STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	09/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/18/18 through 9/21/18. No complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483.73 Requirement for Long-Term Care Facilities.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's emergency preparedness program, the facility staff failed to identify the resident population in the facility to properly plan for their needs in the event of an emergency. The findings include: On 9/18/18 at 2:00 p.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator stated that all	E 007	The filling of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and continue to provide quality care to our residents. E-007	10/31/18

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

Electronically Signed | 10/15/2018

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E 007	Continued From page 1 the residents in the facility were considered a vulnerable population and she had not identified their individual needs. The Administrator presented an outdated roster with a listing of 52 resident names. It was verified the list was an old one with residents that had discharged and others missing from the list that were newly admitted. In addition, the current census in the building was 56. The Administrator stated, "It may be a good idea to place a copy of the Resident roster matrix in the EP binder's appropriate section with the updated information for each resident and their special resident. I was going to do this, but you (survey team) walked in." While searching through the shred box, the Administrator stated she may have had the start of the needs assessment, but misplaced it in the shred box. In addition, the Administrator could not provide succession planning that identified internal persons to assume specific roles in another's absence. Again, she stated she had not completed all the sections of her binder when the survey team walked into the building. The Director of Nursing (DON) joined the interview at 7:30 p.m. and stated she could run things in the Administrator's absence, but had not been expressly given the role nor was it authorized in writing that she would act in the absence of the Administrator ad legally responsible for the operations of the facility. The DON stated, "Why does it have to be me anyway?"	E 007	Action Taken: 1. A list of patient acuity is located in the Facility Assessment Binder. The Facility plan was updated with delegations of authority and succession plans. How others were identified: 2. With new changes in population and new acuity identified the list will be updated accordingly. Systems in Place: 3. In-services provided to department managers by the Regional Clinical Director and Regional Vice President of Operations to educate them on the process. Audits on demographics will be completed every 2 weeks x 8 weeks to ensure accurate refection of current resident population is available. Quality Assurance program: 4.Results of Audits will be reviewed in the monthly and quarterly QAPI meetings. Any discrepancies will be addressed.	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 018		10/31/18

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E 018	Continued From page 2	E 018		

policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the

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E 018	Continued From page 3 hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Emergency Preparedness (EP) program, the facility staff failed to ensure they had a viable tracking system in place to document locations of patients and staff as a part of the facility's EP policies and procedures. The findings include: On 9/18/18 at 2:00 p.m., an interview was conducted with the Administrator and the Director	E 018	E 018 Action Taken: 1. A tracking system is available to document location of patients and staff as part of the Emergency Preparedness policies and procedures. How others were identified: 2. Tracking system policy and procedure	

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E 018	Continued From page 4 of Maintenance. The Administrator presented personal grab and go bags with residents names on them and an information packet that had a resident kardex inside, as well as a face sheet that would be added in the event of an emergency. She stated all staff knew how to initiate the tracking system, but could not explain whether it would be a hard copy documentation and or an electronic database, how they would consider backup in the event of power outages, who would be responsible to compile/secure patient records, and it was not a part of their policy and procedures. The Director of Nursing (DON) joined the interview at 7:30 p.m. and stated with the recent hurricane scare, she started copying patient information and trying to get it together in hard copy form in response to the hurricane, but had since stopped copying. The DON stated they had not addressed a tracking system that would be up and ready if there was emergency "Now" and could only speak to the the personal grab and go bags. The Administrator and the DON stated the nurses and certified nursing assistants (CNA) in the building would know what to do in the event of an emergency. On 9/18/18 at 6:00 p.m. and interview was conducted with CNA #14, #15 and #16. They stated they had not received training on a tracking system and was not sure what it referred to. On 9/18/18 at 6:20 p.m. Licensed Practical Nurse (LPN) #18 stated she had been employed for over three years and never received information about what to implement in the event of an emergency other than tacking resident out of their room, placing them in the hallways and rolling them out the front door. She stated, "Has something changed, if so I wasn't told about it."	E 018	policy and forms are located in the Emergency Preparedness manual and implemented. Systems in Place: 3. Staff In-serviced on Emergency Preparedness process by Regional Clinical Nurse/designee to include tracking systems process for location of residents, medical records and staff. Random staff interviews will be completed by the Administrator/designee 2 x week x 2 months to ensure staff are aware of the process. Quality Assurance Program: 4. Results of Audits will be reviewed in the monthly and quarterly QAPI meetings. Any discrepancies will be addressed.	

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E 018	Continued From page 5 The Administrator was present during this discussion with LPN #18.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at	E 020		10/31/18

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E 020	Continued From page 6 §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: The facility staff failed to develop and implement emergency preparedness policies and procedures to ensure safe evacuation for the facility which included consideration of care and treatment of evacuees, and staff responsibilities during an evacuation. The findings include: On 9/18/18 at 2:00 p.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator stated all staff knew what to do in the event of an emergency. She stated they knew how to process the grab and go bags, and the charge nurses would know what residents needed in order to start the triage system in the event of an emergency. The policy did not include a system to address each individual's needs during an evacuation based on mobility, acuity and or the necessary equipment needed for each resident (i.e., wheelchairs, walkers, oxygen, stretchers, ambulatory). During the interview,the Administrator presented an outdated roster with a listing of 52 resident	E 020	E-20 Action Taken: 1. The facility has a policy and process to ensure safe evacuation for the facility that includes care and treatment for the residents and staff responsibilities. How other were identified: 2. Policy and process implemented with updated resident care list added to the Emergency Preparedness binder. The list will be updated monthly and as needed. Systems in Place: 3. Staff in-serviced on Emergency Preparedness process by the Regional Clinical Nurse/designee to include care and treatment of residents and staff responsibilities. Random staff interviews will be completed	

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E 020	Continued From page 7 names. It was verified the list was an old one with residents that had discharged and others missing from the list that were newly admitted. In addition, the current census in the building was 56. The Administrator stated, "It may be a good idea to place a copy of the Resident roster matrix in the EP binder's appropriate section with the updated information for each resident and their special resident. I was going to do this, but you (survey team) walked in." While searching through the shred box, the Administrator stated she may have had the start of the needs assessment, but misplaced it in the shred box.	E 020	by the Administrator/designee 2 x week x 2 months to ensure staff are aware of process. Quality Assurance Program: 4. Results of Audits will be reviewed in monthly and quarterly QAPI meetings. Any discrepancies will be addressed.	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the	E 022		10/31/18

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E 022	Continued From page 8 following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Emergency Preparedness (EP) the facility staff failed to ensure there was plan to shelter in place for residents and staff who remain in the facility in the event of an emergency in alignment with the facility's risk assessment. The findings include: On 9/18/18 at 2:00 p.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator stated she had shared in a all staff meeting the need for all staff to understand that they may have to shelter in place at the facility in the event of a true emergency. When asked if this plan was a plan set up for all staff that worked in the facility, she stated, "Yes, and I sent out letters to the two agencies that we used to augment our regular staff and they were in agreement with the plan and that the staff would understand they may need to stay if presented with an emergency based on their risk assessment. The agency staff were informed of this plan and are in agreement." On 9/18/18 at 6:00 p.m., during an interview with three agency staff, Certified Nursing Assistant (CNA) #14, #15 and #16, they stated they routinely worked at the facility and were never informed about the shelter in place policy with provisions in case of a true emergency and would not be able to stay. On 9/18/18, at 6:20 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #18. She stated she was never made aware of the shelter in place policy and did	E 022	E 022 Action Taken: 1. The facility has a policy and process to ensure shelter in place guidance for the facility that includes a plan for residents and staff who remain in the facility in the event of an emergency in alignment with the facility's risk assessment. How others were identified: 2. Policy and process implemented to include a chapter that addresses shelter in place guidance. Policy includes guidance for volunteers that remain in the facility. Systems in Place: 3. Staff in-serviced on Emergency Preparedness process by the Regional Clinical Nurse/designee to include shelter in place guidance for staff and volunteers that remain in facility. Random staff interviews will be completed by the Administrator/designee 2 weeks x 2 months to ensure staff are aware of the process. Quality Assurance Program: 4. Results of Audits will be reviewed in the monthly and quarterly QAPI meetings. Any discrepancies will be addressed	

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E 022	Continued From page 9 not know where items were located that would facilitate the plan in cases of an emergency. She stated in the presence of the Administrator that she did not know what had changed regarding emergency plans. A second LPN was interviewed on 9/18/18 at 6:30 p.m. and stated she knew the plan for missing residents, but was not aware of what emergency plans were in place other than fire and missing residents.	E 022	immediately.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of	E 023		10/31/18

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E 023	Continued From page 10 records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Emergency Preparedness (EP) plan the facility staff failed to develop a system of medical documentation that preserved patient information, confidentiality, and secures and maintains availability of records. The findings include: On 9/18/18 at 2:00 p.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator presented personal grab and go bags with residents names on them and an information packet that had a resident kardex inside, as well as a face sheet that would be added in the event of an emergency. She could not explain whether it would be a hard copy documentation and or an electronic database, or how they would maintain the system of medical documentation that preserved patient information, protected the confidentiality of patient information, secured and maintained availability/accessibility of records. The Director of Nursing (DON) joined the interview at 7:30 p.m. and stated with the recent hurricane scare, she started copying patient information and trying to get it together in hard copy form in response to the hurricane, but had	E 023	E 23 Action Taken: 1. The facility has a policy and process to ensure medical documentation that preserves patient information confidentiality and secures and maintains availability of records. How others were identified: 2.Policy and procedures are developed and implemented to include software PCC functions, facility functions and staff responsibilities to preserve medical documentation is available and secure during an evacuation. Systems in Place: 3. Staff in-serviced on Emergency Preparedness process by the Regional Clinical Nurse/designee to include preservation of medical documentation and securing of Medical Records. Random staff interviews will be completed by Administrator/designee 2 x week x 2	

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E 023	Continued From page 11 since stopped copying. The DON stated she was not sure what the plan was to assure confidentiality and accessibility of patient records at the same time and could only speak to the grab and go bags.	E 023	months to ensure staff are aware of the process. Quality Assurance Program: 4. Results of Audits will be reviewed in the monthly and quarterly QAPI meetings. Any discrepancies will be addressed.	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training,	E 036		10/31/18

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E 036	Continued From page 12 testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Emergency Preparedness (EP) plan the facility staff failed to have a training and testing program based on the facility's EP plan. The findings include: On 9/18/18 at 2:00 p.m., an interview was conducted with the Administrator and the Director of Maintenance. She stated she had a review of the facility's EP plan during an all staff meeting, but did not have an official formal training or testing program that reflected the risks identified for the facility and an ability to evaluate the effectiveness of training, identify gaps and areas for improvement, as well as the overall emergency preparedness program. The Director of Nursing (DON) joined the interview at 7:30 p.m. She stated she was present at the all staff meeting and felt all staff knew what to do in the event of an emergency, but there was no sign in sheets or evidence that there was written training and testing program to ensure all staff to include contractors. On 9/18/18 at 6:00 p.m., during an interview	E 036	E 036 Action Taken: 1. The facility has educated staff on the facilities Emergency Preparedness Plan. How others were identified: 2. The facility has implemented an orientation and annual training program that includes Emergency Preparedness training. System in Place: 3. New Staff is trained on Emergency Preparedness during the orientation program. New staff are added to the Relias Training Software to complete training modules on Relias pertaining to Emergency Preparedness. Annual staff training will be required to complete Emergency Preparedness training with a disaster drill.	

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E 036	Continued From page 13 conducted with Certified Nursing Assistant (CNA) #14, #15 and #16, they were unaware of any at staff meeting that reviewed the facility's EP program or that there was a formal training or testing for the same. On 9/18/18, at 6:20 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #18. She stated she was not a part of an all staff meeting regarding the facility's EP plan. She stated in the presence of the Administrator that she did not know what had changed regarding emergency plans. A second LPN was interviewed on 9/18/18 at 6:30 p.m. and stated she knew the plan for missing residents, but was not aware of what emergency plans were in place other than fire and missing residents. On 9/18/18 at 6:20 p.m., during a interview with Licensed Practical Nurse (LPN) #18, she was not aware of an all staff meeting that reviewed the facility's EP program or that there was a EP formal training and testing program.	E 036	Random staff interview will be completed by the Administrator/designee 2 x weekly x 2 months to ensure staff are aware of the process. The HR person/designee will monitor compliance with Relias monthly x 3 months. Quality Assurance Program: 4. Results of Audits will be reviewed in the monthly and quarterly QAPI meetings. Any discrepancies will be addressed.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		10/31/18

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E 037	Continued From page 14 *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 15	E 037		

expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must

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E 037	Continued From page 16 include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Emergency Preparedness (EP) plan the facility staff failed to have an initial training and	E 037	E 037 Action Taken:	

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E 037	Continued From page 17 testing program for new and existing staff based on the facility's EP plan. The findings include: On 9/18/18 at 2:00 p.m., an interview was conducted with the Administrator and the Director of Maintenance. She stated she had a review of the facility's EP plan during an all staff meeting, but did not have an official formal training or testing program that reflected the risks identified for the facility and an ability to evaluate the effectiveness of training, identify gaps and areas for improvement, as well as the overall emergency preparedness program. The Director of Nursing (DON) joined the interview at 7:30 p.m. She stated she was present at the all staff meeting and felt all staff knew what to do in the event of an emergency, but there was no sign in sheets or evidence that there was written training and testing program to ensure all staff to include contractors. Both the Administrator and the DON stated they had not developed an initial training in emergency preparedness for new or existing staff that would maintain documentation of all EP training, and demonstration of staff knowledge of emergency procedures.	E 037	1. The facility has educated staff on the facilities Emergency Preparedness Plan. How others were identified: 2. The facility has implemented an orientation and annual training program that includes Emergency Preparedness training. System in Place: 3.New staff is trained on Emergency Preparedness during orientation program. New staff are added to the Relias Training Software to complete training modules on Relias pertaining to Emergency Preparedness. training with a disaster drill. Random staff interviews will be completed by the Administrator/designee 2 x week x 2 months to ensure staff are aware of the process. The HR person/designee will monitor compliance with Relias monthly x 3 months. Quality Assurance Program: 4.Results of Audits will be reviewed in the monthly and quarterly QAPI meetings. Any discrepancies will be addressed.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/18/18 through 9/21/18.	F 000		

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F 000	Continued From page 18 Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 21 current Resident reviews and 3 closed record reviews.	F 000		
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)(l) 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	F 583		10/31/18

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F 583	Continued From page 19 of personal and medical records except as provided at §483.70(i)(2) or other applicable 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 observation and staff interviews the facility staff failed to protect residents from public view during the delivery of care for 1 of 24 residents (Resident #35), in the survey sample. The facility staff failed to assure Resident #35 privacy was maintained during wound care. The findings included: Resident #35 was originally admitted to the facility 5/13/17 and readmitted 2/19/18, after a discharge 2/15/18, to a local acute care hospital for pneumonia. The current diagnoses included; stroke and pressure ulcers. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident 35's cognitive abilities for daily decision making were moderately impaired. In section "B" (Hearing, Speech and Vision), Resident #36 was coded as having the ability to hear adequately and understand what others are saying using hearing aids.	F 583	F583 Action Taken: 1. Resident #35 is provided privacy during delivery of care. How others are identified: 2. An audit of privacy curtains was conducted to ensure all rooms have privacy curtains to identify any residents at risk of privacy issues. Systems in Place: 3. The DON/designee re-educated staff on providing privacy during delivery of care. Audits will be completed 5 x week x 2 months during Care Keeper Rounds to ensure that the residents are being provided privacy during care. Quality Assurance Program: 4. Results of Audits will be reviewed in monthly and quarterly QAPI Meetings. Any discrepancies will be addressed.	

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In section "G" (Physical functioning), the resident was coded as requiring supervision after set-up with eating and supervision of 1 person with locomotion, extensive assistance of 2 people with bed mobility, extensive assistance of 1 person with transfers, dressing, toileting, personal hygiene and bathing.

On 9/20/18, Resident #35 wound care was observed being provided by the wound care physician and Licensed Practical Nurse (LPN) #1. Resident # 35 resided in the bed closer the window, bed B,and the room door was left opened. LPN #1 pulled the privacy curtain as far as it could be pull for it was missing approximately 6 hooks which attached the privacy curtain to the ceiling tract. The resident's back was first exposed for the physician to provide wound care to the back pressure ulcer. The procedure took approximately 20 minutes because of the complexity of the wound vacuum and the massive pressure ulcer, which the physician said was "one of the worst she has ever seen". After completion of the back wound care the resident's back was covered and the resident was positioned for care of the sacral pressure ulcer which took approximately 10 minutes to complete.

During the wound care procedures the resident could be viewed by anyone walking pass the doorway because the privacy curtain could not close completely and the room door was left opened. The resident's sacrum was exposed when wound care was performed.

Immediately after Resident #35 was covered and repositioned an interview was conducted with LPN #1. LPN #1 stated she pulled the curtain as

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F 583	Continued From page 21 far as it would go and she would notify housekeeping and maintenance that the privacy curtain needed to be repaired. The facility's policy on maintaining privacy was requested several times but not presented. On 9/20/18, at approximately 6:30 p.m., the above findings were shared with the Administrator and Director of Nursing. The Administrator stated the facility staff would immediately completed the task to correct the problem. The Director of Nursing stated the expectation was for staff to recognize and report the privacy curtain was not preventing resident exposure during care, so it could be repair or replaced.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		10/31/18

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F 584	Continued From page 22 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation, the facility staff failed to maintain a safe, clean, comfortable and sanitary environment and failed to ensure 1 of 24 residents (Resident #29) mobility wheel chair was in good repair. 1. During the outside storage shed inspection on 09/20/18, the facility failed to ensure the dietary and maintenance department provided services to maintain a sanitary environment. 2. For Resident #29, the wheel chair with worn, torn and cracked armrest pads. 3. The facility staff failed to assure the privacy curtains in 2 resident rooms were in good repair	F 584	F 584 Action Taken: 1. Resident #29's wheelchair has been repaired or replaced on 9/21/18. The privacy curtains were replaced and hung appropriately to ensure privacy. The storage shed was cleaned and organized. Emergency products are stored in a designated sanitary area. How others were identified: 2. Residents that reside in the facility are at risk for an unsanitary environment.	

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F 584	Continued From page 23 and provided privacy when needed, to assure the resident sitting area adjoining the patio was without wet blankets and the the patio was without dried leaves, dirt, debris. The findings included: 1. On 09/20/18 at approximately 10:30 a.m., the surveyor inspected the facility's outside storage shed with the Maintenance Director and Dietary Manager. During the observation the following were observed; the floor was dirty with dirt, debris, dead bugs and spiders. On a wooden crate was a bag of salt ice (melt) that had wasted on the floor. Inside the shed corners and hanging from the ceiling were spider webs with dead and alive spiders. Also located inside the outside storage shed were the facility's extra emergency supply products used for the residents. The products consisted of three boxes of hinge containers, two boxes of cups, one box of plastic silverware, one box of cups that were open with spider webs with live spider noted in web. Inside the shed were also multiple air conditioning units that were not in use. The AC units were observed with dust, dirt and hanging from them were spider webs with live and dead spiders. On the AC units was a box of foam cups and lids that were open with a live spider and cobweb handing from them. The dietary manager stated, "It was not always like this; if my storage room inside the facility looked like this it would not be accepted; the same goes for out here." The dietary manger said the storage here at this facility has always been a problem.	F 584	Systems in Place: 3. Staff were re-educated on the importance of maintaining a clean, safe, comfortable, and sanitary environment. Care keeper Audits will be completed 5 x a week for 2 months to ensure environment is clean, safe comfortable and sanitary. If any issues are noted it will be corrected and/or reported to be repaired. The Administrator/designee will be making weekly environmental rounds with housekeeping to monitor cleaning schedules, identify privacy curtains or items in need of repair or cleaning to include observations of storage shed. Quality Assurance Program: 4. Results of Audits will be reviewed in the monthly and quarterly QAPI meetings. Any discrepancies will be addressed.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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An interview was conducted with Administrator and Director of Nursing (DON) on 09/20/18 at approximately 6:00 p.m. The DON stated, "The storage shed be cleaned and the extra emergency supply products should be stored in a separate area."

The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings.

The facility's policy titled Care of Storage area and janitor closets (Revision 01/01/2000).
-Supplies upon pallets-protect paper products from insect infestation.

2. Resident #29 was admitted to the facility on 12/18/15. Diagnosis for Resident #29 included but not limited to Muscle weakness (Muscles weakness is reduced strength in one or more muscles https://medlineplus.gov/ency/article/007365.htm).

The current Minimum Data Set (MDS), quarterly assessment with an Assessment Reference Date (ARD) of 08/09/18 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #29 requiring extensive assistance of one with bathing, limited assistance of one with transfer, dressing, toilet use, and personal hygiene and limited assistance of one with bed mobility and supervision with eating The MDS was coded under section G 0600 for wheel chair for mobility devices.

On initial tour of the facility on 09/18/18 at

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approximately 2:40 p.m. Resident #29 was sitting up in her wheel chair. Her wheel chair was observed with worn, torn and cracked armrest pads.

On 09/19/18 at approximately 4:35 p.m., resident was up in her wheel chair. The armrest pads of the wheel chair remained torn and cracked.

An interview was conducted with Resident #29 on 09/20/18 at approximately 10:10 a.m., who stated, "My wheel chair is old and I would like to have a new one." The resident said, "Look at this pointing to the armrest pads, someone should give me a new wheel chair."

On 09/20/18 at approximately 10:25 a.m., the Administrator was made aware of the condition of Resident #29's wheel chair armrest. On the same day at 10:30 a.m., the Administrator met with Resident #29 with the surveyor present. The Administrator stated, "Your wheel chair is pretty messed up, would like a new one" she replied, "Yes, that would be nice." The Administrator stated, "Let me get therapy involved." On the same day at approximately 1:43 p.m., Resident #29's armrest was observed to be replaced with a new one.

The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings.

3. The following observations were made on 9/20/18 at approximately 12:30 p.m., Resident #35's privacy curtain in room (Number), was observed unable to maintain her privacy during care because approximately 6 hooks were

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F 584	Continued From page 26 missing from the front of the curtain. The privacy curtain in room 105B was also observed partially hanging compromising the resident's privacy during care. In the sitting room at the end of the 200 hall, adjoining the patio; wet blankets were observed on the floor in front of the air condition unit and the patio was with a large amount of leaves, dirt, insects, and many boxes stacked very high. The above observations were shared with the Administrator and Director of Nursing on 9/20/18 at approximately 6:30 p.m., the Administrator stated, she had designed a plan for the Maintenance Director to get specific areas including storage areas cleaned and organized. The Administrator also stated she had ordered a storage unit which would allow the items stored in inappropriate places to be moved and stored properly. The storage unit was to be delivered Saturday 9/22/18. The Administrator further stated the Maintenance Director stated the air condition unit was clogged from fresh cut grass,causing the leak into the sitting area therefore; the blankets were put down to soak the water coming from the clogged unit. The Administrator stated the blankets were removed, the water was mopped up and wet signs were placed in the sitting area.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,	F 607		10/31/18

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F 607	Continued From page 27 neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of facility records of employees hired within the last two years, staff interviews, and review of the facility's policy, the facility staff failed to implement their policy for screening new employees for abuse, neglect and mistreatment of others for 1 of 25 employees (Employee #3). The facility's staff failed to obtain a criminal history report within 30 days of hire for 1 employee, Employee #3. The findings included: Review of the Employee's #3, personnel file revealed the Criminal History Report was not completed until 08/20/18. Employee # 3, a Certified Nurses Assistant (CNA) was hired on 07/18/17; the criminal history report in the employee's file was dated, 08/20/18. This indicated Employee #3 had worked in the facility for over a year before the criminal history report results became a part of the employee's file. An interview was conducted with the human resource representative on 09/20/18 at approximately 2:00 p.m. The Human Resource Director stated "the request and results for the criminal history report was not in the employee	F 607	F 607 Action Taken 1. Employee # 3 had a criminal background check completed on 8/30/18. How other were identified: 2. An audit was completed of current employees to verify a criminal background check was completed and in the record. Systems in Place: 3. The Administrator/designee will complete an audit weekly x 2 month to verify that any new employees hired has had a criminal background check completed and in their record. The HR person had been re-educated regarding the process of obtaining a criminal background check for new employees. Quality Assurance: 4. Audits will be reviewed in the monthly/quarterly QAPI meeting. Any discrepancies will be corrected.	

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F 607	Continued From page 28 file therefore she ran the report immediately upon discovering it wasn't in the record, which was 8/20/18". The facility's policy titled "Resident Abuse" in section II Screening reads persons applying for employment with the facility will be screened for a history of abuse, neglect, or mistreating residents to include: (A). References from previous or current employers (with applicant permission). (B). Criminal Background Check. (C). Abuse check with appropriate licensing board and registries, prior to hire. (D). Sworn Disclosure Statement prior to hire. (E). Verify license or registration prior to hire. On 09/20/2018 at approximately 2:30 p.m., the Administrator presented the surveyor with AD HOC (self identified areas, self imposed IJ) Meeting Minutes: Privilege Worked Document. Dated 03/13/18 at 9:00 am. The issues were Background Checks and Staff files. The resolution stated that all files missing background checks will be completed. The above findings were shared with the Administrator and Director of Nursing on 09/21/2018 at approximately 7:30 p.m. The Administrator stated we have been working on this problem through the Quality Assurance committee.	F 607		
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	F 623		10/31/18

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(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

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F 623	Continued From page 30 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. 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.	F 623		

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F 623	Continued From page 31 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 3 of 24 residents (Resident #29, 38 and 35) in the survey sample. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #29 transfer to the hospital on 07/01/18. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #38 transfer and admission to the hospital on 06/08/18. 3. The The facility staff failed to notify the Long-Term Care Ombudsman that Resident #35 was discharged and admitted to a local acute care hospital, 2/15/18. The findings included: 1. Resident #29 was admitted to the facility on 12/18/15. Diagnosis for Resident #29 included but not limited to Anxiety disorder.	F 623	F 623 Action Taken: 1.The ombudsman was notified of residents # 29, 38, and 35 hospital transfers/discharges on 9/28/18. How others were identified: 2. The facility Social Worker conducted an audit back to August 1, 2018 to identify any other discharges and notified the Ombudsman. Systems in Place: 3. The Social Services Director was re-educated by the Chief Clinical Officer on Reporting discharges and hospitalizations. An audit will be completed monthly by the Administrator or designee to ensure a list of discharges was submitted to the Ombudsman timely. Quality Assurance Program:	

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F 623	Continued From page 32 The current Minimum Data Set (MDS), quarterly assessment with an Assessment Reference Date (ARD) of 08/09/18 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments was dated for 07/01/18-discharge return anticipated. On 07/01/18, according to the facility's documentation, Resident #29 was found with cold hands, shaking and unable to control her arm movement. Resident's vital signs were: BP (131/106), P (81), R (16), T (98.1) but unable to obtained 02 saturations. Resident was started on oxygen via non-rebreather mask at 2 liters. Resident #29 was transported to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 07/02/18. On 09/19/18 at approximately at 2:45 p.m., an interview was conducted with the Social Worker (SW) who stated, "I do not notify the Ombudsman of resident discharges to the hospital or ER visits, I guess it is being done by nursing." An interview was conducted with License Practical Nurse (LPN) #1 on 09/19/18 at approximately 3:10 p.m., who stated, "We do not do that here at this facility." An interview was conducted with Administrator on 09/20/18 at 2:05 p.m., who stated, "I just found out today that the Ombudsman was not being notified of resident's going out the hospital. I will be going over this issue today with the SW who needs to be notifying the Ombudsman."	F 623	4. Audits will be reviewed monthly/quarterly in the QAPI meeting. Discrepancies will be corrected w/re-education completed as needed.	

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An interview was conducted with the Administrator on 09/22/18 at approximately 1:10 p.m. who stated, "There is no policy for notifying the Ombudsman of transfers to the hospital; we follow the regulations."

The facility administration was informed of the finding during a briefing on 09/22/18 at approximately 7:10 p.m. The facility did not present any further information about the findings.

2. Resident #38 was originally admitted to the facility on 06/01/18. Diagnosis for Resident #38 included but not limited to Hypertension (high blood pressure).

The current Minimum Data Set (MDS), a 60-Day Assessment Reference Date (ARD) of 08/17/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments was dated for 06/08/18-discharge return anticipated.

On 06/08/18, according to the facility's documentation, Resident #38 was observed with labored breathing and wheezing. Resident's vital signs were: BP (130/70), P (100), R (24) with SPO2 at 78%. Resident was started on 02 at 3 liters via n/c with SPO2 increasing to 85%. Resident #38 was transported to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 06/20/18.

On 09/19/18 at approximately at 11:20 a.m., an interview was conducted with the Social Worker

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(SW) who stated, "I could not locate where the Ombudsman was notified of Resident #38's transfer to the hospital..."

On 09/19/18 at approximately at 2:45 p.m., an interview was conducted with the Social Worker (SW) who stated, "I do not notify the Ombudsman of resident discharges to the hospital or ER visits, I guess it is being done by nursing."

An interview was conducted with LPN #1 on 09/19/18 at approximately 3:10 p.m., who stated, "We do not do that here at this facility."

An interview was conducted with the Administrator on 09/22/18 at approximately 1:10 p.m. who stated, "There is no policy for notifying the Ombudsman of transfers to the hospital; we follow the regulations."

The surveyor was given a form by the Administrator on 09/22/18 at approximately 1: 40 p.m. The form was titled: Required Transfer and Discharge Notices. The following information was revealed: Transfer to Acute Care Facility (Hospital)-Notice to the LTC Ombudsman when practicable, can be via a monthly list.

The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings.

3. Resident #35 was originally admitted to the facility 5/13/17 and readmitted 2/19/18, after a discharge 2/15/18, to a local acute care hospital for pneumonia. The current diagnoses included; stroke and pressure ulcers.

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F 623	Continued From page 35 The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident #35's cognitive abilities for daily decision making were moderately impaired. The facility's documentation revealed on 2/15/18, Resident #35 was transferred to a local emergency room for an elevated temperature 103.8, as well as hypotension. The blood pressure reading was 82/46 ... Resident #35 was admitted with a diagnosis of pneumonia. The discharge MDS assessments was dated for 2/15/18 and the re-entry MDS assessment was dated 2/19/18. On 09/21/18 at approximately at 1:10 p.m., an interview was conducted with the Social Worker. The Social Worker stated she was not aware of the requirement to notify the Long-Term Care Ombudsman of discharges from the facility and admission to the hospital. The above findings were shared with the Administrator and Director of Nursing on 9/21/16 at approximately 5:55 p.m. An opportunity was given for the facility to present additional information but none was provided.	F 623		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than	F 638		10/31/18

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F 638	Continued From page 36 once every 3 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility staff failed to assure each resident received a non-comprehensive assessment at least every 92 days, for 1 of 24 residents (Resident #1), in the survey sample. The facility staff failed complete a quarterly Minimum Data Set (MDS) for Resident #1 timely. The findings included: Resident #1 was originally admitted to the facility 1/22/13 and discharged from the facility anticipated on 10/6/17, returning 10/9/17. The current diagnoses include dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/18/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired abilities for daily decision making. The 4/18/18 MDS assessment also was coded as requiring set-up and supervision with eating and locomotion, limited assistance with bed mobility, extensive assistance of 1 person with transfers, dressing, toileting, and personal hygiene, and bathing. On 7/19/18, Resident #1 did not have a comparative quarterly, significant change or other Omnibus Budget Reconciliation Act (OBRA) MDS assessment completed for review. The last OBRA assessment to be transmitted and accepted into	F 638	F 638 Action Taken: 1.Quarterly MDS for Resident #1 opened on 9/21/18. How other were identified: 2.Missed MDS's has the potential to effect other residents. Review of MDS timeliness completed on 9/22/18. Systems in Place: 3. Re-education of MDS Coordinator on timeliness of MDSs completed on 9/25/18. Quality Assurance Program: 4. MDS Coordinator to review timeliness of completed MDS weekly x 4 weeks. Results will be presented to QAPI for review.	

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the Centers for Medicare/Medicaid Services (CMS) was dated 4/18/18, per the facility's Casper Report MDS 3.0 Missing OBRA Assessment Report.

An interview was conducted with the MDS Coordinator on 9/21/18, at approximately 2:15 p.m., the MDS Coordinator stated the quarterly MDS assessment was not located in the systems therefore; the conclusion was it was missed. The MDS Coordinator stated the quarterly assessment was due July 2018, and she didn't understand what happened for she uses 2 books to track MDS assessments as well as the software audit program within the MDS assessments. She stated another strategy; to open all resident next assessments would be instituted. The MDS Coordinator submitted documentation the quarterly MDS assessment was opened to be completed 9/21/18.

The RAI manual, MDS 3.0 October 2017, page 2-33 included: The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

The above findings were shared with the Administrator and Director of Nursing on 9/21/16 at approximately 5:55 p.m. The Administrator stated there was no facility policy on completing

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F 638	Continued From page 38 the MDS assessment because they follow the Resident Assessment Instrument's guidelines.	F 638		
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 clinical record review, staff interview and facility documentation, the facility staff failed to ensure that 2 of 24 residents (Resident #25 and 38) in the survey sample received a complete and accurate Minimum Data Set (MDS) assessment. 1. The facility staff failed to ensure the Annual MDS with an Assessment Reference Date (ARD) of 02/26/18 and Quarterly MDS with an ARD of 02/02/18 under Section P for the use of Restraints and Alarms was coded correctly for Resident #25. 2. The facility staff failed to ensure the 60-day assessment with an Assessment Reference Date (ARD) of 08/17/18, a 30-day assessment with an ARD date of 07/18/18 and a 14-day assessment with an ARD of 07/4/18 under Section N for the use of Anti-depressant medication use was coded correctly for Resident #38. The findings include: 1. Resident #25 was admitted to the facility 12/21/15. Diagnosis for Resident #25 included but not limited to *Anxiety disorder.	F 641	F 641 Action Taken: 1. MDS for Resident # 25 was modified 9/21/18 and resident # 38 was modified on 10/18/18. How others were identified: 2. Miscoding has potential to effect other residents. Review MDSs coding of Section N, Antidepressants, completed on 9/26/18 for MDS antidepressant coding accuracy. Systems in place: 3. Re-education of MDS Coordinator on Section N Medication coding completed on 9/25/18. Quality Assessment Program: 4. MDS Coordinator to review Section N Medication coding of newly completed MDS weekly for 4 weeks. Results of review to be presented to QAPI for review.	10/31/18

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Resident #25's MDS an annual assessment with an Assessment Reference Date (ARD) of 08/03/18 coded resident with short and long-term memory problems and with moderate cognitive impairment.

Review of Resident #25's annual MDS with an ARD of 02/26/18 was coded for: receiving *physical restraints while in bed. The section P on the MDS under restraints and alarms read as follows: Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjusted to the resident's body that the individual cannot remove easily which restricts freedom, movement or normal access to one's body.

During the initial tour on 09/18/18 at approximately 1:15 p.m., Resident #25's bed was observed without bed rails.

On 09/19/18 at approximately 11:30 a.m., Resident #25's bed remained without bedrails.

An interview was conducted with MDS Coordinator on 09/19/18 at approximately 11:55 a.m., who stated, 'The Director of Nursing (DON) informed me that the surveyor wanted to speak to me related to Resident #25's MDS being coded for the use of side rail restraint." She (MDS Coordinator) said, she immediately went to resident room to assess Resident #25's bed for rails and they were not there. She stated, "The MDS for 02/26/18 and 08/03/18 should not have been coded for use of side rails.

On 09/20/18 at 2:10 p.m. an interview was conducted with MDS Coordinator who stated, "I did not complete a side rail assessment nor did I

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do a visual look at her bed before completing her MDS and that was wrong of me." She then replied, "From now on, I will do an assessment and visit their rooms to make sure there are no side rails before completing the MDS."

The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings.

*Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm).

2. Resident #38 was originally admitted to the facility on 06/01/18. Diagnosis for Resident #38 included but not limited to *Depression.

The current Minimum Data Set (MDS), a 60-Day Assessment Reference Date (ARD) of 08/17/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

Review of Resident #25's 60 day MDS with an ARD date of 08/17/18, 30 day MDS with an ARD date of 07/18/18 and 14 day MDS with an ARD date of 07/04/18 were all coded "0" for receiving antidepressant medications. The section N on the MDS under medications received read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, enter "0" if the resident did not receive medication during the last 7 days.

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Resident #25's comprehensive care plan documented resident with use of Anti-depressant medications. The goal: will be free of psychotropic drug related complications. Some of the intervention to manage goal included provide medications as ordered by physician and evaluate for effectiveness.

Review of Resident #25's August 2018 Medication Administration Record (MAR) revealed the medication Cymbalta (used to treat depression and anxiety) and *Celexa (used to treat depression) was administered daily for the entire month.

Review of Resident #25's July 2018 Medication Administration Record (MAR) revealed the medication Cymbalta was administered daily for the entire month and Celexa was administered daily starting on 07/16/18.

Review of Resident #25's June 2018 Medication Administration Record (MAR) revealed the medication Cymbalta was administered daily starting on 06/21/18.

An interview was conducted with the MDS Coordinator on 09/21/18 at approximately 2:00 p.m. The surveyor asked if the 60 day MDS with an ARD date of 08/17/18, 30 day MDS with an ARD date of 07/18/18 and 14 day MDS with an ARD date of 07/04/18 should have been coded under the section N for antidepressant use. The MDS Coordinator stated, "If the medication Cymbalta is a anti-depressant than yes, it should be coded and Celexa should be coded." On the same day at approximately 2:39 p.m., the MDS Coordinator stated, "Yes, the MDS' should have been coded and I have already done a

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F 641	Continued From page 42 modification for those MDS'." The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings. CMS' RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI) 1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status. Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy. *Depression disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).	F 641		
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--	F 657		10/31/18

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F 657	Continued From page 43 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to revise one (1) of 24 residents (Resident #25) in the survey sample's comprehensive personal centered care plan. The facility staff failed to revise Resident #25's comprehensive person centered care plan to include the discontinued use of bed rails as a restraint. The findings include: 1. Resident #25 was admitted to the facility 12/21/15. Diagnosis for Resident #25 included but not limited to *Anxiety disorder.	F 657	F657 Care Plan Timing and Revision Action Taken: 1. Care Plan for Resident # 25 was modified on 10/18/18. How others were identified: 2. Not revising care plans has the potential to affect other residents. Review of care plan for presence and/or absence of side rails completed on 10/18/18 for MDS side rail care plan revision. Systems in Place:	

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F 657	Continued From page 44 Resident #25's annual MDS (Minimum Data Set) assessment with an Assessment Reference Date (ARD) of 08/03/18 coded resident with short and long-term memory problems and moderate cognitive impairment. Review of Resident #25's annual MDS with an ARD of 08/03/18 and quarterly assessment dated 02/02/18 was coded for receiving physical restraints while in bed. The section P on the MDS under restraints and alarms read as follows: Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjusted to the resident's body that the individual cannot remove easily which restricts freedom, movement or normal access to one's body. Resident #25's comprehensive care plan documented Resident #25 at risk for injury related to physical restraint due to side rails. The goal: maintain least restrictive device. Some of the intervention/approaches to manage goal included complete appropriate restraint and/or side rail assessment per living center policy and reassess for potential reduction. There was no physician's order for the use of side rails. Review of Resident #25's quarterly data collection tool assessment competed on 08/3/18 revealed the following: Coded "no" under are restraints used. During the initial tour on 09/18/18 at approximately 1:15 p.m., Resident #25's bed was observed without bed rails. On 09/19/18 at approximately 11:30 a.m., Resident #25's bed remained without bedrails.	F 657	3. Re-education of MDS Coordinator on care plan revision was conducted on 10/18/18. Quality Assurance Program: 4. MDS Coordinator to review care plan for side rails with completed MDS weekly for 4 weeks. Results of review to be presented to QAPI for review.	

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F 657	Continued From page 45 An interview was conducted with MDS Coordinator on 09/20/18 at 2:10 p.m., who stated, "The Director of Nursing (DON) informed me that the surveyor wanted to speak to me related to the care planning of side rails on Resident #25's care plan. She said, I immediately knew after I reviewed the care plan and saw the use of side rails that I had messed up." She said the care plan should not have been care planned for the use of side rails. There was no physician's order for the use of side rails. The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings. *Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm).	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming for 1 of 24 residents (Resident #151), in	F 677	F 677 Action Taken: 1. Resident # 151 is provided with	10/31/18

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F 677	Continued From page 46 the survey sample. The facility staff failed to provide fingernail care for Resident #151 prior to his fingernails becoming long, thick and discolored. The findings included: Resident #151 was originally admitted to the facility 8/31/18 and has never been discharged from the facility. The current diagnoses included; stroke, dysphagia, aphasia, dementia and with severely impaired vision. The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/7/18 as rarely to never able to make himself understood and rarely to never understands others. The resident was coded as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired abilities to make daily decisions. The resident was also coded for having no mood or behavior problems. In section "G" (Physical functioning) the resident was coded as requiring total care bathing and eating, extensive assistance of 2 people with transfers and toileting, extensive assistance of 1 person with bed mobility, locomotion, dressing, and personal hygiene. Resident #151's person centered care plan dated 9/3/18 had a problem which read; impaired neurological status related to aphasia, stroke and dementia. The goal read; will be free of injury through 12/5/18. The interventions included; Assist in ADL's and mobility as needed. Monitor ADL's for assistance and render care as needed.	F 677	assistance with ADL care as needed. How others were identified: 2. The facility completed an audit of resident fingernails to identify any potential care needs. Systems in Place: 3. Nursing staff were Re-educated by the DON or designee on providing assistance with ADL's to residents based on the needs identified on Care plan and Kardex. Audits will be completed during Care Keeper rounds 5 x week to ensure assistance with ADL care has been administered per residents identified needs. Quality Assurance Program: 4. Audits will be reviewed during monthly and quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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On 9/19/18 at approximately 12:25 p.m., resident #151 was observed seat in a chair beside his bed. The resident reached his hand out and waved to persons entering his room. The surveyor observed the resident's fingernails; all were approximately 2 inches beyond the tip of the nail, very thick and a brownish color.

On 9/20/18 at approximately 11:20 a.m., the Director of Nursing (DON) was asked about Resident #151's fingernails. The DON stated fingernail care is the responsibility of the Certified Nursing Assistants (CNA) and should be provided with baths when needed. The DON stated she wasn't aware of Resident #151's nail she would follow-up and get back with the surveyor.

On 9/20/18 at approximately 2:00 p.m., Resident #115 was observed seated at the nurse's station. The resident reached his hand out and his nails were again observed. They were clean, short, and neat.

On 9/20/18 at approximately 3:10 p.m., an interview was conducted with CNA #5. CNA #5 stated when she gave Resident #151 his shower, his fingernails were cut, filed and cleaned without difficulty. CNA #5 also stated she was a float staff and had not recently been assigned to provide Resident #151's care; therefore she was unable to say why his nails had been so long, thick and dirty.

On 9/21/18 at approximately 5:55 p.m., the above findings were shared with the Administrator, and Director of Nursing (DON). The DON stated the facility doesn't have a fingernail care policy but the expectation is for fingernail care to be

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F 677	Continued From page 48 provided by the CNA on showers days when it's needed and anytime the resident is identified requiring nail care.	F 677		
F 684 SS=D	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, clinical record review and facility documentation, the facility staff failed to follow physician orders for 1 out 24 (Resident #202) in the survey sample. The facility staff failed to follow physician orders for the administration of oxygen therapy. The findings included: Resident #202 was admitted to the facility on 09/07/18. Diagnoses for Resident #202 included but not limited to *Malignant neoplasm of bronchus or lung. Resident #202 Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 09/14/18 coded Resident #202's Brief Interview for Mental Status (BIMS) scored of 08 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #202 as needing extensive assistance of two with bed	F 684	F 684 Action Taken: 1. Resident #202 oxygen is administered per physicians orders. How others were identified: 2. An audit was completed for any residents on oxygen to ensure physician orders were being followed. Systems in Place: 3.Nursing staff were re-educated by the DON/designee on following physician orders. An audit will be completed 5 x week during care keeper rounds to ensure that oxygen is administered per physician orders.	10/31/18

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F 684	Continued From page 49 mobility, extensive assistance of one with transfer, toilet use, personal hygiene and limited assistance and limited assistance of one with bathing and supervision with eating for Activities of Daily Living care. Under section O (Special Treatments, Procedure, and Programs) was coded for respiratory treatments for the use of oxygen therapy. During the initial tour on 09/18/18 at approximately 12:55 p.m., Resident #202's oxygen tubing was observed in his nares but his oxygen was not turned on. On the same day at approximately 4:06 p.m., oxygen delivery remained unchanged. On 09/19/18 at approximately 12:18 p.m., Resident #202 was observed in bed with oxygen cannula in his nares but his oxygen was not turned on. The surveyor asked Resident #202 if his oxygen helped with his breathing, he replied, "No not really; it doesn't feel like much is coming." On the same day at approximately 12:23 p.m., the surveyor and Director of Nurse (DON) entered resident's room. The surveyor asked the DON if Resident #202's oxygen concentrator was turned on, she looked at the oxygen concentrator, then she replied, "No it's not turned on; shaking her head." Review of the clinical record evidenced a physician order dated 09/17/18 which included: oxygen at 2 liters minute via nasal cannula continuously for shortness of breath every shift related to malignant neoplasm of bronchus or lungs. Review of Resident #202's September 2018 Treatment Administration Record (TAR) revealed	F 684	Quality Assurance Program: 4. Audits will be reviewed during monthly and quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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F 684	Continued From page 50 the nurse had signed off on 09/17/18 and 09/18/18 that the resident's oxygen was on and running at 2 liter minutes via nasal cannual continuous for shortness of breath. An interview conducted with DON on 09/21/18 at approximately 6:05 p.m. The surveyor asked, "What is your expectations of your nurses related to following physician orders" she replied, "I expect for all nurses to following MD orders as written with no exceptions." The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings. *Malignant neoplasm of bronchus or lung is a malignant neoplasm of the lung arising from the epithelium of the bronchus or bronchiole.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 685		10/31/18

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F 685	Continued From page 51 Based on observation, resident interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to ensure residents who need replacement assistive devices received necessary services for 2 of 24 residents (Resident #35 and 9), in the survey sample. 1. The facility staff failed to assist resident #35 to obtain replacement hearing aids after they were lost. 2. The facility staff failed to assist resident #9 to maintain optimum hearing abilities by assisting her to replace a broken hearing aid. The findings included: 1. Resident #35 was originally admitted to the facility 5/13/17 and readmitted 2/19/18, after a discharge 2/15/18, to a local acute care hospital for pneumonia. The current diagnoses included; stroke and pressure ulcers. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident 35's cognitive abilities for daily decision making were moderately impaired. In section "B" (Hearing, Speech and Vision), Resident #36 was coded as having the ability to hear adequately and understand what others are saying using hearing aids. In section "G" (Physical functioning), the resident was coded as requiring supervision after set-up with eating and supervision of 1 person with	F 685	F 685 Action Taken: 1.Resident # 35 and Resident # 9 have received assistance to replace their hearing devices. How others were identified: 2.An audit was conducted of the resident population to identify any other residents. Systems in place: 3.Social Service has been re-educated on the facility policy and process for replacement or assistance to replace vision or hearing devices. An audit will be completed monthly x 2 months to ensure any residents with damaged or missing assistive devices have assistance with repair or replacement of items. Quality Assurance Program: 4. Audits will be reviewed in the monthly/quarterly QAPI meeting.	

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locomotion, extensive assistance of 2 people with bed mobility, extensive assistance of 1 person with transfers, dressing, toileting, personal hygiene and bathing.
Observations/date/time

During the screening of residents on 9/18/18 at approximately 2:00 p.m., Resident #35 told the surveyor, "I can't hear you, my hearing aid is lost. Resident #35 roommate's visitor stated, don't worry about it, the staff will find it. Again resident #35 was visited on 9/19/18 at approximately 12:00 p.m., the resident stated she couldn't hear because her hearing aid was missing. A note was written to her on paper and she responded appropriately to the message. On 9/20/18 at approximately 11:15 a.m., Resident #35 told the wound care doctor, "I can't hear you because I have lost my hearing aid or someone has stolen it".

A Physician's order dated 8/26/17, read; may see podiatrist, dentist, audiologist, ophthalmologist.

The active care plan dated 8/26/17, had a problem which read; Impaired Communication due to impaired hearing. The goal read; Resident will be able to communicate basic needs through 10/31/18. The intervention included; ensure placement of hearing aids as needed. If resident losses hearing aids, discussed with son about next time they are lost to buy amplifiers.

An interview was conducted on 9/20/18, at approximately 11:05 a.m., with the Social Worker. The Social Worker stated she was not aware Resident #35's hearing aid was currently missing but she was aware on may occasions her hearings had been missing but they were usually

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found by staff. The Social Worker stated frequently the resident's hearing aides are misplaced because she removes them from her ears and put them on the window sill, meal trays, the bedside table and even in the bed. The Social Worker further stated the Interdisciplinary Team spoke with the resident's son and they agreed to not replace the hearing aids if lost again but to obtain amplifiers for use. The Social Worker stated she overheard the Administrator tell another family representative this therefore she thought it was appropriate information to give Resident #35's son. The Social Worker stated she never considered compatibility or use of amplifiers as a short term resolution while obtaining new hearing aids, just amplifiers permanently because of expense and the resident's dissatisfaction with each pair of hearing aids she's had.

The facility staff was unable to state why the resident was dissatisfied with the hearing aids or if she was applying them appropriately and if she was capable of managing the aid, turning it off and on, changing the batteries, storing it in a safe place, etc.

An interview was conducted on 9/20/18, at approximately 3:35 p.m. with Certified Nursing Assistant (CNA) #1, who stated Resident #35's hearing aid is often missing but they usually find it, in the bed or on the bedside table. She further stated the resident is allowed to keep the hearing aide at bedside because she likes to have it immediately upon awaking each morning.

On 9/20/18, the above findings were shared with the Administrator and Director of Nursing. The Administrator stated she had already directed the

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Social Worker to schedule an appointment and make transportation arrangements for Resident #35, for they were going to make this right.

2. Resident #9 was originally admitted to the facility 12/29/17, and has never been discharged from the facility. The current diagnoses included; hard of hearing and dementia.

The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/6/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #9's cognitive abilities for daily decision making were severely impaired. The resident was coded with no mood or behavior problems.

In section "G" (Physical functioning) the resident was coded as requiring limited assistance with bed mobility and eating, extensive assistance of 1 person with transfers, in room walking, locomotion, dressing, toileting, personal hygiene and bathing.

A Physician's order dated 12/29/17, read; may see podiatrist, dentist, audiologist, ophthalmologist.

The active care plan dated 1/1/18 had a problem which read; "Impaired communication due to impaired cognition and impaired hearing. Resident is hearing well with new hearing aid and amplifier turned off in the other ear". The goal read; Resident will be able to communicate basic needs through 10/25/18. The interventions included; ensure placement of hearing aids as needed. Put amplifier in ear turned off. Speak at an appropriate volume to facilitate resident

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hearing.

A nurse's note date 7/4/18, revealed Resident #9 was screaming at staff about her missing hearing aid and not attending activities. The note stated the resident had attended 2 activities and only the right hearing aide was available for use. The whereabouts of the left hearing aid was not documented.

An interview was conducted with on 9/20/18, with Resident #9 daughter. The daughter stated she had voiced concerns about her mother's hearing aid being broken and how it impeded her ability to communicate and participate in activities. She stated the Administrator told her the facility had paid for one hearing aid and they were not paying for another regardless of what happened to it. The daughter stated the Administrator also told her they would obtain an amplifier only.

An interview was conducted on 9/20/18, at approximately 11:05 a.m., with the Social Worker. The Social Worker stated she had "no conversations with Resident #9's daughter about the missing hearing aids, the Administrator took care of it".

The facility's policy titled Personal Adaptive Device Policy date 1/1/18. The policy stated, many Residents use personal adaptive devices. These devices include eye glasses, dentures and/or partial denture, hearing aids, prosthetics devices (prosthetic limbs, eyes or other devices). In the event that a personal adaptive device is lost, damaged or destroyed as a result of any action of a facility employee, the facility will replace or reimburse the resident for the lost or damaged item. The facility limits its liability to 1

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F 685	Continued From page 56 repair or 1 replacement of a specific item. If an item is lost, damaged or destroyed by the actions of the resident and/or his family member or visitor, the facility is not required to replace the item or reimburse the resident for the lost or damaged item. On 9/20/18, the above findings were shared with the Administrator and Director of Nursing. The Administrator stated she had already directed the Social Worker to schedule an appointment and make transportation arrangements for Resident #9, for they were going to make this right.	F 685		
F 686 SS=G	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 interviews, clinical record review and review of the facility's policy, the facility staff failed to ensure the necessary treatment, care and services were provided to prevent development of pressure ulcers for 2 of 24 residents (Resident #24 and #31) that were	F 686	F 686 Action Taken: 1.Resident #24 had a head to toe skin assessment and Resident # 31 had a	10/31/18

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F 686	Continued From page 57 identified at an advanced stage, resulting in harm. 1. For Resident #24, the staff failed to identify two pressure ulcers prior to being found at an advanced stage resulting in harm. The first wound was found on the left buttocks as an unstageable with a thin layer of eschar (hard black dead tissue) on 07/20/18. The second wound was found on 09/20/18 by the surveyor to the left outer bunion. The wound was found as an unstageable with eschar (hard black dead tissue). 2. The facility staff failed to identify Resident #31 a sacral pressure injury prior to it being found at an advanced stage resulting in harm. The pressure injury was found as a stage 3 pressure injury with 40 percent necrotic tissue. The findings included: 1. Resident #24 was admitted to the facility on 07/18/17. Diagnosis for Resident #24 included but are not limited to *Down Syndrome, *Autistic disorder and *Muscle weakness. Resident #24's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 07/27/18 coded Resident #24 indicating short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. In addition, the MDS coded Resident requiring total dependence of two with transfer, total dependence of one with bathing, personal hygiene, toilet use, dressing and extensive assistance of two with bed mobility. The MDS with an ARD of 07/27/18 under section "M" (Skin Condition - M0100) was coded: Resident has a stage 1 or greater pressure ulcer.	F 686	head to toe skin assessment on 9/20/18. Wounds are assessed weekly for residents #24 and #31 to ensure any new area are identified timely. Skin observations will be completed during ADL care and bathing by the C.N.A. and will be communicated to the nurse utilizing the skin observations form. How others were identified: 2. Head to toe skin assessments was completed on current residents residing in the facility on 9/20/18- 9/21/18 to identify any new areas. Residents residing in the facility will have weekly skin assessment completed by a licensed nurse to identify any new skin issues. Skin observations will be completed during ADL care and bathing by the C.N.A.'s and will be communicated to the nurse utilizing the skin observation form. Systems in Place: 3. Nursing staff was re-educated on the process of completing a head to toe assessment and appropriately documenting the status of findings and existing wounds. A random audit will be completed 3 x week x 2 months by the DON/designee to ensure weekly assessments are being completed. Quality Assurance Program:	

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F 686	Continued From page 58 Under section (M0150) at risk for developing pressure ulcers was coded yes, under section (M0210) for unhealed pressure ulcers was coded yes, under section (M0300) for having stage 2 (2) pressure ulcer and unstageable (1) pressure ulcer was coded yes. Under section (M0610) for dimension of unhealed stage 3 or 4 pressure ulcers or eschar was to identify the pressure ulcer with the largest surface area (length x width) was measured (4.0 cm x 2.0 cm x 0 cm). Under section (M0700) most severe tissue type for any pressure ulcer was coded 4 for eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be shorter or harder that an surrounding skin) and under section (M1200) for skin and treatments was coded for having pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer care, application of nonsurgical dressings and applications of ointments/medications other than feet and application of dressings to feet (with or without tropical medication). Resident #24's care plan initiated 7/27/17 was reviewed and included: conduct weekly skin inspection, moisture skin with lotion as needed; nutrition and hydration support; provide low air loss mattress; skin care after incontinent episodes and apply barrier cream; treatments as ordered. Resident #24's person-centered comprehensive care plan revised on 7/20/18 documented Resident #24 with actual skin breakdown to left buttocks (*pressure ulcer-stage 3) due to assistance required with bed mobility. The goal: pressure ulcer will heal without complication. Some of the intervention/approaches to manage	F 686	4. Audits will be reviewed during the monthly and quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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goal included provide *Pressure air loss mattress, conduct weekly skin inspection and treatment as ordered.

*Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

A Braden Risk Assessment Report was completed on 04/29/18 and on 07/27/18; resident scored a nine indicating very high risk for the development of pressure ulcers. Mobility is completely immobile-does not make even slight change in body or extremity position without assistance.

On 09/20/18 at approximately 4:30 p.m., a wound care observation was conducted with License Practical Nurse (LPN) #1. Resident #24 was lying in bed, positioned on her right side lying on an alternating low air loss pressure mattress. LPN #1 to perform wound care with the assistance of Certified Nursing Assistant (CNA) #6. Prior to starting wound care to the Resident #24, LPN #1 washed her hands x 24 seconds then used hand sanitizer and CNA #6 washed her hands x 20 seconds; both donned a new pair of

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gloves. The LPN repositioned the resident on her right side with the assistance of CNA #6. The CNA pulled the covers off Resident #24 legs. The surveyor observed a wound to residents left bunion without a dressing in place. The surveyor asked, "What is the current treatment to the wound to Resident #24's left bunion" LPN #1 replied, "There is no treatment for that wound." The surveyor asked, "When was the area to the left bunion first identified" she replied, "Just now; by you (surveyor)."

The review of the clinical nurse's note evidenced an entry dated 09/20/18 at 8:22 p.m., indicated the following: The new wound measured 2.5 cm x 2.2 cm with two small inner areas to left bunion. The superior inner area is gray in color. The inferior inner area is black in color and the surrounding tissue is red. The wound physician was notified with the following new orders obtained: cleanse area with wound cleanser, pat dry, apply skin prep around peri wound, apply santyl to wound bed, cover with foam dressing and change daily and as needed.

The review of the clinical nurse's notes evidenced an entry dated 09/21/18 at 3:52 p.m., written by the Director of Nursing (DON) indicated the following: Resident noted with an unstageable are to her left bunion, related to hard eschar to wound - area measured at 2.5 cm x 2.2 cm with wound edges intact. Wound without drainage or order. New order obtained to discontinue Santyl and begin *Betadine daily.

*Betadine is a topical antiinfective (providone-iodine) (Mosby's Dictionary of Medicine, Nursing and Health Professions 7th Edition).

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The current treatment as of 09/21/18 read as follow: Betadine Swabsticks 10% (Providone-Iodine) - apply to left bunion topically every day for wound car. Clean left bunion with wound cleaner, apply *skin prep to peri wound bed, apply betadine swab to eschar plate and leave on to air.

*Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/).

A nurse's note dated 07/20/18 at 4:11 p.m., read, in part: "Resident noted with an *unstageable area to left buttock measuring 4 cm x 2 cm, wound bed noted with thin layer of eschar.

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

On 07/20/18, the initial wound care assessment was completed by Director of Nursing (DON). It read, in part: left buttocks with unstageable measuring 4 cm x 2 cm with thin layer of eschar.

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Wound without drainage or odor. The current treatment plan is as follow: *Santly and *Calcium Alginate.

The current treatment as of 08/02/18 read as follows: Apply santyl to wound bed and calcium alginate, cover with foam dressing daily to left buttocks.

*Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.

*Alginate Dressings are composed of calcium alginate, a gelatinous and water-insoluble substance. When in contact with a wound, the calcium alginate in the dressing reacts with sodium chloride from the wound. This turns the dressing into a hydrophilic gel that maintains a moist environment for the wound (www.medicaldepartmentstore.com/Alginate-Dressings-s/286.htm).

The resident's wound was being cared for by the wound care specialist, and assessed on a weekly basis from 07/26/18 through 09/13/18.

The wound care specialist documented the following:
1. On 09/13/18 - *Stage III to left buttocks, 4.5 cm x 7.0 cm x 0.1 cm with 40% granulation and 60% skin with moderate amount of sero-sanquinous exudate; wound condition - deteriorated. Recommendation: Off-load wound, reposition

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per facility protocol.

2. On 09/06/18 - Stage III to left buttocks, 3.5 cm x 2.5 cm x 0.1 cm with 10% granulation and 90% skin with moderate amount of sero-sanquinous exudate. *Hypergranulation tissue present within the wound margins; wound progress - no change. Recommendation: Off-load wound, reposition per facility protocol. Procedure: cauterization for hypergranulation tissue. Chemical *cauterization of hypergranulation tissue performed on buttock wound with topical anesthetic to facilitate healing. No complications or bleeding.

3. On 08/30/18 - Stage III to left buttock measuring 3.5 cm x 2.0 cm x 0.1 cm with 10% granulation and 90% skin with moderate amount of sero-sanquinous exudate. Wound condition - improved. Recommendation: Off-load wound, reposition per facility protocol.

4. On 08/16/18 - Stage III to left buttocks measuring 1.5 cm x 3.5 cm x 0.1 cm with 30% granulation and 70% skin with moderate amount of sero-sanquinous exudate. Wound condition - no change. Recommendation: Off-load wound, reposition per facility protocol, and obtained consent for debridement.

5. On 08/09/18 - Stage III to left buttocks measuring 2.5 cm x 0.9 cm x 0.1 cm with 100% granulation with moderate amount of sero-sanquinous exudate. Wound condition - improved. Recommendation: Off-load wound, reposition per facility protocol, obtained consent for
debridement.

6. On 08/02/18 - Stage III to left buttocks

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measuring 6.0 cm x 2.5 cm x 0.2 cm with 100% granulation with moderate amount of sero-sanquinous exudate. Wound condition - improved. Off-load wound, reposition per facility protocol and obtained consent for debridement. Hypergranulation tissue present within the wound margins. Procedure: cauterization for hypergranulation tissue. Chemical cauterization of hypergranulation tissue performed on buttock wound with topical anesthetic to facilitate healing. No complications or bleeding.

7. On 07/26/18 - (Pressure-unstageable due to necrosis) to left buttocks measuring 4.0 cm x 2.0 cm x not measurable cm with light serous. Wound with thick adherent black necrotic tissue (eschar) 80% and thick adherent devitalized necrotic tissue 20%.

Hyper-granulation (or overgranulation) is an excess of granulation tissue beyond the amount required to replace the tissue deficit incurred as a result of skin injury or wounding (https://www.ncbi.nlm.nih.gov/pubmed/20335928) .

Cauterization is the process of burning a part of the body cautery. A cautery is a device or agent used in the coagulation of tissue by heat or caustic substances (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition).

The facility administration was informed of the finding during a briefing on 09/07/18 at approximately 7:10 p.m. The facility did not present any further information about the findings. The surveyor asked the DON, what stage you expect your staff to identify a pressure ulcer, she

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replied, "At a stage 1 but no greater than a stage 2." The facility did not present any further information about the findings.

*Down syndrome is a chromosomal condition that is associated with intellectual disability, a characteristic facial appearance, and weak muscle tone (hypotonia) in infancy. All affected individuals experience cognitive delays, but the intellectual disability is usually mild to moderate (https://ghr.nlm.nih.gov/condition/down-syndrome).

*Autistic disorder is a complex neurobehavioral condition that includes impairments in social interaction and developmental language and communication skills combined with rigid, repetitive behaviors (https://www.webmd.com/brain/autism/understanding-autism-basics).

*Muscle weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm).

*Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

*Low air loss mattress is an alternating pressure mattress systems are designed to heal and

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prevent bedsores (http://www.medicalairmattress.com/deluxe.html).

2. Resident #31 was originally admitted to the facility 8/6/18 and has never been discharged from the facility. The resident's diagnoses included; cerebrovascular disease with swallow and speech problems.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/13/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. The resident was also coded for highly impaired hearing, no speech and rarely to never having the ability to understand others. Resident #31 was coded as having no mood or behavior problems.

In section "G" (Physical functioning) the resident was coded as requiring total care of 2 people with transfers and toileting, total care of 1 person with locomotion, personal hygiene, and bathing, extensive assistance of 2 people with bed mobility and extensive assistance of 1 person with dressing and eating.

In section "M" (Skin Condition) the resident was coded as having an unstageable pressure injury present and a potential for additional skin problems. The pressure ulcer coded upon admission was to the left heel.

The most recent Risk for Pressure Ulcer tool,

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dated 8/6/18, revealed a score of 10 for Resident #31. This indicated the resident had a risk for pressure ulcer development because of very limited sensory perception, occasionally moist, chairfastness, immobility, dependence upon staff for provision of fluid intake, always incontinent of bladder and bowels, potential problems from friction when turned and repositioned.

The facility staff presented only 2 weekly skin integrity checks since admission for Resident #31. They were dated 8/15/18 and 8/29/18. Both skin checks were checked; "skin clear, no change of condition assessed".

Review of the clinical record revealed a nurses' note dated 9/12/18 at 13:12, It read; "called to resident's room by Certified Nurse's Assistant (CNA), resident noted with an open area to her sacrum, wound bed dark red, no odor, no drainage, edges uneven, jagged. Resident currently has zinc oxide to be applied each shift. Responsible party and Physician notified. Will have resident seen by the wound care physician".

Clinical documentation revealed the wound care physician assessed Resident #31's sacral pressure injury 9/13/18. The wound care physician 9/13/18, progress note revealed the sacral pressure injury was a stage 3, measuring length 2.7 centimeters by width 2.0 centimeters by depth 0.2 centimeters. The progress note further stated the sacral pressure injury also presented with a moderate amount of sero-sangious drainage, 60 percent granulation tissue and 40 percent necrotic tissue. The wound care physician's progress note stated debridement of the necrotic tissue was recommended. On 9/13/18, the wound care

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physician ordered Alginate calcium, be applied once daily for 30 days, Santyl ointment, apply once daily for 30 days and a secondary dressing; Foam with silicone, apply once daily for 30 days.

A Physician's order dated 9/14/18 read; Santyl Ointment 250 Unit/gram; apply to sacrum topically every night shift for wound management. Clean sacrum with wound cleaner, apply skin prep to peri wound, cover wound bed with Santyl, then apply Alginate calcium, cover with border gauze. Change daily and as needed.

The current care plan dated 8/17/18 read; Pressure ulcer actual or at risk due to assistance required in bed mobility, bowel incontinence, Diagnosis of peripheral vascular disease. 9/14/18 sacrum pressure ulcer. The goal read; skin will remain intact. The interventions included; Braden scale per facility policy, Conduct weekly skin inspection. Float heels. Pillow prop as ordered. Provide pressure reducing wheelchair cushion. Provide pressure reduction/relieving mattress. Provide thorough skin care after incontinence episodes and apply barrier cream. Treatments as ordered.

The facility staff didn't update the care plan with a new goal or interventions after the sacral pressure ulcer was identified and added as a problem.

Resident #31's wound care was observed 9/20/18 at approximately 2:15 p.m. Registered Nurse (RN) #1 washed her hands, pulled down Resident #31's pants, removed the old dressing, removed her gloves, applied a new pair of gloves, cleaned up a small amount of stool, removed her gloves, apply another pair of gloves, applied wound

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cleanser to Resident #31's sacral pressure injury, wiped the pressure injury with 4 by 4 gauze and repeated the wound cleanser, then placed the wound cleanser in the bed, and wiped the pressure injury with 4 by 4 gauze. RN #1 removed her gloves applied another pair of gloves, used her gloved hands to tear the Alginate calcium, applied Santyl ointment (then placed the Santyl tube in the bed,) with cotton tip applicators, applied border gauze, removed her gloves, changed the resident's incontinence brief, pulled her pants up, and repositioned the resident in bed. the dressing wasn't dated or signed. RN #1 cleaned up the used products, discarding everything except the wound cleanser and the Santyl ointment. RN #1 didn't wash her hands or use hand sanitizer during the entire dressing change.

An interview was conducted with Registered Nurse (RN) #1, on 9/20/18, directly after wound care for Resident #31 was completed. RN #1 stated she had to be someplace very soon and it was all she could think of. She also stated I will get training on wound care, since she will be assisting the wound care physician when she is in the facility.

An interview was conducted on 9/20/18, at approximately 2:50 p.m., with the Director of Nursing. She stated the corporate consultant had identified they had a problem with skin checks not getting done. The Director of Nursing stated in-services were conducted on completing shower sheets by the CNA staff on shower days and the Wound Care Protocol. The Director of Nursing stated it is the facility's expectation for pressure injuries to be identified at an early stage, when the area is red or a stage1, not at a stage 3

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or 4. The Director of Nursing also stated the first line of detecting skin impairment should be from direct care observations during daily care and skin checks and skin assessments.

The facility's policy titled Pressure Sore Prevention-Quick Look (Revision-1/2017).
-Assess skin daily (every shift and prn).

Prevention (High Risk)
-Interventions for Minimal and Moderate Risk
-Place on pressure reducing chair device
-Appropriate disciplines to scree - OT/PT
-Care Plan to identify interventions
-Increase turning and reposition

On 9/21/18, at approximately 5:55 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided.

The National Pressure Ulcer Advisory Panel (NPUAP) NOTE: Based on current reported data,
Stage I PrU likely began 12-24 hours prior
Stage II PrU likely began 24 hours prior
Stage III - IV PrU likely began at least 72 hours prior
sDTI PrU purple tissue without epidermal loss likely began 48 hours prior
(file:///C:/Users/eyz54832/AppData/Local/Microsoft/Windows/INetCache/IE/NTPQV9PP/UPDATED-3-9-2014-RCA-Template.pdf)

Definitions:
Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony

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F 686	Continued From page 71 prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Debridement=Debridement is the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process.	F 686		
F 690 SS=D	Zinc oxide-a protective barrier cream Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		10/31/18

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F 690	Continued From page 72 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and review of the facility's educational document, the facility staff failed to provide appropriate care and services for one resident (Resident #6) of 24 residents in the survey sample who was admitted with an indwelling catheter. The facility staff failed to ensure Resident #6	F 690	F 690 Action Taken: 1.Foley Catheter was removed and UTI treated. How others were identified:	

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F 690	Continued From page 73 received appropriate care to prevent and treat a urinary tract infection (UTI). The findings included: Resident #6 was originally admitted to the facility 3/15/18 and has never been discharged from the facility. The current diagnoses included; urinary retention, Parkinson's Disease, dementia, chronic kidney disease, and diabetes. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/13/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #6' cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with eating and extensive assistance of 1 person with with bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. In section "H" Bladder and Bowel, the resident was coded for having an indwelling catheter and frequently incontinent of her bowels. The current Physician's orders had an order dated 4/5/18 which read; Re-insert a 16 french indwelling urinary catheter with a 10 milliliter balloon. Cleanse the meatus and adjacent catheter with soap and water every shift for diagnosis of urinary retention. Change Foley catheter every 30 days. Change drainage bag every 30 days. A physician's order dated 8/8/18 read; Cranberry tablet 450 milligrams, Give 1 tablet by mouth in the morning related to urinary tract infection.	F 690	2. Residents with Foley Catheters residing in facility are at risk. Systems in Place: 3. Nursing staff were re-educated by the DON/designee on the professional standards for care of a Foley catheter, admission Foley catheter assessment and appropriateness of a Foley catheter. A random audit observing Foley catheter care will be completed 3 x week x 2 months by the DON/designee. Audits will be completed during care-keeper rounds 5 x week observing for misplacement of tubing and Foley bags on the floor. Quality Assurance Program: 4. Audits will be reviewed during the monthly and quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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The current care plan had a problem dated 3/18/18 which read; Alteration in elimination of bowel and bladder. History of UTI's, Indwelling catheter. The goals read; I will be free of UTI's through 10/26/18. I will have no complications from use of my indwelling catheter, such as pain, infection, obstruction through 10/26/18. The interventions included; "Foley catheter to straight drainage due to ()." Anchor catheter, avoid excessive tugging on the catheter during transfer and delivery of care. Indwelling catheter care every shift and as needed. Keep the drainage bag of catheter below the level of the bladder at all times and off the floor. Monitor and report signs/symptoms of UTIs, changes in urine color, odor, consistency of urine, dysuria, urinary frequency, fever and pain.

A clinical record note dated 7/31/18, at 7:30 p.m., read Foley catheter removed and reinserted this shift with 18 french 5 milliliter balloon, amber urine with a moderate amount of sediment and blood tinged urine noted...

The clinical record revealed Resident #6 had urine collected 7/24/18 for a urinalysis and culture and sensitivity per physician's order. The laboratory results were reported to the facility 8/1/18. The urinalysis revealed 500 leukocytes (white blood cells) and greater than 100,000 colonies of bacteria. The diagnosis was a pseudomonas aeruginosa, UTI.

Further review of the clinical record revealed a physician's progress note dated 8/10/18, which read; Labs: Urinalysis for leukocytes esterase white blood cells too numerous to count and greater than 100,000 colonies of pseudomonas

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aeruginosa, sensitive to Cipro (an antibiotic). The physician further documented " For the resident's UTI, she will be started on Cipro 250 milligrams by mouth every 12 hours for 5 days. I have written to change the Foley after the second dose of Cipro. It should be noted labs were presented to me today".

The clinical record revealed no documentation indicating why the urinalysis was originally obtained, no documentation of signs/symptoms to monitor for while the facility staff was awaiting the laboratory results and no documentation of the resident's status while the antibiotic was in progress.

Resident # 6 was observed 9/19/18 in a wheel chair sitting in the dining room at approximately 11:45 a.m. the indwelling catheter tubing resting on the floor and cloudy urine with heavy sediment noted in the tubing. Resident #6 was observed at approximately 1:45 p.m. on 9/20/18 seated in a wheel chair during a religious activity, again the indwelling catheter tubing was observed resting on the floor as well as the dignity bag which covered the drainage bag. The urine in the tubing was whitish and thick. On 9/21/18 at approximately 1:26 p.m., Resident #6 was observed sitting in a wheel chair in a dining room with her indwelling catheter tubing resting on the floor as well as the drainage bag. The Director of Nursing and Unit Manager also observed the positioning of the indwelling catheter tubing and drainage bag. The Unit Manager repositioned the drainage bag and tubing to prevent it from making contact with the floor. On 9/21/18 at 2:10 p.m., Resident #6 was assisted to bed. The Certified Nurse Assistant (CNA) #4 attached the indwelling catheter to the lower frame of the bed

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F 690	Continued From page 76	F 690		

and the indwelling catheter was observed resting on the floor. The Unit Manager again repositioned the catheter bag and tubing. As the Unit Manager positioned the tubing it was observed and under the residents leg and pulling away at the point of entrance. The Unit Manager stated she would change the bag and tubing, apply an anchor and ensure the resident received more fluids in an attempt to clear her urine.

On 9/21/19 at approximately 2:35 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information. The Director of Nursing stated she was unable to determine a rationale for use of the indwelling catheter for she was told a urinary retention was not a sufficient diagnosis. The Administrator stated she would contact the hospital which transferred the resident to the facility for a diagnosis and she would contact the resident's daughter for information.

At the time of this writing no additional information and or medical justification for use of the indwelling catheter was provided.

The facility didn't have an Indwelling catheter policy to present at the time of survey therefore an undated document titled Indwelling Urinary Catheter Care and Removal was presented by the Administrator by fax on 9/24/18. It read "Intended to prevent infection and other complications by keeping an indwelling catheter insertion site clean, routine catheter care is performed after the resident's morning bath and immediately after perineal care... An indwelling catheter should be removed when bladder decompression is no longer necessary, when the

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F 690	Continued From page 77 resident can resume voiding or when the catheter is obstructed... To prevent catheter associated UTIs the catheter should be removed as soon as it is no longer needed.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation, the facility staff failed to provide physician ordered oxygen for 1 out 24 (Resident #202) in the survey sample. The facility staff failed to ensure physician ordered oxygen therapy was provided. The findings included: Resident #202 was admitted to the facility on 09/07/18. Diagnoses for Resident #202 included but not limited to *Malignant neoplasm of bronchus or lung. Resident #202 Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 09/14/18 coded Resident #202's Brief Interview for Mental Status (BIMS) scored of 08 out of a possible score of 15 indicating moderate cognitive impairment. In	F 695	F 695 Action Taken: 1.Resident #202's oxygen is administered per physician orders. How others were identified: 2. An audit was completed for any residents on respiratory therapy to ensure that respiratory treatment was provided per physician order. Systems in Place: 3. Nursing staff were re-educated by the DON/designee on following physicians	10/31/18

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F 695	Continued From page 78 addition, the MDS coded Resident #202 as needing extensive assistance of two with bed mobility, extensive assistance of one with transfer, toilet use, personal hygiene and limited assistance and limited assistance of one with bathing and supervision with eating for Activities of Daily Living care. Under section O (Special Treatments, Procedure, and Programs) was coded for respiratory treatments for the use of oxygen therapy. During the initial tour on 09/18/18 at approximately 12:55 p.m., Resident #202's oxygen tubing was observed in his nares but his oxygen was not turned on. On the same day at approximately 4:06 p.m., oxygen delivery remained unchanged. On 09/19/18 at approximately 12:18 p.m., Resident #202 was observed in bed with oxygen cannula in his nares but his oxygen was not turned on. The surveyor asked Resident #202 if his oxygen helped with his breathing, he replied, "No not really; it doesn't feel like much is coming." On the same day at approximately 12:23 p.m., the surveyor and Director of Nurse (DON) entered resident's room. The surveyor asked the DON if Resident #202's oxygen concentrator was turned on, she looked at the oxygen concentrator, then she replied, "No it's not turned on; shaking her head." Review of the clinical record evidenced a physician order dated 09/17/18 which included: oxygen at 2 liters minute via nasal cannula continuously for shortness of breath every shift related to malignant neoplasm of bronchus or lungs.	F 695	orders. An audit will be completed 5 x week during care keeper rounds to ensure respiratory treatment is administered per physician orders. Quality Assurance Program: 4. Audits will be reviewed during the monthly and quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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F 695	Continued From page 79 Review of Resident #202's September 2018 Treatment Administration Record (TAR) revealed the nurse had signed off on 09/17/18 and 09/18/18 that the resident's oxygen was on and running at 2 liter minutes via nasal cannual continuous for shortness of breath. An interview conducted with DON on 09/21/18 at approximately 6:05 p.m. The surveyor asked, "What is your expectations of your nurses related to following physician orders" she replied, "I expect for all nurses to following MD orders as written with no exceptions." The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings. *Malignant neoplasm of bronchus or lung is a malignant neoplasm of the lung arising from the epithelium of the bronchus or bronchiole.	F 695		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		10/31/18

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F 712	Continued From page 80 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, the facility staff failed to ensure 1 of 24 Residents (Resident #8) in the survey sample was seen by a physician or his/her designee at least once every 30 days for 90 days and every 60 days thereafter. Findings included: Resident #8 was admitted to the facility on 04/27/18. Diagnoses included but were not limited to: *Chronic Obstructive Pulmonary Disease (COPD), *Diabetes Type II and *Fracture of the left femur. Resident #8's Minimum Data Set (MDS), a significant change with an Assessment Reference Date of 06/20/18 coded Resident # 8 Brief Interview for Mental Status (BIMS) score of 04 out of a possible score of 15 indicating severe cognitive impairment. In addition, the MDS coded Resident #8 extensive assistance of one with bathing, personal hygiene, toilet use and dressing, limited assistance of one with bed mobility and transfer and supervision with eating for Activities of Daily Living care. Review of the clinical record review revealed Physicians progress notes dated for 04/30/18 and 08/10/18.	F 712	F 712 Action Taken: 1.Resident # 8 was seen by the physician. How others were identified: 2. An audit was completed by the Medical Records/designee to ensure that residents were seen by a physician once every 30 days for 90 days and every 60 days thereafter. Systems in Place: 3. The Administrator/designee re-educated the Medical Records staff and nursing staff on the requirements for physician visits. The Medical Director also received notification of the visiting requirements for physicians. Medical Records will complete an audit weekly x 2 months to monitor for timeliness of physician visits. Quality Assurance Program	

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F 712	Continued From page 81 An interview was conducted with Director of Nursing (DON) on 09/20/18 at approximately 2:55 p.m., who stated, "The only MD Progress Notes located in the resident's medical record was for 04/30/18 and 08/10/18." The surveyor asked, "When a resident is admitted to the facility, how often should they be seen by the physician or Nurse Practitioner (NP) she replied, "Every 30 days for 90 days then every 60 days." The surveyor asked, "Was Resident #8 seen every 30 days x 90 days as a new admission" she replied, "No." The Administrator provided a typed letter on 09/21/18 at approximately 1:50 p.m. The letter read; Bayside of Poquoson response to a request for an MD visit policy. The CMS dictates that our doctor visits according to Medicare and Medicaid guidelines. The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings. *COPD 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 (https://medlineplus.gov/ency/article/007365.htm) *Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm). *Femur fracture (the femur is the thighbone,	F 712	4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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F 712	Continued From page 82 which extends from the pelvis to the knee. It is the largest and strongest bone in the body). A fracture is a traumatic injury to the bone in which the continuity of the bone tissue is broken (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition.)	F 712		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		10/31/18

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F 756	Continued From page 83 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview the facility, the failed to ensure 1 of 24 Residents (Resident #38) in the survey sample was seen by the pharmacist for Medication Regimen Review on a monthly basis. The findings included: Resident #38 was originally admitted to the facility on 06/01/18. Diagnosis for Resident #38 included but not limited to *Depression. Resident #38's Minimum Data Set (MDS), a 60-Day Assessment Reference Date (ARD) of 08/17/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #38 requiring extensive assistance of two with transfer, extensive assistance of one with bed mobility, dressing, toilet use, personal hygiene and bathing and supervision withe eating. Resident #38's comprehensive care plan documented Resident #38 with potential for drug related complications associated with the use of psychotropic medications for anti-depressant and anti-anxiety medications. The goal: the resident will be free of psychotropic drug related	F 756	F 756 Action Taken: 1.Resident # 38 has had a medication regimen review completed 7/18/18 & 8/29/18. It was in hardcopy, not on PCC. How others were identified: 2. An audit was conducted and the Medication Regimen reviews were completed timely. Systems in Place: 3. Licensed nursing staff and the DON were re-educated by the Regional Clinical Director on medication regimen reviews on a monthly basis and follow-up for recommendations from the pharmacy consultant. An audit will be completed by the DON monthly x 3 months to ensure that the residents have a medication regimen review by pharmacy consultant. Quality Assurance Program	

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F 756	Continued From page 84 complications. Some of the intervention/approaches to manage goal included to have monthly pharmacy review of medication regimen. Review of the clinical record review revealed Medication Regimen Review notes for 06/11/18 and 09/11/18. An interview was conducted with Director of Nursing (DON) on 09/21/18 at approximately 1:08 p.m. who stated, "We were only able to locate two pharmacist visits in Resident #38's clinical record. One visit was on 06/11/18 and the other on 09/11/18. The DON stated, "The pharmacist should see all residents on a monthly basis." The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings. The facility's policy titled Medication Monitoring - Medication Regimen Review and Reporting 8.1 (Revision-2007). -Policy: Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identity, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the IDT, including the resident, their family and/or resident representative.	F 756	4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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F 756	Continued From page 85 -Procedures read in part... 2. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. *Depression disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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	F 758		10/31/18

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F 758	Continued From page 86 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and review of the facility's policy the facility staff failed to ensure one (Resident #44) of 24 residents in the survey sample did not receive unnecessary medications. The facility's staff failed to ensure a gradual dose reduction attempt was made for Resident #44's antipsychotic drugs, Buspirone Hcl and Seroquel. The findings included: Resident #44 was originally admitted to the facility 11/1/17 and she has never been discharged from	F 758	F 758 Action Taken: 1. Resident # 44 has been reviewed for gradual dose reduction by the physician. The pharmacy completed a GDR on 6/11/18. The physician reduced Haldol on 8/15/18. How other were identified:	

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F 758	Continued From page 87 the facility. The diagnoses included; Alzheimer's disease and dementia without behavioral disturbances. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/18 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The facility staff interview revealed the resident was with short and long term memory problems and severely impaired cognitive abilities for daily decision making. The 8/16/18, MDS assessment also revealed Resident #44 was without mood or behavior problems. She required total care of 2 people with bathing, extensive assistance of 2 people with transfers, extensive assistance of 1 person with bathing bed mobility, locomotion, personal hygiene, dressing, eating and toileting. The physician's order summary revealed the following orders: Buspirone Hcl 30 milligram (mg) 1 tablet by mouth 2 times daily for dementia with behavioral disturbances; Seroquel 25 mg; 1 tablet by mouth 2 times a day for behavioral disturbances dated 1/17/18; and an 8/15/16 order for Haloperidol 1 mg; 1 tablet by mouth every 12 hours for dementia with behavioral disturbances. Resident #44's active care plan dated 3/20/18, had a problem reading; Potential for drug related complications associated with use of psychotic medications - Antipsychotic and antianxiety The goal read; will be free of psychotropic drug related complications. The interventions read; Assess for pain. For the anxiety-Monitor for side effects and	F 758	2. An audit was completed to review residents that are on psychotropic medications to ensure that they are not receiving unnecessary medications and that Gradual Dose Reductions are initiated if appropriate. Systems in Place: 3. Licensed nursing staff and DON were re-educated by the Pharmacists/designee on Chemical Restraints and Unnecessary Medication Policies. An audit will be completed weekly x 2 months by the IDT in the Chemical Restraint QA meeting reviewing residents for Gradual Dose Reductions of medications, antianxiety, hypnotics, anti-depressants and antipsychotics will be reviewed monthly at a minimum. Quality Assurance Program 4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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report to physician, drowsiness, morning hang over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headaches, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence. For the antipsychotic-drowsiness, dry mouth, constipation, blurred vision, EPS, weight gain, edema, postural hypotension, sweating, loss of appetite and urinary retention.

Care plan listed the following behaviors as a problem; elopement risk, wandering in the halls without regards to safety, angry episodes with staff in which she stands up and walks down the hall aimlessly, combativeness with caregivers, angry episodes in which she talks to herself and cries, a confrontation with another resident, yelling and swinging, slapped another resident. The goal read; will remain safe during placement at the Living Center. The interventions included; involve resident in preferred activities, remove her from angry situations with other residents before slapping, hitting occurs, talk with resident when she is anxious and try to calm her down, , when resident is agitated offer snacks or walk the resident. When resident is combative with caregivers stop care, let her calm down and then attempt again.

On 9/21/18 at approximately 12:05 p.m., Resident #44 was observed in bed positioned in a sitting position, motionless, staring ahead but not focusing on persons entering the room. She didn't respond when spoken to and didn't reach out when a hand was presented for a handshake.

The Director of Nursing stated on 9/21/18, at approximately 2:15 p.m., there was not a behavioral monitoring flow sheet to monitor

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targeted behaviors or a document revealing what interventions were effective when behaviors were exhibited. The Director of Nursing further stated in August 2018 a dose reduction of the Haloperidol was made because the resident was very lethargic and requiring more staff assistance, including with consuming meal. The significant change MDS assessment also revealed the resident had decline in all activities of daily living and the resident was no longer walking.

A clinical record review of the pharmacy reviews revealed no dose reduction attempts for Buspirone Hcl or Seroquel and no physician and or designee documentation that a gradual dose reduction is clinically contraindicated. A pharmacy review for the drug Seroquel was forwarded to the physician 1/11/18 and 5/16/18. The 1/11/18 review had a physician's note reading "no change". The 5/16/18 review had no physician response.

The facility's policy titled; Medication Regimen Review and Reporting date of 11/17 read; The Medication Regimen Review (MMR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risk associated with medication.

On 9/21/18 at approximately 5:55 p.m., the above findings were shared with the Administrator and Director of Nursing, An opportunity was offered for the facility to provide additional information but none was provided.

Buspirone Hcl is an antianxiety medication, use to slow down the central nervous system. (https://www.ncbi.nlm.nih.gov/pubmedhealth/PM

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F 758	Continued From page 90 HT0008896/?report=details) Seroquel is an antipsychotic medication used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions. (https://medlineplus.gov/druginfo/meds/a698019.html) Haloperidol is an antipsychotic medication used to treat psychotic disorders (conditions that cause difficulty telling the difference between things or ... and things or ideas that are not real). Haloperidol is also used to control motor tics. (https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=haloperidol)	F 758		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and review of the facility's	F 773	F 773	10/31/18

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F 773	Continued From page 91 educational document, the facility staff failed to notify the ordering physician and/or designee of laboratory results outside of clinical reference range for 1 of 24 residents (Resident #6), in the survey sample. The facility staff failed to report to the physician and or designee, Resident #6's abnormal laboratory results indicating a urinary tract infection (UTI) for 14 days, which resulted in a delay in treatment. The findings included: Resident #6 was originally admitted to the facility 3/15/18 and has never been discharged from the facility. The current diagnoses included; urinary retention, Parkinson's Disease, dementia, chronic kidney disease, and diabetes. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/13/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #6' cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with eating and extensive assistance of 1 person with with bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. In section "H" Bladder and Bowel, the resident was coded for having an indwelling catheter and frequently incontinent of her bowels. The current Physician's orders had an order dated 4/5/18 which read; Re-insert a 16 french	F 773	Action Taken: 1.Resident # 6 lab results have been communicated to the physician. How others were identified: 2. An audit was completed on current residents residing at the facility with lab work back to September 1, 2018 to ensure any labs outside normal ranges or parameters. Systems in Place: 3. Licensed nurses were re-educated on timely notification to physician when lab results are abnormal or outside normal parameters. The DON/designee will complete a random audit 2 x week x 2 months to ensure appropriate and timely notification to the physician was completed and documented. Quality Assurance Program 4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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indwelling urinary catheter with a 10 milliliter balloon. Cleanse the meatus and adjacent catheter with soap and water every shift for diagnosis of urinary retention. Change Foley catheter every 30 days. Change drainage bag every 30 days. A physician's order dated 8/8/18 read; Cranberry tablet 450 milligrams, Give 1 tablet by mouth in the morning related to urinary tract infection.

The current care plan had a problem dated 3/18/18 which read; Alteration in elimination of bowel and bladder. History of UTI's, Indwelling catheter. The goals read; I will be free of UTI's through 10/26/18. I will have no complications from use of my indwelling catheter, such as pain, infection, obstruction through 10/26/18. The interventions included; "Foley catheter to straight drainage due to ()." Anchor catheter, avoid excessive tugging on the catheter during transfer and delivery of care. Indwelling catheter care every shift and as needed. Keep the drainage bag of catheter below the level of the bladder at all times and off the floor. Monitor and report signs/symptoms of UTIs, changes in urine color, odor, consistency of urine, dysuria, urinary frequency, fever and pain.

The clinical record revealed Resident #6 had urine collected 7/24/18 per physician's order for a urinalysis and culture and sensitivity. The laboratory results were reported to the facility 8/1/18. The urinalysis revealed 500 leukocytes (white blood cells) and greater than 100,000 colonies of bacteria. The diagnosis was a pseudomonas aeruginosa, UTI.

Further review of the clinical record revealed a physician's progress note dated 8/10/18, which

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F 773	Continued From page 93 read; Labs: Urinalysis for leukocytes esterase white blood cells too numerous to count and greater than 100,000 colonies of pseudomonas aeruginosa, sensitive to Cipro (an antibiotic). The physician further documented " For the resident's UTI, she will be started on Cipro 250 milligrams by mouth every 12 hours for 5 days. I have written to change the Foley after the second dose of Cipro. It should be noted labs were presented to me today". The clinical record revealed no documentation indicating why the urinalysis was originally obtained, no documentation of signs/symptoms to monitor for while the facility staff was awaiting the laboratory results and no documentation of the resident's status while the antibiotic was in progress. On 9/21/19, at approximately 2:35 p.m., the above findings were shared with the Administrator and Director of Nursing. The Director of Nursing stated the laboratory results should have been available on 7/27/18. The Director of Nursing presented an in-service on management of laboratory results dated 8/17/18, because she stated they recognized it as a obtaining laboratory specimens and results were a problem. The document stated "once labs are returned, the results must be called to the physician and the resident representative must be notified. Labs are not to be placed in the physician's binder awaiting the physician's response for that is a delay in treatment. All labs must be filed in the resident's chart under the lab section. You may document on the lab slip the physician and resident representative have been made aware.	F 773		
F 791	Routine/Emergency Dental Srvcs in NFs	F 791		10/31/18

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F 791 SS=D	Continued From page 94 CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		

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F 791	Continued From page 95 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interviews, staff interviews, clinical record review, and review of the facility's policy, the facility staff failed to ensure one (Resident #32) of 24 residents in the survey sample received the services needed to meet their dental needs. The facility staff failed to promptly assist Resident #32 in obtaining replacement dentures once it was made known, they were missing. The findings included; Resident #32 was admitted to the facility 04/08/15. He had never been discharged. The current diagnoses include; Parkinson's Disease, cognitive communication deficit, and unspecified dementia. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/10/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scored 12 out of a possible 15. This indicated Resident #32's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision of 1 person with locomotion and eating, extensive assistance of 2 people with bed mobility, transfers and toileting, and extensive assistance of 1 person	F 791	Action Taken: 1.Resdient #32 has been assisted with getting dentures replaced. How others were identified: 2. An audit was conducted of resident who have dentures. Systems in Place: 3. Social Services and DON were re-educated on regulatory requirements for missing or broken dentures and the requirements for missing or broken dentures and the requirements for timely assistance to obtain new or replacement dentures. To include transportation to appointments. Audits will be completed during care keeper rounds 5 x week x 2 months to monitor residents who may have needs related to dentures or have a need for replacing lost or broken dentures. The care keeper will notify Social Services Director of any issues and the Social Services Director will start the process assisting the resident as needed with the repair or replacement of dentures.	

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F 791	Continued From page 96 with dressing, personal hygiene and bathing. On 09/18/18 at approximately 01:28 p.m., Resident #32 stated he would like to discuss obtaining replacement bottom dentures." Resident #32 stated his lower dentures came up missing approximately nine months to a year ago. The resident also stated his dentures were kept on the bedside table but, one morning Certified Nurse's Assistant (CNA) #1 went to put them in his mouth and they were gone. On 9/19/18 at approximately 11:15 a.m., Resident #32 was observed in his room talking with his wife. The resident was missing a tooth on the left upper side of his mouth. The resident stated the tooth was extracted sometime in August, 2018. The resident was also missing several bottom teeth. An interview was conducted with CNA #1, who said that it was about 9 months ago that she reported to the former Director of Nursing (DON) that Resident #32's dentures were missing. An interview was conducted by telephone with Resident #32's responsible party on 09/20/18 at approximately 12:05 p.m. The responsible party stated she had spoken with staff at various times about Resident #32 missing bottom denture, but she had not spoken with the Social Worker for it was hard getting in touch with her. The responsible party stated that receiving care plan meeting notices in the mail a day before the meeting didn't give her enough time to take off from work to attend the meetings therefore, talking about the resident missing teeth at the care plan meeting was not possible.	F 791	Quality Assurance Program 4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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Copies of the care plan invitations addressed to the responsible party and resident #32 were viewed for the following dates; 02/14/18, 05/15/18 and 08/15/18 and the Resident Care Plan Conference sign in sheets included the following dates: 02/21/18, 05/23/18 and 08/22/18. Signatures for Resident #32 nor his family representative was observed on the Care Plan Conference sign in sheets.

The responsible party stated that facility staff had pursued obtaining resident #31's replacement dentures on two occasions. They arranged for dental services to come to the facility, obtain dental imprints, but as the administrative staff changed someone would "drop the ball" each time. She stated, it's been almost a year since his dentures went missing and the facility's staff had not followed up with her to assist in locating or obtaining more dentures for Resident #32.

An interview was conducted with the Social Worker on 09/19/18 at approximately 2:00 p.m. The Social Worker stated there was no record of any grievances filed concerning resident #32 missing dentures.

On 09/19/18, Resident #32's progress notes written by a dentist were read. The record dated 7/19/18, included a comment made by resident # 32's wife stating that while she wants the resident's dentures to be made as soon as possible; she did not want the dentures to be made on a broken tooth. (The broken tooth was extracted in August, 2018).

09/21/18 at approximately 7:25 p.m., the Social Worker presented an appointment letter for resident #32. The letter stated Resident #32 has

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F 791	Continued From page 98 an appointment on 10/09/18 with a dentist who will come to the facility to see the resident about obtaining replacement dentures. The above findings were shared with the Administrator and the Director of Nursing during the pre-exit interview on 09/21/18, at approximately 7:30 p.m. No further information was presented by the facility's staff. The facility's policy titled Personal Adaptive Device Policy date 1/1/18. The policy stated, many Residents use personal adaptive devices. These devices include eye glasses, dentures and/or partial denture, hearing aids, prosthetics devices (prosthetic limbs, eyes or other devices). In the event that a personal adaptive device is lost, damaged or destroyed as a result of any action of a facility employee, the facility will replace or reimburse the resident for the lost or damaged item. The facility limits its liability to 1 repair or 1 replacement of a specific item. If an item is lost, damaged or destroyed by the actions of the resident and/or his family member or visitor, the facility is not required to replace the item or reimburse the resident for the lost or damaged item.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		10/31/18

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to do so.

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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 100 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility documentation review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 24 residents (Resident #202) in the survey sample. The facility staff failed to ensure Resident #202's Treatment Administration Record (TAR) was accurate for the administration of oxygen usage. The findings included: Resident #202 was admitted to the facility on 09/07/18. Diagnosis for Resident #202 included but not limited to *Malignant neoplasm of bronchus or lung. Resident #202's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 09/14/18 coded Resident #202	F 842	F 842 Action Taken: 1. Resident # 202 oxygen is administered per physician order and noted correctly on TAR. How others were identified: 2. An audit of the TAR was conducted to identify any other residents at risk. Systems in Place: 3. Nursing staff were re-educated by the DON/designee on following physician orders; transcription of those orders must be accurate when placed on the TAR, and the order must be carried out or	

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F 842	Continued From page 101 Brief Interview for Mental Status (BIMS) score of 08 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #202 extensive assistance of two with bed mobility, extensive assistance of one with transfer, toilet use, personal hygiene, limited assistance of one with bathing and supervision with eating for Activities of Daily Living care. Under section O (Special Treatments, Procedure, and Programs) was coded for respiratory treatment for the use of oxygen therapy. During the initial tour on 09/18/18 at approximately 12:55 p.m., Resident #202's oxygen cannula tubing was observed in his nares but his oxygen concentrator was not turned on. On the same day at approximately 4:06 p.m., oxygen delivery for Resident #202 remains unchanged (oxygen concentrator not turned on). On 09/19/18 at approximately 12:18 p.m., Resident #202 was observed in bed with oxygen cannula in his nares but his oxygen remained off. The surveyor asked Resident #202 if his oxygen helped with his breathing, he replied, "No not really; it doesn't feel like much is coming." On the same day at approximately 12:23 p.m., the surveyor and Director of Nurse (DON) entered resident's room. The surveyor asked the DON if Resident #202's oxygen concentrator was turned on, she looked at the oxygen concentrator, then she replied, "No it's not turned on; shaking her head." Review of the clinical record evidenced a physician order dated 09/17/18 for oxygen at 2 liters minute via nasal cannula continuously for shortness of breath every shift related to	F 842	implemented prior to signing TAR. The DON/designee will complete an audit 3 x week to ensure that physician orders are correct and being transcribed correctly from the order to the TAR and also being carried out per order. Quality Assurance Program 4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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F 842	Continued From page 102 malignant neoplasm of bronchus or lungs. This order was also noted on the Treatment Administration Record (TAR) for September 2018. Review of Resident #202's September 2018 TAR, revealed the nurse had signed off on 09/17/18 and 09/18/18 that residents oxygen was on and running at 2 liter minutes via nasal cannula continuous for shortness of breath. The above information was shared with Administration staff during a pre-exit meeting on 09/21/18 at 7:10 p.m. The surveyor asked the DON, "When do you expect for the your nurses to document a resident's treatment has been completed on the TAR" she stated, "I expect for the nurse sign off a treatment has been competed after the assessment has been completed and not before." The DON also stated, "I expected for all nurses to monitor and verify the oxygen flow rate, to assess for respiratory distress and notify the physician of the changes. No additional information was provided. *Malignant neoplasm of bronchus or lung is a malignant neoplasm of the lung arising from the epithelium of the bronchus or bronchiole.	F 842		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 868		10/31/18

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F 868	Continued From page 103 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review, and review of the facility's policy, the facility staff failed to consistently have required members at each quarterly Quality Assessment and Assurance Committee (QAA) meeting. The facility staff failed to have a Medical Director or Designee present for 2 of 4 quarterly meetings. The findings included: On 09/21/18 at approximately 4:55 p.m., an interview was conducted with the Administrator, Director of Nursing and the Regional Director of Clinical Services. The facility's sign-in records were reviewed for their QAA meetings on 9/17/17, 12/17/17, 3/2018 and 6/2018. The sign-in records dated 9/17/17 and 12/17/17, revealed the Medical Director and/or Designee was not present for the meeting. The facility's policy titled Quality Assurance dated 2/20/17, read the QAA committee will meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee will	F 868	F 868 Action Taken: 1. The Medical Director/designee will attend QAPI meetings quarterly. How other were identified: 2. Quarterly QAPI meetings will be announced with written notice given to the Medical Director in advance so they can arrange to attend or have a designee attend. Systems in Place: 3. The Medical Director was re-educated by the Administrator of the requirements of attending QA meetings. This included sending a designee if he could not attend. The administrator will complete an audit monthly x 3 months to ensure the Medical Director or designee attends the monthly/Quarterly QAPI meetings.	

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F 868	Continued From page 104 direct all activities including approving proposed monitoring, evaluating and review of services. Under Procedure the policy stated, the Administrator will hold the position of chairperson of the QAA committee. The committee may consist of the Medical Director, Administrator, Director of Nursing and at least 3 other staff members. On 9/21/18, the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided.	F 868	Quality Assurance Program 4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		10/31/18

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F 880	Continued From page 105 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 106 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to maintain effective infection control practices during the provision of care for 2 of 24 residents (Residents #31 and #6), in the survey sample. 1. The facility staff failed to perform appropriate hand hygiene during wound care for Resident #31. 2. The facility staff failed to ensure Resident #6's indwelling catheter was managed in a manner to minimize the risk of contamination and infections. The findings included: 1. Resident #31 was originally admitted to the facility 8/6/18 and has never been discharged from the facility. The resident's diagnoses included; cerebrovascular disease with swallow and speech problems. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/13/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. The resident was also coded for highly impaired hearing, no speech and rarely to never having the ability to understand others. Resident #31 was coded as having no mood or behavior problems.	F 880	F 880 Action Taken: 1. Resident #31 and resident and resident #6 received effective infection control practices during their provision of care. RN #1 no longer works at the facility, resigned 9/24/18 effective immediately. How others were identified: 2. Residents that reside in the facility are at risk for this practice. RN #1 no longer works at the facility, resigned 9/24/18 effective immediately. Systems in Place: 3. Nursing staff were re-educated by the DON/designee on infection control practices while providing care. An audit will be completed 5 x week during care keeper rounds to ensure effective infection control practices during provision of care is observed to include hand hygiene. An audit will be completed 2 x week x 2 months to observe wound care for appropriate infection control practices. Quality Assurance Program 4. Audits will be reviewed during the	

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F 880	Continued From page 107 In section "G" (Physical functioning) the resident was coded as requiring total care of 2 people with transfers and toileting, total care of 1 person with locomotion, personal hygiene, and bathing, extensive assistance of 2 people with bed mobility and extensive assistance of 1 person with dressing and eating. In section "M" (Skin Condition) the resident was coded as having an unstageable pressure injury present and a potential for additional skin problems. Review of the clinical record revealed a nurses' note dated 9/12/18 at 13:12, It read; "called to resident's room by Certified Nurse's Assistant (CNA), resident noted with an open area to her sacrum, wound bed dark red, no odor, no drainage, edges uneven, jagged. Resident currently has zinc oxide to be applied each shift. Responsible party and Physician notified. Will have resident seen by the wound care physician". Clinical documentation revealed the wound care physician assessed Resident #31's sacral pressure injury 9/13/18. The wound care physician 9/13/18, progress note revealed the sacral pressure injury was a stage 3, measuring length 2.7 centimeters by width 2.0 centimeters by depth 0.2 centimeters. The progress note further stated the sacral pressure injury also presented with a moderate amount of sero-sangious drainage, 60 percent granulation tissue and 40 percent necrotic tissue. The wound care physician's progress note stated debridement of the necrotic tissue was recommended. On 9/13/18, the wound care physician ordered Alginate calcium, be applied	F 880	monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	

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once daily for 30 days, Santyl ointment, apply once daily for 30 days and a secondary dressing; Foam with silicone, apply once daily for 30 days.

A Physician's order dated 9/14/18 read; Santyl Ointment 250 Unit/gram; apply to sacrum topically every night shift for wound management. Clean sacrum with wound cleaner, apply skin prep to peri wound, cover wound bed with Santyl, then apply Alginate calcium, cover with border gauze. Change daily and as needed.

Resident #31's wound care was observed 9/20/18 at approximately 2:15 p.m. Registered Nurse (RN) #1 washed her hands, pulled down Resident #31's pants, removed the old dressing, removed her gloves, applied a new pair of gloves, cleaned up a small amount of stool, removed her gloves, apply another pair of gloves, applied wound cleanser to Resident #31's sacral pressure injury, wiped the pressure injury with 4 by 4 gauze and repeated the wound cleanser, then placed the wound cleanser in the bed, and wiped the pressure injury with 4 by 4 gauze. RN #1 removed her gloves applied another pair of gloves, used her gloved hands to tear the Alginate calcium, applied Santyl ointment (then placed the Santyl tube in the bed,) with cotton tip applicators, applied border gauze, removed her gloves, changed the resident's incontinence brief, pulled her pants up, and repositioned the resident in bed. the dressing wasn't dated or signed. RN #1 cleaned up the used products, discarding everything except the wound cleanser and the Santyl ointment.

RN #1 didn't wash her hands or use hand sanitizer during the entire dressing change.

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An interview was conducted with Registered Nurse (RN) #1, on 9/20/18, directly after wound care for Resident #31 was completed. RN #1 stated she had to be someplace very soon and it was all she could think of. She also stated I will get training on wound care, since she will be assisting the wound care physician when she is in the facility.

An interview was conducted on 9/20/18, at approximately 2:50 p.m., with the Director of Nursing. The Director of Nursing stated it is the facility's expectation for good hand hygiene during wound care utilizing soap and water or a hand sanitizer. The Director of Nursing stated the focus in handwashing during wound care should be ensuring the hands are cleaned between going from dirty to clean, for this prevents infections.

On 9/21/19 at approximately 2:35 p.m., the above findings were shared with the Administrator and Director of Nursing. The Administrator stated they would ensure RN #1 received the education needed.

2. Resident #6 was originally admitted to the facility 3/15/18 and has never been discharged from the facility. The current diagnoses included; urinary retention, Parkinson's Disease, dementia, chronic kidney disease, and diabetes.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/13/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #6' cognitive abilities for daily decision making were moderately impaired.

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F 880	Continued From page 110 In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with eating and extensive assistance of 1 person with with bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. In section "H" Bladder and Bowel, the resident was coded for having an indwelling catheter and frequently incontinent of her bowels. The current Physician's orders had an order dated 4/5/18 which read; Re-insert a 16 french indwelling urinary catheter with a 10 milliliter balloon. Cleanse the meatus and adjacent catheter with soap and water every shift for diagnosis of urinary retention. Change Foley catheter every 30 days. Change drainage bag every 30 days. A physician's order dated 8/8/18 read; Cranberry tablet 450 milligrams, Give 1 tablet by mouth in the morning related to urinary tract infection. The current care plan had a problem dated 3/18/18 which read; Alteration in elimination of bowel and bladder. History of UTI's, Indwelling catheter. The goals read; I will be free of UTI's through 10/26/18. I will have no complications from use of my indwelling catheter, such as pain, infection, obstruction through 10/26/18. The interventions included; "Foley catheter to straight drainage due to ()." Anchor catheter, avoid excessive tugging on the catheter during transfer and delivery of care. Indwelling catheter care every shift and as needed. Keep the drainage bag of catheter below the level of the bladder at all times and off the floor. Monitor and report signs/symptoms of UTIs, changes in urine color, odor, consistency of urine, dysuria, urinary frequency, fever and pain.	F 880		

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	495264	A. BUILDING _____ B. WING _____	09/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 111	F 880		

A clinical record note dated 7/31/18, at 7:30 p.m., read Foley catheter removed and reinserted this shift with 18 french 5 milliliter balloon, amber urine with a moderate amount of sediment and blood tinged urine noted...

The clinical record revealed Resident #6 had urine collected 7/24/18 for a urinalysis and culture and sensitivity. The laboratory results were reported to the facility 8/1/18. The urinalysis revealed 500 leukocytes (white blood cells) and greater than 100,000 colonies of bacteria. The diagnosis was a pseudomonas aeruginosa, UTI.

Further review of the clinical record revealed a physician's progress note dated 8/10/18, which read; Labs: Urinalysis for leukocytes esterase white blood cells too numerous to count and greater than 100,000 colonies of pseudomonas aeruginosa, sensitive to Cipro (an antibiotic). The physician further documented " For the resident's UTI, she will be started on Cipro 250 milligrams by mouth every 12 hours for 5 days. I have written to change the Foley after the second dose of Cipro. It should be noted labs were presented to me today".

The clinical record revealed no documentation indicating why the urinalysis was originally obtained, no documentation of signs/symptoms to monitor for while the facility staff was awaiting the laboratory results and no documentation of the resident's status while the antibiotic was in progress.

Resident # 6 was observed 9/19/18 in a wheel chair sitting in the dining room at approximately 11:45 a.m. the indwelling catheter tubing resting

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F 880	Continued From page 112	F 880		

on the floor and cloudy urine with heavy sediment noted in the tubing. Resident #6 was observed at approximately 1:45 p.m., 9/20/18 seated in a wheel chair during a religious activity, again the indwelling catheter tubing was observed resting on the floor as well as the dignity bag which covered the drainage bag. The urine in the tubing was whitish and thick. On 9/21/18 at approximately 1:26 p.m., Resident #6 was observed sitting in a wheel chair in a dining room with her indwelling catheter tubing resting on the floor as well as the drainage bag. The Director of Nursing and Unit Manager also observed the positioning of the indwelling catheter tubing and drainage bag. The Unit Manager repositioned the drainage bag and tubing to prevent it from making contact with the floor. On 9/21/18 at 2:10 p.m., Resident #6 was assisted to bed. The Certified Nurse Assistant (CNA) #4 attached the indwelling catheter to the lower frame of the bed and the indwelling catheter was observed resting on the floor. The Unit Manager again repositioned the catheter bag and tubing. As the Unit Manager positioned the tubing it was observed and under the residents leg and pulling away the point of entrance. The Unit Manager stated she would change the bag and tubing, apply an anchor and ensure the resident received more fluids in an attempt to clear her urine.

On 9/21/19 at approximately 2:35 p.m., the above findings were shared with the Administrator and Director of Nursing. The Director of Nursing stated it was their expectation for the catheters to be anchored to prevent trauma as well as discomfort and to keep the drainage bag below the bladder but not to rest on the floor.

The Infection Control Policy was requested

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F 880	Continued From page 113 multiple times but not received. The facility didn't have an Indwelling catheter policy to present at the time of survey therefore an undated document titled Indwelling Urinary Catheter Care and Removal was presented by the Administrator by fax 9/24/18. It read "Intended to prevent infection and other complications by keeping an indwelling catheter insertion site clean, routine catheter care is performed after the resident's morning bath and immediately after perineal care... An indwelling catheter should be removed when bladder decompression is no longer necessary, when the resident can resume voiding or when the catheter is obstructed... To prevent catheter associated UTIs the catheter should be removed as soon as it is no longer needed.	F 880		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on general observation, staff interviews and facility documentation review, the facility staff failed to ensure the kitchen was free of pests (roaches and other insects). The findings included: The initial tour of the kitchen was completed with the Dietary Manager on 09/18/18 at approximately 11:25 a.m. In the dishwasher area was a large sticky roach pad with numerous amount of dead roaches and other bugs	F 925	F 925 Action Taken: 1. The kitchen is monitored and observed to be free of pest. The bug traps were removed from the kitchen during survey. How others were identified: 2. An environmental round was completed to identify any area in need of pest	10/31/18

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F 925	Continued From page 114 attached. The dietary manager stated, "That should not be there; it should have been removed." She (dietary manager) said it is a lot better now than what it was; at one time, the roaches were really bad. The dietary manager stated, "The cracks along the wall under the dishwasher is now sealed but before then; it was really bad with roaches coming inside." Review of the pest control log revealed consistent target pets: September 2018 (insect trap for cockroaches and spiders), August 2018 (cockroaches), July 2018 (ants), June 2018 (ants and cockroaches), May 2018 (insect monitor trap for German cockroaches), April 2018 (insect monitor trap for ants and cockroaches), March 2018 (ants and cockroaches), February 2018 (insect monitor trap for cockroaches and American cockroaches), January 2018 (cockroaches), December 2017 (insect monitor trap for cockroaches), November 2017 (insect trap and phantom liquid for cockroaches), October 2017 (insect monitor trap for cockroaches) and September 2017 (insect monitor trap for roaches). The facility administration was informed of the finding during a briefing on 09/21/18 at approximately 7:10 p.m. The facility did not present any further information about the findings.	F 925	control. Systems in Place: Staff were re-educated on communication if pest are observed. Audits will be completed during Care keeper rounds 5 x week x 2 months to observe for any indication of pest. If pest are noted it will be communicated to pest control services to increase frequency above monthly service. The Administrator/designee will review the pest control log weekly x 2 months to observe for trends or repeat infestation. Quality Assurance Program 4. Audits will be reviewed during the monthly/quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed.	