was asked to provide their policies regarding the facility's cleaning of the garbage and the refuse area but no additional information was provided. On 04/03/19 at approximately 6:01 p.m., ASM, (administrative staff member), # 1, the administrator, ASM # 2, director of nursing, and ASM # 3, regional vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	F 814		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	**F 880** It is the practice of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	5-9-19

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F 880	Continued From page 157 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	I Resident # 34 had no negative outcome and his/her current wounds have no signs of infection as a result of the alleged deficient practice. RN #1 no longer works at the facility. Resident #23 had no negative outcome as a result of the alleged deficient practice. There were no specific residents identified in the statement of deficiencies related to staff touching the surface of plates being served to residents. II Licensed nurses will follow infection control practices during the completion of treatments Licensed nurses will follow infection control practices during medication pass Facility staff will follow infection control practices when delivering food on plates and setting up food for residents during meals.	

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F 880	Continued From page 158 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow infection control practices for one of 47 residents in the survey sample and for one of six residents in the medication administration observation, (Resident #23), and in one of one facility dining rooms, (main dining room). 1. The facility staff failed to follow infection control practices during a wound are observation for Resident # 34. 2. The facility staff popped Resident #23's pills into a gloved hand that had just touched the medication cart and then administered the medication to Resident #23. 3. The facility staff failed to serve food to the residents in a sanitary manner during a dining room observation. Staff were observed touching the food surface of plates that were then served to residents. The findings include:	F 880	**III** On or before 5/4/19 the DON, Unit Managers, or designee will conduct an in-service education for facility licensed nurses and agency nurses regarding: • F 880 —Infection Prevention and Control to include medication pass infection principles and infection control during treatments. • Use of gloves and handwashing requirements. • Medication pass principles governing infection control Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift On or before 5/4/19 the DON, Unit Managers, or designee will conduct an in-service education for nursing staff to include agency nurses regarding: • F 880 —Infection Prevention and Control as it relates to carrying and delivery and set up of food items	

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F 880	Continued From page 159 1. The facility staff failed to follow infection control practices during a wound care observation for Resident # 34. Resident # 34 was admitted to the facility on 10/22/2018 with diagnoses that included but were not limited to respiratory failure, diabetes mellitus [a complex and chronic disorder of metabolism due either to partial or total lack of insulin secretion by the pancreas (1)], chronic kidney disease requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine (2)], and depression. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 3/23/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily cognitive decisions. Resident #34 was coded as requiring extensive assistance of one staff member for most of her activities of daily living. Observation was made on 4/5/19 at 7:50 a.m. of Resident #34's skin, accompanied by RN (registered nurse) #1. RN #1 proceeded to gather her supplies to take in the room. RN #1 was observed taking her computer into the resident's room and placing it on a stack of the resident belongings in the resident's chair. She also brought in a box of wound measuring plastic sheets and placed the box on the resident's bed, on top of the sheets. The resident's sheet and blanket were pulled back to the footboard of the bed. RN #1 took the box of wound measuring	F 880	**IV** Beginning 5/6/19 the DON, Unit Managers, Infection Control nurse or designee will conduct an audit of completion of dressing changes to verify that infection control practices are maintained during dressing changes. Any discrepancy noted during the audit will be addressed at that time with immediate education to the staff member. Results of the audit will be submitted by the Infection control nurse, monthly, to the QAPI committee for its review and recommendations. Beginning 5/6/19, the DON, Unit Managers, Infection Control nurse or designee will conduct random audits re: medication pass observations to verify that infection control practices are maintained during medication pass. Any discrepancy noted during the audit will be addressed at that time with immediate education to the staff member. Results of the audit will be submitted by the Infection control nurse, monthly, to the QAPI committee for its review and recommendations.	

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F 880	Continued From page 160 plastic sheets and placed them on the folded back sheets, placing it in the inside of the resident's bed. The observation was completed with no observed concerns with the resident's skin. Resident #34 asked RN #1 to put her blankets in her bag that she takes to dialysis. RN #1 picked up her computer and placed it on the resident's bed. Then proceeded to put the blankets in the bag as requested. RN #1 then washed her hands. She then picked up her computer and the box of wound measuring plastic sheets and placed them on top of the treatment cart outside the resident's room. RN #1 then used hand sanitizer and walked away from the treatment cart. An interview was conducted with RN #1 on 4/5/19 at 8:00 a.m. RN #1 was asked if it is acceptable to bring the computer into a residents room, place it on a resident's personal belongings, and then place it on the resident's bed. RN #1 stated, "I guess not." When asked why the staff should not put the computer on someone's belongings or bed, RN #1 stated, "I guess for infection control reasons." RN #1 was informed of the above observation of the wound measuring sheets on the resident's bed linens. When asked if this was following infection control practices, RN #1 stated, "No, I guess not. I will have to throw out the whole box." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/5/19 at 10:35 a.m. When asked if it is appropriate to take the computer, used on the treatment and medication administration carts, into the resident's room to do wound care, ASM #2 stated, "No, they are to be left on the treatment cart." When asked if the computer	F 880	Beginning 5/6/19 the DON, Unit Managers, Dietary Manager, Infection control nurse or designee will conduct an audit of food delivery to ensure infection control practices are maintained. This audit will take place 5 days per week for 1 week and cover all 3 meals then weekly for 7 weeks at random meals during the day. Any discrepancy noted during the audit will be addressed at that time with immediate education to the staff member. Results of the audit will be submitted by the Infection control nurse, monthly, to the QAPI committee for its review and recommendations.	

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F 880	Continued From page 161	F 880		

should be placed on the resident's personal belongings and on the bed, ASM #2 stated, "It shouldn't be in the room at all." ASM #2 was made aware of the above concern at this time.

On 4/5/19 at 1:00 p.m., a request was made of ASM #3, the vice president of clinical services, for a policy related to taking equipment used throughout the facility into a resident's room and placing the equipment on a resident's personal belongings and the bed. At 3:13 p.m. ASM #3 stated the facility did not have a policy on the request made and stated, "It's normal practice not to take that into the room when performing treatments."

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 163.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.

2. The facility staff popped Resident #23's pills into a gloved hand that had just touched the medication cart and then administered the medication to Resident #23.

Resident #23 was admitted to the facility on 1/4/19 with the diagnoses of but not limited to chronic obstructive pulmonary disease (1), high blood pressure, solidary pulmonary nodule (2) and gastro-esophageal reflux disease. Resident #23's Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 1/11/19, coded Resident #23 as having no cognitive impairment

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F 880	Continued From page 162 in his ability to make daily life decisions. On 4/3/19 at 8:21 to 8:40 a.m., an observation of medication administration was observed. LPN (Licensed Practical Nurse) #2 was observed administering medications during this time to Resident #23. On 4/3/19 at 8:21 a.m., LPN #2 was observed washing her hands, opening the medication cart with her keys, and then putting gloves on her hands. LPN #2 then opened the medication cart drawer with her gloved hand. LPN #2 pulled out one of Resident #23's medication packets and pop the pill into her gloved hand and then place the pill into the medication cup. LPN #2 was observed pulling out another one of Resident #23's medication packets popping the pill into her gloved hand and then placing the pill into the medication cup. LPN #2 pulled out another one of Resident #23's medication packets, popped the pill into her gloved hand, and then place the pill into the medication cup. LPN #2 then locked the medication cart with her gloved hand, picked up the medication cup with her gloved hand and handed the cup to Resident #23. On 4/4/19 at 12:38 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2 regarding the process of infection control for medication administration. When asked about the process, LPN #2stated, "I washed my hands first, sang the birthday song, and put on gloves. I administered his (Resident #23) meds (medications) per order. I opened the cart without having gloves on. I took out the bubble packs and removed the meds over a cup with the same gloves on as I identified the meds. One pill fell onto the cart and I disposed of it and got a	F 880		

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F 880	Continued From page 163 new pill." When asked if any of the medications were placed into her gloved hand and then placed into the cup, LPN #2 stated, "No." When LPN #2 was asked if she was adhering to infection control measures, she stated, "I probably wasn't. No ma'am, I wasn't." When LPN #2 was asked what the issues with infection control during her medication administration were, LPN #2 stated, "The issues were when I opened the cart drawer and the pill packets with the same gloves on." A review of the facility's policy "Handwashing" documented in part, "To provide guidelines to employees for proper and appropriate handwashing that will aid in the prevention of infection." A review of the facility's policy "Administration of Medications" documented in part, "All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis ...Wash hands before and after each administration of medication or hand sanitizer as appropriate." On 4/4/19 at 4:15 PM, ASM (Administrated Staff Member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. (1) Chronic Obstructive Pulmonary Disease makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." This	F 880		

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F 880	Continued From page 164	F 880		

information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=copd&_ga=2.160000441.566140716.1522143307-139120270.1477942321

(2) Solidary Pulmonary Nodule: is an isolated, single lesion in a round or oval shape with a diameter of ?3 cm (centimeters) in lung parenchyma (the portion of the lung involved in gas transfer), surrounded entirely by gas-containing lung tissue. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3886703/

3. The facility staff failed to serve food to the residents in a sanitary manner during a dining room observation. Staff were observed touching the food surface of plates that were then served to residents.

On 4/2/19 between 12:12 and 1:15 p.m., an observation of the main dining room was conducted. OSM (Other Staff Member) #2 was observed lifting a packet of bread, and a butter packet, then placed them onto her left arm. OSM #2 then lifted a bowl of vegetables with her thumb above the top of the rim of the bowl and when she placed the bowl on the table, she touched the top of the rim of the bowl with her thumb.

On 4/2/19 at 1:10 p.m., OSM #3 was observed bringing a saucer with grilled cheese sandwich to a resident and had her thumb on top of the rim of the saucer. OSM #3 then touched the top of the rim of the desert saucer as she was removing the

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F 880	Continued From page 165 wrapping and placed the desert saucer on the table. On 4/4/19 at 8:17 a.m., an interview was conducted with CNA #1. When CNA #1 was asked to demonstrate how to serve resident's plates, she demonstrated lifting the plate from the bottom. When CNA #1 was asked to demonstrate how to remove plastic wrap from a plate, she demonstrated removing the plastic wrap and then placed her thumb on the edge of the top of the rim of the plate. When CNA #1 was asked where she placed her thumb, she stated "It was on the side." When the surveyor pointed out to CNA #1 that her thumb was on the edge of the top of the rim of the plate, CNA #1 stated, "It should not be there. Your hands should not be where the resident's food is at." When CNA #1 was asked why bare fingers or thumbs should not touch the top of the rim of the plates, CNA #1 stated, "Infection. You don't want your hands to touch their food. We had two meetings for the dining room to serve food in a more restaurant style and how to hold the plates." A review of the facility's policy "Handwashing" documented in part, "To provide guidelines to employees for proper and appropriate handwashing that will aid in the prevention of infection." On 4/4/19 at 4:15 PM, ASM (Administrated Staff Member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. In "Fundamentals of Nursing, Lippincott Williams and Wilkins 2007 page 140-143" "The hands are	F 880		

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F 880	Continued From page 166 conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection....typically hands are washed with soap before coming on duty; before and after direct or indirect patient contact;...before preparing or administering medications...."	F 880		