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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 6/24/19 through 6/27/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| E 015 SS=C | Subsistence Needs for Staff and Patients<br>CFR(s): 483.73(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. | E 015 | 1. Staff will be educated on fire watch procedures. The facility will amend its Federal Emergency Preparedness Plan (Fed EPP) to include sewage and waste disposal services.<br>2. There is only one required Federal EP, therefore no additional reviews were needed.<br>3. The ED (Executive Director) educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- Subsistence Needs for Staff and Patients specific to policies for the provision of subsistence needs, and will continue to monitor in accordance with the standard.<br>4. Any findings will be reported to the monthly QAPI Committee for further review.<br>5. AOC Date: 08/06/19 | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Rhoades Kreutter | Executive Director | 07/24/19 |

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

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| E 015 | Continued From page 1 | E 015 | | |

(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to provide documentation that the emergency preparedness plan addressed Fire Watch training for staff; and for provisions for sewage and waste disposal services during an emergency.

The findings included:

The facility emergency preparedness plan failed to have documentation of staff Fire Watch training and for the provision of sewage and waste disposal services during an emergency.

During a review of the emergency preparedness plan on 06/26/19 at 1:20 P.M., the administrator was asked for documentation concerning Fire Watch training for staff and for sewage and

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| E 015 | Continued From page 2<br>waste disposal services. The administrator stated he did not have documentation of the facility having sewage and waste disposal services. A review of employee training records did not indicate staff had been trained in the Fire Watch process. | E 015 | | |
| E 037 SS=C | EP Training Program<br>CFR(s): 483.73(d)(1)<br><br>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:<br><br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The | E 037 | 1. The facility will amend its Fed EPP to include an initial emergency preparedness training program for staff.<br>2. There is only one required EPP, therefore no additional reviews were needed.<br>3. The ED (Executive Director) educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- EP Training and Testing specific to providing staff with initial and annual training on the emergency plan. The Executive Director/ designee will educate staff on the facility emergency plan. Emergency plan training will be added to the facility's training calendar, and will continue to be monitored in accordance with the standard.<br>4. Any findings will be reported to the monthly QAPI Committee for further review.<br>5. AOC Date: 08/06/19 | |

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| E 037 | Continued From page 3 | E 037 | | |

hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

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| E 037 | Continued From page 4<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected | E 037 | | |

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| E 037 | Continued From page 5 | E 037 | | |

roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have an initial emergency preparedness training program.

The findings included:

During an interview on 06/26/19 at 2:22 P.M. with the administrator, he was asked for documentation for an initial training program in emergency preparedness policies and procedures for all new new and existing staff. The administrator stated, the facility had not conducted an initial training program for emergency preparedness.

The facility staff failed to have an initial emergency preparedness training program.

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| F 000 | Continued From page 6 | F 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted from 6/24/19 through 6/27/19. Seven complaints were investigated during survey. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census at this 114 certified bed facility was 110 at the time of the survey. The survey sample consisted of 49 current record reviews and 8 closed records. | F 000 | | |
| F 561 SS=E | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the | F 561 | 1. Resident #108 shower preferences were updated.<br>2. All residents that reside in the facility are at risk for not having shower preferences followed as indicated in the comprehensive care plan. An audit was completed to ensure current residents shower preferences have followed by 08/01/19.<br>3. The DCS (Director of Clinical Services) or designee will educate nursing staff to ensure residents receive showers as preferred and as indicated on the care plan.<br>4. The DCS or designee will audit to ensure shower preferences are honored weekly for 5 residents weekly for four weeks, then 5 residents monthly for 3 months. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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| F 561 | Continued From page 7 | F 561 | | |

facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, staff interviews, resident interview, and facility document review the facility staff failed to ensure that shower preferences were followed for one of 57 residents in the survey sample, Resident #108.

The facility staff failed to ensure that Resident #108's shower preferences were followed as indicated in the comprehensive care plan.

The findings included:

Resident #108 was originally admitted to the facility on 6/29/18 and readmitted on 12/6/18 with diagnoses to include but not limited to, Spina Bifida, Mild Intellectual Disabilities and Bipolar Disorder.

Resident #108's most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 5/30/19. The Brief Interview for Mental Status was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under Section G Functional Status G0120 Bathing Resident #108 was coded as requiring total dependence with one person physical assist.

Resident #108's Comprehensive Care Plan was

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reviewed and is documented in part, as follows:

Focus: Name (Resident #108) has an ADL (activities of daily living) self-care performance deficit related to late loss adl's as exhibited by: increased need for assist with adl's. Date Initiated: 10/27/18

Interventions: BATHING SHOWERING: she requires total assistance by one to two staff with bathing and showering-prefers twice a week and as necessary. Date Initiated: 10/27/18.

On 6/25/19 at 1:45 P.M. Resident #108 was asked what was her preference for bathing. Resident #108 stated, "I take a bed bath most of the week but I prefer to have a shower twice a week. My shower days are Monday and Thursdays on the 3-11 shift. I'm lucky if I get a shower once a month. My preference is to have a shower twice a week so I can wash my hair and it makes me feel better."

The Shower Schedule for the Green Unit was reviewed. According to the Shower Schedule Resident
#108 is to receive showers on Mondays and Thursdays.

Resident #108's ADL CNA (Certified Nursing Assistant) Flow sheets for April, May, and June of 2019 were reviewed and are documented in part, as follows:

April 2019-Resident #108 received a shower on 4/19/19 and 4/29/19.
May 2019-Resident #108 received a shower on 5/9/19.
June 2019-Resident #108 had received no

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showers as of 6/24/19.

On 4/27/19 an interview was conducted with the Assistant Director of Nursing (ADON) who was also filling in as the Green Unit Manager. The ADON was asked to review the Green Unit Shower Schedule and then Resident #108's ADL Flow sheets and to tell me when the resident had received a shower. The ADON stated, "Her (Resident #108) shower days are Monday and Thursdays. It looks like she got 2 showers in April, one in May and she hasn't gotten any in June so far. She should have a shower at least twice a week."

On 6/27/19 at approximately 3:30 P.M. the above information was shared with the Administrator, the Director of Nursing and the Corporate Nurse Consultant. The Director of Nursing stated, "Residents should receive two showers a week and she is even care planned as it being a preference for her, we will see that it gets done."

The facility policy titled "Bathing/Showering" revised 9/1/17 was reviewed and is documented in part, as follows:

Policy: Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference.

Prior to exit no further information was shared.

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| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). | F 580 | 1. Resident #5 no longer resides in facility. Resident #107 notified the responsible party and physician was notified on 07/24/19. Resident #6 physician was notified on 07/23/19 of missed dose of insulin.<br>2. All residents that reside in the facility are at risk for not having responsible party and physician notified. An audit was completed for the last 7 days to ensure notification to responsible party and physician was completed by 7/29/19.<br>3. The DCS or designee will educate nursing staff to ensure that responsible party and physician were notified appropriately was completed 08/01/19.<br>4. The DCS or designee will audit to ensure that appropriate notification to responsible party and physician have been completed on 5 residents monthly for 3 months. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to notify the responsible party and physician after a resident to resident abuse incident for two of 57 residents in the sample, Resident #5 and #107; and failed to notify the physician of medications not administered per order for Resident #6.

1. For Resident #5 and Resident #107, facility staff failed to notify the responsible parties and physician after a sexual encounter had occurred on 3/6/19.

2. For Resident #6, facility staff failed to notify the physician of missed doses of insulin.

The findings include:

1a. Resident #5 was admitted to the facility on 6/20/18 with diagnoses that included but were not limited to Pick's Disease (1), muscle weakness, difficulty walking, and major depressive disorder. Resident #5's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/11/19. Resident #5 was coded as being

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severely impaired in cognitive function scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one staff member with ADLs (activities of daily living) such as dressing, bed mobility and transfers; and supervision only with walking.

1b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy (2), Hepatitis C (3), and altered mental status. Resident #107's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #5's clinical record revealed a nursing note that documented possible sexual abuse on 3/6/19. The following was documented: "Reported to this writer that resident (Resident #5) in room (number of Resident #5's room) was lured in (number of Resident #107's room). Seen with paints (sic) down as well as lips touching each others. Made DON (Director of Nursing) aware. Instructed by DON to keep resident's apart."

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

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Further review of Resident #5's and Resident #107's clinical record failed to evidence that the physician and responsible parties for both residents were notified.

On 6/26/19 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the corporate consultant. When asked the process if her nurses were to report two residents engaging in sexual relations especially on the Peach unit, ASM #2 stated that she would separate the residents, start an investigation to see if the incident requires reporting. ASM #2 stated that if both residents can give consent; she would then provide the residents privacy. ASM #2 stated that if the residents could not give consent, she would then call the RPs and if the RPs give consent she would ensure the residents are safe and practicing safe sex. ASM #2 denied being aware of the incident on 3/6/19 between Resident #5 and Resident #107, despite the nursing note written on 3/6/19 documenting that the DON was made aware. ASM #2 confirmed that there was no evidence that the physicians and RPs (Responsible Parties) were notified regarding the incident on 3/6/19.

On 6/26/19 at 5:13 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who was working on 3/6/19. When asked what had happened on 3/6/19; LPN #1 stated that a CNA (Certified Nursing Assistant) had alerted her that she had seen Resident #5 in Resident #107's room. LPN #1 stated that because she was not sure if the residents were cognitively intact enough to consent to any sexual

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activity; she separated the residents, and alerted administration (the DON). LPN #1 stated; "I told (Name of DON-Director of Nursing). She told me to keep them apart." When asked if she had contacted the physicians and RP's regarding the incident on 3/6/19, LPN #1 stated, " I don't remember." LPN #1 confirmed that she had not documented that she notified the physician and the RPs.

On 6/27/19 at 3:15 p.m., an interview was conducted with ASM #8 the physician and medical director. When asked if he expects to be notified after a resident to resident altercation or for any resident to resident abuse, ASM #8 stated that usually every time the facility submits a FRI, he is notified. ASM #8 stated that she could recall being made aware of an incident on 3/20 regarding the two residents (Resident #5 and Resident #107). ASM #8 stated that as far as being made aware of an incident prior to that, he could not recall. ASM #8 stated that he would assume the nurses documented somewhere that they notified him. ASM #8 stated that nurses should be documenting every time they notify him regarding a resident.

On 6/27/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.

Review of the facility's abuse policy documents revealed in part, the following: "Any person who observes or becomes aware of an incident of resident abuse, neglect or mistreatment of resident belongings, whether alleged, suspected or observed, must report the incident to the Executive Director, Director of Clinical Services

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Immediately. The Executive Director, Director of Clinical Services or Clinical Services Supervisor will initiate the procedure for incident investigation and reporting...Alleged, suspected or observed abuse...are thoroughly investigated by the Executive Director and/or Director of Clinical Services. Alleged suspected or observed violations are reported immediately to the...Ombudsman and all other officials required by state law. In all cases, the Executive Director or Director of Clinical Services will immediately notify the resident's legal guardian, family member, responsible party or significant other of the alleged, suspected or observed abuse, neglect or mistreatment. If a resident abuses another resident, the abusive resident's physician will be contacted and appropriate action will be taken to prevent further such behavior. If the abusive resident's behavior cannot be controlled, thereby posing a threat of harm to others in the facility, the resident will be discharged."

Definitions:
(1) "Pick's disease is a neurological condition characterized by a slowly progressive deterioration of behavior, personality, or language. People with Pick's disease have abnormal substances (called Pick bodies) inside nerve cells in the damaged areas of the brain. Pick bodies contain an abnormal form of a protein called tau. This protein is found in all nerve cells, but people with Pick's disease have an abnormal amount or type of this protein." This information was obtained from The National Institutes of Health.
https://rarediseases.info.nih.gov/diseases/7392/picks-disease.

(2) "Wernicke's encephalopathy is a degenerative

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brain disorder caused by the lack of thiamine (vitamin B1). It may result from alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders, or the effects of chemotherapy. B1 deficiency causes damage to the brain's thalamus and hypothalamus. Symptoms include mental confusion, vision problems, coma, hypothermia, low blood pressure, and lack of muscle coordination (ataxia)." This information was obtained from The National Institutes of Health.
https://www.ninds.nih.gov/Disorders/All-Disorders/Wernicke-Korsakoff-Syndrome-Information-Page
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(3) Hepatitis C- Hepatitis is inflammation of the liver. Chronic hepatitis C is a long-lasting infection. If it is not treated, it can last for a lifetime and cause serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death. Hepatitis C spreads through contact with the blood of someone who has HCV. This contact may be through
-Sharing drug needles or other drug materials with someone who has HCV. In the United States, this is the most common way that people get hepatitis C.
-Getting an accidental stick with a needle that was used on someone who has HCV. This can happen in health care settings.
-Being tattooed or pierced with tools or inks that were not sterilized after being used on someone who has HCV
-Having contact with the blood or open sores of someone who has HCV
-Sharing personal care items that may have come in contact with another person's blood, such as razors or toothbrushes

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-Being born to a mother with HCV
-Having unprotected sex with someone who has HCV." This information was obtained from The National Institutes of Health. https://medlineplus.gov/hepatitisc.html.
2. For Resident #6, facility staff failed to notify the physician of missed doses of insulin.

Resident #6 was re-admitted to the facility on 2/7/18 with diagnoses which included congestive heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin. The facility staff failed to notify the physician of physician ordered insulin and anti -anxiety medication not being available to Resident #6.

Resident #6 was assessed on A Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS). Resident #6 was assessed in the area of Activities of Daily Living (ADL's) as requiring supervision with set-up only in the areas of transfer and dressing with limited assistance with one person physical assist in the area of toileting. In the area of Medications this resident was assessed as receiving Insulin injections, anti-anxiety and anti-depressant medications.

A Care Plan dated 3/25/19 indicated: "Focus- Resident #6 has diabetes mellitus and neuropathy. Goal- Resident will have no complications related to diabetes. Interventions- Diabetes medications as ordered by doctor. Monitor / document for side effects and effectiveness." "An anti-anxiety medication care

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plan indicated- Goal - At risk for discomfort or adverse reactions related to anti-anxiety therapy. Interventions- administer Anti-Anxiety medications as ordered by physician."

Physician order dated 6/10/19 indicated: Novolin 70/30 flex pen Suspension Pen-injector 100 unit/ml (insulin).
Lorazepam tablet 0.5 mg (milligram) give one tablet by mouth twice a day.

A review of a Medication Administration Record (MAR) dated March 2019 indicated on March 6, 7 and 11th Novolin 70/30 Suspension (70/30) 100 units was not administered as ordered.

A review of the MAR dated March 2019 indicated on March 21, 2019 Lorazepam 0.5 mg was not administered as ordered.

A review of a MAR dated June 2019 indicated on June 20, and 21, 2019 Novolin 70/30 100 units was not administered as ordered.

A review of a MAR dated June 2019 indicated on June 23, 2019 Lorazepam 0.5 mg was not administered as ordered.

A Nursing Progress note dated March 6, 2019 indicated: Novolin 70/30 Flexpen 100 unit subcutaneously in the morning related to type 2 Diabetes Mellitus with Diabetic Neuropathy, awaiting pharmacy.

A Nursing Progress note dated June 21 2019 (12:50) indicated: "Insulin not available; pharmacy notified 6/21: to be delivered today. MD aware continuing to monitor.

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| F 580 | Continued From page 19<br>A Nursing Progress note dated June 21, 2019 (19:16 (7:16 PM)) medication did not arrive during afternoon delivery.<br><br>The physician was not notified of medications being not available and Resident #6 not receiving medications as ordered.<br><br>During an interview on 6/27/19 at 11:45 A.M. with the Director of Nursing and the Regional Nurse Consultant they stated, staff should have contacted the doctor concerning Resident #6 missed insulin.<br><br>The facility staff failed to notify Resident #6's physician when medications were not available. | F 580 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and | F 582 | | |

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| F 582 | Continued From page 20<br>periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on a medical record review, facility document review and staff interviews the facility staff failed to ensure a Notice of Medicare Non-Coverage was given timely prior to the last covered skilled day of 1/23/19 for one of 57 residents in the survey sample, Resident # 92. | F 582 | 1. Resident #92 no longer resides at the facility.<br>2. All residents are at risk for not receiving timely notification of a notice of Medicare non coverage. An audit was completed for the last 30 days to ensure notifications of notice of Medicare non coverage were completed timely. No other issues were identified.<br>3. An education was completed with the social services department by ED to ensure timely notification of notice of Medicare non coverage was completed on 07/23/19.<br>4. The MDS Coordinator (Minimum Data Set Coordinator) or designee will audit to ensure that appropriate notification to responsible party and physician have been completed on 5 residents monthly for 3 months. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019<br>Past noncompliance: no plan of correction required. | |

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This is cited as Past Non-Compliance.

The findings included:

Resident #92 is a 86 year old admitted to the facility on 1/10/19 with diagnoses to include but not limited to Acute Bronchitis, Dysphagia and Generalized Muscle Weakness.

Resident #92's Notice of Medicare Non-Coverage (NOMNC) document with Skilled Nursing Services ending on 1/23/19 was reviewed and is documented in part, as follows:

Telephone Notification:
1/22/19 at 3:20 P.M. spoke with son about mother's last covered day for therapy being 1/23/19. QIO (Quality Improvement Organization) phone number given, appeal rights and timeframe provided/explained: No.

On 06/25/19 at 12:47 PM an interview was conducted with the current facility Social Worker regarding the timeframe as to when should a resident/resident representative be notified of their Notice's of Medicare Non-Coverage. The Social Worker stated, "The notices should be give 48 hours prior to the last covered day so the resident has adequate time to request an appeal if they desire." The Social Worker was shown the Notice of Medicare Non-Coverage for Resident #92 and asked if the resident had been given a 48 hour notice. The Social Worker stated, "No, it was given the day before at 3:20 P.M., it was less that 24 hours."

The facility policy titled "Notice of Medicare Provider Non-Coverage Generic Notice" revised 11/10/2015 was reviewed and is documented in

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part, as follows:

Policy: A Notice of Medicare provider Non-Coverage will be utilized to notify resident of non-Medicare coverage. The facility will utilize the CMS (Center Medicare Services) specific Notice of Medicare Provider Non-Coverage form. The form cannot be changed other than the addition of the facility logo and placement of the facility name, address and telephone number above the title of the form if it is not in the logo.

The form will be reviewed with the resident or authorized representative.

Procedure:

1. The facility will give a completed copy of the notice to the resident receiving services no later than 2 days before the termination of skilled services.

2. The resident must be able to understand the purpose and contents of the notice in order sign for receipt of it. The resident must be able to understand that he or she may appeal the termination decision. If the resident is unable to comprehend the contents of the notice, it must be delivered to and signed by an authorized representative.

Guidance given by www.medicare.gov included:
While you're getting SNF (Skilled Nursing Facility...services, you should get a notice called "Notice of Medicare Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains:
The date your covered services will end
That you may have to pay for services you get

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| F 582 | Continued From page 23<br>after the coverage end date given on your notice<br>Information on your right to get a detailed notice about why your covered services are ending<br>Your right to a fast appeal and information on how to contact the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your state to request a fast appeal<br><br>On 6/27/19 at approximately 3:30 P.M. the above information was shared with the Administrator, the Director of Nursing and the Corporate Nurse Consultant. The Corporate Nurse Consultant shared that she had done a mock survey in the building in January 2019 and identified Notice of Medicare Non-Coverage issues. A Plan of Correction was developed on 1/17/19 to include training and weekly<br>Notice of Medicare Non-Coverage audits with a facility date of compliance of 2/1/19. Past non-compliance will be given since no Notice of Medicare Non-Coverage issues were identified after the 2/1/19 date. | F 582 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the | F 583 | | |

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| F 583 | Continued From page 24<br>residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews the facility staff failed for one resident (Resident #55), in the survey sample of 57, to ensure privacy was maintained during a wound care dressing change for Resident #55.<br><br>The findings included:<br><br>Resident #55 was originally admitted to the facility on 01/24/19. Diagnosis for Resident #55 included but are not limited to right below the knee amputation. Resident #55's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 04/26/19 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive | F 583 | 1. LPN #5 was educated on privacy on 06/27/19 by the ED.<br>2. Residents with treatments have the potential to be affected. No other residents having treatments were affected.<br>3. The DCS and or designee will educate the License staff on Resident privacy completed on 08/01/19.<br>4. The DCS (Director of Clinical Service) and or designee will do wound care observation audit to ensure privacy is provided twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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| F 583 | Continued From page 25 | F 583 | | |

impairment. In addition, the MDS coded Resident #55 as extensive assistance of one with bathing and toilet use and limited assistance of one with dressing and personal hygiene for Activities of Daily Living care. Section M-skin condition was coded for surgical wound care.

Resident #55 resided in a private room; the room did not have a privacy curtain. During a wound dressing observation on 06/26/19 at approximately 8:30 a.m., with License Practical Nurse (LPN) #5, the resident's window blind and door remained open throughout the entire dressing change to Resident #55's surgical wound to his right stump. On the same day at approximately 8:45 a.m., the Director of Nursing walked pass the open door while wound care was being performed by LPN #5. The DON knocked on Resident #55's opened door then stated, "I'm going to close the door." The LPN stated, "I usually close the door during a dressing change for privacy." People walking in the hallway or outside of his window could view the surgical wound care dressing change performed by LPN #5.

An interview was conducted with the Director of Nursing (DON) on 06/26/19 at approximately 9:11 a.m. She said the nurse should have closed the door and window blind during wound care to maintain privacy and dignity. On the same day at approximately 2:14 p.m., an interview was conducted with LPN #5 who stated, "Resident #55's window blind and door should have been closed during the dressing change to his right stump surgical incision to maintain his privacy."

The Administrator, Director of Nursing and Regional Director of Clinical Services was

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| F 583 | Continued From page 26<br>informed of the finding during a briefing on 06/27/19 at approximately 3:40 p.m. The facility did not present any further information about the findings.<br><br>The facility's policy titled Virginia Resident's Rights and Responsibilities (Effective: 01/07.)<br>-Each nursing facility resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.<br><br>As a nursing facility resident, you have the following rights under federal and state law:<br>-Privacy to include but not limited to: To have privacy when care or medical treatment is being provided. | F 583 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for | F 584 | | |

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| F 584 | Continued From page 27<br>the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility staff failed to provide a homelike environment during the dining observation from 06/24/19 to 06/27/19 on the Peach Unit (Memory Care Unit).<br><br>Facility staff served resident meals on trays during the dining observation on the Peach Unit.<br><br>The findings include:<br><br>On 06/24/19 at approximately 7:05 PM all nineteen residents sitting at the dining table on the Peach unit were served dinner on their trays. | F 584 | 1. Staff #9, CNA#7, LPN #8 was educated on not serving meals on trays completed on 7/16/19.<br>2. All residents have the potential to be affected. The facility completed an audit to ensure that meals are not served on trays.<br>3. Nursing staff and dietary staff have been educated by the ED or designee to ensure meals are not served on the trays in the dining room was completed by 08/01/19.<br>4. The Executive Director and or designee will complete an audit to ensure trays are not served on trays in the dining room twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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On 06/25/19 at approximately, 11:56 AM all nineteen residents sitting at the dining table with their meals on their trays.

On 06/26/19 at approximately 12:20 PM all residents sitting at the table had their meals left on trays.

On 06/27/19 at approximately 12:23 PM all nineteen residents sitting at the dining table had their meals served on trays.

On 6/27/19 at approximately 9:00 AM an interview was conducted with Other Staff #9 (Food Service Director) concerning leaving the resident's meals on their trays. She stated that "It's not a fine dining experience on the Peach Unit." "Only in main Dining." "We've tried to leave the trays on the tables before but it just didn't work on the unit." A policy on Fine Dining was requested.

On 6/27/19 at approximately 10:10 AM, an interview was conducted with CNA #7 (Certified Nursing Assistant) concerning the above. She said "We don't do that back here, because in the main dining it's fine dining." "It's been like this since I've been here for 2 years."

On 6/27/19 at approximately, 10:15 AM an interview was conducted with LPN #8 (Licensed Practical Nurse) concerning the above. She responded, "A lot of them spill stuff." "We don't want anyone to slip and fall." "Everything is contained in the tray." "We have to be very careful of fall risks."

On 6/27/19 at approximately 4:24 PM the

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| F 584 | Continued From page 29<br>Regional Nurse was approached for a policy concerning Fine Dining. She said that there is no policy on Fine Dining. She also stated that Fine Dining will be instituted in the near future on Alzheimer/Dementia Care Units.<br><br>On 06/07/19 at approximately 4:43 PM a Pre-exit interview was conducted with the Nurse Consultant, Director of Nursing, The Regional Nurse and the Administrator. The above findings were discussed. The Nurse Consultant stated "I don't see anything wrong with it." There were no other comments made. | F 584 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure a resident was free from abuse for one of 57 residents in the survey sample, Resident #5. | F 600 | | |

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| F 600 | Continued From page 30<br><br>Facility staff failed to ensure Resident #5 was separated and protected from Resident #107 after a sexual encounter on 3/6/19 between the two residents; another sexual encounter occurred on 3/20/19.<br><br>The findings include:<br><br>1a. Resident #5 was admitted to the facility on 6/20/18 with diagnoses that included but were not limited to Pick's Disease (1), muscle weakness, difficulty walking, and major depressive disorder. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/11/19. Resident #5 was coded as being severely impaired in cognitive function scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one staff member with ADLs (activities of daily living) such as dressing, bed mobility and transfers; and supervision only with walking.<br><br>1b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy (2), Hepatitis C (3), and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function on the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking. | F 600 | 1. Resident #5 and resident #107 are separated after and resident #5 was transferred off unit. Resident #107 has had no further incidents.<br>2. All residents have the potential to be affected. The facility completed an audit to ensure that residents that currently reside in the facility are free from abuse. No other issues were identified.<br>3. Licensed and non-licensed staffs have been educated by the DCS or designee to ensure residents are separated at the time of an incident to ensure they are free from abuse was completed on 08/01/19.<br>4. The ED and or designee will complete an audit to ensure residents are separated and at the time of an incident and will be placed on increased supervision and evaluated by Provider, twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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Review of Resident #5's clinical record revealed a nursing note that documented possible sexual abuse on 3/6/19. The following was documented: "Reported to this writer that resident (Resident #5) in room (number of Resident #5's room) was lured in (number of Resident #107's room). Seen with paints (sic) down as well as lips touching each others. Made DON (Director of Nursing) aware. Instructed by DON to keep resident's apart."

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

Further review of Resident #5's and Resident #107's clinical record failed to evidence that staff were keeping the resident's separated.

Review of Resident #5's comprehensive care plan dated 12/10/18 with the latest revision on 3/21/19; failed to reflect the above incident between Resident #5 and Resident #107.

Review of Resident #107's comprehensive care plan dated 12/12/18 with the latest revision on 6/25/19; failed to reflect the above incident between Resident #5 and Resident #107.

Further review of the FRIs revealed a second incident had occurred between Resident #5 and Resident #107 on 3/20/19. The following was documented in the FRI: "Report date 3/20/19, Incident date 3/20/19: Incident Type: The residents were found in (Name of Resident #5's) room lying together partially undressed. The two

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residents were immediately separated...during the delivery of dinner, staff noted (name of Resident #5) and (name of Resident #107) on the bed in her room with their clothing partially removed. Neither resident wanted to discuss if the had sexual intentions. The residents were immediately separated, skin assessments completed and no signs of physical injury noted to either resident. MD (Medical Doctor) and RP (Responsible Party) were notified...Employee action initiated or taken: (Name of Resident #5) was moved to another room off the unit and (name of Resident #107) was placed on q (every) 15 minute checks). (Name of Resident #5's RP) did not want to contact the police."

The five day investigation follow up dated 5/25/19, documented in part, the following: "During dinner time staff was in the process of passing out meal trays. As a staff member entered the room to get (name of Resident #5) she encountered (Resident #107) on top of (name of Resident #5) both with there (sic) clothing down around their ankles. (Name of Resident #107) was immediately removed and taken to his room. The staff performed an assessment of (Name of Resident #5) and found no visualization of penetration, redness, swelling, bruising, or discharge. Staff informed to conduct q 15 minute checks on (Resident #107). (Resident #5) was immediately transferred off the unit and placed on another unit within the facility (off the locked unit). Both residents appear not to have experienced any emotional trauma from the incident. Findings: Based on staff, resident and review of the medical record the facility has substantiated that both residents were partially unclothed but there is no supporting evidence to suggest that sexual intercourse has occurred..."

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Further review of Resident #107's progress notes revealed a social worker note dated 3/21/19 at 2:23 p.m., that documented the following: "Resident noted to be fond of a female resident. He normally stays in his room but has been favored by a female resident. He is alert and understands when being spoken to. Denies having a relationship with any residents that reside here. Understands boundaries and voices that he will follow. Does not engage in conversation long begins to talk about other things. No agitation or aggression noted. Will be monitored for changes."

Further review of Resident #5's progress notes revealed the social worker attempted to meet with Resident #5 twice on 3/22/19, but was unsuccessful due to the resident sleeping. The social worker met with Resident #5 on 3/25/19, and documented the following: "Met with (Name of Resident #5) at bedside. She is in bed sleeping and was easy to awake. She appears to be depressed as evidence as no positive response when mentioning food or her mother which generally elicits a positive response or smile. May be related to the move from the unit where her surroundings were familiar...she has a bruise and swelling to upper lip. Notified (Name of CNA (certified nursing assistant). Will continue to monitor resident."

Review of Resident #5's psych physician note dated 4/10/19 documented the following: "...being seen for increased reports of depression. Pt (patient) was moved from Peach (locked unit) to Blue unit d/t (due to) interaction with another resident on Peach. RN (Registered Nurse) reports depression increased with move, spends

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her day in her room, hypersomnia. Attempted to speak to pt (patient) in her room "don't talk to me." Ignored questions about feelings, depression, anxiety, insomnia, mood. Encouraged an open safe space to talk. After review of chart, speaking to RN, and pt evaluation, restarting escitalopram (Lexapro) (4)...discussed changes with RN...Initiate escitalopram 10 mg (milligrams) PO (by mouth) QD (every day)...will continue to monitor."

There was no further evidence that Resident #5 experienced continued depression or psychological harm as a result of the above encounters with Resident #107.

On 6/25/19 at 5:37 p.m., an interview was conducted with LPN #1, the nurse who worked when both sexual encounters had occurred. When asked the process if she were to see abuse between two residents in the facility, LPN #1 stated that she would remove the victim from the situation and report the abuse to administration. When asked who her abuse coordinator was, LPN #2 stated that the DON (Director of Nursing) was the abuse coordinator. When asked what was usually put into place after a resident is abused by another resident, LPN #2 stated that q (every 15 min) checks are usually conducted for three days and recorded on a tracking record. When asked how other clinical staff, i.e. nursing aides and nurses are made aware of resident to resident abuse, LPN #1 stated that nurses and nursing aides are given report. When asked the purpose of the care plan, LPN #1 stated the purpose of the care plan was to serve as a guide to care for the residents. When asked if the care plan should be updated after a resident to resident altercation, LPN #1

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stated, "It should be updated."

On 6/26/19 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the corporate consultant. When asked the process if her nurses were to report two residents engaging in sexual relations especially on the Peach unit, ASM #2 stated that she would separate the residents, start an investigation to see if the incident requires reporting. ASM #2 stated that if both residents can give consent; she would then provide the residents privacy. ASM #2 stated that if the residents could not give consent, she would then call the RPs and if the RPs give consent she would ensure the residents are safe and practicing safe sex. ASM #2 denied being aware of the incident on 3/6/19 between Resident #5 and Resident #107, despite the nursing note written on 3/6/19 documenting that the DON was made aware. When asked what had happened on 3/20/19 between Resident #5 and Resident #107; ASM #2 stated that it was reported to her that Resident #107 was found on top of Resident #5 with their pants pulled down. ASM #2 stated that at this time Resident #5 was able to remove her own pants. ASM #2 stated that as soon as she found out, she immediately separated the residents, called the responsible parties and called the physician. ASM #2 stated that she had moved Resident #5 off the Peach unit and to the Blue unit. ASM #2 stated that she had performed an assessment on Resident #5 and there were no visible signs of penetration or injury. ASM #2 stated that since both residents could not give consent at this time, she had reported this incident to the state agencies. ASM #2 stated that Resident #5 could not tell her what had happened

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and if she had consented to Resident #107's advances. ASM #2 stated that Resident #107 denied anything happening. ASM #2 stated that Resident #107 said he was trying to take Resident #5 to the bathroom. ASM #2 stated that Resident #5's responsible party did not want Resident #5 sent to the hospital for a rape kit because she didn't want to put her daughter through that stress. ASM #2 confirmed that nothing was put into place to prevent the 3/20/19 incident because she was not made aware of the incident on 3/6/19. ASM #2 confirmed that there was no evidence that the physicians and RPs (responsible parties) were notified regarding the incident on 3/6/19.

On 6/26/19 at 4:50 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #4, an aide who witnessed both sexual incidents on 3/6/19 and 3/20/19. CNA #4 stated that she would immediately separate the residents and report any suspected abuse to her supervisor. CNA #4 stated that she could not recall too much on 3/6/19 but that she had reported to the nurse (LPN #1) that Resident #5 was in Resident #107's room. CNA #4 stated that she was just told to keep the residents separated. CNA #4 stated that the nursing staff tried as much as they could to keep the residents separated and that it was hard when there was only two nursing aides and one nurse to the Peach unit. CNA #4 stated that there are supposed to be three aides on the Peach unit. CNA #4 stated that sometimes Resident #107 was left unattended if the aides were in the residents' rooms providing care and there was only one nurse working both the blue and peach units. CNA #4 stated that Resident #107 had not had any other sexual encounters with an other residents, only Resident #5. CNA #4 stated that

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she had been working on the Peach Unit for a total of 5 years.

On 6/26/19 at 5:13 p.m., further interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who was working on 3/6/19. When asked what had happened on 3/6/19; LPN #1 stated that a CNA had alerted her that she had seen Resident #5 in Resident #107's room. LPN #1 stated that because she was not sure if the residents were cognitively intact enough to consent to any sexual activity; she separated the residents, and alerted administration (the DON). LPN #1 stated; "I told (Name of Director of Nursing). She told me to keep them apart." When asked if it was difficult to keep Resident #5 and Resident #107 apart, LPN #1 stated that if she is passing out medications and a CNA is in a room providing care, it was difficult to keep an eye on them. LPN #1 stated that there should be three CNA's on Peach Unit and lately there had been two. LPN #1 could not recall how many CNAs were on shift the day of 3/6/19 or 3/20/19. LPN #1 stated that she is the only nurse usually working 7 a.m. to 7 p.m. on the Peach Unit. When asked if she could provide this writer with the 15 minute checks that were conducted on 3/6/19 for Resident #107, LPN #1 stated that q 15 minute checks were never written down. LPN #1 stated there was no way to prove that 15 minute checks were conducted on Resident #107 on 3/6/19. When asked if anyone else was notified after a resident to resident altercation or sexual incident, LPN #1 stated that she would alert the medical doctor and the responsible parties (RP). When asked if she had contacted the physicians and RP's regarding the incident on 3/6/19, LPN #1 stated, "I don't remember." LPN #1 confirmed that she had not documented that she notified the

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physician and the RPs. LPN #1 also confirmed that Resident #5's and Resident #107's care plans were not revised after the 3/6/19 incident.

Review of the as-worked schedules for 3/6/19 and 3/20/19 as well as the punch time sheets for all staff working on the Peach and Blue units, revealed that both units were fully staffed on 3/6/19 and 3/20/19. There was no evidence that one nurse worked both the Blue and Peach units on 3/6/19 and 3/20/19.

On 6/27/19 at 5:30 p.m., ASM #1, the Administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.

Review of the facility's abuse policy documents in part, the following: "Any person who observes or becomes aware of an incident of resident abuse, neglect or mistreatment of resident belongings, whether alleged, suspected or observed, must report the incident to the Executive Director, Director of Clinical Services Immediately. The Executive Director, Director of Clinical Services or Clinical Services Supervisor will initiate the procedure for incident investigation and reporting...Alleged, suspected or observed abuse...are thoroughly investigated by the Executive Director and/or Director of Clinical Services. Alleged suspected or observed violations are reported immediately to the...Ombudsman and all other officials required by state law. If a resident abuses another resident, the abusive resident's physician will be contacted and appropriate action will be taken to prevent further such behavior. If the abusive resident's behavior cannot be controlled, thereby posing a threat of harm to others in the facility,

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the resident will be discharged."

No further information was presented by the facility staff.

(1) "Pick ' s disease is a neurological condition characterized by a slowly progressive deterioration of behavior, personality, or language. People with Pick's disease have abnormal substances (called Pick bodies) inside nerve cells in the damaged areas of the brain. Pick bodies contain an abnormal form of a protein called tau. This protein is found in all nerve cells, but people with Pick's disease have an abnormal amount or type of this protein." This information was obtained from The National Institutes of Health.
https://rarediseases.info.nih.gov/diseases/7392/picks-disease.

(2) "Wernicke's encephalopathy is a degenerative brain disorder caused by the lack of thiamine (vitamin B1). It may result from alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders, or the effects of chemotherapy. B1 deficiency causes damage to the brain's thalamus and hypothalamus. Symptoms include mental confusion, vision problems, coma, hypothermia, low blood pressure, and lack of muscle coordination (ataxia)." This information was obtained from The National Institutes of Health.
https://www.ninds.nih.gov/Disorders/All-Disorders/Wernicke-Korsakoff-Syndrome-Information-Page.

(3) Hepatitis C- Hepatitis is inflammation of the liver. Chronic hepatitis C is a long-lasting infection. If it is not treated, it can last for a

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| F 600 | Continued From page 40<br>lifetime and cause serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death. Hepatitis C spreads through contact with the blood of someone who has HCV. This contact may be through<br>-Sharing drug needles or other drug materials with someone who has HCV. In the United States, this is the most common way that people get hepatitis C.<br>-Getting an accidental stick with a needle that was used on someone who has HCV. This can happen in health care settings.<br>-Being tattooed or pierced with tools or inks that were not sterilized after being used on someone who has HCV<br>-Having contact with the blood or open sores of someone who has HCV<br>-Sharing personal care items that may have come in contact with another person's blood, such as razors or toothbrushes<br>-Being born to a mother with HCV<br>-Having unprotected sex with someone who has HCV." This information was obtained from The National Institutes of Health. https://medlineplus.gov/hepatitisc.html. | F 600 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and | F 607 | | |

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| F 607 | Continued From page 41<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to implement abuse policies and report and investigate allegations of abuse; and failed to ensure resident safety after abuse had occurred for four of 57 residents in the survey sample, Resident #5, #82, #107 and #41.<br><br>1. For Resident #5, facility staff failed to implement abuse policies and report, investigate and ensure Resident safety after a sexual encounter with Resident #107 on 3/6/19.<br><br>2. For Resident #82, facility staff failed to implement abuse policies and report, investigate and ensure Resident safety after a physical altercation with Resident #107 on 6/24/19.<br><br>3. The facility staff failed to implement the written policy and procedure to report allegation of abuse to the Administrator in a timely manner for Resident #41.<br><br>The findings include:<br><br>1a. Resident #5 was admitted to the facility on 6/20/18 with diagnoses that included but were not limited to Pick's Disease (1), muscle weakness, difficulty walking, and major depressive disorder. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/11/19. Resident #5 was coded as being severely | F 607 | 1. A facility reported incident was initiated on resident #5, #41, #82 and resident #107 according to policy and procedure and an investigation was initiated.<br>2. All residents have the potential to be affected. The facility completed an audit of the residents that currently resident in the facility for the last 30 days to ensure that abuse polices have been implemented and reported was completed on 07/23/19. No other issues were identified.<br>3. Licensed staff have been educated by the DCS or designee on the policy and procedures of abuse investigation that was completed by 08/01/19.<br>4. The ED and or designee will complete an audit to ensure policy and procedures of abuse are implemented and investigated twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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impaired in cognitive function scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one staff member with ADLs (activities of daily living) such as dressing, bed mobility and transfers; and supervision only with walking.

1b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy (2), Hepatitis C (3), and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #5's clinical record revealed a nursing note that documented possible sexual abuse on 3/6/19. The following was documented: "Reported to this writer that resident (Resident #5) in room (number of Resident #5's room) was lured in (number of Resident #107's room). Seen with paints (sic) down as well as lips touching each others. Made DON (Director of Nursing) aware. Instructed by DON to keep resident's apart."

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

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Further review of Resident #5's and Resident #107's clinical record failed to evidence that staff were keeping the resident's separated to prevent further abuse.

Further review of the FRIS revealed a second incident had occurred between Resident #5 and Resident #107 on 3/20/19. The following was documented in the FRI: "Report date 3/20/19, Incident date 3/20/19: Incident Type: The residents were found in (Name of Resident #5's) room lying together partially undressed. The two residents were immediately separated...during the delivery of dinner, staff noted (name of Resident #5) and (name of Resident #107) on the bed in her room with their clothing partially removed. Neither resident wanted to discuss if the had sexual intentions. The residents were immediately separated, skin assessments completed and no signs of physical injury noted to either resident. MD (medical doctor and RP (responsible party) were notified...Employee action initiated or taken: (Name of Resident #5) was moved to another room off the unit and (name of Resident #107) was placed on q (every) 15 minute checks). (Name of Resident #5's RP (responsible party) did not want to contact the police."

The five day investigation follow up dated 5/25/19, documented in part, the following: "During dinner time staff was in the process of passing out meal trays. As a staff member entered the room to get (name of Resident #5) she encountered (Resident #107) on top of (name of Resident #5) both with there clothing down around their ankles. (Name of Resident #107) was immediately removed and taken to his

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room. The staff performed an assessment of (Name of Resident #5) and found no visualization of penetration, redness, swelling, bruising, or discharge. Staff informed to conduct q 15 minute checks on (Resident #107). (Resident #5) was immediately transferred off the unit and placed on another unit within the facility (off the locked unit). Both residents appear not to have experienced any emotional trauma from the incident. Findings: Based on staff, resident and review of the medical record the facility has substantiated that both residents were partially unclothed but there is no supporting evidence to suggest that sexual intercourse has occurred..."

On 6/25/19 at 5:37 p.m., an interview was conducted with LPN #1, the nurse who worked when both sexual encounters had occurred. When asked the process if she were to see abuse between two residents in the facility, LPN #1 stated that she would remove the victim from the situation and report the abuse to administration. When asked who her abuse coordinator was, LPN #2 stated that the DON (Director of Nursing) was the abuse coordinator. When asked what was usually put into place after a resident is abused by another resident, LPN #2 stated that q (every 15 min) checks are usually conducted for three days and recorded on a tracking record. When asked how other clinical staff, i.e. nursing aides and nurses are made aware of resident to resident abuse, LPN #1 stated that nurses and nursing aides are given report. When asked the purpose of the care plan, LPN #1 stated the purpose of the care plan was to serve as a guide to care for the residents. When asked if the care plan should be updated after a resident to resident altercation, LPN #1 stated, "It should be updated."

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On 6/26/19 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the corporate consultant. When asked the process if her nurses were to report two residents engaging in sexual relations especially on the Peach unit, ASM #2 stated that she would separate the residents, start an investigation to see if the incident requires reporting. ASM #2 stated that if both residents can give consent; she would then provide the residents privacy. ASM #2 stated that if the residents could not give consent, she would then call the RPs and if the RPs give consent she would ensure the residents are safe and practicing safe sex. ASM #2 denied being aware of the incident on 3/6/19 between Resident #5 and Resident #107, despite the nursing note written on 3/6/19 documenting that the DON was made aware. When asked what had happened on 3/20/19 between Resident #5 and Resident #107; ASM #2 stated that it was reported to her that Resident #107 was found on top of Resident #5 with their pants pulled down. ASM #2 stated that at this time Resident #5 was able to remove her own pants. ASM #2 stated that as soon as she found out, she immediately separated the residents, called the responsible parties and called the physician. ASM #2 stated that she had moved Resident #5 off the Peach unit and to the Blue unit. ASM #2 stated that she had performed an assessment on Resident #5 and there were no visible signs of penetration or injury. ASM #2 stated that since both residents could not give consent at this time, she had reported this incident to the state agencies. ASM #2 stated that Resident #5 could not tell her what had happened and if she had consented to Resident #107's

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advances. ASM #2 stated that Resident #107 denied anything happening. ASM #2 stated that Resident #107 said he was trying to take Resident #5 to the bathroom. ASM #2 stated that Resident #5's responsible party did not want Resident #5 sent to the hospital for a rape kit because she didn't want to put her daughter through that stress. ASM #2 confirmed that nothing was put into place to prevent the 3/20/19 incident because she was not made aware of the incident on 3/6/19. ASM #2 confirmed that there was no evidence that the physicians and RPs (responsible parties) were notified regarding the incident on 3/6/19.

On 6/26/19 at 4:50 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #4, an aide who witnessed both sexual incidents on 3/6/19 and 3/20/19. CNA #4 stated that she would immediately separate the residents and report any suspected abuse to her supervisor. CNA #4 stated that she could not recall too much on 3/6/19 but that she had reported to the nurse (LPN #1) that Resident #5 was in Resident #107's room. CNA #4 stated that she was just told to keep the residents separated. CNA #4 stated that the nursing staff tried as much as they could to keep the residents separated and that it was hard when there was only two nursing aides and one nurse to the Peach unit. CNA #4 stated that there are supposed to be three aides on the Peach unit. CNA #4 stated that sometimes Resident #107 was left unattended if the aides were in the residents' rooms providing care and there was only one nurse working both the blue and peach units. CNA #4 stated that Resident #107 had not had any other sexual encounters with an other residents, only Resident #5. CNA #4 stated that she had been working on the Peach Unit for a

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| F 607 | Continued From page 47<br>total of 5 years.<br><br>On 6/26/19 at 5:13 p.m., further interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who was working on 3/6/19. When asked what had happened on 3/6/19; LPN #1 stated that a CNA had alerted her that she had seen Resident #5 in Resident #107's room. LPN #1 stated that because she was not sure if the residents were cognitively intact enough to consent to any sexual activity; she separated the residents, and alerted administration (the DON). LPN #1 stated; "I told (Name of Director of Nursing). She told me to keep them apart." When asked if it was difficult to keep Resident #5 and Resident #107 apart, LPN #1 stated that if she is passing out medications and a CNA is in a room providing care, it was difficult to keep an eye on them. LPN #1 stated that there should be three CNA's on Peach unit and lately there had been two. LPN #1 could not recall how many CNAs were on shift the day of 3/6/19 or 3/20/19. LPN #1 stated that she is the only nurse usually working 7a.m. to 7 p.m. on the Peach unit. When asked if she could provide this writer with the 15 minute checks that were conducted on 3/6/19 for Resident #107, LPN #1 stated that q 15 minute checks were never written down. LPN #1 stated there was no way to prove that 15 minute checks were conducted on Resident #107 on 3/6/19. When asked if anyone else was notified after a resident to resident altercation or sexual incident, LPN #1 stated that she would alert the medical doctor and the responsible parties (RP). When asked if she had contacted the physicians and RP's regarding the incident on 3/6/19, LPN #1 stated, " I don't remember." LPN #1 confirmed that she had not documented that she notified the physician and the RPs. LPN #1 also confirmed | F 607 | | |

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that Resident #5's and Resident #107's care plans were not revised after the 3/6/19 incident.

Review of the as-worked schedules for 3/6/19 and 3/20/19 as well as the punch time sheets for all staff working on the Peach and Blue units, revealed that both units were fully staffed on 3/6/19 and 3/20/19. There was no evidence that one nurse worked both the Blue and Peach units on 3/6/19 and 3/20/19.

On 6/27/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.

(1) "Pick's disease is a neurological condition characterized by a slowly progressive deterioration of behavior, personality, or language. People with Pick's disease have abnormal substances (called Pick bodies) inside nerve cells in the damaged areas of the brain. Pick bodies contain an abnormal form of a protein called tau. This protein is found in all nerve cells, but people with Pick's disease have an abnormal amount or type of this protein." This information was obtained from The National Institutes of Health.
https://rarediseases.info.nih.gov/diseases/7392/picks-disease.

(2) "Wernicke's encephalopathy is a degenerative brain disorder caused by the lack of thiamine (vitamin B1). It may result from alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders, or the effects of chemotherapy. B1 deficiency causes damage to the brain's thalamus and hypothalamus. Symptoms include mental confusion, vision problems, coma,

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hypothermia, low blood pressure, and lack of muscle coordination (ataxia)." This information was obtained from The National Institutes of Health.
https://www.ninds.nih.gov/Disorders/All-Disorders/Wernicke-Korsakoff-Syndrome-Information-Page.

(3) Hepatitis C- Hepatitis is inflammation of the liver. Chronic hepatitis C is a long-lasting infection. If it is not treated, it can last for a lifetime and cause serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death. Hepatitis C spreads through contact with the blood of someone who has HCV. This contact may be through
-Sharing drug needles or other drug materials with someone who has HCV. In the United States, this is the most common way that people get hepatitis C.
-Getting an accidental stick with a needle that was used on someone who has HCV. This can happen in health care settings.
-Being tattooed or pierced with tools or inks that were not sterilized after being used on someone who has HCV
-Having contact with the blood or open sores of someone who has HCV
-Sharing personal care items that may have come in contact with another person's blood, such as razors or toothbrushes
-Being born to a mother with HCV
-Having unprotected sex with someone who has HCV." This information was obtained from The National Institutes of Health.
https://medlineplus.gov/hepatitisc.html.

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2. For Resident #82, facility staff failed to implement abuse policies and report, investigate and ensure Resident safety after a physical altercation with Resident #107 on 6/24/19.

2a. Resident #82 was admitted to the facility on 3/15/19 and readmitted on 5/9/18 with diagnoses that included but were not limited to dementia without behavioral disturbance, muscle weakness and high blood pressure. Resident #82's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #82 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam.

2b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy, Hepatitis C, and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #82's clinical record revealed the following nursing note dated 6/24/19: "resident attempting to get out of bed and roommate was observed hitting him in the face trying to make him lay down. no bruising observed at this time."

The next note dated 6/24/19 documented the

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following: "placed call to RP (Responsible Party) made aware of incident with roommate."

Review of Resident #107's clinical record revealed the following note dated 6/24/19: "Heard resident yelling from room lay down lay down. CNA (Certified Nursing Assistant) entered room observed this resident hitting roommate trying to make him lay down. Call placed to RP left message to return call. PA (Physician's Assistant) made aware. Supervisor and ADON (Assistant Director of Nursing) made aware."

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

On 6/25/19 at 2:21 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #5. When asked the process if she were to see a resident hit another resident, CNA #5 stated that she would separate the residents, deescalate the situation and redirect the residents. CNA #5 stated that she would report the incident to her charge nurse. CNA #5 then gave an example and stated that Resident #107 had hit his roommate the day prior at approximately 1:45 p.m. and that she had reported this to her charge nurse (LPN #1). CNA #5 stated that she had written a statement for her nurse. When asked what staff were doing to ensure Resident #82 was safe from Resident #107, CNA #5 stated that they were trying to ensure that they were not in their room at the same time. When asked if she had worked that morning, CNA #5 stated that she did and was working until 3 p.m. CNA #5 was told about the

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above observations during lunch. CNA #5 confirmed that the residents were not separated during this time. When asked how CNAs were made aware of resident to resident altercations, CNA #5 stated that nurses tell them in report.

On 6/25/19 at 2:25 p.m., LPN #1 could be reached for an interview.

On 6/25/19 at 2:59 p.m., the FRI and investigation so far for Resident #107 and Resident #82 was requested from the DON (Director of Nursing) (ASM (administrative staff member) #2. ASM #2 stated that she didn't have a FRI because she wasn't aware of any resident to resident altercation between Resident #107 and #82. ASM #2 stated that maybe the Administrator had submitted one and she would go check.

On 6/25/19 at 5:20 p.m., ASM #3, the corporate nurse stated that the Administrator had been made aware of the resident to resident altercation between Resident #107 and #82 on 6/24/19, but did not report this incident to the appropriate state agencies or initiate an investigation because there were no injuries. ASM #3 stated that she had just in-serviced the Administrator on the abuse policy and went over when to report and investigate abuse. ASM #3 stated that the Administrator was using the old abuse policy and thought he didn't have to report and separate the residents because there were no injuries. ASM #3 stated that they had just moved Resident #107 to a private room to protect Resident #82.

On 6/25/19 at 5:37 p.m., this writer was able to get in touch with LPN #1. When asked what had happened on 6/24/19 between Resident #107

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and Resident #82, LPN #1 stated that it was reported to her by the CNA that Resident #107 had slapped Resident #82. LPN #1 stated that staff attempted to get Resident #107 out of his room but were unsuccessful. LPN #1 stated that they did q 15 minute checks on Resident #107. When asked if she could provide those checks, LPN #1 stated that the staff were not writing it down and she could not prove staff were doing this. LPN #1 stated that she had reported this incident to the ADON and Administrator. LPN #1 stated that most of the day 6/25/19, Resident #82 was out of the room and at the table doing activities with the activity assistant. LPN #1 was told about the above observations at lunch. When asked if Resident #82 was protected from Resident #107 after being slapped by Resident #107, LPN #1 stated that they just moved Resident #107 to a private room. When asked if this was after this surveyor had alerted the DON by asking for a FRI, LPN #1 stated yes.

On 6/27/19 at 12:00 p.m., an interview was conducted with ASM #1, the Administrator. When asked the process when it is reported to him that abuse, or an allegation of abuse had occurred between two residents, ASM #1 stated that he would report actual abuse that day to the appropriate state agencies, separate the residents and start and investigation. ASM #1 stated that the incident between Resident #107 and #82 was reported to him on 6/24/19 but that he did not report the incident until 6/25/19 to the appropriate state agencies. ASM #1 stated that he figured he did not have to report if there were no physical injuries that required physician intervention. When asked why he ended up reporting the incident on 6/25/19, ASM #1 stated that his DON had asked him if he had submitted

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a FRI regarding the incident. ASM #1 showed this surveyor the fax confirmation to report the incident to the OLC on 6/25/19 at 3:47 p.m. When asked why an investigation wasn't started immediately and what they had in place to protect Resident #82 from Resident #107, ASM #1 stated, "We (administrator and ADON) felt at the time to monitor." When asked if he was educated on the abuse policy prior to his employment with the facility in February 2019; ASM #1 stated that he was.

Review of ASM #1 employee file revealed that he was educated on the abuse policy on 2/15/19. Review of the in-service dated 6/25/19 revealed that he and the DON were re-educated on the abuse policy.

On 6/27/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.

Review of the facility's abuse policy documents in part, the following: "Any person who observes or becomes aware of an incident of resident abuse, neglect or mistreatment of resident belongings, whether alleged, suspected or observed, must report the incident to the Executive Director, Director of Clinical Services Immediately. The Executive Director, Director of Clinical Services or Clinical Services Supervisor will initiate the procedure for incident investigation and reporting...Alleged, suspected or observed abuse...are thoroughly investigated by the Executive Director and/or Director of Clinical Services. Alleged suspected or observed violations are reported immediately to the...Ombudsman and all other officials required

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by state law. If a resident abuses another resident, the abusive resident's physician will be contacted and appropriate action will be taken to prevent further such behavior. If the abusive resident's behavior cannot be controlled, thereby posing a threat of harm to others in the facility, the resident will be discharged."
3. The facility staff failed to implement written policy and procedure to report an allegation of abuse to the Administrator in a timely manner for Resident #41.

Resident #41 was admitted to the facility on 05/06/2011 and discharged to the hospital on 06/22/2019. Diagnoses included but were not limited to, Traumatic Brain Injury and Epilepsy. Resident #41's Significant Change in Status Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 07/20/2018 was coded with a BIMS (Brief Interview for Mental Status) score of 6 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #41 as requiring extensive assistance of 2 for bed mobility, extensive assistance of 1 for transfer, walk in room, walk in corridor, dressing, eating, toilet use, personal hygiene and physical help in part of bathing activity with assistance of 1. Resident #41's Discharge Assessment Minimum Data Set with an Assessment Reference Date of 10/09/2018 was coded for short-term memory problem and moderately impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #41 as requiring limited assistance with bed mobility, transfer, walk in room, walk in corridor, dressing, toilet use and supervision with eating and personal hygiene.

On 06/25/2019 Resident #41's closed record was

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reviewed and revealed a letter dated October 1, 2018 addressed to the Virginia Department of Health from the facility's previous Administrator, (Administration #6), stating that Certified Nursing Assistant (CNA) #2 reported that on 09/22/2018 she walked into Resident #41's room and found her to be disrobed with a male CNA in the room, CNA #1. The letter also stated that Adult Protective Services visited the facility on 09/24/2018 to investigate in response to an anonymous caller. The letter also stated that Adult Protective Services reported the allegation to (County) Law Enforcement and a detective was in the facility on 9/25/2018 and stated he would return on 10/01/2018 to complete his investigation. The Fax Transaction Report was reviewed and it indicated that the letter was faxed to Virginia Department of Licensure and Certification, Adult Protective Services and Ombudsman on 09/24/2018. Witness statements dated 09/24/2018, 09/25/2018 and 09/30/2018 which had been obtained were reviewed. Review of CNA #2's Witness Statement revealed that on 09/22/2018 she was doing 1 on 1 care with Resident #41 and she opened the door to go into her room and Resident #41 was completely naked with only her pants around her right ankle and CNA #1 came from behind (Resident's name) door and stated that he was delivering towels and helping Resident #41 to get into her night clothes. CNA #2 had written, "I never saw him touch (Resident's name) but he had no reason to be in her room." CNA #2 wrote, "I never told the nurse on duty that night because I wasn't sure what was happening but decided to report it to the nurse on Sunday. I reported it to Licensed Practical Nurse (LPN) # 1 on the Peach Unit. " CNA #2 also wrote that she reported it to the Unit Manager on that Sunday.

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Review of LPN #1's Witness Statement dated 09/24/2018 revealed that CNA #2 reported to her what she had seen. LPN #1 documented that she immediately reported to the supervisor on and the Unit Manager. LPN #1 also documented that she interviewed Resident #41 and CNA #1 and then assigned CNA #1 male residents and Resident #41 was given to another CNA. Review of Administrative Staff Member's (ASM) #7 (Unit Manager) Witness Statement dated 09/24/2018 revealed that on 09/23/2018 a CNA had voiced a concern to her about an incident that she had witnessed with Resident #41 and CNA #1. ASM #7 documented as follows, "I did not call the Director of Nursing as CNA #1 has had (Resident's Name) on his assignment on and off for at least a year and a half. (Resident Name) yells and screams if anyone touches her inappropriately of if she perceives any injury. As this did not occur on 09/23/2018 and no one reported (Resident name) yelling, screaming or crying, I did not send CNA #1 home, I had him reassigned." Review of "Employee Corrective Action Form" revealed that the facilities previous Director of Nursing (ASM #5) had counseled CNA #1 on 09/24/2018 and the Corrective Plan of Action is documented in part as follows, "Suspension pending investigation is recommended....." Review of Census Entry report revealed that Resident #41 had a room change to Room (Number) on 09/25/2018.

On 06/25/2019 at approximately 5:10 p.m., an interview was conducted with CNA #1 and he stated, "Resident #41's 1 on 1 nurse had stepped away, don't know why, may have went to get something to eat. I went into (Resident's name) room to pass out towels and when I turned around (Resident's name) walked across the

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room and sat down on the bed and had taken off her clothes. Then (Resident's name) 1 on 1 aide waked back in the room and the 1 on 1 aide and I walked out of the room." CNA #1 was asked, "Did Resident #41 have clothes on when you went into the room?" CNA #1 stated, "Yes." CNA #1 was asked, "Did you usually pass out towel's?" CNA #1 stated, "Yes." CNA #1 was asked, " When were you taken off of the assignment?" CNA #1 stated, " The next day I was told not to work with (Resident's name) and I was put on an assignment with just male resident's."

On 06/26/2019 at approximately 2:00 p.m., an interview was conducted with LPN #1 and asked her to review the incident in September of 2018 that involved Resident #41 and CNA #1. LPN #1 stated, "I can't remember anything." LPN #1 was asked, "What would you do if you suspected abuse or something out of the normal had occurred?" LPN #1 stated, "I would assess my resident and go to the DON (Director of Nursing) and Supervisor. I would remove the resident from the situation."

On 06/26/2019 at approximately 3:00 p.m., a telephone number was requested for the Unit Manager whom had provided a witness statement on 09/24/2018, Registered Nurse (RN) #5. The Director of Nursing stated that the nurse was no longer an employee at the facility.

On 06/27/2019 at 7:00 a.m., an interview was conducted over the telephone with CNA #2 and she stated, "I was assigned to do 1 on 1 with (Resident's name). She could dress herself and go to the bathroom. I was just suppose to sit outside her room in a chair to make sure no one went in, she had behaviors. (Resident's name)

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was quiet so I got up and went to the nurses station and then about 10 minutes later I went back down to her room to check on her because I was told if she was asleep I could leave and go home, it was about 10 p.m." CNA #1 stated that she had worked a double shift that day, 7 am - 3 p.m. and second shift. CNA #1 stated, "When I opened the door up I saw CNA #2 at the back of the door, standing closer to the bathroom door and holding something in his hand, a gown or something, and he jumped like he was startled." CNA #2 was asked, "Where was Resident #41 located in the room?" CNA #2 stated, "She was standing closer to the middle of the room." CNA #1 stated, "CNA #1 was not in reach of (Resident's name)." CNA #2 stated, "CNA #1 may have been coming out of the bathroom. CNA #1 stated he was helping her to change." CNA #2 was asked, "How did CNA #1 get into Resident #41's room if you were sitting in the chair?" CNA #2 stated, "When I went up to the nurses station I had my back to the room." CNA #2 stated, "I was written up for leaving my post." CNA #2 was asked, "Can you explain - when you were assigned to do 1 on 1 were you responsible for all of Resident #41's care?" CNA #2 stated, "Well no, it's a little difficult to explain. (Resident's name) was on CNA #1's assignment and I was assigned to do 1 on 1 care with her. I didn't usually work back there on the unit, I usually worked on the Green Unit, I'm not sure how they work things. I didn't know if CNA #1 usually helped Resident #41 or not. I wasn't sure if I should say something or not. I just thought it was odd. I kept thinking about what happened so I reported it to the nurse the next morning. I should have reported it within 2 hours." CNA #2 repeated several times during the interview that she never saw CNA #1 touch Resident #41.

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| F 607 | Continued From page 60<br><br>On 06/27/2019 at approximately 6:15 p.m., at pre-exit meeting the Administrator and Registered Nurse Consultant was informed of the findings. The facility did not present any further information about the findings.<br><br>Complaint Deficiency. | F 607 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified | F 609 | | |

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| F 609 | Continued From page 61<br>appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to report an allegation of abuse to the appropriate state agencies for four of 57 residents in the survey sample, Resident #5, #82, #107 and #41.<br><br>1. Facility staff failed to report a sexual encounter that had occurred between Resident #5 and Resident #107 on 3/6/19 to the appropriate state agencies.<br><br>2. Facility staff failed to report a resident to resident altercation that had occurred between Resident #82 and Resident #107 on 6/24/19 to the appropriate state agencies.<br><br>3. The facility staff failed to report allegation of abuse in a timely manner for Resident #41.<br><br>The findings include:<br><br>1a . Resident #5 was admitted to the facility on 6/20/18 with diagnoses that included but were not limited to Pick's Disease (1), muscle weakness, difficulty walking, and major depressive disorder. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/11/19. Resident #5 was coded as being severely impaired in cognitive function scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one staff member with ADLs (activities of daily living) such as dressing, bed mobility and transfers; and supervision only | F 609 | 1. A facility reported incident was submitted and reported to the appropriate agencies on resident #5, #107, #82 and #41completed on 06/25/19.<br>2. All residents have the potential to be affected. The facility completed an audit of the residents that currently resident in the facility for the last 30 days to ensure that allegations of abuse were reported in a timely fashion was completed on 07/26/19. No other issues were identified.<br>3. ED and DCS have been educated by the RDCS (Regional Director of Clinical Services) on reporting of an allegation in a timely manner was completed 06/25/19. All staff will complete education on timely reporting of abuse.<br>4. The ED and or designee will complete an audit to ensure timely notification of allegation twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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with walking.

1b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy (2), Hepatitis C (3), and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #5's clinical record revealed a nursing note that documented possible sexual abuse on 3/6/19. The following was documented: "Reported to this writer that resident (Resident #5) in room (number of Resident #5's room) was lured in (number of Resident #107's room). Seen with paints (sic) down as well as lips touching each others. Made DON (Director of Nursing) aware. Instructed by DON to keep resident's apart."

Review of Resident #107's clinical record revealed no documentation regarding the above incident.

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

On 6/25/19 at 5:37 p.m., an interview was

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conducted with LPN #1, the nurse who worked when both sexual encounters had occurred. When asked the process if she were to see abuse between two residents in the facility, LPN #1 stated that she would remove the victim from the situation and report the abuse to administration. When asked who her abuse coordinator was, LPN #2 stated that the DON (Director of nursing) was the abuse coordinator.

On 6/26/19 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the corporate consultant. When asked the process if her nurses were to report two residents engaging in sexual relations especially on the Peach unit, ASM #2 stated that she would separate the residents, start an investigation to see if the incident requires reporting to the appropriate state agencies. ASM #2 stated that if both residents can give consent; she would then provide the residents privacy. ASM #2 stated that if the residents could not give consent, she would then call the RPs and if the RPs give consent she would ensure the residents are safe and practicing safe sex. ASM #2 denied being aware of the incident on 3/6/19 between Resident #5 and Resident #107, despite the nursing note written on 3/6/19 documenting that the DON was made aware. ASM #2 stated that the administrator was the abuse coordinator.

On 6/26/19 at 5:13 p.m., further interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who was working on 3/6/19. When asked what had happened on 3/6/19; LPN #1 stated that a CNA (certified nursing assistant) had alerted her that she had seen Resident #5 in Resident #107's room. LPN #1 stated that

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because she was not sure if the residents were cognitively intact enough to consent to any sexual activity; she separated the residents, and alerted administration (the DON). LPN #1 stated; "I told (Name of DON). She told me to keep them apart."

On 6/27/19 at 5:30 p.m., ASM #1, the Administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.

2. Facility staff failed to report a resident to resident altercation that had occurred between Resident #82 and Resident #107 on 6/24/19 to the appropriate state agencies.

2a. Resident #82 was admitted to the facility on 3/15/19 and readmitted on 5/9/18 with diagnoses that included but were not limited to dementia without behavioral disturbance, muscle weakness and high blood pressure. Resident #82's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #82 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam.

2b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy, Hepatitis C, and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff

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Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #82's clinical record revealed the following nursing note dated 6/24/19: "resident attempting to get out of bed and roommate was observed hitting him in the face trying to make him lay down. no bruising observed at this time."

Review of Resident #107's clinical record revealed the following note dated 6/24/19: "Heard resident yelling from room lay down lay down. CNA (Certified Nursing Assistant) entered room observed this resident hitting roommate trying to make him lay down. Call placed to RP (Responsible Party) left message to return call. PA (Physician's Assistant) made aware. Supervisor and ADON (Assistant Director of Nursing) made aware."

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

On 6/25/19 at 2:21 p.m., an interview was conducted with CNA #5. When asked the process if she were to see a resident hit another resident, CNA #5 stated that she would separate the residents, deescalate the situation and redirect the residents. CNA #5 stated that she would report the incident to her charge nurse. CNA #5 then gave an example and stated that Resident #107 had hit his roommate the day prior at

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approximately 1:45 p.m. and that she had reported this to her charge nurse (LPN #1). CNA #5 stated that she had written a statement for her nurse. When asked what staff were doing to ensure Resident #82 was safe from Resident #107, CNA #5 stated that they were trying to ensure that they were not in their room at the same time. When asked if she had worked that morning, CNA #5 stated that she did and was working until 3 p.m. CNA #5 was told about the above observations during lunch. CNA #5 confirmed that the residents were not separated during this time. When asked how CNAs were made aware of resident to resident altercations, CNA #5 stated that nurses tell them in report.

On 6/25/19 at 2:59 p.m., the FRI and investigation so far for Resident #107 and Resident #82 was requested from the DON (Director of Nursing) (ASM-administrative staff member) #2. ASM #2 stated that she didn't have a FRI because she wasn't aware of any resident to resident altercation between Resident #107 and #82. ASM #2 stated that maybe the Administrator had submitted one and she would go check.

On 6/25/19 at 5:20 p.m., ASM #3, the corporate nurse stated that the administrator had been made aware of the resident to resident altercation between Resident #107 and #82 on 6/24/19, but did not report this incident to the appropriate state agencies or initiate an investigation because there were no injuries. ASM #3 stated that she had just in-serviced the Administrator on the abuse policy and went over when to report and investigate abuse. ASM #3 stated that the Administrator was using the old abuse policy and thought he didn't have to report and separate the

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residents because there were no injuries. ASM #3 stated that they had just moved Resident #107 to a private room to protect Resident #82.

On 6/25/19 at 5:37 p.m., this writer was able to get in touch with LPN #1. When asked what had happened on 6/24/19 between Resident #107 and Resident #82, LPN #1 stated that it was reported to her by the CNA that Resident #107 had slapped Resident #82. LPN #1 stated that staff attempted to get Resident #107 out of his room but were unsuccessful. LPN #1 stated that they did q 15 minute checks on Resident #107. When asked if she could provide those checks, LPN #1 stated that the staff were not writing it down and she could not prove staff were doing this. LPN #1 stated that she had reported this incident to the ADON and Administrator. LPN #1 stated that most of the day 6/25/19, Resident #82 was out of the room and at the table doing activities with the activity assistant. LPN #1 was told about the above observations at lunch. When asked if Resident #82 was protected from Resident #107 after being slapped by Resident #107, LPN #1 stated that they just moved Resident #107 to a private room. When asked if this was after this surveyor had alerted the DON by asking for a FRI, LPN #1 stated yes.

On 6/27/19 at 12:00 p.m., an interview was conducted with ASM #1, the Administrator. When asked the process when it is reported to him that abuse, or an allegation of abuse had occurred between two residents, ASM #1 stated that he would report actual abuse that day to the appropriate state agencies, separate the residents and start and investigation. ASM #1 stated that the incident between Resident #107 and #82 was reported to him on 6/24/19 but that

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he did not report the incident until 6/25/19 to the appropriate state agencies. ASM #1 stated that he figured he did not have to report if there were no physical injuries that required physician intervention. When asked why he ended up reporting the incident on 6/25/19, ASM #1 stated that his DON had asked him if he had submitted a FRI regarding the incident. ASM #1 showed this surveyor the fax confirmation to report the incident to the OLC on 6/25/19 at 3:47 p.m. When asked why an investigation wasn't started immediately and what they had in place to protect Resident #82 from Resident #107, ASM #1 stated, "We (Administrator and ADON) felt at the time to monitor." When asked if he was educated on the abuse policy prior to his employment with the facility in February 2019; ASM #1 stated that he was.

Review of ASM #1 employee file revealed that he was educated on the abuse policy on 2/15/19. Review of the in-service dated 6/25/19 revealed that he and the DON were re-educated on the abuse policy.

On 6/27/19 at 5:30 p.m., ASM #1-the Administrator, ASM #2-the DON and ASM #3-the corporate nurse consultant were made aware of the above concerns.

Review of the facility's abuse policy documents in part, the following: "Any person who observes or becomes aware of an incident of resident abuse, neglect or mistreatment of resident belongings, whether alleged, suspected or observed, must report the incident to the Executive Director, Director of Clinical Services Immediately. The Executive Director, Director of Clinical Services or Clinical Services Supervisor will initiate the

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procedure for incident investigation and reporting...Alleged, suspected or observed abuse...are thoroughly investigated by the Executive Director and/or Director of Clinical Services. Alleged suspected or observed violations are reported immediately to the...Ombudsman and all other officials required by state law."
3. The facility staff failed to report allegation of abuse in a timely manner for Resident #41.

Resident #41 was admitted to the facility on 05/06/2011 and discharged to the hospital on 06/22/2019. Diagnosis included but were not limited to, Traumatic Brain Injury and Epilepsy. Resident #41's Discharge Assessment Minimum Data Set with an Assessment Reference Date of 10/09/2018 was coded for short-term memory problem and moderately impaired cognitive skills for daily decision making.

On 06/25/2019 Resident #41's closed record was reviewed and revealed a letter dated October 1, 2018 addressed to the Virginia Department of Health from the facility's previous Administrator, (Administration #6), stating that Certified Nursing Assistant (CNA) #2 reported that on 09/22/2018 she walked into Resident #41's room and found her to be disrobed with a male CNA in the room, CNA #1. The letter also stated that Adult Protective Services visited the facility on 09/24/2018 to investigate in response to an anonymous caller. The letter also stated that Adult Protective Services reported the allegation to (County) Law Enforcement and a detective was in the facility on 9/25/2018 and stated he would return on 10/01/2018 to complete his investigation. The Fax Transaction Report was reviewed and it indicated that the letter was faxed

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to Virginia Department of Licensure and Certification, Adult Protective Services and Ombudsman on 09/24/2018. Witness statements dated 09/24/2018, 09/25/2018 and 09/30/2018 which had been obtained were reviewed. Review of CNA #2's witness statement revealed that on 09/22/2018 she was doing 1 on 1 care with Resident #41 and she opened the door to go into her room and Resident #41 was completely naked with only her pants around her right ankle and CNA #1 came from behind (Resident's name) door and stated that he was delivering towels and helping Resident #41 to get into her night clothes. CNA #2 had written, "I never saw him touch (Resident's name) but he had no reason to be in her room." CNA #2 wrote, "I never told the nurse on duty that night because I wasn't sure what was happening but decided to report it to the nurse on Sunday. I reported it to Licensed Practical Nurse (LPN) # 1 on the Peach Unit. " CNA #2 also wrote that she reported it to the Unit Manager on that Sunday. Review of LPN #1's witness statement dated 09/24/2018 revealed that CNA #2 reported to her what she had seen. LPN #1 documented that she immediately reported to the supervisor on and the Unit Manager. LPN #1 also documented that she interviewed Resident #41 and CNA #1 and then assigned CNA #1 male residents and Resident #41 was given to another CNA. Review of Administrative Staff Member's (ASM) #7 (Unit Manager) Witness Statement dated 09/24/2018 revealed that on 09/23/2018 a CNA had voiced a concern to her about an incident that she had witnessed with Resident #41 and CNA #1. ASM #7 documented as follows, "I did not call the Director of Nursing as CNA #1 has had (Resident's Name) on his assignment on and off for at least a year and a half. (Resident Name)

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yells and screams if anyone touches her inappropriately of if she perceives any injury. As this did not occur on 09/23/2018 and no one reported (Resident name) yelling, screaming or crying, I did not send CNA #1 home, I had him reassigned." Review of "Employee Corrective Action Form" revealed that the facilities previous Director of Nursing (ASM #5) had counseled CNA #1 on 09/24/2018 and the Corrective Plan of Action is documented in part as follows, "Suspension pending investigation is recommended....." Review of Census Entry report revealed that Resident #41 had a room change to Room (number) on 09/25/2018.

On 06/26/2019 at approximately 2:00 p.m., an interview was conducted with LPN #1 and asked her to review the incident in September of 2018 that involved Resident #41 and CNA #1. LPN #1 stated, "I can't remember anything." LPN #1 was asked, "What would you do if you suspected abuse or something out of the normal had occurred?" LPN #1 stated, "I would assess my resident and go to the DON (Director of Nursing) and Supervisor. I would remove the resident from the situation."

On 06/26/2019 at approximately 3:00 p.m., a telephone number was requested for the Unit Manager whom had provided a witness statement on 09/24/2018, Registered Nurse (RN) #5. The Director of Nursing stated that the nurse was no longer an employee at the facility.

On 06/27/2019 at approximately 6:15 p.m., at pre-exit meeting the Administrator and Registered Nurse Consultant was informed of the findings. The facility did not present any further information about the findings.

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| F 610 SS=E | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to conduct an investigation and keep residents free from further abuse for two of 57 residents in the survey sample, Resident #5 and Resident #82.<br><br>1. Facility staff failed to investigate a sexual encounter between Resident #5 and Resident #107 on 3/6/19; and failed to protect Resident #5 from a second sexual encounter with Resident #107 on 3/20/19. | F 610 | 1. A facility reported incident and an investigation was initiated and completed for residents #5, #107 and #82 on 3/25/19 and 6/28/19.<br>2. All residents have the potential to be affected. The facility completed an audit of the residents that currently resides in the facility for the last 30 days to ensure that allegations of abuse were investigated was completed on 07/26/19. No other allegations were noted.<br>3. ED and DCS have been educated by the RDCS on investigating allegation of abuse was completed on 06/25/19.<br>4. The ED and or designee will complete an audit to ensure allegations of abuse were investigated twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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2. For Resident #82, facility staff failed to investigate a resident to resident altercation between Resident #82 and Resident #107; and failed to prevent further potential abuse from Resident #107.

The findings include:

1a. Resident #5 was admitted to the facility on 6/20/18 with diagnoses that included but were not limited to Pick's Disease (1), muscle weakness, difficulty walking, and major depressive disorder. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/11/19. Resident #5 was coded as being severely impaired in cognitive function scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one staff member with ADLs (activities of daily living) such as dressing, bed mobility and transfers; and supervision only with walking.

1b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy (2), Hepatitis C (3), and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #5's clinical record revealed a

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nursing note that documented possible sexual abuse on 3/6/19. The following was documented: "Reported to this writer that resident (Resident #5) in room (number of Resident #5's room) was lured in (number of Resident #107's room). Seen with paints (sic) down as well as lips touching each others. Made DON (Director of Nursing) aware. Instructed by DON to keep resident's apart."

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

Further review of Resident #5's and Resident #107's clinical record failed to evidence that staff were keeping the resident's separated to prevent further abuse.

Further review of the FRIS revealed a second incident had occurred between Resident #5 and Resident #107 on 3/20/19. The following was documented in the FRI: "Report date 3/20/19, Incident date 3/20/19: Incident Type: The residents were found in (Name of Resident #5's) room lying together partially undressed. The two residents were immediately separated...during the delivery of dinner, staff noted (name of Resident #5) and (name of Resident #107) on the bed in her room with their clothing partially removed. Neither resident wanted to discuss if the had sexual intentions. The residents were immediately separated, skin assessments completed and no signs of physical injury noted to either resident. MD (Medical Doctor) and RP (Responsible Party) were notified...Employee

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action initiated or taken: (Name of Resident #5) was moved to another room off the unit and (name of Resident #107) was placed on q (every) 15 minute checks). (Name of Resident #5's RP) did not want to contact the police."

The five day investigation follow up dated 5/25/19, documented in part, the following: "During dinner time staff was in the process of passing out meal trays. As a staff member entered the room to get (name of Resident #5) she encountered (Resident #107) on top of (name of Resident #5) both with there clothing down around their ankles. (Name of Resident #107) was immediately removed and taken to his room. The staff performed an assessment of (Name of Resident #5) and found no visualization of penetration, redness, swelling, bruising, or discharge. Staff informed to conduct q 15 minute checks on (Resident #107). (Resident #5) was immediately transferred off the unit and placed on another unit within the facility (off the locked unit). Both residents appear not to have experienced any emotional trauma from the incident. Findings: Based on staff, resident and review of the medical record the facility has substantiated that both residents were partially unclothed but there is no supporting evidence to suggest that sexual intercourse has occurred..."

On 6/25/19 at 5:37 p.m., an interview was conducted with LPN #1, the nurse who worked when both sexual encounters had occurred. When asked the process if she were to see abuse between two residents in the facility, LPN #1 stated that she would remove the victim from the situation and report the abuse to administration. When asked who her abuse coordinator was, LPN #2 stated that the DON

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(Director of nursing) was the abuse coordinator. When asked what was usually put into place after a resident is abused by another resident, LPN #2 stated that q (every 15 min) checks are usually conducted for three days and recorded on a tracking record. When asked how other clinical staff, i.e. nursing aides and nurses are made aware of resident to resident abuse, LPN #1 stated that nurses and nursing aides are given report. When asked the purpose of the care plan, LPN #1 stated the purpose of the care plan was to serve as a guide to care for the residents. When asked if the care plan should be updated after a resident to resident altercation, LPN #1 stated, "It should be updated."

On 6/26/19 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #3, the corporate consultant. When asked the process if her nurses were to report two residents engaging in sexual relations especially on the Peach unit, ASM #2 stated that she would separate the residents, start an investigation to see if the incident requires reporting. ASM #2 stated that if both residents can give consent; she would then provide the residents privacy. ASM #2 stated that if the residents could not give consent, she would then call the RPs and if the RPs give consent she would ensure the residents are safe and practicing safe sex. ASM #2 denied being aware of the incident on 3/6/19 between Resident #5 and Resident #107, despite the nursing note written on 3/6/19 documenting that the DON was made aware. When asked what had happened on 3/20/19 between Resident #5 and Resident #107; ASM #2 stated that it was reported to her that Resident #107 was found on top of Resident

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#5 with their pants pulled down. ASM #2 stated that at this time Resident #5 was able to remove her own pants. ASM #2 stated that as soon as she found out, she immediately separated the residents, called the responsible parties and called the physician. ASM #2 stated that she had moved Resident #5 off the Peach unit and to the Blue unit. ASM #2 stated that she had performed an assessment on Resident #5 and there were no visible signs of penetration or injury. ASM #2 stated that since both residents could not give consent at this time, she had reported this incident to the state agencies. ASM #2 stated that Resident #5 could not tell her what had happened and if she had consented to Resident #107's advances. ASM #2 stated that Resident #107 denied anything happening. ASM #2 stated that Resident #107 said he was trying to take Resident #5 to the bathroom. ASM #2 stated that Resident #5's responsible party did not want Resident #5 sent to the hospital for a rape kit because she didn't want to put her daughter through that stress. ASM #2 confirmed that nothing was put into place to prevent the 3/20/19 incident because she was not made aware of the incident on 3/6/19. ASM #2 confirmed that there was no evidence that the physicians and RPs (Responsible Parties) were notified regarding the incident on 3/6/19.

On 6/26/19 at 4:50 p.m., an interview was conducted with CNA (certified nursing assistant) #4, an aide who witnessed both sexual incidents on 3/6/19 and 3/20/19. CNA #4 stated that she would immediately separate the residents and report any suspected abuse to her supervisor. CNA #4 stated that she could not recall too much on 3/6/19 but that she had reported to the nurse (LPN #1) that Resident #5 was in Resident #107's

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room. CNA #4 stated that she was just told to keep the residents separated. CNA #4 stated that the nursing staff tried as much as they could to keep the residents separated and that it was hard when there was only two nursing aides and one nurse to the Peach unit. CNA #4 stated that there are supposed to be three aides on the Peach unit. CNA #4 stated that sometimes Resident #107 was left unattended if the aides were in the residents' rooms providing care and there was only one nurse working both the blue and peach units. CNA #4 stated that Resident #107 had not had any other sexual encounters with an other residents, only Resident #5. CNA #4 stated that she had been working on the Peach Unit for a total of 5 years.

On 6/26/19 at 5:13 p.m., further interview was conducted with LPN (licensed practical nurse) #1, the nurse who was working on 3/6/19. When asked what had happened on 3/6/19; LPN #1 stated that a CNA (Certified Nursing Assistant) had alerted her that she had seen Resident #5 in Resident #107's room. LPN #1 stated that because she was not sure if the residents were cognitively intact enough to consent to any sexual activity; she separated the residents, and alerted administration (the DON). LPN #1 stated; "I told (Name of DON (Director of Nursing). She told me to keep them apart." When asked if it was difficult to keep Resident #5 and Resident #107 apart, LPN #1 stated that if she is passing out medications and a CNA is in a room providing care, it was difficult to keep an eye on them. LPN #1 stated that there should be three CNA's on Peach unit and lately there had been two. LPN #1 could not recall how many CNAs were on shift the day of 3/6/19 or 3/20/19. LPN #1 stated that she is the only nurse usually working 7a.m. to 7 p.m.

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on the Peach unit. When asked if she could provide this writer with the 15 minute checks that were conducted on 3/6/19 for Resident #107, LPN #1 stated that q 15 minute checks were never written down. LPN #1 stated there was no way to prove that 15 minute checks were conducted on Resident #107 on 3/6/19.

On 6/27/19 at 5:30 p.m., ASM #1, the Administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.

2. For Resident #82, facility staff failed to investigate a resident to resident altercation between Resident #82 and Resident #107; AND failed to prevent further potential abuse from Resident #107.

2a. Resident #82 was admitted to the facility on 3/15/19 and readmitted on 5/9/18 with diagnoses that included but were not limited to dementia without behavioral disturbance, muscle weakness and high blood pressure. Resident #82's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/21/19. Resident #82 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status Exam.

2b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy, Hepatitis C, and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately

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impaired in cognitive function of the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #82's clinical record revealed the following nursing note dated 6/24/19: "resident attempting to get out of bed and roommate was observed hitting him in the face trying to make him lay down. no bruising observed at this time."

The next note dated 6/24/19 documented the following: "placed call to RP (responsible party) made aware of incident with roommate."

Review of Resident #107's clinical record revealed the following note dated 6/24/19: "Heard resident yelling from room lay down lay down. CNA (Certified Nursing Assistant) entered room observed this resident hitting roommate trying to make him lay down. Call placed to RP (Responsible Party) left message to return call. PA (Physician's Assistant) made aware. Supervisor and ADON (Assistant Director of Nursing) made aware."

Review of the facility FRIs (facility reported incidents) revealed that a FRI was not submitted to the OLC (Office of Licensure and Certification) and other state agencies regarding this incident. An investigation could not be found regarding this incident.

On 6/25/19 at 12:30 p.m., an observation was made of Resident #107. He was up eating lunch in his room with his roommate (Resident #82). Both residents were left unattended.

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On 6/25/19 at 12:43 p.m., an observation was made of Resident #107. He was wiping food off Resident #82's lap.

On 6/25/19 at 2:21 p.m., an interview was conducted with CNA #5. When asked the process if she were to see a resident hit another resident, CNA #5 stated that she would separate the residents, deescalate the situation and redirect the residents. CNA #5 stated that she would report the incident to her charge nurse. CNA #5 then gave an example and stated that Resident #107 had hit his roommate the day prior at approximately 1:45 p.m. and that she had reported this to her charge nurse (LPN #1). CNA #5 stated that she had written a statement for her nurse. When asked what staff were doing to ensure Resident #82 was safe from Resident #107, CNA #5 stated that they were trying to ensure that they were not in their room at the same time. When asked if she had worked that morning, CNA #5 stated that she did and was working until 3 p.m. CNA #5 was told about the above observations during lunch. CNA #5 confirmed that the residents were not separated during this time. When asked how CNAs were made aware of resident to resident altercations, CNA #5 stated that nurses tell them in report.

On 6/25/19 at 2:25 p.m., LPN #1 could be reached for an interview.

On 6/25/19 at 2:59 p.m., the FRI and investigation so far for Resident #107 and Resident #82 was requested from the DON (Director of Nursing) (ASM (administrative staff member) #2. ASM #2 stated that she didn't have a FRI because she wasn't aware of any resident

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to resident altercation between Resident #107 and #82. ASM #2 stated that maybe the administrator had submitted one and she would go check.

On 6/25/19 at 5:20 p.m., ASM #3, the corporate nurse stated that the Administrator had been made aware of the resident to resident altercation between Resident #107 and #82 on 6/24/19, but did not report this incident to the appropriate state agencies or initiate an investigation because there were no injuries. ASM #3 stated that she had just in-serviced the Administrator on the abuse policy and went over when to report and investigate abuse. ASM #3 stated that the Administrator was using the old abuse policy and thought he didn't have to report and separate the residents because there were no injuries. ASM #3 stated that they had just moved Resident #107 to a private room to protect Resident #82.

On 6/25/19 at 5:37 p.m., this writer was able to get in touch with LPN #1. When asked what had happened on 6/24/19 between Resident #107 and Resident #82, LPN #1 stated that it was reported to her by the CNA that Resident #107 had slapped Resident #82. LPN #1 stated that staff attempted to get Resident #107 out of his room but were unsuccessful. LPN #1 stated that they did q 15 minute checks on Resident #107. When asked if she could provide those checks, LPN #1 stated that the staff were not writing it down and she could not prove staff were doing this. LPN #1 stated that she had reported this incident to the ADON and Administrator. LPN #1 stated that most of the day 6/25/19, Resident #82 was out of the room and at the table doing activities with the activity assistant. LPN #1 was told about the above observations at lunch. When

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asked if Resident #82 was protected from Resident #107 after being slapped by Resident #107, LPN #1 stated that they just moved Resident #107 to a private room. When asked if this was after this surveyor had alerted the DON by asking for a FRI, LPN #1 stated yes.

On 6/27/19 at 12:00 p.m., an interview was conducted with ASM #1, the Administrator. When asked the process when it is reported to him that abuse, or an allegation of abuse had occurred between two residents, ASM #1 stated that he would report actual abuse that day to the appropriate state agencies, separate the residents and start and investigation. ASM #1 stated that the incident between Resident #107 and #82 was reported to him on 6/24/19 but that he did not report the incident until 6/25/19 to the appropriate state agencies. ASM #1 stated that he figured he did not have to report if there were no physical injuries that required physician intervention. When asked why he ended up reporting the incident on 6/25/19, ASM #1 stated that his DON had asked him if he had submitted a FRI regarding the incident. ASM #1 showed this surveyor the fax confirmation to report the incident to the OLC on 6/25/19 at 3:47 p.m. When asked why an investigation wasn't started immediately and what they had in place to protect Resident #82 from Resident #107, ASM #1 stated, "We (Administrator and ADON) felt at the time to monitor." When asked if he was educated on the abuse policy prior to his employment with the facility in February 2019; ASM #1 stated that he was.

Review of ASM #1 employee file revealed that he was educated on the abuse policy on 2/15/19. Review of the in-service dated 6/25/19 revealed

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| F 610 | Continued From page 84<br>that he and the DON were re-educated on the abuse policy.<br><br>On 6/27/19 at 5:30 p.m., ASM #1, the Administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.<br><br>Review of the facility's abuse policy documents in part, the following: "Any person who observes or becomes aware of an incident of resident abuse, neglect or mistreatment of resident belongings, whether alleged, suspected or observed, must report the incident to the Executive Director, Director of Clinical Services Immediately. The Executive Director, Director of Clinical Services or Clinical Services Supervisor will initiate the procedure for incident investigation and reporting...Alleged, suspected or observed abuse...are thoroughly investigated by the Executive Director and/or Director of Clinical Services. Alleged suspected or observed violations are reported immediately to the...Ombudsman and all other officials required by state law. If a resident abuses another resident, the abusive resident's physician will be contacted and appropriate action will be taken to prevent further such behavior. If the abusive resident's behavior cannot be controlled, thereby posing a threat of harm to others in the facility, the resident will be discharged." | F 610 | | |
| F 622 SS=E | Transfer and Discharge Requirements<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or | F 622 | | |

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| F 622 | Continued From page 85<br>discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br>(F) The facility ceases to operate.<br>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.<br><br>§483.15(c)(2) Documentation. | F 622 | 1. Resident #32, #41, #65, #108 and # 317 returned to the facility on 6/4/19 and has been here ever since. Resident #265 no longer resides at facility.<br>2. Residents who are transferred out of the facility have the potential to be affected. A 30 day review of residents who were transferred was in compliance. No other issues were identified.<br>3. DON and or Designee will re-educate the staff to provide the care plan to the receiving provider at the time of transfer to the hospital was completed by 08/01/19.<br>4. The DCS and or designee will conduct an audit of to ensure the care plan is provided at the time of transfer to the receiving facility twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC: 08/06/2019 | |

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When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and

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any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's care plan to include their goals for six of 57 residents (Resident #317, #32, #41, #265, #65 and #108) after being transferred to the hospital.

The findings included:

1. The facility staff failed to ensure that Resident #317's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital on 04/01/19. Resident #317 was originally admitted to the facility on 10/31/16. Diagnosis for Resident #317 included but not limited to acute respiratory failure with hypoxia.

The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 04/12/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments was dated for 04/01/19-discharge return anticipated.

On 06/13/18, according to the facility's documentation, per family request, Emergency Services was called to transport Resident #317 to the local Emergency Room (ER) due to resident complained of being dizzy, nauseous, extreme weakness and had vomited several times (unwitnessed).

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On 06/25/19 at approximately 1:40 p.m., a request was made to the Director of Nursing (DON) for evidence that the facility provided written information of Resident #317's care plan to include their goals was sent prior to or shortly after being transferred to the hospital on 04/01/19. On the same day at approximately 2:04 p.m., the DON stated, "I was unable to locate in Resident #317's clinical record the care plan was sent when discharged to the hospital on 04/01/19.

The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/27/19 at approximately 3:40 p.m. The facility did not present any further information about the findings.

2. The facility staff failed to send Resident #32's Care Plan goals when discharged to the hospital on 06/13/2019.

Resident #32 was admitted to the facility on 01/26/2019. Resident #32 was discharged to the hospital on 06/13/2019 and readmitted to the facility on 06/18/2019. Diagnoses included but were not limited to, Peripheral Vascular Disease and Type 2 Diabetes Mellitus. Resident #32's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/05/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #32 as requiring set up help only with eating, supervision with assistance of 1 for toilet use, independent with bed mobility, transfer, dressing, bathing and independent with personal hygiene with assistance of 1.

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On 06/25/2019 at approximately 12:00 p.m., the Director of Nursing (DON) and Registered Nurse (RN) Consultant was asked, "Can you provide documentation that the Care Plan goals were sent with Resident #32 upon discharge to the hospital on 06/13/2019?"

On 06/25/2019 at approximately 1:00 p.m., the RN Consultant stated, "The Nurses have been educated to send the Bed Hold Notice and Care Plan goals with the resident's on discharge to the hospital but they just did not do it."

On 06/25/2019 at 2:45 p.m., an interview was conducted with the DON and she stated, "I am unable to provide documentation that the Bed Hold Notice and Care Plan goals were sent out with (Resident name) to the hospital." The DON was asked, "What are your expectations of Nursing when sending residents to the hospital?" The DON stated, "I expect the Nurses to send the Bed Hold Notice and Care Plan goals to the hospital and document in the Nurse Notes."

On 06/27/2019 at approximately 6:15 p.m., at the pre-exit meeting the Administrator and the Registered Nurse Consultant was informed of the finding. The facility did not present any further information about the finding.

3. The facility staff failed to send Resident #41's Care Plan goals when discharged to the hospital on 06/22/2019.

Resident #41 was admitted to the facility on 05/06/2011 and discharged to the hospital on 06/22/2019. Diagnoses included but were not limited to, Traumatic Brain Injury and Epilepsy. Resident #41's Discharge Assessment Minimum

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Data Set with an Assessment Reference Date of 10/09/2018 was coded for short-term memory problem and moderately impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #41 as requiring limited assistance with bed mobility, transfer, walk in room, walk in corridor, dressing, toilet use and supervision with eating and personal hygiene.

On 06/25/2019 at approximately 12:00 p.m., the Director of Nursing (DON) and Registered Nurse (RN) Consultant was asked, "Can you provide documentation that the Care Plan goals were sent with Resident #41 upon discharge to the hospital on 06/22/2019?"

On 06/25/2019 at approximately 1:00 p.m., the RN Consultant stated, "The Nurses have been educated to send the Bed Hold Notice and Care Plan goals with the resident's on discharge to the hospital but they just did not do it."

On 06/25/2019 at 2:45 p.m., an interview was conducted with the DON and she stated, "I am unable to provide documentation that the Bed Hold Notice and Care Plan goals were sent out with (Resident name) to the hospital." The DON was asked, "What are your expectations of Nursing when sending residents to the hospital?" The DON stated, "I expect the Nurses to send the Bed Hold Notice and Care Plan goals to the hospital and document in the Nurse Notes."

On 06/27/2019 at approximately 6:15 p.m., at pre-exit meeting the Administrator and the Registered Nurse Consultant was informed of the finding. The facility did not present any further information about the finding.

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4. The facility staff failed to ensure that Resident #265's Plan of Care Summary to include their care plan goals were sent upon transfer-discharge to the hospital on 04/05/19.

Resident #265 was originally admitted to the nursing facility on 11/12/18 and readmitted on 04/08/19 and expired on 04/12/19. Diagnoses included but were not limited to, Peripheral Vascular Disease, Local Infection of the skin and Subcutaneous Tissue and Venous Insufficiency.

The current Minimum Data Set (MDS) a quarterly MDS with an Assessment Reference Date (ARD) of 03/06/19 coded the resident with a 02 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The section M on the MDS under Pressure Ulcers read as follows: Resident at risk for Pressure Ulcers as being "Yes". This section also indicates that the resident has 2 Venous and Arterial Ulcers present. The Discharge MDS assessment dated 04/05/19-discharge return anticipated, resident re-admitted on 04/08/19.

An interview was conducted with Licensed Practical Nurse (LPN) #7 on 06/25/19 at approximately, 10:48 AM concerning Resident transfers-discharges. She was asked "What paperwork is sent with the resident when they are being sent out to the hospital." LPN #7 replied that "we usually will send out a copy of the MAR (Medication Administration Record), the Face Sheet, bed hold notice, E-Interact SBAR (Situation, Background, Assessment, Recommendation) and the History and Physical."

On 6/27/19 at approximately 9:30 AM an interview was conducted with the DON (Director

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of Nursing) concerning Residents Discharge/transfer notes and care plan. The DON stated there is no note specifying that a care plan was sent to the hospital when resident was transferred.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 05/16/19 at approximately, 12:22 PM concerning Resident transfers-discharges. He was asked "What paperwork is sent with the resident when they are being sent out to the hospital." LPN #1 replied that "we usually will send out a copy of the MAR (Medication Administration Record), the Face Sheet, bed hold notice, Quality Assurance, SBAR (Situation, Background, Assessment, Recommendation) and the History and Physical." He was asked if the care plan is normally sent. He stated, "We don't send a care plan."

An interview was conducted with the Administrator and Director of Nursing (DON) on 05/16/19 at approximately 5:09 PM. They were asked what should have been done concerning the above issue. The DON stated that "we will send care plan to the hospital with the resident."

On 06/27/19 at approximately, 4:43 PM a pre-exit interview was conducted. Present were the Nurse Consultant, the Director Of Nursing, the Regional Nurse Consultant and the Administrator. They were debriefed on the above concerns.

5. The facility staff failed to ensure comprehensive care plan goals were sent upon discharge to the hospital for Resident #65 on 4/30/19.

Resident #65 was admitted on 3/24/18 and

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readmitted on 5/4/19 with diagnoses to include but not limited to Quadriplegia, Failure to Thrive and Pressure Ulcers.

Resident #65's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 5/10/19. The Brief Interview for Mental Status was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #65's MDS history was reviewed and revealed the following:

1. A Unplanned Discharge-return anticipated MDS with an ARD of 4/30/19.
2. A Entry MDS with an ARD of 5/4/19.

Resident #65 Progress Note dated 4/30/19 at 18:52 (6:52 P.M.) was reviewed and is documented in part, as follows: Resident had labs critical and called LTC (Physician Group) and they said to send out resident emergency. Resident left to go to hospital around 5:45.

Resident #65's Hospital Discharge Summary dated 5/4/19 was reviewed and is documented in part, as follows:

Resident #65's Medical Record was reviewed and there was no documentation to support that the comprehensive care plan goals were sent with the resident upon transfer to the hospital on 4/30/19.

06/26/19 at 11:04 A.M. an interview was conducted with the Director of Nursing regarding Resident #65's hospital discharge on 4/30/19; and if there was any documentation to support that a care plan was sent with the resident upon

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transfer to the hospital The Director of Nursing stated, "No I could not find anything to show we sent those documents with him. Our process is to send the bedhold policy and the care plan at the time of transfer."

On 6/27/19 at approximately 3:30 P.M. the above information was shared with the Administrator, the Director of Nursing and the Corporate Nurse Consultant. Prior to exit no further information was shared.

6. The facility staff failed to ensure comprehensive care plan goals were sent upon discharge for Resident #108 on 11/29/18.

Resident #108 was originally admitted to the facility on 6/29/18 and readmitted on 12/6/18 with diagnoses to include but not limited to Spina Bifida, Mild Intellectual Disabilities and Bipolar Disorder.

Resident #108's most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 5/30/19. The Brief Interview for Mental Status was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #108's MDS history was reviewed and revealed the following:

1. A Quarterly Unplanned Discharge-return anticipated MDS with an ARD of 11/29/18.
2. A Entry MDS with an ARD of 12/6/18.

Resident #108's Progress Note dated 11/29/18 at 20:09 (8:09 P.M.) was reviewed and is documented in part, as follows:

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Behavior Note: CNA (Certified Nursing Assistant) reported that resident stated she drank a whole bottle of wound cleanser. Charge nurse entered room and resident admitted to drinking wound cleanser. Resident stated she was depressed and tried to kill herself. Called 911 in to transport to Name (Hospital) ER (emergency room). 911 in to transport resident. Report called to ER. Unit manager notified and is aware.

Resident #108's Medical Record was reviewed and there was no documentation to support that comprehensive care plan goals were sent with the resident upon transfer to the hospital on 11/29/18.

06/26/19 at 11:04 A.M. an interview was conducted with the Director of Nursing regarding Resident #108's hospital discharge on 11/29/18 and if there was any documentation to support that a care plan was sent with the resident upon transfer to the hospital The Director of Nursing stated, "No I could not find anything to show we sent those documents with her. Our process is to send the bedhold policy and the care plan at the time of transfer."

On 6/27/19 at approximately 3:30 P.M. the above information was shared with the Administrator, the Director of Nursing and the Corporate Nurse Consultant. Prior to exit no further information was shared.

The facility policy titled "Transfer/Discharge Notification and Right to Appeal" revised 3/26/18 was reviewed and is documented in part, as follows:

Policy: Transfer and discharges of residents,

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| F 622 | Continued From page 96<br>initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements.<br><br>Procedure: Transfer/Discharge Requirements:<br>Documentation: When the center transfers or discharges a resident under any of the circumstances listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider<br>*Comprehensive care plan goals. | F 622 | | |
| F 625 SS=E | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§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-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(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<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At | F 625 | | |

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| F 625 | Continued From page 97<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy upon discharge/transfer for five of 57 resident's (Resident #317, 32, 41, 65 and 108) after being transferred to the local hospital.<br><br>The findings included:<br><br>1. The facility staff failed to provide the Resident #317 or their representative a copy of the bed hold policy upon discharge/transfer to the hospital on 04/01/19. Resident #317 was originally admitted to the facility on 10/31/16. Diagnosis for Resident #317 included but not limited to acute respiratory failure with hypoxia.<br><br>The Discharge MDS assessments was dated for 04/01/19 - discharge return anticipated.<br><br>On 06/13/18, according to the facility's documentation, per family request, Emergency Services was called to transport Resident #317 to the local Emergency Room (ER) due to resident complained of being dizzy, nauseous, extreme weakness and had vomited several times (unwitnessed).<br><br>On 06/25/19 at approximately 1:40 p.m., a request was made to the Director of Nursing (DON) for evidence that the facility provided | F 625 | 1. Resident #32 (readmitted on 6/18/19), #41(readmitted on 6/29/19), #65 (readmitted on 5/4/19), #108 (readmitted on 12/6/18) and #317 (readmitted on 06/04/19).<br>2. All residents have the potential to be affected. The facility will conduct a review of residents to ensure the resident or resident representative were given the bed hold policy upon transfer to the local hospital in the past thirty days was completed by 07/26/19.<br>3. The DCS or designee will educated licensed staff on ensuring written information was provided to the resident regarding bed hold upon transfer to hospital to be completed by 08/01/19.<br>4. The DCS or designee will ensure that when residents are transferred to the hospital the resident or resident representative are is provided in writing information regarding the bed hold policy twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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written information of the Notice of Bed-Hold Policy to the resident or resident representative prior to or shortly after their transfer to the hospital on 04/01/19. On the same day at approximately 2:04 p.m., the DON stated, "I am unable to locate in Resident #317's clinical record the bed hold policy was issued to the resident or their representative when discharged to the hospital on 04/01/19.

The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/27/19 at approximately 3:40 p.m. The facility did not present any further information about the findings.

2. The facility staff failed to provide Resident #32 or resident representative a written Bed Hold Notice when discharged to the hospital on 06/13/2019.

Resident #32 was admitted to the facility on 01/26/2019. Resident #32 was discharged to the hospital on 06/13/2019 and readmitted to the facility on 06/18/2019.

On 06/25/2019 at approximately 12:00 p.m., the Director of Nursing (DON) and Registered Nurse (RN) Consultant was asked, "Can you provide documentation that the Bed Hold Notice was sent with or provided to Resident #32 upon discharge to the hospital on 06/13/2019?"

On 06/25/2019 at approximately 1:00 p.m., the RN Consultant stated, "The Nurses have been educated to send the Bed Hold Notice and Care Plan goals with the resident's on discharge to the hospital but they just did not do it."

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On 06/25/2019 at 2:45 p.m., an interview was conducted with the DON and she stated, "I am unable to provide documentation that the Bed Hold Notice and Care Plan goals were sent out with (Resident name) to the hospital." The DON was asked, "What are your expectations of Nursing when sending residents to the hospital?" The DON stated, "I expect the Nurses to send the Bed Hold Notice and Care Plan goals to the hospital and document in the Nurse Notes."

On 06/27/2019 at approximately 6:15 p.m., at pre-exit meeting the Administrator and the Registered Nurse Consultant was informed of the finding. The facility did not present any further information about the finding.

3. The facility staff failed to provide Resident #41's or resident representative a Bed Hold Notice when discharged to the hospital on 06/22/2019.

Resident #41 was admitted to the facility on 05/06/2011 and discharged to the hospital on 06/22/2019. Diagnosis included but were not limited to, Traumatic Brain Injury and Epilepsy.

On 06/25/2019 at approximately 12:00 p.m., the Director of Nursing (DON) and Registered Nurse (RN) Consultant were asked, "Can you provide documentation that the Bed Hold Notice was sent with Resident #41 upon discharge to the hospital on 06/22/2019?"

On 06/25/2019 at approximately 1:00 p.m., the RN Consultant stated, "The Nurses have been educated to send the Bed Hold Notice and Care Plan goals with the resident's on discharge to the

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hospital but they just did not do it."

On 06/25/2019 at 2:45 p.m., an interview was conducted with the DON and she stated, "I am unable to provide documentation that the Bed Hold Notice and Care Plan goals were sent out with (Resident name) to the hospital." The DON was asked, "What are your expectations of Nursing when sending residents to the hospital?" The DON stated, "I expect the Nurses to send the Bed Hold Notice and Care Plan goals to the hospital and document in the Nurse Notes."

On 06/27/2019 at approximately 6:15 p.m., at pre-exit meeting the Administrator and the Registered Nurse Consultant was informed of the finding. The facility did not present any further information about the finding.

4. The facility staff failed to ensure a Bed Hold Policy was sent with Resident #65 or provided to the resident representative upon discharge to the hospital on 4/30/19.

Resident #65 was admitted on 3/24/18 and readmitted on 5/4/19 with diagnoses to include but not limited to Quadriplegia, Failure to Thrive and Pressure Ulcers.

Resident #65's Progress Note dated 4/30/19 at 18:52 (6:52 P.M.) was reviewed and is documented in part, as follows: Resident had labs critical and called LTC (Physician Group) and they said to send out resident emergency. Resident left to go to hospital around 5:45.

Resident #65's Medical Record was reviewed and there was no documentation to support that a Bedhold Notice was sent with the resident upon transfer to the hospital on 4/30/19.

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06/26/19 at 11:04 A.M. an interview was conducted with the Director of Nursing regarding Resident #65's hospital discharge on 4/30/19 and if there was any documentation to support that a bedhold notice was sent with the resident upon transfer to the hospital The Director of Nursing stated, "No I could not find anything to show we sent those documents with him. Our process is to send the bedhold policy and the care plan at the time of transfer."

On 6/27/19 at approximately 3:30 P.M. the above information was shared with the Administrator, the Director of Nursing and the Corporate Nurse Consultant. Prior to exit no further information was shared.

5. The facility staff failed to ensure a Bed Hold Policy was sent with Resident #108 or provided the the resident representative upon discharge to the hospital on 11/29/18.

Resident #108 was originally admitted to the facility on 6/29/18 and readmitted on 12/6/18 with diagnoses to include but not limited to Spina Bifida, Mild Intellectual Disabilities and Bipolar Disorder.

Resident #108's Progress Note dated 11/29/18 at 20:09 (8:09 P.M.) was reviewed and is documented in part, as follows:

Behavior Note: CNA (Certified Nursing Assistant) reported that resident stated she drank a whole bottle of wound cleanser. Charge nurse entered room and resident admitted to drinking wound cleanser. Resident stated she was depressed and tried to kill herself. Called 911 in to transport

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to Name (Hospital) ER (emergency room). 911 in to transport resident. Report called to ER. Unit manager notified and is aware.

Resident #108's Medical Record was reviewed and there was no documentation to support that a Bedhold Notice was sent with the resident upon transfer to the hospital on 11/29/18.

06/26/19 at 11:04 A.M. an interview was conducted with the Director of Nursing regarding Resident #108's hospital discharge on 11/29/18 and if there was any documentation to support that a bedhold notice was sent with the resident upon transfer to the hospital The Director of Nursing stated, "No I could not find anything to show we sent those documents with her. Our process is to send the bedhold policy and the care plan at the time of transfer."

On 6/27/19 at approximately 3:30 P.M. the above information was shared with the Administrator, the Director of Nursing and the Corporate Nurse Consultant. Prior to exit no further information was shared.

The facility policy titled "Transfer/Discharge Notification and Right to Appeal" revised 3/26/18 was reviewed and is documented in part, as follows:

Policy: Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements.

Procedure: Transfer/Discharge Requirements: Documentation: When the center transfers or discharges a resident under any of the

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| F 625 | Continued From page 103<br>circumstances listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider<br>*All other necessary information, including copies of the resident's discharge summary and other documentation, as applicable to ensure safe and effective transition of care. | F 625 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility document review and staff interviews the facility staff failed to ensure that a Comprehensive Minimum Data Set dated 5/30/19 was accurately coded to include a Level II PASRR (Preadmission Screening and Resident Review for one of 57 residents in the survey sample, Resident #108.<br><br>The facility staff failed to ensure that Resident #108's Annual Minimum Data Set dated 5/30/19 was accurately coded to include a Level II PASRR (Preadmission Screening and Resident Review).<br><br>The findings included:<br><br>Resident #108 was originally admitted to the facility on 6/29/18 and readmitted on 12/6/18 with diagnoses to include but not limited to Spina Bifida, Mild Intellectual Disabilities and Bipolar Disorder. | F 641 | 1. Resident # 108 MDS (Minimum Data Set) was modified on 06/27/19.<br>2. An audit was completed on current residents in the facility to ensure section A 1500 was coded accurately. No other residents affected.<br>3. MDS staff was reeducated on MDS accuracy by the ED on 07/18/19.<br>4. MDS or designee will monitor the twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance<br>Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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Resident #108's most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 5/30/19. The Brief Interview for Mental Status was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under Section A 1500 Preadmission Screening and Resident Review: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition-Resident #108 was coded as 0=No.

Resident #108's Comprehensive Care Plan was reviewed and is documented in part, as follows:

Focus: Name (Resident #108) has impaired cognitive function related to mild intellectual disability-pasrr in place. Date Initiated: 10/27/18

Resident #108's Level II PASRR Screening dated 6/28/18 provided by the facility was reviewed and is documented in part, as follows:

Summary of Findings: 1. Disability: Intellectual Disability
AXIS 2: Mild Intellectual Disability
Related Condition: Spina Bifida

On 6/27/19 at 11:44 AM an interview was conducted with MDS Coordinator RN #2 regarding Resident #108's Annual MDS dated 5/30/19 PASRR coding and if it was accurate. MDS Coordinator RN #2 looked in the residents electronic medical record and noted that the resident did have a level 2 PASRR. MDS Coordinator RN #2 stated, "Yes, her Annual MDS completed on 5/30/19 is wrong, it should have

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| F 641 | Continued From page 105<br>been coded as Yes under the PASRR section. I will do a modification today."<br><br>The Annual MDS that was modified on 6/27/19 was reviewed and is documented in part, as follows:<br><br>Under Section A 1500 Preadmission Screening and Resident Review: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition-Resident #108 was coded as 1=Yes.<br><br>A1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions:<br>1: B. Intellectual Disability<br>1: C. Other related conditions.<br><br>The facility policy titled "MDS" revised 9/25/17 was reviewed and is documented in part, as follows:<br><br>Policy: The center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to, the collection of data regarding functional status, strengths, weaknesses and preferences using the federal and/or state required RAI (Resident Assessment Instrument).<br><br>On 6/27/19 at approximately 3:30 P.M. the above information was shared with the Administrator, the Director of Nursing and the Corporate Nurse Consultant. Prior to exit no further information was shared. | F 641 | | |
| F 656 | Develop/Implement Comprehensive Care Plan | F 656 | | |

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| F 656 SS=D | Continued From page 106<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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. | F 656 | 1. Resident #97 fall care plan was reviewed and updated with appropriate interventions was completed on 06/27/19.<br>2. All residents have the potential to be affected. MDS/designee will audit that fall care plans have been implemented for current residents completed on date.<br>3. MDS/designee will re-educate IDT team on patient centered care plans development and implementation completed by ED on 07/18/19.<br>4. MDSC/designee will audit care plans to ensure fall care plans have been implemented twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision<br>5. AOC date: 08/06/2019 | |

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(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 observations, resident interview, staff interview and clinical record review the facility staff failed to develop a comprehensive care plan for one of 57 residents in the survey sample, Resident #97.

The facility staff failed to include care area 'falls" on the comprehensive care plan when Resident #97 was identified as a fall risk.

The findings included:

Resident #97 was admitted to the facility on 05/27/2019. Diagnosis included but were not limited to, Chronic Obstructive Pulmonary Disease and Diabetes Mellitus. Resident #97's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 06/03/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #97 as requiring total dependence of 1 for transfer, toilet use and bathing, extensive assistance of 1 for bed mobility, dressing and personal hygiene and supervision with set up help only for eating.

On 06/27/2019 review of Resident #97's clinical record revealed a "Fall Risk Evaluation" dated 05/27/2019 with a score of 10. Documentation on the Fall Risk Evaluation is as follows, "A Total Score of 10 or above deems residents at risk." Resident #97's comprehensive care plan was

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| F 656 | Continued From page 108<br>reviewed, there was no evidence that "Fall Risk" was addressed in care plan.<br><br>On 06/27/2019 at 12:55 p.m., an interview was conducted with Registered Nurse (RN) #4, MDS Coordinator, and she was asked, "Is Resident #97 evaluated as a Fall Risk?" RN #4 stated, "Yes, he is a Fall Risk." RN #4 was asked, "Is Fall Risk included on Resident #97's comprehensive care plan?" RN #4 stated, "No I don't see it in the care plan." RN #4 was asked, "Should Fall Risk be care planned?" RN #4 stated, "Yes it should be care planned." RN #4 was asked, "Who was responsible for ensuring it was care planned?" RN #4 stated, "The MDS Coordinator." RN #4 stated, "I will revise the care plan to include Fall Risk."<br><br>On 06/27/2019 at approximately 6:15 p.m., at the pre-exit meeting the Administrator and Registered Nurse Consultant was informed of the finding. The facility did not present any further information about the finding. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident. | F 657 | | |

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| F 657 | Continued From page 109<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to revise the care plan after resident to resident altercations for three of 57 residents in the survey sample, Residents #5, #107 and #7.<br><br>1. Facility staff failed to revise the care plan after a sexual encounter had occurred between Resident #5 and Resident #107 on 3/6/19.<br><br>2. Facility staff failed to revise the care plan after a resident to resident physical altercation had occurred between Resident #7 and Resident #107.<br><br>The findings include:<br><br>1a. Resident #5 was admitted to the facility on 6/20/18 with diagnoses that included but were not limited to Pick's Disease (1), muscle weakness, difficulty walking, and major depressive disorder. | F 657 | 1. Resident # 5 no longer resides in the facility. Resident #107 and #7 care plans have been revised regarding the previous altercations.<br>2. All residents have the potential to be affected. MDS will audit current resident care plans to be sure they have been revised when resident altercations occur was completed by 07/29/19.<br>3. MDS or designee will reeducate IDT team on revision of patient centered care plans was completed 07/18/19.<br>4. MDS or designee will audit that care plans have been revised when altercations occurred twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision<br>5. AOC date: 08/06/2019 | |

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Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/11/19. Resident #5 was coded as being severely impaired in cognitive function scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one staff member with ADLs (activities of daily living) such as dressing, bed mobility and transfers; and supervision only with walking.

1b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy (2), Hepatitis C (3), and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff Assessment for Mental Status exam. Resident #107 was coded as being independent with ADL (activities of daily living) and requiring supervision only with walking.

Review of Resident #5's clinical record revealed a nursing note that documented possible sexual abuse on 3/6/19. The following was documented: "Reported to this writer that resident (Resident #5) in room (number of Resident #5's room) was lured in (number of Resident #107's room). Seen with paints (sic) down as well as lips touching each others. Made DON (Director of Nursing) aware. Instructed by DON to keep resident's apart."

Review of Resident #5's comprehensive care plan dated 12/10/18 with the latest revision on

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3/21/19, failed to reflect the above incident between Resident #5 and Resident #107.

Review of Resident #107's comprehensive care plan dated 12/12/18 with the latest revision on 6/25/19, failed to reflect the above incident between Resident #5 and Resident #107.

On 6/25/19 at 5:37 p.m., an interview was conducted with LPN #1, the nurse who worked when both sexual encounters had occurred. When asked the process if she were to see abuse between two residents in the facility, LPN #1 stated that she would remove the victim from the situation and report the abuse to administration. When asked who her abuse coordinator was, LPN #2 stated that the DON (Director of Nursing) was the abuse coordinator. When asked what was usually put into place after a resident is abused by another resident, LPN #2 stated that q (every 15 min) checks are usually conducted for three days and recorded on a tracking record. When asked how other clinical staff, i.e. nursing aides and nurses are made aware of resident to resident abuse, LPN #1 stated that nurses and nursing aides are given report. When asked the purpose of the care plan, LPN #1 stated the purpose of the care plan was to serve as a guide to care for the residents. When asked if the care plan should be updated after a resident to resident altercation, LPN #1 stated, "It should be updated." On 6/26/19 at 6:57 p.m., LPN #1 confirmed that Resident #5's and Resident #107's care plans were not revised after the 3/6/19 incident.

On 6/27/19 at approximately 3:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. When

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asked the purpose of the care plan, ASM #2 stated that the purpose of the care plan was to understand the care for each resident such as psychosocial needs, use of devices (splints) or anything related to care. When asked if it was important for the care plan to be accurate, ASM #2 stated that it was. When asked if the care plan was updated for resident to resident altercations, ASM #2 stated that it would be updated for the victim and the aggressor. When asked why the care plan should be updated after a resident to resident altercation, ASM #2 stated that it should be updated to monitor for any psychosocial changes after an incident and to alert staff about the incident. When asked if CNAs have access to the care plans, ASM #2 stated that they had their own kardex that be automatically updated once the care plan was updated. ASM #2 stated that care plans were updated immediately following the incident. ASM #2 stated that all nurses can revise the care plan.

On 6/27/19 at 5:30 p.m., ASM #1, the Administrator, ASM #2, the DON and ASM #3, the corporate nurse consultant were made aware of the above concerns.

(1) "Pick's disease is a neurological condition characterized by a slowly progressive deterioration of behavior, personality, or language. People with Pick's disease have abnormal substances (called Pick bodies) inside nerve cells in the damaged areas of the brain. Pick bodies contain an abnormal form of a protein called tau. This protein is found in all nerve cells, but people with Pick's disease have an abnormal amount or type of this protein." This information was obtained from The National Institutes of Health.

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https://rarediseases.info.nih.gov/diseases/7392/picks-disease.

(2) "Wernicke's encephalopathy is a degenerative brain disorder caused by the lack of thiamine (vitamin B1). It may result from alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders, or the effects of chemotherapy. B1 deficiency causes damage to the brain's thalamus and hypothalamus. Symptoms include mental confusion, vision problems, coma, hypothermia, low blood pressure, and lack of muscle coordination (ataxia)." This information was obtained from The National Institutes of Health.
https://www.ninds.nih.gov/Disorders/All-Disorders/Wernicke-Korsakoff-Syndrome-Information-Page
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(3) Hepatitis C- Hepatitis is inflammation of the liver. Chronic hepatitis C is a long-lasting infection. If it is not treated, it can last for a lifetime and cause serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death. Hepatitis C spreads through contact with the blood of someone who has HCV. This contact may be through
-Sharing drug needles or other drug materials with someone who has HCV. In the United States, this is the most common way that people get hepatitis C.
-Getting an accidental stick with a needle that was used on someone who has HCV. This can happen in health care settings.
-Being tattooed or pierced with tools or inks that were not sterilized after being used on someone who has HCV
-Having contact with the blood or open sores of

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someone who has HCV
-Sharing personal care items that may have come in contact with another person's blood, such as razors or toothbrushes
-Being born to a mother with HCV
-Having unprotected sex with someone who has HCV." This information was obtained from The National Institutes of Health. https://medlineplus.gov/hepatitisc.html.

2. Facility staff failed to revise the care plan after a resident to resident physical altercation had occurred between Resident #7 and Resident #107 on 6/1/19.

2a. Resident #7 was admitted to the facility on 5/30/14 with diagnoses that included but were not limited to Dementia with Lewy Bodies (1), unspecified psychosis, and high blood pressure. Resident #7's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/13/19. Resident #7 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

2b. Resident #107 was admitted to the facility on 11/28/18 with diagnoses that included but were not limited to Wernicke's encephalopathy, Hepatitis C, and altered mental status. Resident #107's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/25/19. Resident #107 was coded as being moderately impaired in cognitive function of the Staff Assessment for Mental Status exam.

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Review of Resident #7's nursing notes revealed a note dated 6/1/19 that documented the following: "alteration (sic) with resident. was (sic) hit in the mouth by resident. RP (Responsible Party) and PA (Physician's Assistant) made aware. don (DON-Director of Nursing) notified."

Review of Resident #107's nursing notes dated 6/1/19 revealed the following note: "altercation with (Resident #7's). Hit resident in mouth. staff separated at this time. Placed call to RP and PA made aware."

Review of the facility FRIS (facility reported incidents) revealed that this incident was reported to the appropriate state agencies in a timely manner. The FRI dated 6/1/19 documented the following: "(Name of Resident #107) punched Resident #7 in mouth for no unknown reason. Staff immediately separated residents. (Name of Resident #7) was placed on 1:1 observation. (Name of Resident #7) was assessed by nurse and did not require any treatment intervention at this time. The MD (medical doctor) and RP (responsible party) were notified and a facility investigation has been initiated." The five day follow up to the FRI dated 6/5/19 documented the following: "(Name of Resident #107) was observed walking up to (Resident #7) who was sitting at a table without being provoked punched (Resident #7). Staff immediately separated the two residents. (Name of Resident #7) has no visible injuries and no other changes in condition were noted."

Review of Resident #7's care plan dated 10/11/18 with the latest revision on 4/1/19, failed to reflect the above incident with Resident #107.

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Review of Resident #107's comprehensive care plan dated 12/12/18 with the latest revision on 6/25/19, failed to reflect the above incident between Resident #5 and Resident #107.

On 6/27/19 at approximately 3:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. When asked the purpose of the care plan, ASM #2 stated that the purpose of the care plan was to understand the care for each resident such as psychosocial needs, use of devices (splints) or anything related to care. When asked if it was important for the care plan to be accurate, ASM #2 stated that it was. When asked if the care plan was updated for resident to resident altercations, ASM #2 stated that it would be updated for the victim and the aggressor. When asked why the care plan should be updated after a resident to resident altercation, ASM #2 stated that it should be updated to monitor for any psychosocial changes after an incident and to alert staff about the incident. When asked if CNAs have access to the care plans, ASM #2 stated that they had their own kardex that be automatically updated once the care plan was updated. ASM #2 stated that care plans were updated immediately following the incident. ASM #2 stated that all nurses can revise the care plan. ASM #2 confirmed that Resident #107 and Resident #7's care plan was not revised after the altercation on 6/1/19.

Facility policy titled, "Plans of Care," documents in part, the following: "Review, update and/or revise the comprehensive care plan based on changing goals, preferences, and needs of the resident and in response to current interventions after the completion of each OBRA MDS

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| F 657 | Continued From page 117<br>assessment, and as needed. The interdisciplinary team shall ensure the plan of care addresses an resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being."<br><br>(1) Lewy Bodies Dementia- "Lewy body dementia (LBD) is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. Lewy body dementia is one of the most common causes of dementia." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/what-lewy-body-dementia. | F 657 | | |
| F 658 SS=E | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on complainant investigation, observation, resident interviews, staff interviews, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for three out of 57 residents (Residents #55, #32 and #465) in the survey sample.<br><br>1. The facility staff failed to follow the physician | F 658 | | |

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| F 658 | Continued From page 118<br>orders for the treatment of the following wounds: right below the knee *amputation site (surgical incision) and skin tear to right elbow for Resident #55.<br><br>2. The facility staff failed to follow physician orders and administer treatments to a right BKA (Below the Knee Amputation) for Resident #32.<br><br>3. The facility failed to justify treatment with elimite cream for Resident #465.<br><br>The findings included:<br><br>1. Resident #55 was originally admitted to the facility on 01/24/19. Diagnosis for Resident #55 included but are not limited to Right below the knee amputation. Resident #55's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 04/26/19 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, under section M (Skin conditions) was coded for surgical wounds with surgical wound care.<br><br>An interview was conducted with Resident #55 on 06/25/19 at approximately 4:13 p.m. The resident said "the nurses are not changing my dressings as ordered by the doctor." The resident stated, "Sometimes my dressing will go 4 to 5 days before being changed (pointing to surgical incision to right stump)."<br><br>Review of the Treatment Administration Record (TAR) for June 2019 revealed the following treatment orders: | F 658 | 1. Resident # 55, #32 and #465 no longer resides at the facility.<br>2. All residents have the potential to be affected. DCS or designee will review that all current resident treatments are administered as ordered was completed by 07/29/19.<br>3. DCS or designee will reeducate licensed staff on ensuring treatments are administered per physician order was completed by 08/01/19.<br>4. DCS or designee will audit the TAR and MD orders to ensure residents are receiving treatments as ordered twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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-Right below the knee stump: cleanse with normal saline, apply *Algisite, cover with foam dressing and stump shrinker, change every other day for right stump care (start date 06/13/19). Further review of the clinical record for June 2019 evidenced there were no initials by the nurse; indicating the surgical wound care (right stump) treatment was not completed at 9:00 a.m., on 06/17/19.

-Apply skin prep to right above the amputation site every shift for skin protection (start date: 06/20/19). Further review of the clinical record for June 2019 evidenced there were no initials by the nurse; indicating treatment was not completed at 12:00 p.m., on the following days: 6/21, 6/22, 6/23 and 6/24/19.

Review of the Treatment Administration Record (TAR) for May 2019 revealed the following treatment orders:

-Apply *Santyl ointment to right above knee amputation topically every shift for wound treatment (start date: 05/02/19). Further review of the clinical record for May 2019 evidenced there were no initials by the nurses, indicating the surgical wound care (right stump) treatment was not completed at 12:00 p.m., on the following days: 5/06, 5/07, 5/08, 5/09, 5/11, 5/12, 5/14, 5/16, 5/18, 5/19, 5/21, 5/23, 5/25, 5/26, 5/28 and 5/29/19.

-Cleanse skin tear to right elbow with normal saline, pat dry, apply bacitracin ointment, cover with dry dressing daily until healed (start date: 05/03/19). Further review of the clinical record for May 2019 evidenced there were no initials by the nurse, indicating the skin tear treatment was not

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completed at 12:00 p.m., on the following days: 05/06, 05/07, 05/08, 05/09, 05/11, 05/12, 05/14, 05/15, 05/16, 05/18 and 05/19/19.

An interview was conducted with Licensed Practical Nurse (LPN) #2 on 06/29/19 at approximately 2:14 p.m., who stated, "If the TAR has holes (having missing initials) then the treatment was not done."

On 06/27/19 at approximately 12:03 p.m., an interview was conducted with LPN #3, who said "There should never be holes on the Medication Administration Record (MAR) or TAR." She stated, "If there are holes on the MAR or TAR, which means the medication was not administered or the treatment was not done."

An interview conducted with Director of Nursing (DON) on 06/27/19 at approximately 1:05 p.m. The surveyor asked "What is your expectations of your nurses related to following physician orders," she replied, "I expect for all nurses to follow physician orders as written with no exceptions." The DON stated, "If it's not signed off then the treatment was not done."

The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/27/19 at approximately 3:40 p.m. The facility did not present any further information about the findings.

The facility's policy titled: Clinical Guideline Skin and Wound (Effective date: 04/01/17). Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated

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| F 658 | Continued From page 121<br>to promote skin health, healing and decrease worsening of/prevention of pressure ulcer.<br><br>Process to include but not limited to:<br>-License Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record.<br>-Evaluate the effectiveness of interventions, and progress towards goals during the care management meeting and as needed.<br><br>Definitions:<br><br>*Amputation is the removal of a body part, either by surgery or they occur by accident or trauma to the body (https://medlineplus.gov/ency/article/007365.htm).<br><br>*Algisite is a calcium-alginate dressing which forms a soft, gel that absorbs when it comes into contact with wound exudate. Algisite helps utilize the proven benefits of moist wound management http://www.smith-nephew.com).<br><br>*Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.<br><br>Complaint deficiency.<br><br>2. The facility staff failed to follow physician orders and administer treatments to a right BKA (Below Knee Amputation) for Resident #32. | F 658 | | |

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Resident #32 was admitted to the facility on 01/26/2019. Resident #32 was readmitted to the facility on 06/18/2019. Diagnoses included but were not limited to, Peripheral Vascular Disease and Type 2 Diabetes Mellitus. Resident #32's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/05/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #32 as requiring set up help only with eating, supervision with assistance of 1 for toilet use, independent with bed mobility, transfer, dressing, bathing and independent with personal hygiene with assistance of 1.

On 06/25/2019 at approximately 2:15 p.m., an interview was conducted with Resident #32 and he stated that he has an open area on the bottom of his right BKA (Below Knee Amputation) and the nursing staff have not changed the dressing in 2 weeks.

On 06/25/2019 the surveyor requested to observe wound care when provided by the nursing staff on 06/26/2019.

On 06/26/2019 at 9:16 a.m., the surveyor observed Licensed Practical Nurse #2 provide wound care on Resident #32's right BKA. The wound was observed to be an open clean area with some depth, no drainage and located on the incision line of the resident's Right BKA.

Review of Resident #32's clinical record on 06/26/2019 revealed the following:

The Order Recap Report revealed an order dated

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05/24/2019 with a Start Date on 05/25/2019 and with an end date of 06/18/2019 and read as follows: Right BKA gently cleanse, pat dry apply Aquacel Ag and Allevyn Daily and then apply Shrinker one time a day related to cellulitis of Right Lower Limb. Review of the Treatment Administration Record for the treatment order dated to start on 05/25/2019 and to end on 06/18/2019 to the Right BKA had 25 total available spaces for documentation. 17 spaces (05/25, 05/26, 05/27, 05/28, 05/29, 05/31, 06/02, 06/04, 06/05, 06/08, 06/09, 06/11, 06/14, 06/15, 06/16, 06/17, 06/18) had no documentation, they were blank. Review of Nurse Progress Note's revealed Resident #32 was discharged to the hospital on 06/13/2019 and returned on 06/18/2019. There was no documentation to evidence that treatments were administered on 05/25, 05/26, 05/27, 05/28, 05/29, 05/31, 06/02, 06/04, 06/05, 06/08, 06/09 and 06/11/2019.

The Order Summary Report revealed an order dated 06/20/2019 with a Start Date on 06/21/2019 and read as follows: Right BKA surgical site: Cleanse with NS (Normal Saline), pat dry, cover with foam dressing QD (Every Day) shift for wound care. Review of the Treatment Administration Record for the treatment order dated to start on 06/21/2019 to the Right BKA only had documentation in one space, on 06/26/2019. Spaces for 06/21/2019 through 06/25/2019 were blank, no documentation. Review of Nurse Progress Note's revealed documentation indicating treatment was provided on 06/21/2019. No documentation to evidence that treatments were administered on 06/22, 06/23, 06/24 and 06/25/2019.

On 06/27/2019 at 9:55 a.m., an interview was

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conducted with Licensed Practical Nurse (LPN) #2 and she was asked, "What does an empty space on the Treatment Administration Record mean?" LPN #2 stated, "It indicates that the treatment was not done or the nurse did not click that it was done."

On 06/27/2019 at approximately 6:15 p.m., at pre-exit meeting the Administrator and Registered Nurse Consultant was informed of the finding. The facility did not present any further information about the finding.

3. The facility staff could not justify treatment with *elimite cream to Resident #465's bilateral legs.

Resident #465 was admitted to the nursing facility on 4/30/18 with diagnoses that included malignant neoplasm of the brain, peripheral vascular disease (PVD), cellulitis of right and left lower limb with sepsis, history of blood clots of the deep veins of the left upper extremity, high blood pressure, obesity and venous insufficiency. The resident had a Do Not Resuscitate (DNR) order upon admission. Resident #465 was discharged to the local hospital on 5/25/18 and admitted due to complications in wound healing and recurrence of sepsis. He was readmitted to the nursing facility on 6/3/18. The resident was placed on hospice services on 8/27/18 and expired in the facility on 9/2/18.

The admission Minimum Data Set (MDS) assessment dated 5/7/18 coded Resident #465 with a score of 11 out of possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was moderate in the skills needed for daily decision making. The resident was coded to have vascular ulcers. The resident was assessed totally dependent on two staff for

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bathing, and locomotion on and off the unit.

The care plan dated 5/18/18 identified the resident had impaired skin integrity to lower extremities related to cellulitis, lymphedema and vascular wounds. The goal set by the staff for the resident was that the cellulitis and vascular wounds would show signs of healing. Some of the goals set for the resident to accomplish this goal included administer treatment and medications as ordered by the physician and if the resident refuses treatments/interventions, wait and try again. The care plan did not identify signs or symptoms of scabies or that treatment was provided to the resident prophylactically.

The Treatment Administration Record (TAR) indicated on 6/13/18 elimite cream was applied to bilateral lower leg extremity, but there was no physician's order to support or justify the treatment. During the infection control interview and review of the facility's surveillance records, there were no cases of scabies in June 2018.

On 6/27/19 at 1:25 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated she could not find evidence to support treatment with elimite.

On 6/27/19 at 8:30 a.m., a call was made to the area epidemiologist to ascertain whether he had evidence of any scabies cases in the month of June 2018. The epidemiologist was out of the office until 7/5/19.

On 6/27/19 at 5:00 p.m., a telephone interview was conducted with the Nurse Practitioner. She checked her records and stated, "I remember this man very well and issued orders for him, but

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| F 658 | Continued From page 126<br>none of them included elimite. He had no issues with scabies or symptoms that would require treatment with elimite. I have no recollection of this order. This had to have been ordered in error. This is something out of the blue. I have nothing in my progress notes and I do not see anything in (attending physician's name) progress notes. I find this very strange."<br><br>*Elimite or Permethrin is a topical cream used to treat scabies. Permethrin is a neurotoxin that works by paralyzing nerves in respiratory muscles of scabies causing their death (https://www.medicinenet.com/permethrin-topical_cream/article).<br><br>The facility's policy titled Physician's Orders dated 8/22/17 indicated orders are transcribed to all appropriate areas (MAR, TAR, etc.). The nurse shall sign off the orders upon completion or verification of transcription. The attending physician, Nurse Practitioner reviews and confirms the orders.<br><br>Complaint Deficiency. | F 658 | | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced | F 684 | | |

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| F 684 | Continued From page 127<br>by:<br>Based on record review and staff interviews, the facility staff failed to provide physician ordered medications and treatments for 3 of 57 residents in the survey sample, Resident #6, #465, & #265.<br><br>1. The facility staff failed to provide Resident #6 with medications as ordered by the physician.<br><br>2. The facility staff failed to provide wound care for Resident #465.<br><br>3. The facility staff failed to provide treatment for a venous stasis ulcer wound for Resident #265.<br><br>The findings included:<br><br>1. Resident #6 was re-admitted to the facility on 2/7/18 with diagnoses which included type two diabetes, long term use of insulin, dysphagia, depression, anxiety, congestive heart failure, hyperlipidemia, and COPD. The facility staff failed to provide physician ordered insulin and anti-anxiety medication to Resident #6.<br><br>Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #6 was assessed in the area of Activities of Daily Living (ADL's) as requiring supervision with set-up only in the areas of transfer and dressing with limited assistance; with one person physical assist in the area of toileting. In the area of Medications this resident was assessed as receiving Insulin injections, | F 684 | 1. Resident #6, #265 and #465 no longer reside at the facility.<br>2. All residents have the potential to be affected. DCS or designee will review that residents are receiving medication and treatments as ordered by the physician. No other residents were affected.<br>3. DCS or designee will re-educate nursing staff on administering medications and treatments as ordered by the physician was completed by 08/01/19.<br>4. DCS or designee will audit MD orders to ensure residents are receiving medication and treatments as ordered twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision<br>5. AOC date: 08/06/2019 | |

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anti-anxiety and anti-depressant medications.

A Care Plan dated 3/25/19 indicated: "Focus-Resident #6 has diabetes mellitus and neuropathy. Goal- Resident will have no complications related to diabetes. Interventions-Diabetes medications as ordered by doctor. Monitor/ document for side effects and effectiveness." "An anti-anxiety medication care plan indicated-Goal-At risk for discomfort or adverse reactions related to anti-anxiety therapy. Interventions-administer Anti-Anxiety medications as ordered by physician."

Physician order dated 6/10/19 included: Novolin 70/30 flex pen Suspension Pen-injector (insulin) 100 unit/ml (milliliter) and Lorazepam tablet 0.5 mg (milligram) give one tablet by mouth twice a day (anti-anxiety medication).

A review of a Medication Administration Record (MAR) dated March 2019 indicated on March 6, 7 and 11th Novolin 70/30 Suspension (70/30) 100 units was not administered as ordered.

A review of the MAR dated March 2019 indicated on March 21, 2019 Lorazepam 0.5 mg was not administered as ordered.

A review of a MAR dated June 2019 indicated on June 20, and 21 2019 Novolin 70/30 100 units was not administered as ordered.

A review of a MAR dated June 2019 indicated on June 23, 2019 Lorazepam 0.5 mg was not administered as ordered.

A Nursing Progress note dated March 6, 2019 indicated: Novolin 70/30 Flexpen 100 unit

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subcutaneously in the morning related to type 2 Diabetes Mellitus with Diabetic Neuropathy, awaiting pharmacy.

A Nursing Progress note dated June 21 2019 (12:50) indicated: "Insulin not available; pharmacy notified 6/21: to be delivered today. MD aware continuing to monitor.

A Nursing Progress note dated June 21, 2019 (19:16) medication did not arrive during afternoon delivery.

During an interview on 6/25/19 at 2:45 P.M. with Resident #6, she stated, " My medications have ran out several times. Back in March and just this past weekend. I get my insulin twice a day. They are short of staff, I have to make up my own bed and change my own sheets."

During an interview on 6/26/19 at 11:15 A.M. with the Director of Nursing (DON) and Regional Nurse Consultant they were asked why Resident #6 medications were not available. The DON stated insulin is available on site and staff should have gone in the stat box and got her insulin. The DON stated, staff should have ordered the medication more timely.

Pharmacy Policy indicated: " If any order is not received, check for a communication slip indicating: Back orders-
Ordered-too-soon notifications;
Drug-drug interactions;
Formulary changes;
Any other communication explaining the reason a medication to item was not delivered."
2. Resident #465 was admitted to the nursing facility on 4/30/18 with diagnoses that included

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malignant neoplasm of the brain, peripheral vascular disease (PVD), cellulitis of right and left lower limb with sepsis, history of blood clots of the deep veins of the left upper extremity, high blood pressure, obesity and venous insufficiency.

Resident #465 was discharged to the local hospital on 5/25/18 and admitted due to complications in wound healing and recurrence of sepsis. He was readmitted to the nursing facility on 6/3/18. The resident was placed on hospice services on 8/27/18 and expired in the facility on 9/2/18.

The admission Minimum Data Set (MDS) assessment dated 5/7/18 coded Resident #465 with a score of 11 out of possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was moderate in the skills needed for daily decision making. The resident was coded to have vascular ulcers. The resident was assessed totally dependent on two staff for bathing, and locomotion on and off the unit.

The care plan dated 5/18/18 identified the resident had impaired skin integrity to lower extremities related to cellulitis, lymphedema and vascular wounds. The goal set by the staff for the resident was that the cellulitis and vascular wounds would show signs of healing. Some of the goals set for the resident to accomplish this goal included administered treatment and medications as ordered by the physician and if the resident refuses treatments/interventions, wait and try again.

Review of the Treatment Administration Records (TAR) from admission through discharge on 9/2/18 indicated the following:

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-Eleven blanks on the TAR related to treatment for bilateral leg cellulitis for the month of May 2018.

-Sixty-five blanks on the TAR related to treatment to eight individual wounds that included the left back of knee, left and right dorsal foot, left lateral leg, left lateral malleolus, right medial lower leg, left foot and top of right foot in the month of July 2018.

-Forty-one blanks on the TAR related to treatment to eight individual wounds that included the left back of knee, left and right dorsal foot, left lateral leg, left lateral malleolus, right medial lower leg, left foot and top of right foot in the month of August 2018.

On 6/27/19 at 11:20 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #5. There were no nurses available for interview that provided direct care for the resident during his stay in the nursing facility. LPN #5 stated she remembered Resident #465 and knew that he often refused treatment but the facility required an entry by the nurse on the TAR with a legend that would either indicate the resident refused the treatment, was hospitalized, on hold and or other. If the legend for other was entered, a nurses note was required. LPN #5 stated, "We were told in the past that we could not leave any blanks on the TAR or on the Medication Administration Record (MAR) before leaving our shift because if it was not documented, it was not done."

On 6/27/19 at 1:25 p.m., the above interview was shared with the Director of Nursing (DON). The DON stated it was the facility's policy and her expectation that the nurses entered their initials

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and the code to explain a reason for not administering treatment or medication. She stated blanks were not an acceptable practice, and gave the indication the treatment was not provided. The DON said, "I want to say he refused treatment, but I can't prove it."

No further information was provided prior to survey exit on 6/27/19.

Complaint Deficiency.
3. Resident #265 was originally admitted to the nursing facility on 11/12/18 and readmitted on 04/08/19. The resident expired on 04/12/19 therefore a closed record review was conducted. Diagnoses for resident included, but not limited to, Peripheral Vascular Disease, Local Infection of the skin and Subcutaneous Tissue and Venous Insufficiency.

The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/06/19 coded the resident with a 02 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Section M under Pressure Ulcers read as follows: Resident at risk for Pressure Ulcers as being "Yes." This section also indicated that the resident had 2 Venous and Arterial Ulcers present.

According to the Physician Order Form for April 2019, Resident #265 should have received the following wound care orders: Clean Bilateral Extremity (BLE) with dermal wound cleanser, cover wounds with xeroform, followed by ABD, wrap with kerlix every two days for wounds.

The treatment was missed on 4/1/19 on the 7

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a.m.-3 p.m. shift because the resident arrived from dialysis late. The oncoming nurse did not provide wound care either. There was no documentation of which days Resident #265 went to the wound clinic.

The review of the Resident #265's comprehensive care plan included the following:

Focus: Resident has a Venous Stasis Ulcer of the bilateral lower extremities relating to PVD (Peripheral Vascular Disease). Interventions: Wound Care Clinic as ordered.

Focus: Resident will refuse dressing changes. Interventions: Medications as ordered to promote wound healing, Weekly Treatment and documentation. Unna Boot as ordered.

Focus: Resident has the potential for skin integrity. Interventions: Weekly skin assessments, treatments as ordered.

Focus: Resident has chronic pain relating to gout and vascular wounds.
Interventions: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor for pain during wound care.

Focus: The resident has cellulitis of the Lower Extremities. Interventions: Monitor Document and Report to MD signs and symptoms of delirium.

On 06/26/19 at approximately 2:53 PM an interview was conducted with Licensed Practical Nurse (LPN) #2 concerning the above resident. She was asked if she had ever cared for the above resident. She said that when resident

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wasn't receiving wound care at the wound clinic, she was the wound care nurse. "The resident had vascular disease and poor circulation. She had an unnaboot that could only be taken off on days of wound treatment." She stated that Resident had vascular wounds on her legs. "I did wound care 3 days a week." "Other days were up to the nurses." "Resident was initially admitted with one wound on her leg." "She was in a lot of pain towards the end of her life." The nurses gave her oral and topical pain medications. "I was here the day she passed away."

On 06/26/19 at approximately 4:50 PM an interview was conducted with (Certified Nursing Assistant) CNA #12. The CNA was asked if she could elaborate on the above Resident. "In the end she was confused a lot. She also thought she was being attacked or someone was in her bed. She would talk strange. She had sores on her legs and they stayed wrapped; there was drainage. When asked if she was in pain? CNA #12 stated "Yes; once I tell the nurses she wouldn't complain anymore." "I wasn't here when she passed."

On 6/27/19 at 4:24 PM an interview was conducted with the Regional Nurse Consultant concerning Resident #265's wound care. She stated that the assign nurse did not do the wound care because resident was at dialysis. She ended her shift at 3:30 PM. The evening nurse should have provided wound care but she didn't. "We did QAPI (Quality Assurance and Performance Improvement) it because it wasn't done" The Regional Nurse Consultant was asked what should have been done? She responded, "The nurse should have done it." "There is no nursing note on 04/01/19 indicating wound care was

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| F 684 | Continued From page 135<br>done."<br><br>On 06/27/19 at approximately, 4:43 PM a pre-exit interview was conducted. Present were the Nurse Consultant, the Director of Nursing, the Regional Nurse Consultant and the Administrator. They were debriefed on the above concerns. | F 684 | | |
| F 692 SS=D | Complaint Deficiency.<br>Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, and clinical record reviews the facility staff failed to provide a nutritional supplement per physician orders for | F 692 | 1. CNA #5 and LPN #1 were educated on 06/26/19 to ensure residents receive supplements as ordered.<br>2. All residents have the potential to be affected. DCS or designee will review that residents are receiving supplements as ordered by the physician. No other residents were affected.<br>3. DCS or designee will educate nursing staff on administering supplements as ordered by the physician; was completed by 08/01/19.<br>4. DCS or designee will audit to ensure residents are receiving supplements as ordered twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision<br>5. AOC date: 08/06/2019 | |

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one of 57 Residents in the survey sample (Resident #63).

The facility staff failed to provide the nutritional supplement, Mighty Shake, on 6/25/19.

The findings included:

Resident #63 was originally admitted to the facility 9/27/18 and readmitted on 4/19/19. The current diagnoses were Alzheimer's Dementia and feeding difficulties.

The Significant Change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/09/19 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview coded the resident with long and short term memory problems as well as severely impaired decision making abilities.

On 06/25/19 at approximately 11:42 AM Resident #63 was observed sitting at a table waiting for lunch. The lunch trays arrived at 11:56 AM. Resident #63 was observed touching her food but not eating until 12:43 PM when Certified Nursing Assistant (CNA) #5 walked over to assist the resident with feeding. Resident #63 resisted. At approximately, 12:49 PM the resident's tray was removed from the table.

CNA #5 was interviewed shortly after removing the Resident's tray from the table. She was asked if the resident had eaten anything. The CNA #5 stated, "No she never does but I tried to feed her." Surveyor stated that she noticed that Resident #63 was only fed for a few minutes. The CNA stated "She never does eat anything." The

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surveyor asked CNA #5 does Resident #63 receive a supplemental shake with her meals. She stated "Yes." She was then asked why the Resident didn't receive her shake today; She replied, "Dietary didn't put it on the tray."

On 06/26/19 an interview was conducted with Licensed Practical Nurse (LPN) #1 concerning Resident #63 nutritional needs and weight loss issues. She stated that Resident #63 receives a med-Pass supplement at 9 AM, 1 PM, and 5 PM.

A review of the Hospice care plan read: "Diet as tolerated, Thickened liquids." The Doctor's order included: "Mighty Shake with every meal."

On 6/27/19 at approximately, 9:00 AM an interview was conducted with the Other Staff #9(Dietary Manager) She was asked if a Resident doesn't receive their nutritional shake on their tray what should happen? She responded, "The staff should call to the kitchen and we'll bring it."

On 06/27/19 The dietary manager was asked to provide a copy of Resident #63's meal ticket and it was confirmed that the "Mighty Shake was on meal ticket."

On 6/27/19 at approximately 10:15 AM an interview was conducted with LPN #8 concerning Resident not receiving her nutritional shake with her meals. She responded, "We try to coach her to eat or drink her shake." She was asked what should you have done? She stated, "I would have called to dietary for the Mighty Shake or went to the kitchen to pick it up."
Nurse was also asked if Resident was supposed to receive her "Mighty Shake" at mealtime. She stated "Yes."

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| F 692 | Continued From page 138<br><br>The Resident's care plan stated that Resident is able to feed self with set up supervision assistance. It also states that Resident should be monitored at meal times to ensure completion of meals.<br><br>On 06/07/19 at approximately, 4:43 PM a pre-exit interview was conducted. Present were the Nurse Consultant, the Director Of Nursing, The Regional Nurse and the Administrator. They were debriefed on the above concerns. No comments were made. | F 692 | | |
| F 727 SS=D | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility information obtained during the Complaint investigation, Sufficient and Competent Nurse Staffing task, and staff interviews, the facility staff failed to staff an Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. | F 727 | | |

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| F 727 | Continued From page 139<br><br>1. The facility staff failed to staff an RN , for at least 8 consecutive hours on 06/16/19 and utilized the Director of Nursing as a charge nurse with a resident census greater than 60.<br><br>2. The facility staff failed to ensure RN coverage eight hours in a twenty-four hour period on 4/14/18, 4/15/18 and 6/24/18.<br><br>The findings included:<br><br>1. A review of the as work schedules from April 2019 through June 26, 2019, were reviewed which resulted in further review of the Registered Nurse (RN) weekend coverage. During the review of the as worked schedule for 06/16/19 it revealed the Director of Nursing (DON) worked on the Blue Unit as the floor nurse passing medications. The current census on 06/16/19 was 108. The review concluded there was no RN supervisor/charge nurse other than the DON for at least 8 hours consecutive hours on 06/16/19.<br><br>An interview was conducted with the DON on 06/26/19 at approximately 10:50 a.m. The DON stated, "I worked on 06/16/19 from 7a (a.m.)-7p (p.m.), as the floor nurse but there was another RN who worked as the supervisor/charge nurse." The DON reviewed the as worked scheduled with the surveyor present. After the DON reviewed the as worked schedule she stated, "Oh, RN #5 called out for the 7a-7p shift, on the Blue Unit." The surveyor asked, "Was there a RN supervisor /charge nurse in the facility for 8 hours on 06/16/19?", she replied "No." The surveyor asked, "Is the DON consider supervisor/charge nurse coverage when there is a census of 60 or greater?" She replied, "The facility is 114 beds | F 727 | 1. The facility has reviewed its procedures to ensure RN is utilized 8 Hrs per day and that the DON may not serve as a charge nurse completed on 07/18/19.<br>2. All residents have the potential to be affected. The facility will ensure that an RN is utilized 8 hours per day and that the DON may not serve as a charge nurse.<br>3. ED or designee will educate nursing leadership that and RN (Register Nurse) must be utilized 8 hours a day and the DON may not be utilized as a charge nurse was completed by 07/26/19.<br>4. ED or designee will audit the schedule to ensure an RN is utilized 8 hours a day and a DON is not utilized as a charge nurse twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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| F 727 | Continued From page 140<br>and no the DON is not considered a supervisor/charge nurse when the facility has a census greater than 60."<br><br>The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/27/19 at approximately 3:40 p.m. The facility did not present any further information about the findings.<br>2. The facility staff failed to ensure RN (Registered Nurse) coverage for eight hours in a twenty-four hour period on 4/14/18, 4/15/18 and 6/24/18.<br><br>During review of the facility's staffing for Registered Nurse (RN) coverage, the facility failed to ensure there was an RN for at least 8 consecutive hours a day seven days a week on 4/14/18, 4/15/18 and 6/24/18.<br><br>On 6/27/19 at 10:45 a.m., the Director of Nursing (DON) stated they had no facility policy on the mandate for RN coverage because they followed the federal regulation. She confirmed through review of the as worked nursing staffing schedule that there was no RN coverage 8 consecutive hours in the 24 hours on 4/14/18, 4/15/18 and 6/24/18.<br><br>Complaint Deficiency. | F 727 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in | F 755 | | |

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| F 755 | Continued From page 141<br>§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.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility staff failed to provide pharmaceutical services for one resident (Resident #6) in the survey sample of 57 residents.<br><br>For Resident #6, facility staff failed to ensure medications were available for administration per physician's order.<br><br>The findings included: | F 755 | 1. Resident #6 medication orders were reviewed by DCS and medication is currently available.<br>2. All residents have the potential to be affected. An audit was completed to ensure current residents have medications available as ordered was completed by 07/29/19.<br>3. DCS or designee will educated licensed nursing staff on quality monitoring of medication rooms to ensure that ordered medications are available; was completed 08/01/19.<br>4. DCS or designee will audit MAR to ensure residents are receiving insulin and lorazepam as ordered; twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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Resident #6 was re-admitted to the facility on 2/7/18 with diagnoses that included congestive heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin.

Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #6 was assessed in the area of Activities of Daily Living (ADL's) as requiring supervision with set-up only in the areas of transfer and dressing with limited assistance with one person physical assist in the area of toileting. In the area of Medications this resident was assessed as receiving Insulin injections, anti-anxiety and anti-depressant medications.

A Care Plan dated 3/25/19 indicated: "Focus-Resident #6 has diabetes mellitus and neuropathy. Goal-Resident will have no complications related to diabetes. Interventions-Diabetes medications as ordered by doctor. Monitor-document for side effects and effectiveness. An anti-anxiety medication care plan indicated-Goal-At risk for discomfort or adverse reactions related to anti-anxiety therapy. Interventions-administer Anti-Anxiety medications as ordered by physician.

Physician orders dated 6/10/19 indicated: Novolin 70/30 flex pen Suspension Pen-injector 100 unit/ml (milliliters) (insulin).
Lorazepam tablet 0.5 mg (milligram) give one

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| F 755 | Continued From page 143 | F 755 | | |

tablet by mouth twice a day.

A review of a Medication Administration Record (MAR) dated March 2019 indicated on March 6, 7 and 11th Novolin 70/30 Suspension (70/30) 100 units was not administered as ordered.

A review of the MAR dated March 2019 indicated on March 21, 2019 Lorazepam 0.5 mg was not administered as ordered.

A review of a MAR dated June 2019 indicated on June 20, and 21 2019 Novolin 70/30 100 units was not administered as ordered. And on June 23, 2019 Lorazepam 0.5 mg was not administered as ordered.

A Nursing Progress note dated March 6, 2019 indicated: Novolin 70/30 Flexpen 100 unit subcutaneously in the morning related to type 2 Diabetes Mellitus with Diabetic Neuropathy, awaiting pharmacy.

A Nursing Progress note dated June 21 2019 (12:50) indicated: "Insulin not available; pharmacy notified 6/21: to be delivered today. MD aware continuing to monitor.

A Nursing Progress note dated June 21, 2019 (19:16) medication did not arrive during afternoon delivery.

During an interview on 6/25/19 at 2:45 P.M. with Resident #6, she stated, "My medications have ran out several times. Back in March and just this past weekend ( June 21-23, 2019). I get my insulin twice a day..."

During an interview on 6/26/19 at 11:15 A.M. with

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| F 755 | Continued From page 144<br>the Director of Nursing (DON) and Regional Nurse Consultant they were asked why Resident #6 medications were not available. The DON stated insulin is available on site and staff should have gone in the stat box and got her insulin. The DON stated, staff should have ordered the medication more timely.<br><br>Pharmacy Policy indicated: " If any order is not received, check for a communication slip indicating: Back orders-<br>Ordered-too-soon notifications;<br>Drug-drug interactions;<br>Formulary changes;<br>Any other communication explaining the reason a medication to item was not delivered." | F 755 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility staff failed to ensure two of 57 residents were free from significant medication errors.<br><br>1. The facility staff failed to ensure Resident #6 received insulin per physician's order.<br><br>2. The facility staff failed to ensure that Resident #32 received his insulin per physician's order.<br><br>The findings included:<br><br>1. Resident #6 was re-admitted to the facility on 2/7/18 with diagnoses which included congestive | F 760 | | |

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| F 760 | Continued From page 145<br>heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin. The facility staff failed to provide physician ordered insulin and anti-anxiety medications to Resident #6.<br><br>Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In the area of Medications this resident was assessed as receiving Insulin injections, anti-anxiety and anti-depressant medications.<br><br>A Care Plan dated 3/25/19 indicated:<br>Focus-Resident #6 has diabetes mellitus and neuropathy. Goal-Resident will have no complications related to diabetes. Interventions-Diabetes medications as ordered by doctor. Monitor- document for side effects and effectiveness. An anti-anxiety medication care plan indicated- Goal - At risk for discomfort or adverse reactions related to anti-anxiety therapy. Interventions- administer Anti-Anxiety medications as ordered by physician.<br><br>Physician order dated 6/10/19 indicated: Novolin 70/30 flex pen Suspension Pen-injector 100 unit/ml (milliliters) (insulin).<br>Lorazepam tablet 0.5 mg (milligram) give one tablet by mouth twice a day.<br><br>A review of a Medication Administration Record (MAR) dated March 2019 indicated on March 6, 7 and 11th Novolin 70/30 Suspension (70/30) 100 units was not administered as ordered. | F 760 | 1. Resident #6 and #32 medication orders were reviewed by DCS and MD was notified and medication and supplements are available.<br>2. All residents have the potential to be affected. An audit was completed to ensure that current residents are receiving their medications as ordered by the physician; was completed by 7/29/19.<br>3. DCS or designee will educate licensed nursing staff to administer medications as ordered was completed by 08/01/19.<br>4. DCS or designee will audit MARS to ensure residents are receiving insulin as ordered; twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly.<br>for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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A review of the MAR dated March 2019 indicated on March 21, 2019 Lorazepam 0.5 mg was not administered as ordered.

A review of a MAR dated June 2019 indicated on June 20, and 21 2019 Novolin 70/30 100 units was not administered as ordered. And on June 23, 2019 Lorazepam 0.5 mg was not administered as ordered.

A Nursing Progress note dated March 6, 2019 indicated: Novolin 70/30 Flexpen 100 unit subcutaneously in the morning related to type 2 Diabetes Mellitus with Diabetic Neuropathy, awaiting pharmacy.

A Nursing Progress note dated June 21 2019 (12:50) indicated: "Insulin not available; pharmacy notified 6/21: to be delivered today. MD aware continuing to monitor."

A Nursing Progress note dated June 21, 2019 (19:16) medication did not arrive during afternoon delivery.

During an interview on 6/25/19 at 2:45 P.M. with Resident #6, she stated, "My medications have ran out several times. Back in March and just this past weekend. I get my insulin twice a day. They are short of staff, I have to make up my own bed and change my own sheets."

During an interview on 6/26/19 at 11:15 A.M. with the Director of Nursing (DON) and Regional Nurse Consultant they were asked why Resident #6 medications were not available. The DON stated insulin is available on site and staff should have gone in the stat box and got her insulin. The

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DON stated, staff should have ordered the medication more timely.

Pharmacy Policy indicated: "If any order is not received, check for a communication slip indicating: Back orders-
Ordered-too-soon notifications;
Drug-drug interactions;
Formulary changes;
Any other communication explaining the reason a medication to item was not delivered."

2. Resident #32 was admitted to the facility on 01/26/2019. Resident #32 was discharged to the hospital on 06/13/2019 and readmitted to the facility on 06/18/2019. Diagnoses included but were not limited to, Peripheral Vascular Disease and Type 2 Diabetes Mellitus.

Resident #32's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/05/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment.

On 06/25/2019 at approximately 5:00 p.m., Resident #32 stated, "There are times that the Nurses don't give me my insulin."

On 06/26/2019 a review of Resident #32's Clinical Record revealed the following:

The Physician Order Summary revealed that Resident #32 has an order for Lantus SoloStar Pen-Injector 100 Unit/ML (Milliliter) (Insulin Glargine) Inject 50 Unit subcutaneously in the morning related to Type 2 Diabetes Mellitus with Unspecified Complications was ordered on 06/18/2019 with a Start Date of 06/19/2019.
Review of the Medication Administration Record

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(MAR) revealed a blank space on 06/22/2019.

Review of the Physician Order Summary revealed that Resident #32 had an order for Lantus SoloStar Pen-Injector 100 Unit/ML (Insulin Glargine) Inject 50 unit subcutaneously in the evening related to Type 2 Diabetes Mellitus with Unspecified Complications was ordered on 06/18/2019 with a Start Date of 06/19/2019. Review of the MAR revealed blank spaces on 06/21, 06/22 and 06/24/2019.

Review of the Physician Order Summary revealed that Resident #32 has an order for Humulin R Solution 100 Unit/ML (Insulin Regular Human) Inject 15 unit subcutaneously with meals related to Type 2 Diabetes Mellitus with Unspecified Complications was ordered on 06/19/2019 with a Start Date of 06/19/2019. Review of the MAR revealed blank spaces for 06/21 at 11 a.m., 06/21 at 4 p.m., 06/22 at 8 a.m., 06/22 at 11 a.m., 06/22 at 4 p.m. and 06/24/2019 at 4 p.m.

Review of the Physician Order Summary revealed that Resident #32 had an order for Humulin R Solution 100 Unit/ML (Insulin Regular Human) Inject as per sliding scale: if 251 - 299 = 2 units; 300 - 349 = 4 units; 350 - 399 = 6 units; subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with Unspecified Complications was ordered on 06/18/2019 with a Start Date of 06/18/2019. Review of the MAR revealed blank spaces for 06/21 at 11 a.m., 06/21 at 4 p.m., 06/22 at 4 p.m. and 06/24/2019 at 4 p.m.

On 06/26/2019 at approximately 3:00 p.m., an interview was conducted with the Director of Nursing (DON) and reviewed Resident #32's

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| F 760 | Continued From page 149<br>concern of not receiving his insulin at times. The DON stated, "(Resident name) goes out to the hospital frequently. Was he out at the hospital, did he refuse his insulin?" The Director of Nursing was asked, "What are your expectations of the Nurses administering and documenting Insulin's?" The Director of Nursing stated, "I expect the Nurses to administer insulin's as ordered and document. If the resident refuses the insulin they should document on the MAR." The DON was asked, "What does a blank space on the MAR indicate?" The DON stated, "That the medication was not given." The DON also stated that she had been told if the Nurse documents information on 2 different computers that there may be a problem with some of the documentation not being shown.<br><br>Nurse Progress Notes were reviewed for the period of 06/21/2019 through 06/24/2019 and there was no evidence that Resident #32 refused his insulin or was out of the facility.<br><br>On 06/27/2019 at approximately 6:15 p.m., at pre-exit meeting the Administrator and Registered Nurse Consultant was informed of the finding. The facility did not present any further information about the finding. | F 760 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. | F 761 | | |

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| F 761 | Continued From page 150<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, it was determined that facility staff failed to secure medications on one of four medications carts; a medication cart on the blue unit. And failed to ensure one of two medication rooms were free from expired biologicals; the green unit medication storage room.<br><br>1. Facility staff failed to ensure the medication cart on the Blue Unit was locked when it was left unattended.<br><br>2. The facility staff failed to dispose of multiple expired influenza vials stored in the refrigerator in the medication room located on the Green Unit.<br><br>The findings include:<br><br>1. On 6/25/19 at 11:20 a.m., the medication cart | F 761 | 1. The medication cart on blue unit was locked and secured on 6/25/19. The expired influenza vials stored in the refrigerator in the medication room on the green unit were disposed of on 06/26/19.<br>2. All residents have the potential to be affected. An audit was completed to ensure all medication carts were locked and secured on 06/25/19. An audit was completed to ensure medications in medication refrigerators are not expired on 06/26/19. No other issues identified.<br>3. The DCS and or designee will educate the License staff on ensuring medications that are expired are destroyed and that medication carts are locked and secured when not supervised; was completed by 07/26/19.<br>4. The DON and or designee will audit medication storage observation twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision<br>5. AOC date: 08/06/2019 | |

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on the blue unit was observed to be unlocked. The keys to the medication cart sat on top of the cart. Licensed Practical Nurse (LPN) #5 was at the nurse's station at the time and in view of the cart. LPN #5 then walked away from the station with the cart unlocked and keys on the cart. The medication cart was left unattended for approximately 14 minutes. During this time, dietary staff was observed going by the medication cart with the meal trays. A resident was also observed ambulating up and down the hallway near the medication cart. At 11:34 a.m., the ADON (Assistant Director of Nursing) locked the medication cart. At 11:37 a.m., LPN #5 came back to the medication cart.

On 6/25/19 at 11:37 a.m., an interview was conducted with LPN #5. When asked how the medication cart should be left when not attended, LPN #5 stated that the cart should be locked. LPN #5 stated that her keys should also be in her pocket and not on top of the cart. LPN #5 confirmed that her cart was left unlocked but that she had given her keys to a nurse who had brought over a resident's medication who was being transferred to her unit. When asked why the medication cart should be locked, LPN #5 stated that it should be locked so that residents did not have access to medications or narcotics. When asked if some residents could reach the top of her medication cart, LPN #5 stated, "Some of them can." When asked if she had a lot of residents who could ambulate around the unit, LPN #5 stated, "Yes."

On 6/27/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the consultant were made

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aware of the above concerns.

Facility policy titled,"Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles," documents in part the following: "Facility should ensure that only authorized Facility staff, as defined by Facility should have possession of the keys, access cards, electronic codes,or combinations which open medication storage areas. Store all drugs and biologicals in locked compartments..."

No further information was presented prior to exit.

2. On 06/26/19 at approximately 4:54 PM an inspection was made on the Green Unit in the medication storage room with Licensed Practical Nurse #10 (LPN). Three boxes of influenza vaccines with a total of 28 vials with an expiration date of 06/20/19 were observed. LPN #10 was asked would you normally discard the expired vaccines? She responded "I don't know, but I can find out."

On 06/27/19 at approximately, 9:30 AM an interview was conducted with the Director of Nursing concerning the expired influenza vaccines. She was asked when do they start and stop giving residents the influenza vaccines? She stated that they give the influenza vaccine from September to April. She also stated that they got rid of the expired flu vaccines on the Green Unit.

On 06/27/19 at approximately 11:40 AM upon inspection of Med Cart on the "Blue Unit" it was observed that the medication cart was unlocked. There were Residents and visitors walking, sitting and standing near the nurses station. The nurse was delivering lunch trays at the time. At

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| F 761 | Continued From page 153<br>approximately, 11:47 AM, the facility Administrator walked past the nurses station, stopped by the surveyor and informed that the medication cart had been left unattended for a few minutes and it appeared unlocked. He went over to the cart and pushed the lock inward to lock the cart and stated that he would tell the nurse that she left her cart unlocked. The Administrator was asked what should have been done? He stated "The cart should have been locked."<br><br>On 06/27/19 at approximately 3:16 PM an interview was conducted with LPN #2 (Licensed Practical Nurse) on the Blue Unit concerning her cart being unlocked. She stated that she was busy giving out trays to her residents.<br><br>On 06/27/19 at approximately, 4:43 PM a pre-exit interview was conducted. Present were the Nurse Consultant, the Director Of Nursing, the Regional Nurse Consultant and the Administrator. They were debriefed on the above concerns. The nurse consultant stated "I thought that I had discarded those vaccines." | F 761 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention | F 880 | | |

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| F 880 | Continued From page 154<br>and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed | F 880 | 1. Resident #10 wound was covered. Resident did not have any adverse reaction.<br>2. All residents have the potential to be affected. An audit was completed to ensure treatments were applied as ordered; was completed by 07/29/19.<br>3. The DCS and or designee will educate the licensed staff on ensuring treatments are completed as ordered; was completed by 08/01/19.<br>4. The DON and or designee will assess residents to ensure treatments are in place as ordered, twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.<br>5. AOC date: 08/06/2019 | |

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by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility staff failed to follow infection control practices, increasing the chances of infection, illnesse and disease for one of 57 residents in the survey sample (Resident #10.)

The facility staff failed to cover an open wound on Resident #10's left lower extremity in a timely manner.

The findings included:

Resident #10 was originally admitted to the facility 02/07/18. Resident #10's diagnoses included Major Depressive Disorder and Muscle Weakness.

The Annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/11/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of a possible 15 which indicated Resident #10's cognitive abilities for

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daily decision making were not intact.

On 06/25/19 at approximately 10:30 AM, Resident #10 was observed showing activity staff an uncovered wound on her left lower extremity as she was sitting. The staff commented, "I will tell (Licensed Practical Nurse-LPN#1)."

On 06/25/19 at 11:33 AM the area was still exposed on Resident #10's left lower extremity.

On 06/25/19 at 1:35 PM the area was still exposed. When approached, the nurse stated she will just put a Band-Aid on Resident's left leg until after medication pass. She also stated that resident will remove her dressing.

On 06/25/19 at approximately, 2:11 PM LPN #1 put in a new order for the above resident because she didn't have necessary supplies.

On 06/25/19 at approximately 2:24 PM wound care was observed on Resident's Left Lower Leg without difficulty. Procedure tolerated well by Resident.

On 06/26/19 at 10:18 AM there was no documentation in the nursing note seen prior to yesterday about the resident removing her dressing.

On 6/27/19 at approximately 10 AM an interview was conducted with Other Staff #8 concerning the Resident's wound on her left lower extremity. He said that he told the nurse around 10:30 AM that Resident had a sore on her leg unwrapped. Other Staff #8 said that the nurse told him that she would get it. Other Staff #8 states that "staff will usually take care of things when we tell them."

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Careplan Focus reads Resident has actual impairment to the skin relating to venous ulcer to the left lower leg. Goal: Resident will have minimal complications relating to venous ulcer of left lower extremity through the review date. Interventions Reads: Complete wound care per physician orders.

The physician's order summary stated to clean lower left ulcer with dermal wound cleanser, apply calmoseptine cream around wound cover with mepilex. Plain foam wrap (LLE) Left Lower Extremity from toes to 1 inch below knee 3 layers profore one time a day every Wednesday for lower leg ulcer.

On 06/26/19 at approximately 10:19 AM an interview was conducted with LPN #1 concerning the uncovered area on the Resident's left lower extremity yesterday. She was asked why did she wait as long as she did before coverings resident's wound? She stated, "It took a while because there were no dressings on the treatment cart." "I eventually covered it."

On 06/27/19 at approximately 4:43 PM a Pre-exit interview was conducted with the Nurse Consultant, Director of Nursing, The Regional Nurse Consultant and the Administrator. The above findings were discussed. No comments were made.