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	495280	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER AT LAKE RIDGE	12185 CLIPPER DRIVE LAKE RIDGE, VA 22192

(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 5/14/19 through 5/16/19. The facility was in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/14/19 through 5/16/19. 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 49 at the time of the survey. The survey sample consisted of 25 resident reviews.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews, and facility documentation review, the facility staff failed to accommodate needs and preferences for 7 residents (Resident #12, Resident #15, Resident #5, Resident #28, Resident #190, Resident #20, Resident #6) in a sample size of 25 residents.	F 558	f0558 Residents 12, 5, 20, 189, 6 and 15 are current residents. Residents 190 and 28 are no longer residents. An initial audit yielded other potential residents affected by this practice. Resident 5 was provided a sling for use on 5/15/19. Resident 6's call bell was repositioned to be within reach of resident on 5/15/19.	6/28/19

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

Electronically Signed | 06/08/2019

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F 558	Continued From page 1 1. For Resident #12, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 2 of 14 opportunities the call light was activated. 2. For Resident #15, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 3 of 15 opportunities the call light was activated. 3. Resident #5 was not provided a hoyer lift sling to get out of bed in the morning on 5-14-19 due to lack of equipment. 4. For Resident # 28 the facility staff failed to answer call bells in timely manner for a Resident who requires assistance with transfer and ambulation. 5. For Resident #190 the facility staff failed to answer call bells in a timely manner for a Resident who needs assistance with transfer and ambulation. 6. For Resident #20, the facility staff failed, for three hours to respond to the Resident's call bell and request for assistance 7. For Resident #6, the facility staff failed to ensure that her call bell was within reach. The findings included: 1. For Resident #12, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 2 of 14 opportunities the call light was activated.	F 558	Staff will be re educated on responding to resident call system. Center's policy revised to instruct staff to deactivate call light when able to render requested service. Staff will be re-educated on proper positioning of the call bell for resident access. Center's Administrator to audit call bell response weekly for 3 months and implement corrective actions where appropriate. Center's central supplies to conduct weekly audit of hoyer lift slings for residents requiring hoyer transfer to ensure center has adequate supply. Center to observe a minimum of 5 residents 3 days a week for 6 weeks to ensure call bells are positioned appropriately for easy access to residents, variances will be corrected and responsible staff will be re-educated. Director of Nursing will present results of audits to QAPI monthly for 3 months for oversight and recommendation.	

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F 558	Continued From page 2	F 558		

Resident #12, an 85-year old male, was admitted to the facility on 08/24/2018. Diagnoses included but not limited to spastic hemiplegia, paralytic syndromes, muscle weakness, depression, and flaccid neurogenic bladder. Cognitive disorders were not on the list of diagnoses.

Resident #12's most recent Minimum Data set with Assessment Reference Date of 02/13/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as a 6 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, dressing, and personal hygiene were coded as requiring extensive assistance from staff.

On 05/14/19 at approximately 12:00 PM, an interview with Resident #12 was conducted. Resident #12 was in bed with the head of the bed elevated approximately 45 degrees. When asked if the facility staff answered the call light promptly when he needed assistance, Resident #12 stated, "Sometimes it seems like it takes forever for staff to come." Resident #12 stated that sometimes he needs help positioning in the bed and calls for assistance.

On 05/14/19 at 2:55 PM, call logs for the past week for the health center were requested from Employee J from the information technology department.

On 5/14/19 at 4:15 PM in an interview with the Administrator she stated that her expectation is for call bells to be answered within 15 minutes. She stated that she didn't know why they were longer perhaps staff forgot to cut off the call bell and was in the room doing care.

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On 05/15/2019 at approximately 9:00 AM, the facility staff provided call logs for Resident #12 with a date range of 05/08/2019 through 05/13/2019. Of the 14 times the call light was activated, there were 2 instances where the duration was longer than 15 minutes. On 05/12/2019 at 7:11 AM, the duration was 21 minutes and 7 seconds. On 05/12/2019 at 10:22 PM, the duration was 30 minutes and 2 seconds.

On 05/15/19 at approximately 10:10 AM, an interview with Employee J was conducted. Employee J stated that the system is programmed to do certain things when the button is pushed. Employee J stated that the activated call bell routes to the certified nurse assistant (CNA) pager and if it isn't answered, it flows over to nurse pager.

The facility staff provided a copy of their policy entitled, "Responding to call light." The listed procedures documented, "1. Respond to location of call light. 2. Ask resident what assistance is needed. 3. If certified to perform care, render care. 4. If not certified to render care, notify a member of the nursing team and/or supervisor. 5. Please ensure call light is reset."

On 05/16/2019 at approximately 2:30 PM, the Administrator stated they had no further documentation or information to offer.

2. For Resident #15, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 3 of 15 opportunities the call light was activated.

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Resident #15, an 89-year old female, was admitted to the facility on 10/10/2017. Diagnoses included but not limited to chronic kidney disease, dementia without behavior disturbance, Parkinson's disease, cognitive communication deficit, muscle weakness, and difficulty in walking.

Resident #15's most recent minimum Data set with an Assessment Reference Date of 02/20/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 12 out of possible 15 indicative of moderate cognitive impairment. Functional status for bed mobility, transfers, dressing, and toileting was coded as requiring extensive assistance from staff.

On 05/14/19 at approximately 1:55 PM, an interview with Resident #15 was conducted. When asked if the staff answer the call light promptly when she needs assistance, Resident #15 stated, "Sometimes it's a long time before they come." Resident #15 stated that she needs help to get into her chair or to get positioned for a nap. Resident #15 also stated, "I can't get up by myself."

On 05/14/19 at 2:55 PM, call logs for the past week for the health center were requested from Employee J from the information technology department.

On 5/14/19 at 4:15 PM in an interview with the Administrator she stated that her expectation is for call bells to be answered within 15 minutes. She stated that she didn't know why they were longer perhaps staff forgot to cut off the call bell and was in the room doing care.

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On 05/15/2019 at approximately 9:00 AM, the facility staff provided call logs for Resident #12 with a date range of 05/08/2019 through 05/14/2019. Of the 15 times the call light was activated, there were 3 instances where the duration was longer than 15 minutes. On 05/08/2019 at 9:23 AM, the duration was 28 minutes and 43 seconds. On 05/11/2019 at 7:56 PM, the duration was 23 minutes and 24 seconds. On 05/13/2019 at 4:26 PM, the duration was 15 minutes and 31 seconds.

On 05/15/19 at approximately 10:10 AM, an interview with Employee J was conducted. Employee J stated that the system is programmed to do certain things when the button is pushed. Employee J stated that the activated call bell routes to the certified nurse assistant (CNA) pager and if it isn't answered, it flows over to nurse pager.

The facility staff provided a copy of their policy entitled, "Responding to call light." The listed procedures documented, "1. Respond to location of call light. 2. Ask resident what assistance is needed. 3. If certified to perform care, render care. 4. If not certified to render care, notify a member of the nursing team and/or supervisor. 5. Please ensure call light is reset."

On 05/16/2019 at approximately 2:30 PM, the Administrator stated they had no further documentation or information to offer.

3. Resident #5 was not provided a hoyer lift sling

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to get out of bed in the morning on 5-14-19 due to lack of equipment.

Resident #5, was admitted to the facility on 5-11-18. Diagnoses included diabetes, sarcoidosis, and abnormal posture. The Resident's neck was bent laterally to the right, so profoundly, that the Resident's right cheek laid on her right clavicle and shoulder.

Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-24-19 was coded as an annual assessment. Resident #5 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. Resident #5 was also coded as requiring extensive assistance to total dependence on one to two staff members to perform activities of daily living, such as hygiene, transferring, and bed mobility.

On 5-14-19 at 12:00 noon, Resident #5 was observed in bed, with the head of the bed elevated, during initial tour of the facility. A Resident interview was conducted, and the Resident complained that "this morning I couldn't even get up to get my lunch today because they had no strap clean for the hoyer lift for me". She explained that she got up for lunch and went back to bed around 4:00 p.m., which was her choice, "because if I didn't go back at 4:00 p.m., I would be up til 9:00 p.m., or 10:00 p.m.", and she stated that she could not sit up comfortably that long. She went on to say that today, "I won't be able to get out of bed at all. That just makes no sense."

Review of the resident's clinical record revealed the resident's current POS (physician order

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sheet), for May 2019. Contained was an order for "Physical therapy evaluation for appropriate mechanical lift device" ordered on 1-29-19.

On 5-14-19 at approximately 4:00 p.m., Resident #5 was again interviewed and observed returning to bed from a wheel chair. CNA B was in the room with the Resident and stated the Resident did get up for "about 2 hours after they found a hoyer lift sling for her, however, they were only able to get her up from 2:00 p.m., until 4:00 p.m., because there was no lift sling for the hoyer mechanical lift for her.

Resident #5's care plan was reviewed and revealed that the document was last revised on 5-2-19, and noted that the resident was dependent on 2 staff members to provide mechanical lift for transferring.

On 5-16-19 at end of day debrief the DON (director of nursing), and Administrator were notified of above findings. No further information was provided.

4. For Resident # 28 the facility staff failed to answer call bells in timely manner for a Resident who requires assistance with transfer and ambulation.

Resident #28 is an 84 year old woman originally admitted to the facility with diagnoses of but not limited to Hypertension, History of hip fracture with artificial hip replacement, (Coronary Artery Disease), CAD, Congestive Heart failure and

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Asthma.

On 3/19/19 Resident was admitted to the facility prior to admission to hospital for planned surgical repair of hardware from prior hip fracture. The Resident went out for surgery on 4/6/19 and was readmitted on 4/12/19. Residents most recent (Minimum Data Set) MDS was dated 3/31/19 and it was a 14 -Day PPS. According to the most recent MDS Resident # 28 had a (Brief Interview of Mental Status) BIMS score of 15 / 15 indicating no cognitive impairment.

On 5/14/19 at 2:15 PM an interview was conducted with Resident #28 who stated she had no problems with the facility other than the time it took for staff to answer the call bells. She further elaborated by saying "If the staff would answer the call bells this place would be great!" She relayed an incident where she had put the call bell on because she wanted something for her cough. She stated that someone came in and turned the call bell off and told her she would let the nurse know what she needed. She stated that happened three times and no nurse came. She stated after that I just got up by myself and walked to the nurses' station to tell her.

On 5/14/19 at 3:00 P.M., an interview was conducted with Employee J (Information Technology), when asked if this surveyor could have a copy of the call bell response times he replied "I don't think I can get that." When asked what company they use he stated Status Solutions and when asked what program he stated Sara. He was then informed by this surveyor that we request these logs from other facilities using the same system and are able to get them, he stated he would try to get them.

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On 5/14/19 at 4:15 PM in an interview with the Administrator she stated, my expectation is for call bells to be answered within 15 minutes. I know they get the care they need.

According to the facility call logs provided by Status Solutions from 5/1/19 through 5/14/19

5/2/19 - Call bell rang from 4:33 PM to 4:56 PM - total 22 min. 21 sec.
5/3/19 - Call bell rang from 7:05 AM to 7:23 AM - total 18 min 10 sec.
5/3/19 - Call bell rang from 7:38 AM to 7:53 AM - total 14 min. 56 sec.
5/3/19 - Call bell rang from 1:33 PM to 1:56 PM - total 22 min 46 sec.
5/4/19 - Call bell rang from 7:59 AM to 8:15 AM - total 16 min. 19 sec
5/4/19 - Call bell rang from 8:24 PM to 8:50 PM - total 26 min. 5 sec
5/5/19 - Call bell rang from 8:10 AM to 8:24 AM - total 14 min. 15 sec
5/5/19 - Call bell rang from 8:43 AM to 9:18 AM - total 34 min 35 sec
5/6/19 - Call bell rang from 8:03 AM to 8:19 AM - total of 15 min 46 sec.
5/7/19 - Call bell rand from 7:01 AM to 7:30 AM - total 28 min 41 sec.
5/10/19 - Call bell rang from 7:35 AM to 7:53 AM total of 18 min 7 sec
5/11/19 Call bell rang from 7:01 AM to 7:44 AM - total 43 min 37 sec
5/11/19 Call bell rang from 12:30 PM to 12:50 PM total of 20 min 10 sec.
5/13/19 Call bell rang from 4:12 PM to 4:52 PM total of 20 min 40 sec.
5/13/19 Call bell rang from 9:10 PM to 9:27 PM total of 17 min 5 sec.

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On 5/15/19 at 4:30 PM in an interview with CNA A, CNA A stated that Resident # 98 needs assistance to get up and go to the bathroom and she needs help getting out of bed and to her chair.

On 5/16/19 at the end of day meeting, the Administrator was made aware of the issues with answering call bells timely and no further information was provided.

5. For Resident #190 the facility staff failed to answer call bells in a timely manner for a Resident who needs assistance with transfer and ambulation.

Resident # 190 a 59 year old woman was admitted to the facility on 5/9/19. The Resident had no (Minimum Data Set) MDS information available as she was a new admission. The Resident was admitted to the facility with diagnoses of but not limited to recent Right hip replacement surgery, foot drop in Right foot, difficulty walking, general weakness, (Chronic Obstructive Pulmonary Disease) COPD, Atrial Fibrillation and Diabetes.

On 5/14/19 at 2:25 PM an interview was conducted with Resident #190 who stated the staff take too long to answer call bells. She stated that the facility is nice but if you have to use the bathroom 20 minutes is way too long to wait. When asked what type of assistance she requires Resident #190 stated she had a hip replacement surgery but something went wrong and she ended up with foot drop as well so she is unable

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to ambulate or transfer alone.

On 5/14/19 at 3:00 P.M. an interview was conducted with Employee J (Information Technology), when asked if this surveyor could have a copy of the call bell response times he replied "I don't think I can get that." When asked what company they use he stated Status Solutions and when asked what program he stated Sara. He was then informed by this surveyor that we request these logs from other facilities using the same system and are able to get them. He stated he would try to get them.

On 5/14/19 at 4:15 PM in an interview with the Administrator she stated, my expectation is for call bells to be answered within 15 minutes. I know they get the care they need.

According to the facility call logs provided by Status Solutions from 5/1/19 through 5/14/19

5/9/19 - Call bell rang from 7:14 AM to 7:31 AM - total 17 min. 18 sec.
5/10/19 Call bell rang from 9:17 AM to 9:37 AM total 19 min 40 sec.
5/10/19 Call bell rang from 12:35 PM to 12:50 PM total 15 min 9 sec.
5/11/19 Call bell rang from 1:38 AM to 1:55 AM total 16 min 42 sec.
5/11/19 Call bell rang from 2:30 PM to 3:06 PM total 19 min 32 sec.
5/11/19 Call bell rang from 5:59 PM to 6:15 PM total 15 min 56 sec.
5/12/19 Call bell rang from 1:44 PM to 2:15 PM total 31 min 45 sec.
5/12/19 Call bell rang from 3:02 PM to 3:22 PM total 19 min 32 sec.
5/14/19 Call bell rang from 8:19 AM to 8:42 Am

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total 23 min 4 sec.

On 5/15/19 at 4:30 PM, an interview was conducted with Employee H who stated that Resident # 98 needed assistance to get up and go to the bathroom and she needed help getting out of bed and to her chair.

On 5/16/19 at the end of day meeting, the Administrator was made aware of the issues with answering call bells timely and no further information was provided.

6. For Resident #20, the facility staff failed, for three hours to respond to the Resident's call bell and request for assistance.

Resident # 20, was admitted to the facility on 6/24/08. The resident's diagnoses included but were not limited to: constipation, MDD single episode, allergic rhinitis, heartburn, pruritus, hyperlipidemia, heart disease, obesity, chronic diastolic heart failure, pyridoxine deficiency, polyosteoarthritis, rheumatoid arthritis.

Resident #20's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/20/19, was coded as a quarterly assessment. Resident #20 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated being cognitively intact. Resident #20, was also coded as requiring extensive of assistance of staff for bed mobility, transfers, dressing, and personal hygiene. She was coded as being totally

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dependent upon staff for toileting and bathing.

During an interview with Resident #20 on 05/14/19 at 01:33 PM, Resident #20 stated, "I have called for help and waited over an hour." When asked how often this occurs, Resident #20 stated, "it happens too often" and indicated it is an ongoing concern.

Review of the facility call bell response log on 5/15/19 revealed that on 5/8/19, Resident #20 used her call bell at 2:11pm to call for assistance. Three hours later, at 5:11pm her call bell was still sounding and had not been responded to.

On 5/15/19 at 10:10am an interview was conducted with Employee J, Information Systems Director. Employee J stated, "the system is programmed so when the call bell is pressed it notifies multiple people. If there is no response after 30 minutes, it resets and resends all of the notifications again." When Employee J was asked to interpret the call bell response log for Resident #20 on 5/8/19, Employee J stated, "it tells me it wasn't responded to." When Employee J was asked what happens when a resident uses their call bell, Employee J and the DON stated, "it activates a notification to the CNA, the supervisor and after a minute the DON and Administrator get a text on their phone."

On 5/15/19 the DON (Director of Nursing, Employee B) was asked about the incident on 5/8/19 when Resident #20's call bell went off for 3 hours. The DON stated, "I can tell you someone will check- people will come by and pop their heads in."

On 5/15/19 the Administrator stated, "an

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acceptable time and my expectation is for call bells to be answered within 15 minutes. We don't know what happened at that time, her care is exceptional. I know they get the care they need."

Review of the facility policy titled, "Call light" with an effective date of May 2018, read "Emergency call system will be made available to all residents in room, bathrooms and other areas as deemed necessary. Residents are to have a method to activate the emergency call system herein referred to as call lights in bedrooms and bathrooms."

Review of the facility policy titled, "Responding to call light" with an effective date of, May 2018 read, "All staff to respond to all lights. 1. Respond to location of call light. 2. Ask resident what assistance is needed. 3. If certified to perform care, render care 4. If not certified to render care, notify a member of the nursing team and/or supervisor 5. Please ensure call light is reset."

On 5/15/19 the facility Administrator and DON were made aware of the facility staff's failure to respond to Resident #20's call light for 3 hours.

No further information was provided.

7. For Resident #6, the facility staff failed to ensure that the call bell was within reach.

Resident #6 was an 89 year old who was admitted to the facility on 2/18/18. Resident #6's

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diagnoses included Generalized Muscle Weakness, History of Falls, Difficulty in walking, Arthritis, Polyneuropathy, Hypertension, and Unspecified Cataract.

The Minimum Data Set, which was an Annual Assessment, with an Assessment Reference Date of 1/3/19 was reviewed. Resident #6 was coded as having a Brief Interview of Mental Status Score of 8, indicating moderate cognitive impairment. In addition, Resident #8 was coded as not having any mood or behavioral issues.

On 5/15/19 at 8:31 A.M., an observation was conducted of Resident #6 in her bed. Resident #6's call bell was on the floor, out of reach. Resident #6 stated that she had no way to let the staff know what she needed. She said that due to the wound on the back of her knee, it was difficult for her to get up and use her walker when it was time for her to go to the bathroom. Resident #6 stated that she didn't remember the last time that the call bell was within reach.

On 5/15/19 a review was conducted of facility documentation. The call bell response log was reviewed. During the previous 7 days, the call bell had not been activated during any shift.

On 5/15/19 at 2:30 P.M., a Resident Group Interview was conducted. The group unanimously agreed that their call bells were not routinely answered in a timely manner. They stated that it usually took staff between 30 minutes and one hour to answer the call bell. They further stated that the facility had reduced the number of available Certified Nursing Assistants, and that additional staff were needed to meet their needs.

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F 558	Continued From page 16 On 5/15/19 at approximately 3:30 P.M., an interview was conducted with the facility Administrator (Employee A). The administrator stated, "The resident probably knocked the call bell off the bed." No further information was provided.	F 558		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview facility documentation and clinical record review the facility staff failed to ensure one Residents was free from neglect for 1 of 25 sampled Residents (#34). For Resident #34 who had a recent history of falls with fracture, the facility staff left the Resident on the toilet without supervision, neglecting the Resident's known needs, and the Resident fell.	F 600	F 0600 Resident 34 is current resident at nursing center. Resident 34's care plan was revised on 6/14/19 for fall interventions including supervision while toileting. Other residents assessed as a fall risk and requires assistance with toileting are potentially at risk. The fall risk assessments for current residents were reviewed and if the fall score is 10 or below, the resident's care plan will be reviewed and revised to include	6/28/19

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F 600	Continued From page 17 The findings included: Resident #34 was admitted to the facility on 12-26-18 with diagnoses including; Dementia, glaucoma, lack of coordination, muscle weakness, and fall with fracture of the tibia, and fibula, and was non-weight bearing at the time of admission from the hospital for surgery related to that fracture on 12-26-18. The Resident was also hard of hearing and wore hearing aids. Resident #34's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3-20-19. Resident #34 was coded with a Brief Interview of Mental Status score of 7, indicating moderate cognitive impairment. Resident #34 was extensively dependant on one staff member for assistance with activities of daily living care, such as bed mobility, transferring, and toileting. On the physician's progress notes, most described the Resident as hard of hearing (HOH). Nursing staff and the Resident's daughter indicated the Resident was very hard of hearing, and this could be a barrier to communication, and understanding instructions. On 2-25-19 the physician's progress notes indicated the Resident had fallen on 2-23-19 while trying to stand from a wheel chair. On 3-5-19 the nursing notes documented that the Resident had been left alone on the toilet and had fallen. On 5-14-19 at approximately 1:00 p.m., Resident #34's daughter was interviewed. The daughter stated "I was not aware that mom fell from the toilet unattended. She can't be left alone on the	F 600	interventions for fall prevention. The fall prevention interventions will be communicated to direct care staff to ensure their knowledge of resident needs. Staff will be re-educated on abuse and neglect prevention/reporting. Nurses and Supervisors will be educated on accurate completion of fall risk evaluation. Nursing staff, including CNAs, will be educated on how to utilize fall risk evaluation. Residents who are evaluated at a score of 10 and below, will have staff in close proximities while they are on the toilet. Up to 5 residents requiring supervision while toileting will be observed weekly for 12 weeks by nursing supervisor. Re-education will be provided as needed. Incident reports and interventions will be reviewed and updated by nursing supervisors. The Fall Investigation Form will be used to determine if incident meets the requirements for abuse/neglect reporting. Administrator and Director of Nursing (DON) will ensure timely reporting of abuse/neglect allegations. Facility DON to present summary of audits to QAPI committee for 3 months.	

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toilet, she will try to get up and fall. She has an immobilizer on her ankle from her fracture, and pain in that leg that she receives pain medication for. She is not supposed to stand on it unassisted, and she doesn't remember that."

The Resident's current care plan was reviewed and revealed no revision or update review, since admission on 12-26-18, and had a goal date of 7-5-19. The care plan stated as problems related to falls and fracture, the 3 following areas, and those interventions are below;

1. Falls - at risk for more falls related to recent fall and fracture - observe and anticipate or intervene with factors causing previous or potential for falls. Answer calls quickly, attempt to anticipate needs for prompt response, and decrease in attempts to ambulate without proper assist.

2. Impaired functional status - has impaired functional status with bed mobility, transfer, walking, toileting, ...etc - weight bear as tolerated with brace when out of bed, stand pivot for transfers with assist of 1 staff.

3. Medical condition Orthopedic - had a recent fracture, requires follow up care. - Assess immobilizer device cast to ensure intact, assess skin under/at edge of immobilizer to ensure no rubbing, friction or pressure is evident. Maintain imposed limitations of non-weight bear right lower extremity educate and remind (Resident) of limitations.

At the time of survey no facility reported incident (FRI) or allegation of neglect was forwarded to the state agency, the Virginia Department of Health Office of Licensure and Certification

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(VDH/OLC).

The facility abuse & neglect policy and procedure documents were requested from the administrator, and obtained.

Review of the policy revealed that all allegations of abuse or neglect be reported within 24 hours after the (incident) allegation is made.

Federal regulations describes neglect as: "the failure of the facility , it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."

On 5-16-19 at 10:30 a.m. the Director of Nursing (DON) was asked for any FRI's for this Resident. She stated there were none.

In summary, the staff were aware of the Resident's fall history with attempts to stand alone, resulting in serious injury, and the Resident was demented, with memory impairment, hard of hearing, and was non-weight bearing. The Resident had a cast device on her left leg which was a fall hazard. she had pain in that leg, poor vision, lack of coordination and weakness. The facility staff placed her on the toilet and left her there alone, and when they returned she was sitting on the floor in the bathroom where she had fallen. Staff did not implement their care plan to "intervene with factors causing previous falls or potential for falls, nor attempt to anticipate needs for prompt response, and decrease in attempts to ambulate without proper assist."

The Administrator and Director of Nursing were

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F 600	Continued From page 20 notified at the end of day meeting on 5-16-19 at 2:00 p.m. that the staff was negligent in providing the care and services required by the Resident, and were deficient in investigating and reporting this incident. No further information was provided by the facility.	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; 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	F 623		6/28/19

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be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how 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

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F 623	Continued From page 22 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the ombudsman of transfer to the hospital for two Residents (Resident #339, Resident 89) in a survey sample of 25 Residents. 1. For Resident #339, the facility staff failed to notify the ombudsman of transfer to the hospital on two occasions. 2. For Resident #89, the facility staff failed to notify the ombudsman of transfer to hospital.	F 623	F0623 Resident 339 and 89 are no longer residents at the nursing center. The State's Long Term Care Ombudsman was notified of their discharges on June 8, 2019. The Ombudsman will notified of discharges on a monthly basis, no later than the 10th day of the following month. An audit will be conducted of current residents in the hospital and if the required information was not sent with resident, the resident/representative will be provided the appropriate information.	

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F 623	Continued From page 23 The findings included: 1. For Resident #339, the facility staff failed to notify the ombudsman of transfer to the hospital on two occasions. Resident #339, was admitted to the facility on 11/14/18. The Resident's diagnoses included but were not limited to: other symptoms and signs involving musculoskeletal system, lack of coordination, muscle weakness, unsteadiness on feet, dysphagia and cognitive communication deficit. Resident #339's most recent MDS (minimum data set) (an assessment tool), was coded as an admission assessment, with an ARD (assessment reference date) of 11/21/18. Resident #339, had a BIMS (brief interview for mental status) score of 9, which indicated moderately impaired cognition. Resident #339 was coded that extensive assistance of two staff members was required for ADL's (activities of daily living) which included, bed mobility, transfers, dressing and personal hygiene. On 5/15/19 during review of Resident #339's clinical record, nursing notes revealed that on 12/13/18, Resident #339 was sent to the hospital. The nursing note dated 12/13/18 at 23:51 read, "Resident was found on the floor close to the bed in her room by Aide. A laceration noted on back of head, measured 2cm x 0.5 cm, with depth 0.3cm. Surrounding area appeared swollen and blood draining. In the incident scene there was a clock with front glass in pieces on the floor, blood on the carpet closer to the TV and two chairs on the side wall. She denied pain, no complain of	F 623	Nursing, social services and transitions nurse will be educated on discharge process and notification requirements including notification of State's Long Term Care Ombudsman. Center's transfer packet has been updated with copy of Bed Hold Policy to ensure resident and responsible parties are notified of the policy at time of discharge. Supervisors will update transfer log when residents go to the hospital and sign off when the bed-hold policy was provided at time of discharge. Log will be reviewed at the morning meeting. If variances are found, they will be immediately corrected. Findings of the audits will be analyzed for trends and Social Worker to present finding of audits to QAPI committee monthly for 3 months.	

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drowsiness, dizziness, or lightheadedness noted. Injury area cleanse with NS, pressure applied to stop bleeding. According to assigned CNA, resident was put to bed after dinner and ADL care had been provided. Resident stated that she lost her balance and hit her head on the side wall while trying to go to the restroom. She believed that the clock fell to the ground resulting from the impact on the wall due to her hitting the wall. Vitals taken x 4 every 15 minutes, pressure applied to stop bleeding, cleanse injured with NS, pat dry and covered with dry gauze. MD notified and ordered to sent to ER for further evaluation and possible sutures to injured area Daughter was notified that walked in shortly after the incident occurred. Pt was sent out via medical transportation, accompanied by daughter."

A nursing note dated 12/16/18 at 17:04 read, "Patient was sent out per daughter/[name] request: approved by Dr. [Dr. name] d/t s/p fall trauma injury noted to right forearm (redness, swelling, pain, inflammation and warm to touch) and c/o pain to right hip. Pain managed with hydrocodone."

Review of the clinical record for Resident #339 revealed no indication that the ombudsman was notified of her transfer to the hospital on 12/13/18 and 12/16/18.

On 5/16/19 at approximately 11 am the facility Administrator was interviewed and asked for verification of the ombudsman notification of Resident #339's transfer to the hospital. The Administrator stated, "we weren't doing it at that time."

The facility administrator was made aware of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 25 facility staff's failure to notify the ombudsman of hospital transfers on 5/16/19. No further information was provided. 2. For Resident #89, the facility staff failed to notify the ombudsman of transfer to hospital. Resident #89, a 78-year old female, was admitted to the facility on 04/13/2018 and discharged on 05/01/2018 due to a transfer to the hospital. Therefore, this was a closed record review. Diagnoses included but not limited to diabetes, hypertension, and atherosclerotic heart disease. Resident #89's most recent Minimum Data Set with an Assessment Reference Date of 04/20/2018 was coded as an admission assessment. The Brief Interview for Mental Status was coded as a 15 out of possible 15 indicative of intact cognition. On 05/16/2019 at approximately 9:30 AM, the nurse's notes were reviewed. A nursing entry dated 05/01/2018 documented that [Resident #89] was sent to the hospital for hyperglycemia after unsuccessfully attempting to correct levels. On 05/16/2019 at approximately 9:45 AM, documentation of ombudsman notification associated with transfer to hospital on 05/01/2018 was requested. On 05/16/19 at 1:45 PM, the Administrator stated, "We have not been notifying ombudsman of transfers."	F 623		

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	495280	A. BUILDING _____ B. WING _____	05/16/2019

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F 623	Continued From page 26 On 05/16/2019, the facility staff provided a policy entitled, "Transfer or Discharge, Emergency." In Section 4, it documented, "Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's attending physician b. Notify the receiving facility that the transfer is being made c. Prepare the resident for transfer d. Prepare a transfer form to send with the resident e. Notify the sponsor or other family member f. Assist in obtaining transportation g. Others as appropriate or as is necessary." Notifying the ombudsman of hospital transfer was not addressed in the policy. On 05/16/2019 at approximately 2:30 PM, the Administrator stated they have no further documentation or information to offer.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		6/28/19

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F 625	Continued From page 27 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the resident of bed hold policy before transfer to the hospital for one Resident (Resident #339) in a survey sample of 25 Residents. For Resident #339, the facility staff failed to notify the resident of the bed hold policy before transfer to the hospital on two occassions. The findings included: Resident #339, was admitted to the facility on 11/14/18. The Resident's diagnoses included but were not limited to: other symptoms and signs involving musculoskeletal system, lack of coordination, muscle weakness, unsteadiness on feet, dysphagia and cognitive communication deficit.	F 625	F625 Resident 339 no longer resides at the nursing center. An audit will be conducted of current residents who are in the hospital and if the required information was not sent with the resident, the resident/representative will be provided the appropriate information. Nursing, social services and transitions nurse will be educated on discharge process and notification requirements including notification of State's Long Term Care Ombudsman. Center's transfer packet has been updated with copy of Bed Hold Policy to ensure resident and responsible parties are provided the policy. Supervisors will update transfer log when residents go to the hospital and sign off	

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F 625	Continued From page 28 Resident #339's most recent MDS (minimum data set) (an assessment tool), was coded as an admission assessment, with an ARD (assessment reference date) of 11/21/18. Resident #339, had a BIMS (brief interview for mental status) score of 9, which indicated moderately impaired cognition. Resident #339, was coded that extensive assistance of two staff members was required for ADL's (activities of daily living) which included, bed mobility, transfers, dressing and personal hygiene. On 5/15/19 during review of Resident #339's clinical record, nursing notes revealed that on 12/13/18 Resident #339 was sent to the hospital. The nursing note dated 12/13/18 at 23:51 read, "Resident was found on the floor close to the bed in her room by Aide. A laceration noted on back of head, measured 2cm x 0.5 cm, with depth 0.3cm. Surrounding area appeared swollen and blood draining. In the incident scene there was a clock with front glass in pieces on the floor, blood on the carpet closer to the TV and two chairs on the side wall. She denied pain, no complain of drowsiness, dizziness, or lightheadedness noted. Injury area cleanse with NS, pressure applied to stop bleeding. According to assigned CNA, resident was put to bed after dinner and ADL care had been provided. Resident stated that she lost her balance and hit her head on the side wall while trying to go to the restroom. She believed that the clock fell to the ground resulting from the impact on the wall due to her hitting the wall. Vitals taken x 4 every 15 minutes, pressure applied to stop bleeding, cleanse injured with NS, pat dry and covered with dry gauze. MD notified and ordered to sent to ER for further evaluation and possible sutures to injured area Daughter was notified that walked in shortly after the	F 625	when the bed-hold policy was provided at time of discharge. Log will be reviewed at the morning meeting. If variances are found, they will be immediately corrected. Findings of the audits will be analyzed for trends and Social Worker will present finding of audits to QAPI committee monthly for 3 months.	

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F 625	Continued From page 29 incident occurred. Pt was sent out via medical transportation, accompanied by daughter." A nursing note dated 12/16/18 at 17:04 read, "Patient was sent out per daughter/[name] request: approved by Dr. [Dr. name] d/t s/p fall trauma injury noted to right forearm (redness, swelling, pain, inflammation and warm to touch) and c/o pain to right hip. Pain managed with hydrocodone." Review of the clinical record for Resident #339 revealed no indication that the resident or her responsible representative was notified of the bed hold policy prior to her transfer to the hospital on 12/13/18 and 12/16/18. On 5/16/18, the facility Administrator was asked where it is noted that Resident #339 was notified of the bed hold policy prior to her transfer and the Administrator stated, "we weren't doing it at that time." The facility administrator was made aware on 5/16/19 of the facility staff's failure to notify the resident of the bed hold policy prior to transfer. No further information was provided.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		6/28/19

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F 656	Continued From page 30 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed develop a care plan for 2 of 25 sampled residents.	F 656	F0656 Resident 91 and 34 are current resident at nursing center. The mandarin oranges and orange juice were removed from resident 91's room on 5/15/19 before	

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F 656	Continued From page 31 1. For Resident # 91, the facility staff failed to develop a care plan for a renal diet. 2. For Resident #34, the facility staff failed to develop a comprehensive care plan for hearing deficits. The Findings included: 1. For Resident # 91, the facility staff failed to develop a care plan for a renal diet. Resident #91 was a 72 year old who was admitted to the facility on 5/8/19. Resident #91's diagnoses included Hypertension, Chronic Kidney Disease, Stage 4 Type 2 Diabetes without Complications, Hyperlipidemia, and Obesity. On 5/14/19 at 3:15 P.M., an interview was conducted with Resident #91 and her son. Resident #91 was concerned that her diet order wasn't being followed. She stated that the facility served her canned peaches that morning, and continued to serve her orange juice for breakfast. She stated, and her son agreed that her potassium level increased and she had to take a new medication the previous night. Resident #91 gave the surveyor her meal ticket, which listed the following prohibited foods: "No banana, orange juice, potato, sweet potato, tomato, apricots, peaches, pears, oranges, spinach, asparagus, Brussels sprouts, collard, turnips, deli meat sausage bacon." Resident #91 was dressed appropriately, and was oriented to person place, time and situation.	F 656	being consumed. The comprehensive care plan was updated to reflect resident 91's renal diet on 5/22/19. Resident 34's care plan for hearing deficits was updated on 5/14/19. Licensed nurses and other interdisciplinary team members will be in serviced on components of a comprehensive care planning. An audit of residents with special diet will be completed to ensure their care plans address dietary needs; if variances are found the care plan will be updated. An audit of residents with impaired hearing will be conducted to ensure that the care plan addresses the resident's hearing deficit. If variances are found the resident's care plan will be updated. The MDS coordinator will audit for accurate, comprehensive and timely completion of care plans for residents with specialty diets and hearing deficits. An audit of 100% of diet changes will be conducted by Director of Dining Operations to ensure changes are reflective in care plan. Director of Dining Operations to utilize meal tray accuracy tracker to ensure compliance with diet orders and prevention of prohibited items on trays unless requested by resident. MDS coordinator to conduct every other week audits on timely and accurate completion of comprehensive care plans for 3 months. MDS coordinator to conduct every other week audit care plans of residents with hearing deficit for 3 months	

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F 656	Continued From page 32 On 5/15/19 at 8:20 A.M., an observation was conducted of Resident #91 eating breakfast. The breakfast tray contained mandarin oranges and orange juice. On 5/15/19, a review was conducted of Resident #91's clinical record. On 5/9/19 the Registered Dietician changed the resident's diet from a regular, no added salt diet, to a renal diet. Resident #91's lab reports were as follows: "Potassium on 4/30/19 - 4.6" "Potassium on 5/13/19 - 5.6 normal range is 3.5 - 5.1" According to a signed telephone order, on 5/13/19 at 2:23 P.M. the MD ordered Kayexalate 30 Grams by mouth x 1 dose (used to decrease elevated potassium). Resident #91's care plan was reviewed. It read, "5/8/19. No added salt diet." On the most recent care plan , dated 5/15/19, The Nutritional status, and Dietary Goals sections were left blank. On 5/14/19 at 2:27 P.M. an interview was conducted with the Registered Dietician (Employee L). She stated, "If the potassium is high, she shouldn't get the foods high in potassium." The Regional Dietician (Employee M) was also present, and stated, "A person who gets too much potassium, it could cause heart failure." On 5/15/19 at 10:42 A.M., an interview was conducted with the Director of Nursing (Employee B). She was asked to describe how the process works to change a diet order. She stated, "the dietician can change the order in the computer	F 656	to ensure appropriate interventions are in place. MDS coordinator to take corrective action where appropriate and present results of audits to QAPI committee. Director of Dining Operations to present findings from meal accuracy tracker and audits of diet changes to QAPI for 3 months	

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F 656	Continued From page 33	F 656		

system. The Dietician writes their own orders. The kitchen and nursing departments are automatically notified of the diet change. The kitchen staff is supposed to make sure that forbidden foods are not on the tray. The nursing staff should also read the ticket on the resident's tray to ensure that food restrictions are followed."

No further information was received.

2. For Resident #34, the facility staff failed to develop a comprehensive care plan for hearing deficits.

Resident #34 was admitted to the facility on 12-26-18 with diagnoses including; Dementia, glaucoma, lack of coordination, muscle weakness, fall with fracture of the tibia, and fibula, and was hard of hearing with hearing aid devices.

Resident #34's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3-20-19. Resident #34 was coded with a Brief Interview of Mental Status score of 7, indicating moderate cognitive impairment. Resident #34 was extensively dependant on one staff member for assistance with activities of daily living care, such as bed mobility, transferring, and toileting.

On the physician's progress notes, it described the Resident as hard of hearing (HOH). Nursing staff and the Resident's daughter indicated the Resident was very hard of hearing, and this could be a barrier to communication, and understanding instructions.

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F 656	Continued From page 34 The Resident's current care plan was reviewed and revealed no care plan for hard of hearing deficits. The Administrator and Director of Nursing were notified at the end of day meeting on 5-16-19 at 2:00 p.m. No further information was provided by the facility.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		6/28/19

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F 657	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise a careplan for one Resident (Resident #341) in a survey sample of 25 Residents. For Resident #341, the facility staff failed to review and revise the careplan after the Resident was diagnosed with a superficial vein thrombosis and was started on an anticoagulant. The findings included: Resident #341, was admitted to the facility on 4/23/19. The Resident's diagnoses included but were not limited to: fracture of left humerus, fracture of left pubis, muscle weakness, lack of coordination, anemia, syncope and collapse, gastrointestinal hemorrhage, hypertension, hyperlipidemia, and gastro-esophageal reflux disease. Resident #341's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 4/30/19 was coded as an admission assessment. Resident #341, had a BIMS (brief interview for mental status) score of 13, which indicated the resident was cognitively intact. She was coded as requiring extensive assistance of staff for, bed mobility, transfers, dressing, toileting, and personal hygiene. Review of Resident #341's clinical record revealed a physician progress note on 4/29/19 that read, Chief Complaint "NP visit per staff/son request for increased edema to LUE (left upper extremity)." The provider noted under plan: "LUE	F 657	F0657 Resident 341 are current resident at nursing center. Resident 341's care plan was reviewed and updated to address edema, superficial vein thrombosis, warm compress order and use of an anticoagulant on 5/15/19. Physician orders for the past 30 days will be reviewed to identify changes in the resident's care needs and the resident's care plan will be reflective of those needs. If variances are found, the care plan will be updated. Nurses re-educated on updating/revising care plans when new orders are received. Nursing supervisor to audit 10% of new orders weekly to ensure care plans are reflective of changes and care plan is update timely. The weekly audits will be analyzed by the DON for trends/patterns and need for additional education to responsible staff. Director of Nursing to present findings of audit to QAPI monthly for 3 months.	

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F 657	Continued From page 36 edema-venous doppler to LUE ordered, encouraged elevation with pillow." Review of the doppler report with a date of service of 5/10/19 revealed, "acute superficial vein thrombosis in the left cephalic vein." Nursing notes dated 5/11/19 9:50am read, "Resident have a new order for warm compress QID (four times a day) to L/U (left upper) arm. Warm compress to L/U/arm done and pain patch applied to L/arm as well. Resident started prednisone this morning and 2.5 mg Eliquis given as order. Pain management effective." Review of Resident #341's careplan reveals no indication of the edema, superficial vein thrombosis, warm compress order, or use of Eliquis (anticoagulant). On 5/16/19 the DON (director of nursing) was shown the careplan for Resident #341 and the DON stated, "it is not in there." No further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review the facility staff failed to provide care and services in	F 658	F0658 Resident #7 and #5 are current resident of the nursing center. Residents were monitored by nursing staff; no	6/28/19

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F 658	Continued From page 37 accordance with professional standards of practice for 3 Residents (Residents # 7, # 190, #5) in a survey sample of 25 Residents. 1a. For Resident #190, the facility staff failed to administer medications per physicians order and; 1b. failed to document that an entry was a late entry. 2. For Resident #7, the facility staff failed to administer 2 consecutive doses of insulin on 05/12/2019 as indicated by sliding scale per physician's orders. 3. For Resident #5, the facility staff failed to ensure insulin was administered on 5-11-19 as ordered by a physician. The findings include: 1a. For Resident #190, the facility staff failed to administer medications per physicians order and; 1b. failed to document that an entry was a late entry. Resident # 190, a 59 year old woman admitted to the facility on 5/9/19 the Resident had no (Minimum Data Set) MDS information available as she was a new admission. The Resident was admitted to the facility with diagnoses of but not limited to recent Right hip replacement surgery, foot drop in Right foot, difficulty walking, general weakness, (Chronic Obstructive Pulmonary Disease) COPD, Atrial Fibrillation and Diabetes On 5/15/19, the clinical record was reviewed. During review of the May 2019 Medication	F 658	changes were noted. The physicians were notified of the medication errors on 6/8/19. Resident 190 is no longer a resident. A late entry on 5/16/19 addresses the refusal on 5/9/19. Re-education and corrective actions will occur with involved staff. May medication records for current residents will be reviewed for accuracy in medication administration. If variances are discovered, the physician will be notified and the responsible staff administering the medication will be re-educated or counseled. Nursing staff will be reeducated on professional standards as outlined in Lippincott Manual of Nursing Practice as it relates to medication administration and documentation. Shift supervisors to validate accurate administration of prescribed medications by auditing 10% of each nurse's MAR documentation daily for 30 days then weekly for 2 months to ensure nursing standards are being followed. Supervisor to take immediate corrective steps, including but not limited to, notifying physicians, monitoring resident and counseling staff as necessary to ensure services meet professional standards. Findings of the above audits will be provided to the Director of Nursing for analysis of trends/patterns and need for additional education and/or disciplinary action Director of Nursing to provide a summary of daily supervisor's audits monthly to QAPI for 3 months.	

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Administration Record (MAR), it was noted that medications for Resident #190 had not been signed off for the following medications and dates:

5/10/19 - 1:00 PM- Simethicone 180 (milligrams) mg 1 capsule by mouth 3 times a day.
5/13/19 - 6:00 AM - Linzess 145 (microgram) mcg capsule- 2 Capsules by mouth every day
5/13/19 - 6:00 AM - Pantoprazole 40 mg. by mouth every day
5/14/19 Lunch- Thrive Gelato [Dietary Supplement] QD with lunch
5/15/19 - 6:00 AM - OxyContin 20 mg by mouth 3 times per day for pain

On 5/15/19 at 1:43 PM, copies of (Medication Administration Record) MAR was submitted and reflected the missing medication administration signatures.

On 5/16/19 at 8:30 AM during an interview with the DON (Director of Nursing), she stated that she checked with the LPN (Licensed Practical Nurse) who gave medications to that resident and that the LPN stated the meds were refused by the Resident. She then produced an MAR that was filled in with R meaning Refused and the last page stating Resident Refused and the dates of the missing medications.

The DON was asked why the document did NOT say LATE ENTRY she said she didn't know. She stated that she told the LPN to put in a late entry. The documents were identical except the new MAR had all the missing medication signatures were filled in. When DON was asked how was someone to know by looking at that document that it was a late entry, she stated there was no

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way to know unless you look at the computer.

According to the DON, the facility used Lippincott for Professional Standards.

According to Lippincott Manual of Nursing Practice, 10th edition, in Box 2-1 entitled, "Common Legal Claims for Departure from Standards of Care" it is documented that a departure from standards of nursing care included, "Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately."

On 5/16/19 during the end of day conference, the Administrator was made aware of the issues with medication administration.

No further documentation was provided.

2. For Resident #7, the facility staff failed to administer 2 consecutive doses of insulin on 05/12/2019 as indicated by sliding scale per physician's orders.

Resident #7, a 78-year old female, was admitted to the facility on 02/20/2018. Diagnoses included but not limited to diabetes, peripheral vascular disease, hypertension, aphasia following cerebral infarction, and generalized muscle weakness.

Resident #7's most recent Minimum Data Set with an Assessment Reference Date of 01/30/2019 was coded as an annual assessment. The Brief Interview for Mental Status was coded as 3 out of possible 15 indicative of severe cognitive impairment. Number of days insulin

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injections were received was coded as 7.

On 05/14/2019 at approximately 3:00 PM, the current physician's orders were reviewed. An excerpt of an order dated 01/14/2019 documented, "Humalog 100unit/ml subcutaneous solution sliding scale check QID (four times a day) FS (fasting sugar) 200 or less give 0 units; 201-250 give 2 units; 251-300 give 4 units; 301-350 give 6 units; 351-400 give 8 units; greater than 400 give 1 units, call MD, recheck in 1 hour."

The Medication Administration Record for May 2019 was reviewed. On 05/12/2019 on the line "BfrBrkfst (before breakfast)", the blood sugar was recorded as 210. Just below it on the line "units", it was documented 0 (units). On the line "BfrLunch (before lunch), the blood sugar level was documented as 283. Just below it on the line "units", it was documented 0 (units). The meal intake flowsheet was reviewed. It was documented that Resident #7 consumed 51-75% of her meal for dinner on 05/11/2019.

For 05/12/2019, Resident #7 consumed 76-100% of her breakfast and 26-50% of her lunch.

On 05/15/19 10:24 AM , the findings were shared with the DON. When asked about her expectations for insulin administration, she stated she expects insulin to be administered as ordered. The DON then looked at the electronic health record of Resident #7 and stated she was unable to find a reason why the insulin was not given.

The facility staff provided a copy of their policy entitled, "Sliding Scale Insulin." The policy

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documented, "A physician protocol for the use of sliding scale insulin will be used in the nursing center." The procedure documented, "The following scale will be initiated upon admission for residents of [physician names]: Regular human insulin finger sticks AC & HS (before meals and at bedtime) FS (fasting sugar) below 200 - 0 units; 201-250 - give 2 units; 251-300 - give 4 units; 301-350 - give 6 units; 351-400 - give 8 units; Above 400 - give 10 units, call MD, recheck in 1 hour."

According to Lippincott Manual of Nursing Practice, 10th edition, in Box 2-1 entitled, "Common Legal Claims for Departure from Standards of Care" it is documented that a departure from standards of nursing care included, "Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately."

On 05/16/2019 at approximately 2:30 PM, the Administrator stated they had no further documentation or information to offer.

3. For Resident #5, the facility staff failed to ensure insulin was administered on 5-11-19 as ordered by a physician.

Resident #5, was admitted to the facility on 5-11-18. Diagnoses included diabetes, sarcoidosis, and long time insulin use.

Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-24-19 was coded as an annual assessment. Resident #5 was coded as having a BIMS (brief

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F 658	Continued From page 42 interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. Resident #5 was also coded as requiring extensive assistance to total dependence on one to two staff members to perform activities of daily living, such as hygiene, and bed mobility. On 5-14-19 at 12:00 noon, Resident #5 was observed in her room in bed. A Resident interview was conducted, and the Resident stated she did not receive her insulin as she should from staff. Review of the resident's clinical record revealed the resident's current POS (physician order sheet), and MAR (Medication Administration Record) for May 2019. Contained was an order for Novolog insulin per sliding scale with fingerstick blood sugars (FSBS) three times per day. If the Resident's blood sugar was above 251 and below 300, give 4 units of the insulin by subcutaneous injection. On 5-11-19 the Resident's FSBS was 254, and no insulin was given, and was documented as such by the nurse. Review of the medication and nursing notes revealed no documentation as to why the insulin was not given. Review of the facility policy revealed that only trained nurses would administer insulin by the physician's orders. On 5-15-19 at 5:00 p.m., the DON (director of nursing) was notified of above findings. The DON stated, "The medication should have been given."	F 658		
F 685	Treatment/Devices to Maintain Hearing/Vision	F 685		6/28/19

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F 685 SS=D	Continued From page 43 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: Based on observation, Resident representative interview, clinical record review, and facility document review, the facility staff failed to ensure treatment services to maintain hearing were afforded one Resident, (Resident #34) in a sample of 25 Residents. For Resident #34, who was hard of hearing, and wore hearing aids, the facility staff failed to provide timely cerumen removal as ordered by a physician, to maintain hearing. The findings included; Resident #34 was admitted to the facility on 12-26-18 with diagnoses including; Dementia, glaucoma, lack of coordination, muscle weakness, fall with fracture of the tibia, and fibula, and was hard of hearing with hearing aid devices. Resident #34's most recent Minimum Data Set (MDS) assessment was a quarterly assessment	F 685	F Tag 0685 Resident #34 is current a resident at facility. New orders obtained from resident's physician on 6/5/19. Resident scheduled for follow up appointment with ENT specialist. Resident's care plan updated to reflect hearing deficit on 5/14/19. Current resident orders will be reviewed to ensure that all orders related to impaired hearing have been implemented. If additional variances are found, the physician will be notified. Nursing in-service will be conducted to include clarifying, transcribing, and administering medications/treatment when orders are written by physicians. Center will utilize electronic physician orders to ensure orders are received, reviewed and followed up by nursing. Center physicians and nurse practitioners will be trained on completing orders.	

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F 685	Continued From page 44 with an Assessment Reference Date (ARD) of 3-20-19. Resident #34 was coded with a Brief Interview of Mental Status score of 7, indicating moderate cognitive impairment. Resident #34 was extensively dependant on one staff member for assistance with activities of daily living care, such as bed mobility, transferring, and toileting. On the physician's progress notes, most described the Resident as hard of hearing (HOH). Nursing staff and the Resident's daughter indicated the Resident was very hard of hearing, and this could be a barrier to communication, and understanding instructions. Review of the Physician's orders revealed that the doctor ordered cerumen removal from the Resident's ears which were "completely occluded" according to the doctor's order on 3-28-19. The order was not clarified, nor administered, and never transcribed onto the Medication and Treatment Administration Records (MARs/TARs), to be completed by staff, which were also reviewed. The physician again wrote two orders on 4-10-19 for the following; 1. "Flush both ears for wax one time." 2. "Debrox 6.5% ear drops 5 drops in both ears at bedtime for impacted cerumen." Review of the nursing notes, physician notes, and physician orders indicated that on 4-11-19 the Debrox treatment was completed by staff, however, not the flush (12 days after the first order was given). It is unknown if there was any effect, as no notes indicate whether cerumen was	F 685	Director of Nursing and/or ADON will complete weekly audits of consultations from external physicians to ensure orders were followed appropriately. If variances are found, corrective action will be taken. Weekly audits will continue for three months. Results will be reviewed at QAPI on a monthly basis for 3 months.	

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F 685	Continued From page 45 removed or not. The doctor again ordered "Cerumen needs removed from both ears" on 4-25-19, and as of the time of survey this order had not been completed, clarified, nor transcribed onto the MAR/TAR for completion by staff. The Resident's current care plan was reviewed and revealed no care plan for cerumen removal nor hearing aids, nor hard of hearing deficits. The Administrator and Director of Nursing were notified at the end of day meeting on 5-16-19 at 2:00 p.m. No further information was provided by the facility.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview facility documentation and clinical record review the facility staff failed to provide supervision for 2 of 25 sampled Residents (#189 and #34). 1. For Resident #189 the facility staff failed to utilize proper amount of staff while transferring a resident via Mechanical Lift. 2. For Resident #34 who had a recent history of falls with fracture, the facility staff left the	F 689	F0689 Resident 189 and 34 are current resident at nursing center. An audit of incident reports for the month of May with residents requiring transfer via mechanical lift yield no other resident affect. An audit of residents who are assessed as being at risk for falls and use the toilet yielded other residents may be potential affected. Responsible staff was counseled with corrective action and re-educated on safe	6/28/19

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F 689	Continued From page 46 Resident on the toilet without supervision, and the Resident fell. The findings included: 1. For Resident #189, the facility staff failed to utilize the proper amount of staff while transferring a resident via Mechanical Lift. Resident #189, a 96 year old woman was admitted to the facility on 6/19/12 with diagnoses of but not limited to Dementia, Hypertension, Diabetes, Hypothyroidism, Chronic ischemic heart disease, Congestive heart failure, and abnormal posture. Resident #189's most recent (Minimum Data Set) MDS a quarterly with an ARD date of 3/16/19 codes Resident #189 as having a (Brief Interview of Mental Status) BIMS score of 00/15 which indicates severe cognitive impairment. Resident is also coded as being total assistance for all aspects of (Activities of Daily Living) ADL's. She is coded as requiring 2 or more people to perform her care and the use of Mechanical Lift for transferring from bed to chair or wheelchair. Resident #189 was the subject of a (Facility Reported Incident) FRI that was submitted to the OLC (Office of Licensure and Certification) on 1/16/19. The FRI states that on 1/16/19 at approximately 11:30 AM the CNA that was working with Resident #189 reported to the LPN and Nursing supervisor that the resident was crying out in pain when she was touched on her right lower leg. The nurse examined and found swelling to the ankle area. The family and the MD (Medical	F 689	transferring techniques with mechanical lifts and supervision of residents with fall risk while toileting. Nurses and Supervisors will be educated on accurate completion of fall risk evaluation. Staff will be educated on how to utilize fall risk evaluation. Residents who are evaluated at a score of 10 and below, will have staff in close proximities while they are on the toilet. Residents who are transferred via mechanical lift will have two staff member present. Therapy screened residents requiring assistance with transfer to ensure proper assisted devices were being utilized appropriately. The facility policy on safe transfers using a mechanical lift has been reviewed. Nursing staff will be re-educated on safe transfer techniques when using a mechanical lift and will demonstrate competency in following the lift instructions for safe transfer. 5 mechanical lift transfers will be observed weekly for 12 weeks by nursing supervisor. Re-education will be provided as needed. 5 residents requiring supervision while toileting will be observed weekly for 12 weeks by nursing supervisor. Reeducation will be provided as needed. Findings from the above audit will be provided to Director of Nursing for analysis of trends/patterns and needs for additional education and/or disciplinary action. Incident reports and interventions will be reviewed and updated by nursing supervisors. The Fall Investigation Form	

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F 689	Continued From page 47 Doctor) were notified and the MD ordered X-Rays. The FRI also states that at 4:30 PM the X-Ray results arrived with a diagnosis of Acute Non-displaced fracture of right distal fibula. The MD and family were notified of the diagnosis and the MD ordered continuation of stabilization and follow up with orthopedics/ podiatry the following morning. On 5/15/19 at 2:00 PM, an interview was conducted with the DON (Director of Nursing) who stated that once she was told that there was a fracture involved she initiated a "Fracture (of unknown cause) Investigation Form" The DON stated that the CNA (Certified Nursing Assistant) that was working with Resident #189 failed to obtain help from a coworker. She stated at all times there should be 2 persons operating the mechanical lift. The DON further stated that she did training on all direct care staff after the incident. According to the statement by the CNA who worked with Resident #189 on 1/15/19 from 3:00 PM to 11:00 PM, "Requested assistance multiple times to help with residents transfer to bed-unable to obtain assistance-transferred via Hoyer lift / mechanical lift to bed." According to facility Policy for Full Body Lift: Policy: All CNA's will be trained in safe and appropriate use of the full body lift. Any time the full body lift is used, there must be 2 trained staff members present to ensure staff and resident safety. On 5/15/19 at the DON also asked for Past Non	F 689	will be used to determine if incident meets the requirements for abuse/neglect reporting. Administrator and Director of Nursing (DON) will ensure timely reporting of abuse/neglect allegations. Facility DON to present summary of audits to QAPI committee for 3 months.	

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Compliance to be considered however, another resident was found to be deficient after the incident on 1/16/19.

On 5/15/19 at 4:30 PM, an interview was conducted with Employee H who stated that "When moving any Resident with a mechanical lift we always have to use two people." When asked how she knows this she stated that she was taught that in annual training.

On 5/16/19, the Administrator was made aware of the issues involving the injury to Resident #189 and no further information was provided.

2. For Resident #34 who had a recent history of falls with fracture, the facility staff left the Resident on the toilet without supervision, and the Resident fell.

Resident #34 was admitted to the facility on 12-26-18 with diagnoses including; Dementia, glaucoma, lack of coordination, muscle weakness, and fall with fracture of the tibia, and fibula, and was non-weight bearing at the time of admission from the hospital for surgery related to that fracture on 12-26-18. The Resident was also hard of hearing and wore hearing aids.

Resident #34's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3-20-19. Resident #34 was coded with a Brief Interview of Mental Status score of 7, indicating moderate cognitive impairment. Resident #34 was extensively dependant on one staff member

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F 689	Continued From page 49	F 689		

for assistance with activities of daily living care, such as bed mobility, transferring, and toileting.

On the physician's progress notes, most described the Resident as hard of hearing (HOH). Nursing staff and the Resident's daughter indicated the Resident was very hard of hearing, and this could be a barrier to communication, and understanding instructions.

On 2-25-19 the physician's progress notes indicated the Resident had fallen on 2-23-19 while trying to stand from a wheel chair. On 3-5-19 the nursing notes documented that the Resident had been left alone on the toilet and had fallen.

On 5-14-19 at approximately 1:00 p.m., Resident #34's daughter was interviewed. The daughter stated "I was not aware that mom fell from the toilet unattended. She can't be left alone on the toilet, she will try to get up and fall. She has an immobilizer on her ankle from her fracture, and pain in that leg that she receives pain medication for. She is not supposed to stand on it unassisted, and she doesn't remember that."

The Resident's current care plan was reviewed and revealed no revision or update review, since admission on 12-26-18, and had a goal date of 7-5-19. The care plan stated as problems related to falls and fracture, the 3 following areas, and those interventions are below;

1. Falls - at risk for more falls related to recent fall and fracture - observe and anticipate or intervene with factors causing previous or potential for falls. Answer calls quickly, attempt to anticipate needs for prompt response, and decrease in attempts to

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ambulate without proper assist.

2. Impaired functional status - has impaired functional status with bed mobility, transfer, walking, toileting, ...etc - weight bear as tolerated with brace when out of bed, stand pivot for transfers with assist of 1 staff.

3. Medical condition Orthopedic - had a recent fracture, requires follow up care. - Assess immobilizer device cast to ensure intact, assess skin under/at edge of immobilizer to ensure no rubbing, friction or pressure is evident. Maintain imposed limitations of non-weight bear right lower extremity educate and remind (Resident) of limitations.

In summary, the staff were aware of the Resident's fall history with attempts to stand alone, the Resident was demented, with memory impairment, hard of hearing, and was non-weight bearing. The Resident had a cast device on her left leg which was a fall hazard. She had pain in that leg, poor vision, lack of coordination and weakness. The facility staff placed her on the toilet and left her there alone, and when they returned she was sitting on the floor in the bathroom where she had fallen. Staff did not implement their care plan to "intervene with factors causing previous falls or potential for falls, nor attempt to anticipate needs for prompt response, and decrease in attempts to ambulate without proper assist."

The Administrator and Director of Nursing were notified at the end of day meeting on 5-16-19 at 2:00 p.m. No further information was provided by the facility.

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F 692	Continued From page 51	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain nutritional status. 1. For Resident #91, the facility staff failed to maintain nutritional status, resulting in an increased potassium level which required pharmacological intervention. 2. For Resident #290, the facility staff failed to provide a therapeutic diet as ordered by the healthcare provider on 05/14/2019.	F 692	F0692 Resident #290 is no longer a resident at nursing center. Resident #91 is a current resident. A dietary representative met with resident #91 on 5/15/19 and reviewed her diet preferences and related dietary restrictions. Dietary staff will be re-educated on adhering to resident preferences and dietary restrictions when preparing meal trays. A review of diet orders for current residents was completed and compared to menu instructions to ensure dietary staff was aware of physician orders and resident	6/28/19

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F 692	Continued From page 52 The Findings included: 1. For Resident #91, the facility staff failed to maintain nutritional status, resulting in an increased potassium level which required pharmacological intervention. Resident #91 was a 72 year old who was admitted to the facility on 5/8/19. Resident #91's diagnoses included Hypertension, Chronic Kidney Disease, Stage 4 Type 2 Diabetes without Complications, Hyperlipidemia, and Obesity. On 5/14/19 at 3:15 P.M., an interview was conducted with Resident #91 and her son. Resident #91 was concerned that her diet order wasn't being followed. She stated that the facility served her canned peaches that morning, and continued to serve her orange juice for breakfast. She stated, and her son agreed that her potassium level increased and she had to take a new medication the previous night. Resident #91 gave the surveyor her meal ticket, which listed the following prohibited foods: "No banana, orange juice, potato, sweet potato, tomato, apricots, peaches, pears, oranges, spinach, asparagus, Brussels sprouts, collard, turnips, deli meat sausage bacon." Resident #91 was dressed appropriately, and was oriented to person place, time and situation. On 5/15/19 at 8:20 A.M., an observation was conducted of Resident #91 eating breakfast. The breakfast tray contained mandarin oranges and orange juice.	F 692	food preferences. Staff, nursing and dietary included, re-educated on validating the accuracy of the meals. Dietary staff will be reeducated on adhering to resident preferences and dietary restrictions when preparing meal trays. Director of Dining Operations to conduct a weekly random audit of 25% of meal trays for 12 weeks to ensure accuracy and adherence to prescribed therapeutic diet orders. Director of Dining services to provide findings of audit to QAPI committee for 3 months.	

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On 5/15/19, a review was conducted of Resident #91's clinical record. On 5/9/19 the Registered Dietician changed the resident's diet from a regular, no added salt diet, to a renal diet.

Resident #91's lab reports were as follows:

"Potassium on 4/30/19 - 4.6"
"Potassium on 5/13/19 - 5.6 normal range is 3.5 - 5.1"

According to a signed telephone order, on 5/13/19 at 2:23 P.M., the MD ordered Kayexalate 30 Grams by mouth x 1 dose (used to decrease elevated potassium).

Resident #91's care plan was reviewed. It read, "5/8/19. No added salt diet." On the most recent care plan , dated 5/15/19, The Nutritional status, and Dietary Goals sections were left blank.

On 5/14/19 at 2:27 P.M. an interview was conducted with the Registered Dietician (Employee L). She stated, "If the potassium is high, she shouldn't get the foods high in potassium." The Regional Dietician (Employee M) was also present, and stated, "A person who gets too much potassium, it could cause heart failure."

On 5/15/19 at 10:42 A.M., an interview was conducted with the Director of Nursing (Employee B). She was asked to describe how the process works to change a diet order. She stated, "the dietician can change the order in the computer system. The Dietician writes their own orders. The kitchen and nursing departments. are automatically notified of the diet change. The kitchen staff is supposed to make sure that forbidden foods are not on the tray. The nursing

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staff should also read the ticket on the resident's tray to ensure that food restrictions are followed."

No further information was received.

2. For Resident #290, the facility staff failed to provide a therapeutic diet as ordered by the healthcare provider on 05/14/2019.

Resident #290, a 71 year old female who was admitted to the facility on 05/03/2019 with diagnoses to include but not limited to chronic obstructive pulmonary disease (COPD), shortness of breath, acute respiratory failure, and malnutrition.

Resident #290's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/2019 was coded as admission from an acute hospital. A comprehensive MDS is pending and the physician's admitting assessment read, "Cognition WNL (within normal limits), AOX4 (alert and oriented to person, place, time, and situation), pleasant, no agitation, able to answer all questions appropriately, able to follow simple commands".

On 05/14/2019 at approximately 12:45 PM, Resident #290 was observed sitting in her room eating her lunch. She stated, "The food here is good but I am concerned that I am not getting what the doctor has ordered for me. He wants me to try and gain weight and get my energy back because I only weigh 80 pounds; I was just in the hospital. He ordered a special Gelato for me that has additional nutrients but I have only received it one time since I have been here. They just tell me that it's not available and that they don't have it.

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F 692	Continued From page 55 The dietician has also recommended it for me. I really want to get better." There was no nutritional supplement observed on her lunch tray. On 05/14/2019 at approximately 1:40 PM, a staff interview was conducted with the Director of Dining Services (Employee K) who stated, "I have never run out of the Thrive Gelato, it is always available for any resident that wants it, everyone likes it, it is like ice cream, I have 3 flavors". At approximately 2:00 PM, Resident #290 was observed eating the Gelato and stated, "thank you so much, they just brought it to me". On 05/16/2019, a review was conducted of Resident #290's clinical record. A comprehensive nutritional evaluation dated 05/06/2019 read: "current wt: 81 (pounds), BMI (body mass index): 14, Interpretation: severely underweight...RD (Registered Dietician) to order Thrive Gelato BID (twice per day) with lunch and dinner". The medication administration record and nursing note on 05/14/2019 at 12:32 PM indicated the Gelato was not given, "supplement not available".	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		6/28/19

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F 725	Continued From page 56 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed to have sufficient nursing staff to meet the needs of seven Residents (Resident #20, Resident #190, Resident #28, Resident #189, Resident #12, Resident #15, Resident #6) in a survey sample of 25 Residents. 1. For Resident #20, the facility staff failed to have adequate staff to respond to the Resident's call bell and request for assistance for three hours. 2. For Resident #190, the facility staff failed to ensure adequate staff available to answer call bell in a timely manner. 3. For Resident #28, the facility staff failed to ensure adequate staff available to answer call bell in a timely manner.	F 725	Residents 12, 5, 20, 189, 6 and 15 are current residents. Residents 190 and 28 are no longer residents. An initial audit yielded other potential residents affected by this practice. Resident 5 was provided a sling for use on 5/15/19. Resident 6's call bell was repositioned to be within reach of resident on 5/15/19. Staff will be re-educated on responding to resident call system. Center's policy revised to state call lights to be deactivated when able to render requested service. Staff will be re-educated on proper positioning of the call bell for resident access. Center's Administrator to audit call bell response weekly for 3 months and implement corrective actions where appropriate. Center to observe a	

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F 725	Continued From page 57 4. For Resident #189, the facility staff failed to provide sufficient staff to safely lift Resident using Hoyer. 5. For Resident #12, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 2 of 14 opportunities the call light was activated. 6. For Resident #15, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 3 of 15 opportunities the call light was activated. 7. For Resident #6, the facility staff failed to provide activities of daily living care in a timely manner. The findings included: 1. For Resident #20, the facility staff failed to have adequate staff to respond to the Resident's call bell and request for assistance for three hours. Resident # 20, was admitted to the facility on 6/24/08. The resident's diagnoses included but were not limited to: constipation, MDD single episode, allergic rhinitis, heartburn, pruritus, hyperlipidemia, heart disease, obesity, chronic diastolic heart failure, pyridoxine deficiency, polyosteoarthritis, rheumatoid arthritis, . Resident #20's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/20/19, was coded as a quarterly assessment. Resident #20	F 725	minimum of 5 residents 3 days a week for 6 weeks to ensure call bells are positioned appropriately for easy access to residents, variances will be corrected and responsible staff will be re-educated. Center to observe a minimum of 5 residents 3 days a week for 6 weeks to ensure residents are safely transferred using Hoyer, variances will be corrected and responsible staff will be re-educated. The Administrator and Director of Nursing will review the facility staffing model to ensure that sufficient staff are available to meet the residents needs in a timely manner. The Administrator and DON will review the "as worked" schedule for 2 months to identify trends/patterns with "call outs", use of agency or temporary staff. Recommendation for change will be made to facility's Executive Director. Center to implement "NO PASS ZONE" ensuring interdisciplinary staff respond to all call lights. Visual ques will be affixed to residents door frame/or designated areas in rooms of residents assessed as being at risk for falls and for residents requiring 2 person assistance during transfers using hoyer lifts. Incidents such as falls will be elevated and reviewed for impact related to staffing. Director of Nursing will be present results of audits to QAPI for 3 months for oversight and recommendation. Resident services to survey resident perspective and obtain input from residents on center's responsiveness to call lights during monthly resident council meeting.	

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was coded as having a BIMS (brief interview for mental status) score of 15, which indicated being cognitively intact. Resident #20, was also coded as requiring extensive of assistance of staff for bed mobility, transfers, dressing, and personal hygiene. She was coded as being totally dependent upon staff for toileting and bathing.

During an interview with Resident #20 on 05/14/19 at 01:33 PM, Resident #20 stated, "I have called for help and waited over an hour." When asked how often this occurs, Resident #20 stated, "it happens too often" and indicated it is an ongoing concern. Resident #20 stated, "they need another aide on the unit, they don't have enough staff to help us."

Review of the facility call bell response log on 5/15/19 revealed that on 5/8/19, Resident #20 used her call bell at 2:11pm to call for assistance. Three hours later, at 5:11pm her call bell was still sounding and had not been responded to.

On 5/15/19 at 10:10am an interview was conducted with Employee J, Information Systems Director. Employee J stated, "the system is programmed so when the call bell is pressed it notifies multiple people. If there is no response after 30 minutes, it resets and resends all of the notifications again." When Employee J was asked to interpret the call bell response log for Resident #20 on 5/8/19, Employee J stated, "it tells me it wasn't responded to." When Employee J was asked what happens when a resident uses their call bell, Employee J and the DON stated, "it activates a notification to the CNA, the supervisor and after a minute the DON and Administrator get a text on their phone."

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On 5/15/19 the DON (Director of Nursing, Employee B) was asked about the incident on 5/8/19 when Resident #20's call bell went off for 3 hours. The DON stated, "I can tell you someone will check- people will come by and pop their heads in."

On 5/15/19 the Administrator stated, "an acceptable time and my expectation is for call bells to be answered within 15 minutes. We don't know what happened at that time, her care is exceptional. I know they get the care they need."

Review of the facility policy titled, "Call light" with an effective date of May 2018, read "Emergency call system will be made available to all residents in room, bathrooms and other areas as deemed necessary. Residents are to have a method to activate the emergency call system herein referred to as call lights in bedrooms and bathrooms."

Review of the facility polity titled, "Responding to call light" with an effective date of, May 2018 read, "All staff to respond to all lights. 1. Respond to location of call light. 2. Ask resident what assistance is needed. 3. If certified to perform care, render care 4. If not certified to render care, notify a member of the nursing team and/or supervisor 5. Please ensure call light is reset."

On 5/15/19 the facility Administrator and DON were made aware of the facility staff's failure to respond to Resident #20's call light for 3 hours.

No further information was provided.

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2. For Resident #28 the facility staff failed to ensure adequate staff available to answer call bells in a timely manner.

Resident #28 is an 84 year old woman originally admitted to the facility with diagnoses of but not limited to Hypertension, History of hip fracture with artificial hip replacement, (Coronary Artery Disease), CAD, Congestive Heart failure and Asthma.

On 3/19/19 Resident was admitted to the facility prior to admission to hospital for planned surgical repair of hardware from prior hip fracture. The Resident went out for surgery on 4/6/19 and was readmitted on 4/12/19. Residents most recent (Minimum Data Set) MDS was dated 3/31/19 and it was a 14 -Day PPS. According to the most recent MDS Resident # 28 had a (Brief Interview of Mental Status) BIMS score of 15/15 indicating no cognitive impairment.

On 5/14/19 at 2:15 PM an interview was conducted with Resident #28 who stated she had no problems with the facility other than the time it took for staff to answer the call bells. She further elaborated by saying "If the staff would answer the call bells this place would be great!" She relayed and incident where she had put the call bell on because she wanted something for her cough. She stated that someone came in and turned the call bell off and told her she would let the nurse know what she needed. She stated

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that happened three times and no nurse came. She stated after that I just got up by myself and walked to the nurses' station to tell her."

On 5/14/19 at 3:00 P.M. an interview was conducted with Employee J (Information Technology), when asked if this surveyor could have a copy of the call bell response times he replied "I don't think I can get that."

When asked what company they use he stated Status Solutions and when asked what program he stated Sara. He was then informed by this surveyor that we request these logs from other facilities using the same system and are able to get them, he stated he would try to get them.

On 5/14/19 at 4:15 PM in an interview with the Administrator she stated, my expectation is for call bells to be answered within 15 minutes. I know they get the care they need.

According to the facility call logs provided by Status Solutions from 5/1/19 through 5/14/19

5/02/19 - Call bell rang from 4:33 PM to 4:56 PM - total 22 min. 21 sec.
50/3/19 - Call bell rang from 7:05 AM to 7:23 AM - total 18 min 10 sec.
5/03/19 - Call bell rang from 7:38 AM to 7:53 AM - total 14 min. 56 sec.
50/3/19 - Call bell rang from 1:33 PM to 1:56 PM - total 22 min 46 sec.
5/04/19 - Call bell rang from 7:59 AM to 8:15 AM - total 16 min. 19 sec.
50/4/19 - Call bell rang from 8:24 PM to 8:50 PM - total 26 min. 5 sec.
5/05/19 - Call bell rang from 8:10 AM to 8:24 AM - total 14 min. 15 sec.

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5/05/19 - Call bell rang from 8:43 AM to 9:18 AM - total 34 min 35 sec.
5/06/19 - Call bell rang from 8:03 AM to 8:19 AM - total of 15 min 46 sec.
5/07/19 - Call bell rand from 7:01 AM to 7:30 AM - total 28 min 41 sec.
5/10/19 - Call bell rang from 7:35 AM to 7:53 AM total of 18 min 7 sec.
5/11/19 - Call bell rang from 7:01 AM to 7:44 AM - total 43 min 37 sec.
5/11/19 - Call bell rang from 12:30 PM to 12:50 PM total of 20 min 10 sec.
5/13/19 - Call bell rang from 4:12 PM to 4:52 PM total of 20 min 40 sec.
5/13/19- Call bell rang from 9:10 PM to 9:27 PM total of 17 min 5 sec.

On 5/15/19 at 4:30 PM in an interview with CNA A stated that Resident # 98 needs assistance to get up and go to the bathroom and she needs help getting out of bed and to her chair.

On 5/16/19 at the end of day meeting the Administrator was made aware of the issues with answering call bells timely and no further information was provided.

3. The facility staff failed to ensure adequate staff available to answer call bells in a timely manner.

Resident # 190 a 59 year old woman admitted to the facility on 5/9/19 the Resident has no (Minimum Data Set) MDS information available as she is a new admission. The Resident was admitted to the facility with diagnoses of but not limited to recent Right hip replacement surgery, foot drop in Right foot, difficulty walking, general

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weakness, (Chronic Obstructive Pulmonary Disease) COPD, Atrial Fibrillation and Diabetes.

On 5/14/19 at 2:25 PM an interview was conducted with Resident #190 who stated the staff take too long to answer call bells. She stated that the facility is nice but if you have to use the bathroom 20 minutes is way too long to wait.
When asked what type of assistance she requires Resident #190 stated she had a hip replacement surgery but something went wrong and she ended up with foot drop as well so she is unable to ambulate or transfer alone.

On 5/14/19 at 3:00 P.M. an interview was conducted with Employee J (Information Technology), when asked if this surveyor could have a copy of the call bell response times he replied "I don't think I can get that."

When asked what company they use he stated Status Solutions and when asked what program he stated Sara. He was then informed by this surveyor that we request these logs from other facilities using the same system and are able to get them, he stated he would try to get them.

On 5/14/19 at 4:15 PM in an interview with the Administrator she stated, my expectation is for call bells to be answered within 15 minutes. I know they get the care they need.

According to the facility call logs provided by Status Solutions from 5/1/19 through 5/14/19

5/9/19 - Call bell rang from 7:14 AM to7:31 AM - total 17 min. 18 sec.
5/10/19 Call bell rang from 9:17 AM to 9:37 AM

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total 19 min 40 sec.
5/10/19 Call bell rang from 12:35 PM to 12:50 PM
total 15 min 9 sec.
5/11/19 Call bell rang from 1:38 AM to 1:55 AM
total 16 min 42 sec
5/11/19 Call bell rang from 2:30 PM to 3:06 PM
total 19 min 32 sec.
5/11/19 Call bell rang from 5:59 PM to 6:15 PM
total 15 min 56 sec.
5/12/19 Call bell rang from 1:44 PM to 2:15 PM
total 31 min 45 sec.
5/12/19 Call bell rang from 3:02 PM to 3:22 PM
total 19 min 32 sec.
5/14/19 Call bell rang from 8:19 AM to 8:42 Am
total 23 min 4 sec.

On 5/16/19 at the end of day meeting the Administrator was made aware of the issues with answering call bells timely and no further information was provided.

4. For Resident #189 the facility staff failed to provide sufficient staff to safely lift Resident using Hoyer which resulted in an injury.

Resident #189 a 96 year old woman was admitted to the facility on 6/19/12 with diagnoses of but not limited to Dementia, Hypertension, Diabetes, Hypothyroidism, Chronic ischemic heart disease, Congestive heart failure, and abnormal posture.

Resident #189's most recent (Minimum Data Set) MDS a quarterly with an ARD date of 3/16/19 codes Resident #189 as having a (Brief Interview of Mental Status) BIMS score of 00/15 which indicates severe cognitive impairment. Resident

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is also coded as being total assistance for all aspects of (Activities of Daily Living) ADL's. She is coded as requiring 2 or more people to perform her care and the use of Mechanical Lift for transferring from bed to chair or wheelchair.

Resident #189 is the subject of a (Facility Reported Incident) FRI that was submitted to the OLC on 1/16/19.

The FRI states that on 1/16/19 at approximately 11:30 AM the CNA that was working with Resident #189 reported to the LPN and Nursing supervisor that the resident was crying out in pain when she was touched on her right lower leg. The nurse examined and found swelling to the ankle area. The family and the MD were notified and the MD ordered X-Rays. The FRI also states that at 4:30 PM the X-Ray results arrived with a diagnosis of Acute Non-displaced fracture of right distal fibula. The MD and family were notified of the diagnosis and the MD ordered continuation of stabilization and follow up with orthopedics/ podiatry the following morning.

On 5/15/19 at 2:00 PM an interview was conducted with the DON who stated that once she was told that there was a fracture involved she initiated a "Fracture (of unknown cause) Investigation Form"

The DON submitted all of the statements and results of her investigation and also stated that the cause of the fracture was improper use of the mechanical lift. She elaborated to say that the CNA that was working with Resident #189 failed to obtain help from a coworker. She stated at all times there should be 2 persons operating the mechanical lift.

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The DON further stated that she did training on all direct care staff after the incident.

According to the statement by the CNA who worked with Resident #189 on 1/15/19 from 3:00 PM to 11:00 PM "Requested assistance multiple times to help with residents transfer to bed-unable to obtain assistance-transferred via Hoyer lift / mechanical lift to bed."

According to facility Policy for Full Body Lift

Policy: All CNA's will be trained in safe and appropriate use of the full body lift. Any time the full body lift is used, there must be 2 trained staff members present to ensure staff and resident safety.

On 5/16/19 the Administrator was made aware of the issues involving the transfer without adequate number of staff and subsequent injury to Resident #189 and no further information was provided.

5. For Resident #12, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 2 of 14 opportunities the call light was activated

Resident #12, an 85-year old male, was admitted to the facility on 08/24/2018. Diagnoses included but not limited to spastic hemiplegia, paralytic syndromes, muscle weakness, depression, and flaccid neurogenic bladder. Cognitive disorders were not on the list of diagnoses.

Resident #12's most recent Minimum Data set

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with Assessment Reference Date of 02/13/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as a 6 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, dressing, and personal hygiene were coded as requiring extensive assistance from staff.

On 05/14/19 at approximately 12:00 PM, an interview with Resident #12 was conducted. Resident #12 was in bed with the head of the bed elevated approximately 45 degrees. When asked if the facility staff answered the call light promptly when he needed assistance, Resident #12 stated, "Sometimes it seems like it takes forever for staff to come." Resident #12 stated that sometimes he needs help positioning in the bed and calls for assistance.

On 05/14/19 at 2:55 PM, call logs for the past week for the health center were requested from Employee J from the information technology department.

On 5/14/19 at 4:15 PM in an interview with the Administrator she stated, my expectation is for call bells to be answered within 15 minutes. She stated that she didn't know why they were longer perhaps staff forgot to cut off the call bell and was in the room doing care.

On 05/15/2019 at approximately 9:00 AM, the facility staff provided call logs for Resident #12 with a date range of 05/08/2019 through 05/13/2019. Of the 14 times the call light was activated, there were 2 instances where the duration was longer than 15 minutes. On 05/12/2019 at 7:11 AM, the duration was 21 minutes and 7 seconds. On 05/12/2019 at 10:22

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PM, the duration was 30 minutes and 2 seconds.

On 05/15/19 at approximately 10:10 AM, an interview with Employee J was conducted. Employee J stated that the system is programmed to do certain things when the button is pushed. Employee J stated that the activated call bell routes to the certified nurse assistant (CNA) pager. If it isn't answered, it flows over to nurse pager.

The facility staff provided a copy of their policy entitled, "Responding to call light." The listed procedures documented, "1. Respond to location of call light. 2. Ask resident what assistance is needed. 3. If certified to perform care, render care. 4. If not certified to render care, notify a member of the nursing team and/or supervisor. 5. Please ensure call light is reset."

On 05/16/2019 at approximately 2:30 PM, the Administrator stated they had no further documentation or information to offer.

6. For Resident #15, the facility staff failed to answer the call light in a timely fashion to provide needed care and services for 3 of 15 opportunities the call light was activated.

Resident #15, an 89-year old female, was admitted to the facility on 10/10/2017. Diagnoses included but not limited to chronic kidney disease, dementia without behavior disturbance, Parkinson's disease, cognitive communication deficit, muscle weakness, and difficulty in walking.

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Resident #15's most recent minimum Data set with an Assessment Reference Date of 02/20/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 12 out of possible 15 indicative of moderate cognitive impairment. Functional status for bed mobility, transfers, dressing, and toileting was coded as requiring extensive assistance from staff.

On 05/14/19 at approximately 1:55 PM, an interview with Resident #15 was conducted. When asked if the staff answer the call light promptly when she needs assistance, Resident #15 stated, "Sometimes it's a long time before they come." Resident #15 stated that she needs help to get into her chair or to get positioned for a nap. Resident #15 also stated, "I can't get up by myself."

On 05/14/19 at 2:55 PM, call logs for the past week for the health center were requested from Employee J from the information technology department.

On 5/14/19 at 4:15 PM in an interview with the Administrator she stated, my expectation is for call bells to be answered within 15 minutes. She stated that she didn't know why they were longer perhaps staff forgot to cut off the call bell and was in the room doing care.

On 05/15/2019 at approximately 9:00 AM, the facility staff provided call logs for Resident #12 with a date range of 05/08/2019 through 05/14/2019. Of the 15 times the call light was activated, there were 3 instances where the duration was longer than 15 minutes.
On 05/08/2019 at 9:23 AM, the duration was 28

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minutes and 43 seconds.
On 05/11/2019 at 7:56 PM, the duration was 23 minutes and 24 seconds.
On 05/13/2019 at 4:26 PM, the duration was 15 minutes and 31 seconds.

On 05/15/19 at approximately 10:10 AM, an interview with Employee J was conducted. Employee J stated that the system is programmed to do certain things when the button is pushed. Employee J stated that the activated call bell routes to the certified nurse assistant (CNA) pager. If it isn't answered, it flows over to nurse pager.

The facility staff provided a copy of their policy entitled, "Responding to call light." The listed procedures documented, "1. Respond to location of call light. 2. Ask resident what assistance is needed. 3. If certified to perform care, render care. 4. If not certified to render care, notify a member of the nursing team and/or supervisor. 5. Please ensure call light is reset."

On 05/16/2019 at approximately 2:30 PM, the Administrator stated they had no further documentation or information to offer.

7. For Resident #6, the facility staff failed to provide activities of daily living care in a timely manner.

Resident #6 was an 89 year old who was admitted to the facility on 2/18/18. Resident #6's diagnoses included Generalized Muscle Weakness, History of Falls, Difficulty in walking, Arthritis, Polyneuropathy, Hypertension, and

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Unspecified Cataract.

The Minimum Data Set, which was an Annual Assessment, with an Assessment Reference Date of 1/3/19 was reviewed. Resident #6 was coded as having a Brief Interview of Mental Status Score of 8, indicating moderate cognitive impairment. In addition, Resident #8 was coded as not having any mood or behavioral issues.

On 5/15/19 at 8:31 A.M., an observation was conducted of Resident #6 in her bed. Resident #6's call bell was on the floor, out of reach. Resident #6 stated that she had no way to let the staff know what she needed. She said that due to the wound on the back of her knee, it was difficult for her to get up and use her walker, when it was time for her to go to the bathroom. Resident #6 stated that she didn't remember the last time that the call bell was within reach.

On 5/15/19 a review was conducted of facility documentation. The call bell response log was reviewed. During the previous 7 days, the call bell had not been activated during any shift.

On 5/15/19 at 2:30 P.M., a Group Interview was conducted. The group unanimously agreed that their call bells were not routinely answered in a timely manner. They stated that it usually took staff between 30 minutes and one hour to answer the call bell. They further stated that the facility had reduced the number of available Certified Nursing Assistants, and that additional staff were needed to meet their needs.

On 5/15/19 at approximately 3:30 P.M., an interview was conducted with the facility Administrator (Employee A). The administrator

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F 725	Continued From page 72 stated, "The resident probably knocked the call bell off the bed." No further information was provided.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		6/28/19

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F 755	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain an accurate record for a controlled medication. Facility staff failed to account for the receipt of a controlled medication from the pharmacy. The Findings included: On 05/15/2019 at approximately 10:30 AM, an inventory of refrigerated controlled medications was conducted with LPN C in the medication storage room. A partial bottle of lorazepam oral concentrate [syrup] 2mg/ml, prescription #9981672, contained 20 ml [millilters] but was documented as 24.50 ml on the individual inventory sheet. LPN C stated, "I don't know how that happened, I see 20 in the bottle but the sheet is 24.5". Two unopened bottles of lorazepam suspension 2mg/ml, prescription #10018839 and #10073360, each containing 30 ml, were observed with seals intact, however there was no record of either bottle on inventory. LPN C had no response when asked about the accounting for the bottles. At approximately 10:40, the Assistant Director of Nursing (ADON, Employee C) and Employee P were informed of the findings. The ADON and Employee P conducted an inventory of the refrigerated lorazepam. The ADON stated, "Our accounting is not accurate, we need to look into this and fix it". On 05/15/2019, a copy of the facility policy regarding controlled medications was requested and received. The facility policy entitled "Storage and Expiration of Medications, Biologicals,	F 755	F755 Pharmacy was notified to assist in investigation to determine root cause of the delivery of controlled medication without a record of receipt and controlled medication count sheet. 100% audit of all controlled medications was completed on June 6 by Director of Nursing to ensure that all controlled medications have record of receipt and accurate counts. Licensed and registered nurses in-serviced on process for receiving controlled drugs, documentation for controlled medications and process for counting and reconciling controlled medication daily per shift. Affected staff receive individualized coaching by center's ADON/Staff development coordinator. Center will destroy control substances on scheduled days and as needed. Supervisors to monitor nurse counts at conclusion of shift for accuracy. Nursing supervisor or designee will audit the controlled medication count sheet and controlled medications daily for 2 weeks. If no discrepancy is identified then the nursing supervisor will audit the controlled medication count sheet and controlled medications three times weekly for 3 months. Director of Nursing or designee will audit 50% of medication administration record and controlled medication count sheets weekly for 1 month and then monthly for 3 months. Any discrepancies identified will be investigated and education provided to	

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F 755	Continued From page 74 Syringes and Needles", revision date 10/31/16, had "Procedure" item 12, "Controlled Substances Storage:", item 12.2, "After receiving controlled substances and adding to inventory...". The facility policy entitled "Inventory Control of Controlled Substances", revision date 01/01/13, had "Procedure" item 2, "Facility should ensure that facility staff count all Schedule 111-V controlled substances in accordance with facility policy and applicable law" and item 5, "A facility representative should regularly check the inventory records to reconcile inventory".	F 755	ensure compliance. Director of Nursing to present findings from audit to QAPI for 3 months	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced	F 757		6/28/19

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F 757	Continued From page 75 by: Based on staff interview facility documentation and clinical record review the facility staff failed to ensure Residents are free from unnecessary medications for 1 Resident (#25) in a survey sample of 25 Residents. For Resident #25 the facility staff administered Tylenol 650 mg on three occasions when Resident has pain rating of 0/10. The findings include: Resident #25 is an 86 year old woman admitted to the facility on 4/25/18 with diagnoses of but not limited to Dementia with behavioral disturbance, Hypertension, Use of Anti-Coagulants, diabetes and stage 3 chronic kidney disease, osteoporosis and feeding difficulties. Resident #25's most recent (Minimum Data Set) MDS was dated 4/3/19 and it was an annual. According to the most recent MDS Resident # 25 had a (Brief Interview of Mental Status) BIMS score of 00/15 indicating severe cognitive impairment. On 5/14/19 during clinical record review it was noted that Resident # 25 had received Tylenol 650 (milligrams) mg without indication for use on three separate occasions. The Medication Administration records read as follows: On 2/15/19 Resident has pain rating of 0 for entire month but Tylenol 650 mg was administered at 9:40 AM	F 757	F757 Resident #25 is a current resident at the nursing center. Resident's physician was notified of medication administration, no new orders given, no adverse reaction noted. A 100% MAR review for PRN pain medications administration for the last 2 weeks will be conducted to identify other residents who may have PRN pain medication in the absence of having documented pain level. If variance is found, the physican will be notified and responsible nurse will be reeducated and/or counseled. Licensed and registered nurses will be reeducated on protocol for administering PRN pain medication. Residents will be assessed prior to administering PRN pain medications for need and assessed after administration for effectiveness. DON will conduct a weekly audit for 12 weeks of 25% PRN pain medications administered to ensure appropriateness and accuracy in documentation and present findings to QAPI for 3 months	

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F 757	Continued From page 76 On 4/17/19 Resident has pain rating of 0 for all entire month but Tylenol 650 mg was administered at 8:19 PM On 5/9/19 Resident has pain rating of 0 every shift for entire month but Tylenol 650 mg was administered at 4:15 PM On 5/14/19 at 4:00 PM in an interview with the DON when asked why the pain ratings were all 0 yet the Resident was given Tylenol 650 mg. she stated well they must have entered the pain rating of 0 before they gave her the Tylenol. When asked for nurses notes to support the use of Tylenol she did not find any notes related to pain. During the end of day meeting on 5/16/19, the Administrator was made aware of the issue with unnecessary meds and no further information was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		6/28/19

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F 758	Continued From page 77 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure resident's are free from unnecessary psychotropic medication use for one Resident (Resident #19) in a survey sample of 25 Residents .	F 758	F0748 Resident 19 is a current resident. New orders obtained to administer Seroquel 25 mg 1/2 tab po q hs secondary to diagnosis of Dementia with BPSD. Behavior log initiated. A review of	

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F 758	Continued From page 78 For Resident #19, the facility staff failed to ensure the medication regime was free from unnecessary psychotropic medications. The findings included: Resident #19, was admitted to the facility on 7/5/18. The Resident's diagnoses included but were not limited to: UTI, retention of urine, unspecified lack of coordination, cognitive communication deficit, dysphagia, extend spec beta lactamase resistance, parkinsons, unspecified dementia without behavioral disorder, hypotension, and unspecified OA (osteoarthritis). Resident #19's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/20/19 was coded as a quarterly assessment. Resident #19 was coded as having a BIMS (brief interview for mental status) score of 11, which indicated moderately impaired cognition. The Resident was coded as requiring extensive assistance of staff for bed mobility, transfers, dressing, and personal hygiene. For toileting and bathing the Resident was totally dependent upon staff. Review of the physician orders for Resident #19 revealed that on 9/24/18 an order was written, that read "seroquel 25 mg 1/2 tab po q hs [by mouth at bedtime] for hallucinations/nightmares." A physician progress note dated 9/24/18 read, "Pt's history is supplemented by staff and RP [name redacted]. Pt is having recurrence of hallucinations per RP. She states she previously was on Seroquel to help and had been taken off	F 758	resident 19's treatment administration Record for the last 60 days yielded a documented behavior noted on May 6. Notes from Geriatric Psychiatrist dated May 14 reads "Dementia with BPSD. I see no evidence of sedation. Husband understands the situation. Goal continues to be comfort therefore no dose reduction indicated". Note from Geriatric Psychiatrist visit dated 4/23/2019 reference BPSD diagnosis and states "Benefit of Seroquel continue" a 100% audit of residents receiving an antipsychotic medication will be completed to ensure that the resident has a diagnosis supporting the use of the antipsychotic and that behaviors are being monitored licensed and registered nurses educated on documenting behaviors and ensuring medication changes and recommendations are consistent with documentation. Interdisciplinary staff to be educated on use of behavior log Director of nursing to conduct audit residents on psychotropic medications to ensure all orders have appropriate diagnosis and accompanying documentation twice monthly for 12 weeks. Director of Nursing will present results of audits to QAPI for 3 months	

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F 758	Continued From page 79 when she had extreme AMS in July. RP requesting she be put back on medication. Pt denies any pain or dysuria. Pt has many UTI's and writer discussed she has completed recent course of abx 9/22 and will start prophylaxis with Hiprex and vitamin C." Review of the entire clinical record to include but not limited to, physician progress notes, nursing notes, social services notes, psychiatry notes, and careplan revealed no documentation of any behaviors or hallucinations. Review of the MAR (Medication administration record) for May 2019 revealed that Resident #19 continues to receive Seroquel 25mg, 1/2 tab at bedtime for hallucinations. On 5/16/19 during an interview with the DON, when asked about the use of Seroquel and documentation to support the use, the DON stated, "there isn't any, activities said they had seen her hallucinate and I told them to document it. I am not aware of any behaviors and see your concern." The DON was made aware of the facility staff's failure to ensure Resident #19 was free of unnecessary psychotropic medication use on 5/16/19. No further information was provided.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		6/28/19

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F 760	Continued From page 80 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to prevent significant medication errors. The facility failed to administer insulin on 5 separate occasions for 3 of 25 sampled residents. 1. For Resident #7, the facility staff failed to administer 2 consecutive doses of insulin on 05/12/2019 as indicated by sliding scale per physician's orders. 2. For Resident # 190 the facility staff omitted giving insulin at 4:30 PM on two consecutive days. 3. For Resident #5, the facility staff failed to ensure insulin was administered on 5-11-19 as ordered by a physician. The findings included: 1. For Resident #7, the facility staff failed to administer 2 consecutive doses of insulin on 05/12/2019 as indicated by sliding scale per physician's orders. Resident #7, a 78-year old female, was admitted to the facility on 02/20/2018. Diagnoses included but not limited to diabetes, peripheral vascular disease, hypertension, aphasia following cerebral infarction, and generalized muscle weakness. Resident #7's most recent Minimum Data Set with an Assessment Reference Date of 01/30/2019 was coded as an annual assessment.	F 760	F760 Resident 7 and 5 are current resident of the nursing center. Resident 190, 7 and 5's physicians were notified of medication error, no adverse effect noted. Resident 190 is no longer a resident. Current residents with orders for insulin administration may have potentially been impacted. 100% audit of current residents orders for insulin administration were reviewed for the past 2 weeks. If variances are found the physician will be notified and responsible party will be re-educated Coaching and individual reeducation, with return demonstration, conducted with involved nurse. Nurses in serviced on insulin administration and accurate documentation. Nursing supervisor to review MAR for residents on insulin weekly for 12 weeks to ensure appropriate interventions were follow and documented accurately. ADON to present a summary of daily insulin medication administration audit monthly to QAPI for the next 3 months	

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F 760	Continued From page 81	F 760		

The Brief Interview for Mental Status was coded as 3 out of possible 15 indicative of severe cognitive impairment. Number of days insulin injections were received was coded as 7.

On 05/14/2019 at approximately 3:00 PM, the current physician's orders were reviewed. An excerpt of an order dated 01/14/2019 documented, "Humalog 100unit/ml subcutaneous solution sliding scale check QID (four times a day) FS (fasting sugar) 200 or less give 0 units; 201-250 give 2 units; 251-300 give 4 units; 301-350 give 6 units; 351-400 give 8 units; greater than 400 give 1 units, call MD, recheck in 1 hour."

The Medication Administration Record for May 2019 was reviewed. On 05/12/2019 on the line "BfrBrkfst (before breakfast)", the blood sugar was recorded as 210. Just below it on the line "units", it was documented 0 (units). On the line "BfrLunch (before lunch), the blood sugar level was documented as 283. Just below it on the line "units", it was documented 0 (units).

The meal intake flowsheet was reviewed. It was documented that Resident #7 consumed 51-75% of her meal for dinner on 05/11/2019. For 05/12/2019, Resident #7 consumed 76-100% of her breakfast and 26-50% of her lunch.

On 05/15/19 10:24 AM , the findings were shared with the DON. When asked about her expectations for insulin administration, she stated she expects insulin to be administered as ordered. The DON then looked at the electronic health record of Resident #7 and stated she was unable to find a reason why the insulin was not given.

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F 760	Continued From page 82	F 760		

The facility staff provided a copy of their policy entitled, "Sliding Scale Insulin." The policy documented, "A physician protocol for the use of sliding scale insulin will be used in the nursing center." The procedure documented, "The following scale will be initiated upon admission for residents of [physician names]: Regular human insulin finger sticks AC & HS (before meals and at bedtime) FS (fasting sugar) below 200 - 0 units; 201-250 - give 2 units; 251-300 - give 4 units; 301-350 - give 6 units; 351-400 - give 8 units; Above 400 - give 10 units, call MD, recheck in 1 hour."

On 05/16/2019 at approximately 2:30 PM, the Administrator stated they had no further documentation or information to offer.

2. For Resident # 190, the facility staff omitted giving insulin at 4:30 PM on two consecutive days.

Resident # 190, a 59 year old woman admitted to the facility on 5/9/19. The Resident had no (Minimum Data Set) MDS information available as she was a new admission. The Resident was admitted to the facility with diagnoses of but not limited to recent Right hip replacement surgery, foot drop in Right foot, difficulty walking, general weakness, (Chronic Obstructive Pulmonary Disease) COPD, Atrial Fibrillation and Diabetes.

On 5/15/19 during clinical record review, it was noted that Resident #190 had orders for the following insulin :

Humalog Mix 75/25 Insulin 100 Units/ (Milliliter)

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ml subcutaneous suspension [Insulin lispro protamine-lispro] give 10 Units subcutaneously twice daily HOLD FOR BLOOD SUGAR [LESS THAN] < 125

It was noted that :
5/12/19 at 4:30 PM the Resident's blood sugar was 133 and insulin was not given
5/13/19 at 4:30 PM the Resident's blood sugar was 159 and insulin was not given

On 5/15/19 at 1:43 PM, copies of (Medication Administration Record) MAR was submitted and reflected the insulin not being given.

On 5/16/19 at 8:30 AM during an interview with the DON (Director of Nursing), she stated that she checked with the LPN (Licensed Practical Nurse) who gave medications to that resident and that the LPN stated the insulin was refused by the Resident.

She then produced another MAR with the last page stating Resident refused Insulin on 5/9/19 at 8:30 AM, 5/11/19 at 8:10 AM, 5/12/19 at 8:21, 5/14/19 at 8:10 and 5/15/19 at 8:09AM.

She produced nothing to address the insulin on 5/12/19 at 4:30 or 5/13/19 at 4:30 PM.

On 5/16/19 during the end of day conference, the Administrator was made aware of the issues with medication administration.

No further documentation was provided.

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F 760	Continued From page 84	F 760		

3. For Resident #5, the facility staff failed to ensure insulin was administered on 5-11-19 as ordered by a physician.

Resident #5, was admitted to the facility on 5-11-18. Diagnoses included diabetes, sarcoidosis, and long time insulin use.

Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-24-19 was coded as an annual assessment. Resident #5 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. Resident #5 was also coded as requiring extensive assistance to total dependence on one to two staff members to perform activities of daily living, such as hygiene, and bed mobility.

On 5-14-19 at 12:00 noon, Resident #5 was observed in her room in bed. A Resident interview was conducted, and the Resident stated she did not receive her insulin as she should from staff.

Review of the resident's clinical record revealed the resident's current POS (physician order sheet), and MAR (Medication Administration Record) for May 2019. Contained was an order for Novolog insulin per sliding scale with fingerstick blood sugars (FSBS) three times per day. If the Resident's blood sugar was above 251 and below 300, give 4 units of the insulin by subcutaneous injection. On 5-11-19 the Resident's FSBS was 254, and no insulin was given, and was documented as such by the nurse.

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F 760	Continued From page 85 Review of the medication and nursing notes revealed no documentation as to why the insulin was not given. Review of the facility policy revealed that only trained nurses would administer insulin by the physician's orders. On 5-15-19 at 5:00 p.m., the DON (director of nursing) was notified of above findings. The DON stated, "The medication should have been given."	F 760		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide an appropriate alternative to accommodate a food allergy for 1 resident (Resident #290) in a sample size of 25 residents. For Resident #290, the facility staff failed to provide any alternative dessert at the lunch meal on 05/14/2019 to accommodate her food allergies.	F 806	F0806 Resident 290 is no longer a resident at the nursing center. Other residents with food allergies may have potentially impacted. a 100% audit will be completed to ensure that resident food allergies are identified in dietary instructions for meal preparation. Residents with known allergies will be provided dietary alternatives. Staff, nursing and dietary included, will be in-serviced on reading the meal tickets	6/28/19

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F 806	Continued From page 86 The Findings included: Resident #290, a 71 year old female who was admitted to the facility on 05/03/2019 with diagnoses to include but not limited to chronic obstructive pulmonary disease (COPD), shortness of breath, acute respiratory failure, and malnutrition. Resident #290's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/2019 was coded as admission from an acute hospital. A comprehensive MDS is pending and the physician's admitting assessment read, "Cognition WNL (within normal limits), AOX4 (alert and oriented to person, place, time, and situation), pleasant, no agitation, able to answer all questions appropriately, able to follow simple commands". On 05/14/2019 at approximately 12:45 PM, Resident #290 was observed sitting in her room eating her lunch. She stated, "I filled out a menu with food selections but they did not give me any dessert. I had selected the regular almond cake and someone drew a frowning face on it with an arrow saying contains chocolate. I guess that's all they have because I didn't get anything else, no one offered anything different to me, and they didn't even give me the Gelato supplement that the doctor ordered for me". No dessert items or nutritional supplements were observed on her lunch tray. On 05/14/2019 at approximately 1:50 PM, a staff interview was conducted with the Registered Dietician (Employee L) who stated, "If she (Resident #290) has allergies, we do not serve food that can harm her, we find a replacement for	F 806	and ensuring meal accommodates residents allergies, intolerance and preferences. Dietary staff will be reeducated on the importance of reading meal tickets to identify known food allergies during tray preparation and/or meal service Director of Dining Operations to conduct random audits on %25 of meals delivered to nursing center weekly for 12 weeks for accuracy. Director of Dining services to provide results of audit to QAPI for 3 months	

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	495280	A. BUILDING _____ B. WING _____	05/16/2019

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F 806	Continued From page 87 that item, I do not know why she wasn't offered a substitution, although looking at her tray ticket it also states that she is allergic to yellow dye and it just so happens that the other cake today contained yellow dye, so that's probably why she wasn't given anything else but we could have worked with her". No further information was received. On 05/16/2019, a review was conducted of Resident #290's clinical record. A comprehensive nutritional evaluation dated 05/06/2019 read: "allergic to chocolate and yellow dye, current wt: 81 (pounds), BMI (body mass index): 14, Interpretation: severely underweight.	F 806		
F 880 SS=E	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	F 880		6/28/19

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conducted according to §483.70(e) and following accepted national standards;

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

§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

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F 880	Continued From page 89 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to follow infection prevention protocols. The dietary manager was observed not wearing personal protective equipment (PPE) in the room of a resident on contact isolation for clostridium difficile. The dietary manager then exited the room without washing hands and entered two other resident rooms without performing hand hygiene. The findings included: On 05/16/19 at 08:35 AM, the dietary manager was observed in the room of Resident #92. There was personal protective equipment stationed outside the room door and a Stop sign posted next to the door. The dietary manager was observed standing inside the room talking with Resident #92 (seated in a chair) and a family member (standing next to Resident #92). The dietary manager and the family member were not wearing PPE. The dietary manager was observed shaking the family member's hand then stooped down next to Resident #92, leg touching the side of the chair, and placed his hand on Resident #92's back/shoulder. LPN A was observed to pass by the room 3 times, looked in the room once, then kept walking past the room without comment. The dietary manager then left the room	F 880	F0880 Dietary manager has been reeducated on transmission-based precautions and the appropriate use of PPE. An initial audit of Dietary and Life Enrichment staff yielded no other incidents of not following transmission-based precautions PPE and/or hand hygiene protocol. non-nursing personnel will be re-educated and observed for compliance in use of PPE for transmission-based precautions and hand hygiene protocol. ADON to observe 2 residents requiring infection precautions weekly for 12 weeks to ensure staff are using appropriate PPE and hand washing. ADON will audit compliance and bring evidence to QA for three months.	

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of Resident #92 and entered the room of Resident #91 and spoke briefly to her without making physical contact. The dietary manager then exited Resident #91's room and entered the room of Resident #239. The dietary manager was observed touching the left bedrail as he spoke to Resident #239 who was lying in bed at the time. The dietary manager then exited Resident #239's room, walked down the hall, activated 2 sets of doors by pressing the door plates, touched the doorknob to open the dietary manager's office, then turned around and got on the elevator. The dietary manager did not perform hand hygiene from the time he left Resident #92's room to the time he got on the elevator.

On 05/16/19 at 08:49 AM, the DON was asked if Resident #92 was on isolation and she stated she would need to check.

On 05/16/19 at 09:03 AM, the ADON was asked if Resident #92 was on isolation and she stated, "Yes, he is on contact precautions for C diff." When asked about the process for observing contact precaution, the ADON stated that staff should wash their hands, don PPE before entering room, remove PPE in room, and immediately wash hands before leaving room. When the ADON was updated on the observations made of dietary manager, the ADON stated the dietary staff was "supposed to be mindful of that (policy)" and report to the nurse first so they will "use appropriate PPE" when entering a resident's room.

On 05/16/2019, an interview with the dietary manager was conducted. When asked about the process for entering a room of a resident on isolation, he stated he normally won't enter an

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isolation room but if required, he would first stop and ask the nurse what proper equipment to wear before entering room. When shared concerns about not donning PPE before entering Resident #92's room, the dietary manager stated he didn't know Resident #92 was still on isolation because he was scheduled to be discharged today (05/16/2019).

The facility staff provided a policy entitled, "Handwashing/Hand Hygiene." In Section 5 (e), it was documented, "Employees must wash their hands for at least twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after entering isolation precaution settings."

On 05/16/2019 at approximately 2:30 PM, the Administrator stated they had no further documentation or information to offer.