STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495261	A. BUILDING _____ B. WING _____	05/09/2019

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HERITAGE HALL LEESBURG	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/07/19 through 05/09/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/07/19 through 05/09/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 164 certified bed facility was 153 at the time of the survey. The survey sample consisted of 50 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550	**F550** **Corrective Action(s)** The Social Services department met with Resident #117 and assistance was provided to resident #117 and a legal Identification Card (ID) from the department of Motor Vehicles has been obtained. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents requesting a legal Identification Card may have potentially been affected. The Social Services Department will conduct resident interviews of all residents to identify any residents that have requested to obtain a Legal Identification Card that have not been obtained. Any/all negative findings will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding.	

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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mary Tarpley, Administrator 6/3/19

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure the right to self determination and access to services outside the facility for one of 50 residents in the survey sample, Resident #117. The facility staff failed to assist Resident #117 in attaining a legal Identification Card (ID) from the Department of Motor Vehicles. The findings include:	F 550	**Systemic Change(s):** The facility policy and procedure for informing residents of their resident rights was reviewed and no changes are warranted at this time. The Social Services Department will be inserviced on the resident rights policy and procedure to include offering assistance to residents that wish to obtain services from outside the facility in the community by the administrator and/or regional nurse consultant. The Activity Director will discuss Resident's Rights monthly during the Resident Council Meeting and report any/all concerns expressed to the Administrator. The Administrator & Social Services Director will investigate & follow through on all concerns. **Monitoring:** The Administrator and Social Services Director are responsible for maintaining compliance. The Social Services department will perform weekly interviews with 5 random residents to make sure their needs and rights are being met coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the Administrator and Social Services director for immediate correction. Detailed findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 6/21/19	

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F 550	Continued From page 2 Resident #117 was admitted to the facility on 6/30/12 with the diagnoses of but not limited to paraplegia (1), high blood pressure, diabetes mellitus, and depression: The most recent MDS (Minimum Data Set), a quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/24/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident required supervision and set up for eating; extensive assistance for hygiene, dressing, and toileting; total assistance for transfers and bathing; and was always incontinent of bowel. In Section H - Bladder and Bowel, the resident was coded as having an indwelling urinary catheter during the look back period. On 5/8/19 at 9:59 AM, an interview was conducted with Resident #117. Resident #117 stated, "I want and need a new walking ID (identification card). I am unable to get a driving service to the DMV I need as it is outside of (name of city). I asked the facility to take me. I asked the social worker (OSM #5 - Other Staff Member) #5 one month ago about five to six times and she is working on it. I went to get my ID last Friday (5/3/19) but when I got on the bus, the driver told me he could not take me because it was not in (name of city). I went to (name of store and restaurant) instead. I was not able to use my gift card because I did not have an ID." On 5/9/19 at 10:39 AM, an interview was conducted with OSM #5. When OSM #5 was asked about assisting Resident #117 to obtain an ID or a walking ID, OSM #5 stated, "Trying to just help coordinating and following up with the DMV paperwork. Getting him there and sitting with	F 550		

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

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F 550	Continued From page 3 him. It is just one of those things I helped him with, first it was in (name of city). Then getting his birth certificate. That was a few years back." OSM #5 was asked when Resident #117 asked her for assistance with obtaining his ID from the DMV, OSM #5 stated, "It has been about a month. He just started going back out in the community." When OSM #5 was asked if the resident requests help should he receive the assistance, OSM #5 stated, "Well regardless of all of that, he wants this done. It is his rights and I get it. Of all of the things to be done in a 24-hour day. I have a million things to do. I know that's not your problem or his problem. I understand. I get it. It should have been done." When OSM #5 was asked if her department makes arrangements for Resident #117 to go out into the community, OSM #5 stated, "We have taken him in the facility van." On 5/9/19 at 10:50 AM, a follow up interview with OSM #5 was conducted. OSM #5 stated, "It (Resident #117's license) expired on 9/30/14. He was going out beforehand. It was this past year due to medical reasons he stopped going out." When OSM #5 was asked what is needed to assist Resident #117 obtain an ID, OSM #5 stated, "I can go and make calls to find out what I need to do." When OSM #5 was asked the reason this was not done when the resident previously asked for assistance, OSM #5 stated, "I getcha (sic) (OSM #5 was observed to shrug her hands). Well he has gone out in the community. I get that. I was not aware of everything and this was expired since 2014. I do the best that I can." When OSM #5 was asked if she has an assistant, she stated, "Yes." When OSM #5 was asked if the facility administration was aware of Resident #117's request, OSM #5	F 550		

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F 550	Continued From page 4 stated, "I am not sure if I have discussed this with them." When OSM #5 was asked how long she has worked at this facility, she stated, "I have been here almost six years." On 5/9/19 at 10:58 AM, an interview with ASM (Administrative Staff Member) #2 (Director of Nursing) was conducted. ASM #2 was asked about her knowledge of Resident #117's request to the social worker (OSM #5), to obtain an ID approximately a month ago and of the residents own attempts to obtain the ID when assistance was not provided as requested. ASM #2 stated, "I saw him in the hall and he told me on Friday he 'was going to get his ID.' I said to him, Oh you're going on an outing. He calls the transport. I asked him if he was going by himself and he said, 'I got it all arranged.' Then I asked him what kind of ID he needed. I was just curious and if he is safe. Then I said Good for you (Resident #117's name). I thought he had it all under control and making his own arrangement. And I thought good for him." When ASM #2 was asked why Resident #117 needed an ID, ASM #2 stated, "He told me he was going to get it done and had arrangements." When ASM #2 was asked if she has spoken with social worker (OSM #5) about Resident #117's request, ASM #2 stated, "I have not talked to OSM #5 about this. I even told him we could put him on the van and take you. He always talks with me. He knows how to get a hold of me. He knows how to get me. I wish if he did not get his needs met he would have talked with me. (Resident #117's name) has a long history of psych (psychiatric) and manipulation. I'm sorry, I thought he already got it done. Maybe it is tomorrow on Friday." On 5/9/19 at 11:10 AM, ASM #2 and two	F 550		

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F 550	Continued From page 5 surveyors spoke with Resident #117 regarding going out in the community last week and his conversation with ASM #2. Resident #117 stated, "I made arrangements to get the ID, but when I got on the bus the driver would not take me out of (name of city)." ASM #2 then stated, "He told me he was going to do it but did not tell me he was not able to get it done. ASM #2 then told Resident #117 she would make the arrangements to get his ID tomorrow. On 5/9/19 at 11:52 AM, a follow up interview with OSM #5 was conducted. When OSM #5 was asked where she would document notes regarding assisting residents, she stated, "I would put them in the electronic clinical record." When OSM #5 was asked if she documented her conversation with Resident #117 when he asked her for assistance a month ago, she looked in the electronic clinical record and stated, "No. I do not have any documentation about that." A review of the clinical record did not reveal nurses notes related to Resident #117's ID request. A review of the facility's policy "Resident Rights" with a revised date of December 2016 that documented in part, "Policy Statement ...Employees shall treat all residents with kindness, respect, and dignity ...Policy interpretation and Implementation ...1. Federal and state laws guarantee certain basic rights to all residents in this facility ...a. a dignified existence; ...e. self-determination ...f. communication with and access to people and services, both inside and outside the facility ...g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United	F 550		

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F 550	Continued From page 6 States ...h. be supported by the facility in exercising his or her rights ...x. communicate with outside agencies ...regarding any matter ..." On 5/9/19 at 1:23 PM, ASM #1 (Administrator) and ASM #4 (Regional Vice President of Operations) were made aware of the findings. No further information was provided by the end of the survey. Reference (1) Paraplegia: Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. Most paralysis is due to strokes or injuries such as spinal cord injury or a broken neck. This information was obtained from the following website: https://medlineplus.gov/paralysis.html	F 550		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 637	**F637** **Corrective Action(s):** Resident #46 has had a Significant Change Assessment completed to reflect her Hospice services. Resident #46's comprehensive care plan has been revised to reflect her resident specific approaches and interventions to include the election of Hospice services.	

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F 637	Continued From page 7 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to complete a significant change assessment when one of 50 residents in the survey, was placed on hospice care, Resident #46. The facility staff failed to complete a significant change assessment when Resident #46 was placed on hospice care on 4/18/19. The findings include: Resident #46 was admitted to the facility on 3/7/19 with diagnoses that included but were not limited to: non displaced fracture of the medial wall of the left acetabulum (hip joint), high blood pressure, and peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (1)]. The most recent MDS (minimum data set) assessment, an unscheduled assessment for Medicare Part A, with an assessment reference date of 4/9/19, coded the resident as having both short and long-term memory issues and as severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to totally dependent upon one or more staff members for all of her activities of daily living. The physician order dated, 4/15/19, documented,	F 637	**Identification of Deficient Practice and Corrective Action(s):** All other residents who have elected Hospices Services may have potentially been affected. A 100% review of all resident receiving Hospice Service will be conducted by the RCC and/or designee to ensure that all residents that are receiving Hospices services have had a significant change assessment completed per RAI manual instructions. Any/all negative findings will be reported to the resident care coordinator at the time of discovery for immediate correction. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Resident Care Coordinators have read section 2 of the Revised LTC Resident Assessment Instrument User's Manual that covers significant change assessments and Hospice Services and have demonstrated through discussion and written examples understanding the Resident Assessment process and the Significant Change process.	

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F 637	Continued From page 8 "GIP (general inpatient) hospice care." The physician order dated, 4/19/19, documented, "D/C (discontinue) GIP hospice - Routine Hospice effective 4/19/19." (Note: The GIP hospice care has to do with payment sources; it does not affect the care of the resident.) Review of the clinical record failed reveal completion of a significant change MDS assessment for Resident #46 after the resident was placed on hospice care on 4/19/19. An interview was conducted with LPN (licensed practical nurse) # 6, the MDS nurse, on 5/8/19 at 1:48 p.m. When asked if a significant change assessment should be completed when a resident is placed under hospice care, LPN #6 stated, "Yes." When asked why the significant change MDS was not completed for Resident #46, LPN #6 stated, "I'd have to look." LPN #6 stated that when a resident is put on hospice care, a significant change assessment should be started. Per the RAI 3.0 Manual, pg. 2-23: "A SCSA (significant change in status assessment) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the	F 637	**Monitoring:** The DON and RCC are responsible for maintaining compliance. The RCC's and/or designee will be conducted weekly MDS audits coinciding with the MDS calendar to verify that assessments are completed and that significant changes are being accurately reflected on the MDS according to RAI manual instructions. Any/all negative findings from the audit will be reported to the DON and the RCC will make corrections at the time of discovery. Aggregate findings of the audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 6/21/19	

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F 637	Continued From page 9 hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing." ASM (administrative staff member) #1, ASM #2, the director of nursing, and ASM #3, the regional nurse consultant were made aware of the above concern on 5/8/19 at 4:45 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.	F 637		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	**F657** **Corrective Action(s):** Resident #46's comprehensive care plan and C.N.A. closet care plan has been reviewed and revised to reflect that Resident #46 is receiving Hospice Services. A Facility Incident & Accident Form was completed for this incident. Resident #36's comprehensive care plan has been reviewed and revised to reflect the discontinuation of Resident 36's incentive Spirometer. A Facility Incident & Accident Form was completed for this incident.	

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F 657	Continued From page 10 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for two of 50 residents in the survey sample, Residents # 46 and #36. 1. The facility staff failed to review and revise the comprehensive care plan when Resident #46 was placed under hospice care. 2. The facility staff failed to review and revise the comprehensive care plan for Resident #36 for a discontinued incentive spirometer (1). The findings include: 1. The facility staff failed to review and revise the comprehensive care plan when Resident #46 was placed under hospice care. Resident #46 was admitted to the facility on 3/7/19 with diagnoses that included but were not limited to: non displaced fracture of the medial	F 657	**Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Facility Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will in-service the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in resident condition.	

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F 657	Continued From page 11 wall of the left acetabulum (hip joint), high blood pressure, and peripheral vascular disease [any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (1)]. The most recent MDS (minimum data set) assessment, an unscheduled assessment for Medicare Part A, with an assessment reference date of 4/9/19, coded the resident as having both short and long-term memory issues and being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to total dependence upon one or more staff members for all of her activities of daily living. The physician order dated, 4/15/19, documented, "GIP (general inpatient) hospice care." The physician order dated, 4/19/19, documented, "D/C (discontinue) GIP hospice - Routine Hospice effective 4/19/19." (Note: The GIP hospice care has to do with payment sources; it does not affect the care of the resident). The comprehensive care plan dated, 3/7/19, documented in part, "Problem/Need - (Resident #46) is in need of rehabilitative services prior to return to home environment." The "Goal & Target Date" documented, "(Resident #46) will discharge to home environment with appropriate services and/or equipment established within the next 90 days." The "Approaches" documented, "Observe (Resident #46)'s progress with rehabilitative program. Communicate with (Resident #46) and family regarding progress and discharge planning needs and requests. Establish any needed services and/or equipment prior to discharge. Problem/Need - (Resident #46) anticipates a short term rehab (rehabilitation) stay, needs	F 657	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 6/21/19**	

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F 657	Continued From page 12 assistance to facility group activities of assessed interest." The "Goal & Target Date" documented "Will engage in independent leisure activities of choice and participate in group activities of assessed interest and show signs of enjoyment around her rehab and nursing schedule's." An interview was conducted with LPN (licensed practical nurse) #5 on 5/8/19 at 1:43 p.m. The above care plan was shown to LPN #5. When asked if the care plan was correct, LPN #5 stated, "No, she's on hospice care now." When asked who updates the care plan, LPN #5 stated the MDS staff do the updates. On 5/8/19 at 1:48 p.m., an interview was conducted with LPN #6, the MDS nurse. LPN #6 reviewed the care plan above. After reviewing the car plan LPN #6 was asked if there was a concern with the care plan. LPN #6 stated, "I see, I see. Social services and activities have not changed their care plan to meet the resident's needs. They were both aware of the resident being placed on hospice care. They have to update their care plans when there is a change in the resident's condition." LPN #6 went to the computer and found that social services had updated the care plan on 4/15/19 but failed to print it out and put it on the active care plan on the unit. When asked where the most up to date care plan is kept, LPN #6 stated, "The printed copy on the unit is the most accurate, up to date care plan." An interview was conducted with other staff member (OSM) # 5, the social services director, on 5/8/19 at 1:59 p.m. When asked if Resident #46 was on hospice care, OSM #5 responded that she was on hospice care. When asked if the	F 657		

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F 657	Continued From page 13 care plan should be updated if a resident goes onto hospice care, OSM #5 stated, "Yes." The active care plan was shown to OSM #5. OSM #5 stated, "It needs to be updated." An interview was conducted with OSM #4, the activities director, on 5/8/19 at 2:03 p.m. The above care plan was reviewed with OSM #4. When asked if this care plan is correct for the present condition of the resident, OSM #4 stated, "When she came in she as here for short term but things have changed and she is now on hospice care." When asked if the care plan should be reviewed and revised to address and reflect this change in the residents care and status, OSM #4 stated, "Yes, it should be." The facility policy, "Care Plans, Comprehensive Person-Centered" documented in part, "12. Assessments of resident are ongoing and care plans are revised as information about the residents and the resident's conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition. b. When the desired outcome is not met. c. When the resident has been readmitted to the facility from a hospital stay. d. At least quarterly, in conjunction with the required quarterly MDS assessment." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for	F 657		

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F 657	Continued From page 14 achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." ASM (administrative staff member) #1, ASM #2, the director of nursing, and ASM #3, the regional nurse consultant were made aware of the above concern on 5/8/19 at 4:45 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. 2. The facility staff failed to review and revise the comprehensive care plan for Resident #36 to address a discontinued incentive spirometer (1). Resident #36 was admitted to the facility on 9/29/18, with diagnoses that included but are not limited to, type 2 diabetes mellitus, emphysema (2), high blood pressure, pneumonia, and dysphonia (3). The most recent MDS (Minimum Data Set), a significant change of status Medicare assessment, with an ARD (Assessment reference date) of 3/12/19, coded the resident as scoring a 14 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident required supervision and set up for eating; limited assistance for dressing, toileting, hygiene, and transfers; and was occasionally incontinent of bladder and frequently incontinent of bowel. On 5/7/19 at 3:47 PM, an observation was made	F 657		

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F 657	Continued From page 15 of Resident #36's incentive spirometer sitting on the bedside table. On 5/8/19 at 9:48 AM, an observation was made of Resident #36's incentive spirometer laying on the bed. On 5/8/19 at 3:06 PM, an observation was made of Resident #36's incentive spirometer laying on the bed. When Resident #36 was asked where she received the incentive spirometer, she stated, "Oh, I have gotten some from here and from the hospital. In fact, I got two from here." A review of the clinical record revealed a physician's order that was dated 2/19/19, which documented in part, " ...Encourage resident use of incentive spirometer 10 times every hour while awake as tolerated ..." with a discontinued date of 3/4/19. A review of the clinical record revealed a comprehensive care plan that was dated 9/24/18, which documented in part, "Problem ...at risk for respiratory ...complications related to ...emphysema ...Approaches ...encourage to use incentive spirometer per order ..." The care plan was not revised to remove the use of the incentive spirometer when it was discontinued on 3/4/19. On 5/9/19 at 12:19 PM, an interview was conducted with LPN (Licensed Practical Nurse) #7. When asked about the process staff follows for reviewing and revising a resident's comprehensive care plan for an incentive spirometer, LPN #7 stated, "If a resident came from the hospital or if the doctor wrote an order for an incentive spirometer, it would be care	F 657		

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F 657	Continued From page 16 planned." When asked what the process is when an order for an incentive spirometer was discontinued, LPN #7 stated, "If I have the order, I will remove it (spirometer from the care plan)." When asked who is responsible for reviewing and revising the care plan, LPN #7 stated, "Most of the time it would the MDS nurse." On 5/9/19 at 1:23 PM, ASM (Administrative Staff Member) #1 (Administrator) and ASM #4 (Regional Vice President of Operations) were made aware of the findings. No further information was provided by the end of the survey. References: (1) A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. By using the incentive spirometer every 1 to 2 hours, or as instructed by your nurse or doctor, you can take an active role in your recovery and keep your lungs healthy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. (2) emphysema: Emphysema is a type of lung condition involving damage to the air sacs (alveoli) in the lungs. As a result, your body does not get the oxygen it needs. Emphysema makes it hard to catch your breath. You may also have a	F 657		

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F 657	Continued From page 17 chronic cough and have trouble breathing during exercise. This information was obtained from the following website: https://medlineplus.gov/emphysema.html (3) dysphonia: Spasmodic dysphonia is difficulty speaking due to spasms (dystonia) of the muscles that control the vocal cords. This information was obtained from the following website: https://medlineplus.gov/ency/article/000753.htm	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on facility document review and clinical record review, it was determined the facility staff failed to ensure one of 50 residents in the survey sample, received care and services in accordance with professional standards for Resident #29. The facility staff failed to have a hospice care order for Resident #29. The findings include: Resident #29 was admitted to the facility on	F 684	**F684** **Corrective Action(s):** Resident #29's attending physician was notified that the facility staff failed to Obtain an order for Hospice services for Resident #29 when admitted to the facility for Hospice respite care. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents under Hospice services may have potentially been affected. The DON, and/or Unit Manager will conduct a 100% audit of all residents receiving Hospice services to identify resident at risk. Residents identified at risk will be corrected at time of discovery and the attending physician will be notified and an order for Hospice services will be obtained. A facility Incident & Accident Form will be completed for each negative finding.	

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F 684	Continued From page 18 1/25/18 and readmitted on 2/27/19 with diagnoses that included but were not limited to: chronic kidney disease (1), hypothyroidism (2), diabetes, dementia, and high blood pressure. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/6/19, coded the resident as scoring a 9 out of 15 on the BIMS (brief interview for mental status) score, indicating she was moderately cognitively impaired for daily decision making. The physician orders summary (POS) dated May 2019, documented, "Level of Care: ICF (Intermediate Care Facility)." The POS failed to evidence an order for hospice care. Review of facility document titled "Omnicare Request for Admission Medication Review" dated 2/27/19, documented, "Coming from home under respite care x5 (for five) days then hospice." The request was documented by, LPN (licensed practical nurse) #1, the Lead Unit Manager. On 05/09/19 at approximately 8:48 a.m., an interview was conducted with LPN #1. LPN #1 was asked if Resident #29 was receiving hospice care at the facility. LPN #1 replied, "Yes. She came in under respite care but she is hospice now." LPN #1 was asked if Resident #29 had an order for hospice. LPN #1 stated, "Let me look through all the orders and I will get back to you." On 05/09/19 at approximately 9:27 a.m., a follow up interview was conducted with LPN #1. LPN #1 presented a document titled "Hummingbird Clinical: Orders" dated 5/9/19, which documented in part, "Admit to routine Hospice care at Heritage	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications and treatments. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. To include obtaining Hospice orders for Hospice respite residents admitted to the facility. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, and/or Unit Managers will perform weekly chart audits of all new Hospice respite residents to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 6/21/19**	

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F 684	Continued From page 19 Hall, Date order received: 3/4/2019, Order Type: Verbal." LPN #1 was asked if this order was part of Resident #29's clinical record. LPN #1 replied, "The hospice company sent it over today. It was not, it's my fault I transcribed her orders but I did not transcribe this order into the system, it should have been done. I called our doctor and got a clarification order today." On 05/09/19 at approximately 11:32 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing (DON) and LPN #1. ASM #2 presented this surveyor a document titled "(Name of Hospice Company) Long Term Care Billing Information Sheet, Administration and Billing" dated 3/5/19, which documented in part, "Nursing facility custodial care bed (hospice routine home care)". ASM #2 was asked if the facility had an order for hospice care. ASM #2 replied, "No. But we have a copy of the hospice bill which was completed when she switched to hospice." On 5/9/19 at approximately 11:37 a.m., LPN #1 presented this surveyor with a "Physician Telephone Order" dated 5/9/19, which documented in part, "Resident is under (name of Hospice Company) routine." The facility policy titled "Medication and Treatment Orders, Dental Services" dated February 2014, document in part, "All orders must be charted and made a part of the resident's medical record and care plan." On 5/9/19 at approximately 12:45 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the Director of Nursing, and ASM #4, Regional Vice President of	F 684		

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F 684	Continued From page 20 Operations, were made aware of the findings. No further information was provided prior to exit. (1) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, it was determined the facility staff failed to ensure respiratory equipment was maintained in a sanitary manner for one of 50 residents in the survey sample, Resident #36. The facility staff failed to store Resident #36's	F 695	**F695** **Corrective Action(s):** Resident #36's attending physician was notified that the facility failed to store resident #36's Incentive Spirometer in a plastic bag when not in use. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents with Incentive Spirometer therapy may have potentially been affected. A 100% review of all residents receiving Incentive Spirometer therapy will be conducted by the DON and/or Unit Managers to identify residents at risk for not having their Incentive Spirometer's improperly stored when not in use. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered.	

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F 695	Continued From page 21 incentive spirometer (1) in a sanitary manner. The findings include: Resident #36 was admitted to the facility on 9/29/18 with the diagnoses of but not limited to type 2 diabetes mellitus, emphysema (2), high blood pressure, pneumonia, and dysphonia (3). The most recent MDS (Minimum Data Set), a significant change of status Medicare assessment, with an ARD (Assessment reference date) of 3/12/19, coded the resident as scoring a 14 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident was coded as requiring supervision and set up for eating; limited assistance for dressing, toileting, hygiene, and transfers; and as occasionally incontinent of bladder and frequently incontinent of bowel. On 5/7/19 at 3:47 PM, an observation was made of Resident #36's incentive spirometer sitting on the bedside table and was uncovered. On 5/8/19 at 9:48 AM, an observation was made of Resident #36's incentive spirometer laying on the bed and was uncovered. On 5/8/19 at 3:06 PM, Resident #36's incentive spirometer was observed laying on the bed uncovered. When Resident #36 was asked where she received the incentive spirometer, she stated, "Oh, I have gotten some from here and from the hospital. In fact, I got two from here." When Resident #36 was asked if the staff puts her incentive spirometer into a bag, she stated, "No, but one time they put it in a store grocery bag."	F 695	**Systemic Change(s):** The facility policy and procedure for Incentive Spirometry usage and storage has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced by the DON and/or Staff development nurse on the facility policy and procedure for proper usage per physician order and proper storage of incentive spirometers when not in use. order. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit managers will perform daily audits of all residents using Incentive Spirometers to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 6/21/19**	

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F 695	Continued From page 22 Resident #36 was observed picking the incentive spirometer up and wiping the mouthpiece off with her hand. A review of the clinical record revealed a speech therapy evaluation and plan of treatment that was dated 3/28/19 to 5/8/19, which documented in part, "Short-term goals ...patient will independently complete 10 reps (repetitions) three times a day of each resistive breathing exercise in order to improve functional breath support for speech. (Target: 5/1/19) ..." the physician signed this on 4/1/19. A review of the clinical record revealed a comprehensive care plan that was dated 9/24/18, which documented in part, "Problem ...at risk for respiratory ...complications related to ...emphysema ...Approaches ...encourage to use incentive spirometer per order ..." Further review of the care plan does not reveal interventions related to storage of the incentive spirometer in a sanitary manner. On 5/9/19 at 12:19 PM, an interview with LPN (Licensed Practical Nurse) #7 was conducted. When asked about the process for storing a resident's incentive spirometer, LPN #7 stated, "Usually with every resident it is different, some like to have it next to them and some we have to encourage them to use it. We put them in a bag, but we would have to remove it from the bag. When LPN #7 was asked if an incentive spirometer was left uncovered would there be a potential for infection or contamination, she stated, "Yes. We try our best to keep it with a mouthpiece holder so it does not touch anything. We wipe the mouthpiece off before they use it. When LPN #7 was asked if the residents have	F 695		

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F 695	Continued From page 23 access to the wipes, she stated, "We have to encourage them to use it and I have to be with the residents on my hall." On 5/9/19 at 1:23 PM, ASM (Administrative Staff Member) #1 (Administrator) and ASM #4 (Regional Vice President of Operations) were made aware of the findings. No further information was provided by the end of the survey. References: (1) A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. By using the incentive spirometer every 1 to 2 hours, or as instructed by your nurse or doctor, you can take an active role in your recovery and keep your lungs healthy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. (2) emphysema: Emphysema is a type of lung condition involving damage to the air sacs (alveoli) in the lungs. As a result, your body does not get the oxygen it needs. Emphysema makes it hard to catch your breath. You may also have a chronic cough and have trouble breathing during exercise. This information was obtained from the following website: https://medlineplus.gov/emphysema.html	F 695		

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F 695	Continued From page 24 (3) dysphonia: Spasmodic dysphonia is difficulty speaking due to spasms (dystonia) of the muscles that control the vocal cords. This information was obtained from the following website: https://medlineplus.gov/ency/article/000753.htm	F 695		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure social services to attain the highest practicable physical, mental and psychosocial well-being for one of 50 residents in the survey sample, Resident #117. The facility staff failed to provide medically related social services to assist Resident #117's personal rights of self-determination in regards to obtaining a legal identification card (ID) from the DMV (division of motor vehicles). The findings include: Resident #117 was admitted to the facility on 6/30/12 with the diagnoses of but not limited to paraplegia (1), high blood pressure, diabetes mellitus, and depression. The most recent MDS (Minimum Data Set), a quarterly Medicare assessment, with an ARD (Assessment reference date) of 4/24/19, coded the resident as scoring a	F 745	**F745** **Corrective Action(s)** The Social Services department met with Resident #117 and assistance was provided to resident #117 and a legal Identification Card (ID) from the department of Motor Vehicles has been obtained. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents requesting assistance to obtain services in the community may have potentially been affected. The Social Services Department will conduct resident interviews of all residents to identify any residents that have requested to obtain a services in the community that have not been obtained. Any/all negative findings will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding.	

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F 745	Continued From page 25 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident required supervision and set up for eating; extensive assistance for hygiene, dressing, and toileting; total assistance for transfers and bathing; and was always incontinent of bowel. In Section H - Bladder and Bowel, the resident was coded as having an indwelling urinary catheter during the look back period. On 5/8/19 at 9:59 AM, an interview was conducted with Resident #117. Resident #117 stated, "I want and need a new walking ID (identification card). I am unable to get a driving service to the DMV I need as it is outside of (name of city). I asked the facility to take me. I asked the social worker (OSM #5 - Other Staff Member) #5 one month ago about five to six times and she is working on it. I went to get my ID last Friday (5/3/19) but when I got on the bus, the driver told me he could not take me because it was not in (name of city). I went to (name of store and restaurant) instead. I was not able to use my gift card because I did not have an ID." On 5/9/19 at 10:39 AM, an interview was conducted with OSM #5. When OSM #5 was asked about assisting Resident #117 to obtain an ID or a walking ID, OSM #5 stated, "Trying to just help coordinating and following up with the DMV paperwork. Getting him there and sitting with him. It is just one of those things I helped him with, first it was in (name of city). Then getting his birth certificate. That was a few years back." OSM #5 was asked when Resident #117 asked her for assistance with obtaining his ID from the DMV, OSM #5 stated, "It has been about a month. He just started going back out in the	F 745	**Systemic Change(s):** The facility policy and procedure for informing residents of their resident rights was reviewed and no changes are warranted at this time. The Social Services Department will be inserviced on the resident rights policy and procedure to include offering assistance to residents that wish to obtain services from outside the facility in the community by the administrator and/or regional nurse consultant. The Activity Director will discuss Resident's Rights monthly during the Resident Council Meeting and report any/all concerns expressed to the Administrator. The Administrator & Social Services Director will investigate & follow through on all concerns. **Monitoring:** The Administrator and Social Services Director are responsible for maintaining compliance. The Social Services department will perform weekly interviews with 5 random residents to make sure their needs and rights are being met coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the Administrator and Social Services director for immediate correction. Detailed findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 6/21/19	

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F 745	Continued From page 26	F 745		

community." When OSM #5 was asked if the resident requests help should he receive the assistance, OSM #5 stated, "Well regardless of all of that, he wants this done. It is his rights and I get it. Of all of the things to be done in a 24-hour day. I have a million things to do. I know that's not your problem or his problem. I understand. I get it. It should have been done." When OSM #5 was asked if her department makes arrangements for Resident #117 to go out into the community, OSM #5 stated, "We have taken him in the facility van."

On 5/9/19 at 10:50 AM, a follow up interview with OSM #5 was conducted. OSM #5 stated, "It (Resident #117's license) expired on 9/30/14. He was going out beforehand. It was this past year due to medical reasons he stopped going out." When OSM #5 was asked what is needed to assist Resident #117 obtain an ID, OSM #5 stated, "I can go and make calls to find out what I need to do." When OSM #5 was asked the reason this was not done when the resident previously asked for assistance, OSM #5 stated, "I getcha (sic) (OSM #5 was observed to shrug her hands). Well he has gone out in the community. I get that. I was not aware of everything and this was expired since 2014. I do the best that I can." When OSM #5 was asked if she has an assistant, she stated, "Yes." When OSM #5 was asked if the facility administration was aware of Resident #117's request, OSM #5 stated, "I am not sure if I have discussed this with them." When OSM #5 was asked how long she has worked at this facility, she stated, "I have been here almost six years."

On 5/9/19 at 10:58 AM, an interview with ASM (Administrative Staff Member) #2 (Director of

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F 745	Continued From page 27	F 745		

Nursing) was conducted. ASM #2 was asked about her knowledge of Resident #117's request to the social worker (OSM #5), to obtain an ID approximately a month ago and of the residents own attempts to obtain the ID when assistance was not provided as requested. ASM #2 stated, "I saw him in the hall and he told me on Friday he 'was going to get his ID.' I said to him, Oh you're going on an outing. He calls the transport. I asked him if he was going by himself and he said, 'I got it all arranged.' Then I asked him what kind of ID he needed. I was just curious and if he is safe. Then I said Good for you (Resident #117's name). I thought he had it all under control and making his own arrangement. And I thought good for him." When ASM #2 was asked why Resident #117 needed an ID, ASM #2 stated, "He told me he was going to get it done and had arrangements." When ASM #2 was asked if she has spoken with social worker (OSM #5) about Resident #117's request, ASM #2 stated, "I have not talked to OSM #5 about this. I even told him we could put him on the van and take you. He always talks with me. He knows how to get a hold of me. He knows how to get me. I wish if he did not get his needs met he would have talked with me. (Resident #117's name) has a long history of psych (psychiatric) and manipulation. I'm sorry; I thought he already got it done. Maybe it is tomorrow on Friday."

On 5/9/19 at 11:10 AM, ASM #2 and two surveyors spoke with Resident #117 regarding going out in the community last week and his conversation with ASM #2. Resident #117 stated, "I made arrangements to get the ID, but when I got on the bus the driver would not take me out of (name of city)." ASM #2 then stated, "He told me he was going to do it but did not tell me he was

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F 745	Continued From page 28 not able to get it done. ASM #2 then told Resident #117 she would make the arrangements to get his ID tomorrow. On 5/9/19 at 11:52 AM, a follow up interview with OSM #5 was conducted. When OSM #5 was asked where she would document notes regarding assisting residents, she stated, "I would put them in the electronic clinical record." When OSM #5 was asked if she documented her conversation with Resident #117 when he asked her for assistance a month ago, she looked in the electronic clinical record and stated, "No. I do not have any documentation about that." A review of the clinical record did not reveal nurses notes related to Resident #117's ID request. A review of the facility's policy "Resident Rights" with a revised date of December 2016 that documented in part, "Policy Statement ...Employees shall treat all residents with kindness, respect, and dignity ...Policy interpretation and Implementation ...1. Federal and state laws guarantee certain basic rights to all residents in this facility ...a. a dignified existence; ...e. self-determination ...f. communication with and access to people and services, both inside and outside the facility ...g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United States ...h. be supported by the facility in exercising his or her rights ...x. communicate with outside agencies ...regarding any matter ..." On 5/9/19 at 1:23 PM, ASM #1 (Administrator) and ASM #4 (Regional Vice President of Operations) were made aware of the findings.	F 745		

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F 745	Continued From page 29 No further information was provided by the end of the survey. Reference (1) Paraplegia: Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. Most paralysis is due to strokes or injuries such as spinal cord injury or a broken neck. This information was obtained from the following website: https://medlineplus.gov/paralysis.html	F 745		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812	**F812** **Corrective Action(s):** The uncovered salad identified in the cook's reach-in refrigerator and the expired milk identified in milk cooler during the initial kitchen tour was immediately removed and disposed of. A facility Incident and Accident form was completed for this incident. OSM #1 & #2 involved with the lunch pass and handling prepared food without changing gloves between handling multiple items have received one-on-one inservice training from the DON on proper infection control practices and the proper handling of prepared food when plating food for the residents during the meal service. A Facility Incident & Accident form has been completed for this incident.	

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F 812	Continued From page 30 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to store and serve food in a sanitary manner in the kitchen and in the main dining room. 1. The facility staff failed to cover a salad in the refrigerator and had an expired milk available for use. 2. The facility staff failed to serve food in a sanitary manner in the Main Dining Room. Facility staff who were at the steam table plating the food handled the plates with their thumbs on the top side of the outer perimeter of the food surface area of the plates while plating food. The findings include: 1. The facility staff failed to cover a salad in the refrigerator and had an expired milk available for use. Observation was made of the kitchen on 5/7/19 at 11:55 a.m. accompanied by other staff member (OSM) #6, the dietary service director. Observation was made of the milk cooler. One fat free half pint milk carton was dated as expired on 5/6/19. When asked if the milk was available for use, OSM #6 stated, "Yes, Ma'am." Observation was made of the cook's reach in refrigerator. A half pan of a salad made of what	F 812	**Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will inspect the walk-in refrigerators and milk coolers to identify any uncovered food or expired milk products to identify any negative findings. Any negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each negative finding identified. The Dietary Manager and/or DON will monitor three meal separate meal passes to identify any negative findings with the plating of resident food and meal set up. All negative findings will be corrected at time of discovery and disciplinary action will be taken as indicated. A facility Incident and Accident form will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The Dietary Manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, to include proper glove usage and hand washing when preparing and plating residents food and ensuring all expired foods items are removed from distribution and that all food items are properly covered and dated when placed in the refrigerators or freezers.	

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F 812	Continued From page 31 appeared to be lettuce and tomatoes was not completely covered with approximately one third of the plastic wrap off the pan and a large slotted spoon in the salad. When asked if the salad should be uncovered, OSM #6 stated, "No, but we just finished lunch." When asked if anything in the refrigerator should be uncovered, OSM #6 stated, "No, Ma'am." The facility policy, "Food Storage - covering, labeling, dating food," documented in part, "Refrigeration Storage: 1. All foods must be covered, labeled and dated with a date label. All food should be monitored each day to be assured that the foods will be used, consumed or discarded by the use by date or expired date." The policy further documented, "Pantry Refrigerators Storage: 1. Follow the manufacturer' expiration dates or use by dates when provided to determine when a food should be discarded." SAM (administrative staff member) #1, SAM #2, the director of nursing, and SAM #3, the regional nurse consultant were made aware of the above concern on 5/8/19 at 4:45 p.m. No further information was provided prior to exit. 2. The facility staff failed to serve food in a sanitary manner in the Main Dining Room. Facility staff who were at the steam table plating the food handled the plates with their thumbs on the top side of the outer perimeter of the food surface area of the plates while plating food. On 05/07/19 at 5:07 PM, an observation was made of the Main Dining Room dinner service. Two staff members, OSM #1 (dietary aid) and	F 812	**Monitoring:** The Dietary Manager and the DON are responsible for maintaining compliance. The Dietary manager will complete the Dietary food storage audit tool daily to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The DON, Dietary manager and/or Unit Managers will monitor 3 random meal passes a week to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 621/19**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 32 OSM #2 (dietary cook) were at the steam table plating food for dinner service to the residents. OSM #1 and OSM #2 had gloves on, but were handling multiple items, including tongs, serving spoons, plates, bowls, meal tickets, etc., thus contaminating their gloves, and were then observed placing their thumbs on the top side of the outer perimeter of the food surface area of the plates while plating food. On 5/8/19 8:30 AM, in an interview with OSM #2 through her daughter OSM #3 (Ancillary Aid), as an interpreter, OSM #2 stated that she did not recall having her thumbs on top of the plate but that the plate is supposed to be handled with the hand underneath and no fingers on top. A review of the facility policy "Preventing Foodborne Illness - Food Handling" documented, "3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents." On 5/8/19 at 5:20 PM, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) and ASM #3 (Regional Nurse Consultant) were made aware of the findings. No further information was provided by the end of the survey.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842	**F842** **Corrective Action(s):** Resident #14's attending physician has been notified that the facility staff failed to accurately document the administration Miralax for Resident 14. A facility medication error form has been completed for this incident.	

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	495261	A. BUILDING _____ B. WING _____	05/09/2019

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F 842	Continued From page 33 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or	F 842	Resident #127's comprehensive care plan was reviewed and the other resident care plan that was attached to resident #127's was removed and properly filed. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all resident MAR's and Care Plans will be conducted by the DON, RCC, QA Nurse and or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the DON or Regional Nurse Consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's and care plans. according to the acceptable professional standards and practices.	

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F 842	Continued From page 34 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for two of 50 residents in the survey sample, Resident #14 and Resident #127. 1. The facility staff failed to document the correct medication for Resident #14, she was administered Miralax (1) however Metamucil (2) was documented in Resident #14's clinical record. 2. The facility staff failed to ensure Resident # 127's care plan did not include information for the	F 842	**Monitoring:** The Administrator and DON are responsible for maintaining compliance. The DON, RCC and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 6/21/19**	

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F 842	Continued From page 35 care of another resident. The findings include: 1. The facility staff failed to document the correct medication for Resident #14, she was administered Miralax (1) however Metamucil (2) was documented in Resident #14's clinical record. Resident #14 was admitted to the facility on 1/4/2008 with diagnoses that included but were not limited to: constipation, falls, chronic kidney disease and postural kyphosis (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/24/19, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as having highly impaired vision. Resident #14 was coded as being frequently incontinent of both bowel and bladder. The physician order summary dated, May 2019, documented, "Metamucil 2 tablespoons with 4 to 8 oz of water PO (by mouth) daily. DX (diagnoses) constipation." The physician order summary dated, May 2019, documented, "Miralax powder dissolve 1 capful (17 GM [grams]) in 4 to 8 oz. of water or juice and take PO Q (every) Monday, Wednesday and Friday." On 05/07/19 at approximately 03:52 p.m., an	F 842		

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F 842	Continued From page 36 observation was made of LPN (licensed practical nurse) #2 during medication pass. LPN #2 pulled the medication cart to the room of Resident #14. Resident #14 was sitting in her wheelchair at the door of her room. LPN #2 asked Resident #14 if she had a bowel movement today. Resident #14 replied, "No." LPN #2 then told Resident #14, "It's time for your Metamucil." LPN #2 then sanitized his hands with hand sanitizer and unlocked his medication cart from the bottom drawer he pulled a white plastic bottle labeled "MiraLax". LPN #2 then poured a cap full (of Miralax) and poured approximately 4 oz. of water into a clear plastic cup. He then mixed the capful of Miralax into the water, handed it to Resident #14, and stated, "Here is your Metamucil." Resident #14 then drank the water with the Miralax. LPN #2 then documented on the electronic MAR. Review of the medication administration record (MAR) for May 2019 documented the above physician medication orders. The MAR documented that "Metamucil 2 tablespoons with 4 to 8 oz. of water PO daily. DX (diagnoses) constipation." was administered on May 7 2019 at 5:00 p.m. Further review of the MAR revealed "Miralax powder dissolve 1 capful (17 GM [grams]) in 4 to 8 oz. of water or juice and take PO Q (every) Monday, Wednesday and Friday." was not documented as given on May 7 2019. On 05/08/19 at approximately 2:33 p.m., an interview was conducted with LPN #2. LPN #2 was asked if there was any difference between Miralax and Metamucil. LPN #2 replied, "Miralax is a laxative that helps soften stool and Metamucil is basically the same thing but has a different	F 842		

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F 842	Continued From page 37	F 842		

consistency." LPN #2 was asked if he was aware that during medication pass he told Resident #14 he was going to give her Metamucil but instead gave her Miralax. LPN #2 replied, "Yes, but they are similar. I should have given her the Metamucil. It was a mistake." LPN #2 was asked should a medical record be accurate. LPN #2 replied, "Yes." Resident #14' MAR was then reviewed with LPN #2. LPN #2 was then asked what he documented as being given. LPN #2 replied, "Metamucil." LPN #2 was then asked if Resident #14's medical record was accurate. LPN #2 replied, "No."

On 05/08/19 at approximately 03:05 p.m., an interview was conducted with LPN #1, the Lead Unit Manager. LPN #2 was then asked if a MAR was a part of a medical record. LPN #1 replied, "Yes." LPN #1 was asked should the medical record be accurate. LPN #1 replied, "Yes, that's important. It's part of the chart and lets everyone else know that comes on after you know what has happened to the resident." LPN #1 was asked if you give Miralax should you document that you gave Metamucil. LPN #1 replied, "No."

The facility policy, "Administering Medications" documented in part, "Medications shall be administered in a safe and timely manner, and as prescribed. The individual administering the medication must check the label THREE (3) [SIC] times to verify the right resident, right medication, rights dosage, right time and right method (route) of administration before giving the medication. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: The date and time the medication was administered."

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F 842	Continued From page 38 On 5/9/19 at approximately 1:45 p.m., LPN #1 gave this surveyor a facility document titled "Medication Error Report" dated 5/8/19, which documented in part, "Nurse administered Miralax instead of Metamucil." On 5/8/19 at approximately 5:45 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the Director of Nursing, and ASM #3, Regional Nurse Consultant, were made aware of the findings. No further information was provided prior to exit. (1) Polyethylene glycol 3350 comes as a powder to be mixed with a liquid and taken by mouth. It is usually taken once a day as needed for up to 2 weeks. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take polyethylene glycol 3350 exactly as directed. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603032.html. (2) Psyllium, a bulk-forming laxative, is used to treat constipation. It absorbs liquid in the intestines, swells, and forms a bulky stool, which is easy to pass. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601104.html (3) Kyphosis is a curving of the spine that causes a bowing or rounding of the back. This leads to a hunchback or slouching posture. This information was obtained from the website: https://medlineplus.gov/ency/article/001240.htm	F 842		

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F 842	Continued From page 39 2. The facility staff failed to ensure Resident # 127's care plan did not include information for the care of another resident. Resident # 127 was admitted to the facility on 04/23/2019 with diagnoses that included but were not limited to depressive disorder (1), anxiety (2), gastroesophageal reflux disease (3), and dysphagia (4). Resident # 127's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/30/19, coded Resident # 127 as scoring a 3 (three) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 127 was coded as requiring extensive assistance of one staff member for activities of daily living. On 05/08/19 at 1:50 p.m., a review of the facility's care plan book for the "Grove Unit" was conducted to locate Resident # 127's current comprehensive care plan. While reviewing the comprehensive care plan for Resident # 127 dated, 04/23/2019 another resident's care plan was stapled to Resident # 127's care plan. The other resident's care plan documented problem areas of activities dated 04/23/2019, nutrition dated 04/24/2019, and rehabilitation 04/22/2019. On 05/08/19 at 2:35 p.m., an interview was conducted with RN (registered nurse) # 2, MDS Coordinator. When asked to describe the process for filing the resident's care plans RN # 2 stated, "We file the care plans in the care plan books. The other care plan shouldn't have been attached to (Resident 127's). Someone just	F 842		

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F 842	Continued From page 40 attached it mistakenly." On 05/08/19 at approximately 4:12 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	**F880** **Corrective Action(s):** The Kitchen ice machine drain has been repaired/correct and now has the appropriate air gap between the drain and the floor. A facility Incident & Accident form has been completed for this incident.	

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F 880	Continued From page 41 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	**Identification of Deficient Practice(s) and Corrective Action(s):** All other ice machine drains may have potentially been affected. The Maintenance Staff will inspect all facility ice machines to ensure proper air gaps are achieved to prevent potential cross contamination from the plumbing system. Any negative findings will be corrected at time of discovery. An incident & accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The Maintenance Staff have been inserviced on the Federal and State regulations for the correct air gap required for plumbing system drainage pipes on plumbing fixture equipment or nonfood equipment. **Monitoring:** The Maintenance Director is responsible for maintaining compliance. The Maintenance Director and/or Maintenance Assistant will complete weekly preventative maintenance facility rounds to monitor for compliance. All negative findings will be corrected upon discovering. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: 6/21/19**	

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F 880	Continued From page 42 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to properly maintain an ice machine in a manner to prevent the spread of disease for one of four facility ice machines, (the kitchen ice machine). The facility staff failed to ensure the drainage pipe for the ice machine in the kitchen was above the level of the floor drain in the kitchen. The findings include:	F 880		

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F 880	Continued From page 43 Observation was made of the ice machine in the kitchen on 5/7/19 at 12:18 p.m. The plastic drainage pipe was resting on the metal floor drain. This observation was verified with OSM #7, the director of maintenance. When asked if the drain was at the proper height, OSM #7 stated, "No, I check it weekly. They must be hitting it when the mop." On 5/7/19 at approximately 4:00 p.m., OSM #7 presented a document of "Work History Report" that documented on 4/13/19 the ice machines in the building were inspected and the air gaps were functioning properly." On 5/9/19 at approximately 9:00 a.m., OSM #7 presented a document titled, "What is An Air Gap?" that documented in part, "Health codes require two air gap installations for each ice machine...The other air gap, or backflow prevention, must be between an ice machine drain and the sewer drain. This makes sure sewer lines can't create a vacuum which allows water to flow back up into the machine contaminating ice that could end up in someone's drink." ASM (administrative staff member) #1, ASM #2, the director of nursing, and ASM #3, the regional nurse consultant were made aware of the above concern on 5/8/19 at 4:45 p.m. No further information was provided prior to exit.	F 880		