STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495177	A. BUILDING _____ B. WING _____	05/30/2019

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COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/28/19 through 5/30/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/28/19 through 5/30/19. No complaints were investigated. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 140 certified bed facility was 100 at the time of the survey. The survey sample consisted of 27 current Resident reviews and one closed record review.	F 000	F tag 641 **Corrective Action:** The MDS for resident #63 was corrected on 5/30/2019. The assessment has been submitted and accepted. 1:1 education will be completed with LPN #1. Completed on 6/17/2019 **Identification of others:**	7/12/19
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) for one of 28 resident in the survey sample, Resident #63. The facility staff incorrectly coded the resident with the diagnosis of bipolar disorder. Findings included:	F 641	Any resident who has had a MDS completed by LPN #1 could have potential for an error in coding of diagnosis for Bipolar/Manic Depression. An audit will be completed of MDS assessments completed by LPN #1 for the past 90 days to validate no other discrepancies in the coding of Bipolar/Manic Depression. Any discrepancies will be immediately corrected and submitted. Completed 6/14/2019	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Victor Emodi | TITLE: Adm | (X6) DATE: 6/21/19

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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F 641	Continued From page 1 Resident #63 admitted to the facility on 4/25/17. Diagnoses for this resident included, but were not limited to: high blood pressure, PVD (peripheral vascular disease), diabetes mellitus, increased lipids, thyroid disorder, arthritis, anxiety, depression, manic depression, morbid obesity, right BKA (below the knee amputation), history of venous thrombosis and embolism. Resident #63 had an MDS trigger in the LTCS (long term care software) process for "No PASAAR II with diagnosis." The resident's most current MDS (minimum data set) was annual assessment dated 4/11/19. The resident did not trigger for anything in Section A1500. Preadmission Screening and Resident Review and did not trigger for anything in Section A.1510 Level II Preadmission Screening and Resident Review Conditions. This MDS did reveal that the resident had a documented diagnosis of manic depression (bipolar) in Section I. Active Diagnoses. The resident's CAAS (care area assessment summary) section of this MDS was reviewed. The resident did not trigger for mood, behaviors or psychosocial well being. The resident had CAAS worksheets for mood and psychosocial well being, which were reviewed. The CAAS worksheet documented under mood state on the MDS, "...relapse of an underlying mental health problem, anxiety disorder, depression (other than bipolar), and manic depression (bipolar)..." The resident's CCP (comprehensive care plan) was reviewed and did not document anything regarding depression, manic depression and/or anxiety.	F 641	**System Changes:** • Coding of Section I will be validated during Care Plan Conference meetings to validate there are no discrepancies in the coding of Bipolar/Manic Depression. • MDS nurses will review instructions for the coding of section I of the assessment. • DON and QA Coordinator will randomly audit section I of the assessment. **Monitoring:** • The Social Worker will submit a report of discrepancies in the coding of Bipolar/Manic Depression to the QA Coordinator following each Care Plan meeting.	

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F 641	Continued From page 2 On 05/29/19 at 4:08 PM, LPN (Licensed Practical Nurse) #1 (who was also the MDS coordinator) was interviewed regarding the above findings, specifically related to a PASAAR Level II for this resident. LPN #1 was made aware of a possible MDS discrepancy. LPN #1 stated that she did not know anything about the PASAAR. The LPN pulled the information up on the computer and stated, that a diagnosis of bipolar would trigger for a Level II and stated that this would be an error for this resident. LPN #1 stated, "Ok, this is my mistake I marked manic depression (bipolar) by accident. She does not have that, she has anxiety and depression, but not bipolar, I will have to fix that." No further information and/or documentation was presented prior to the exit conference on 5/30/19 at 5:00 PM to evidence that the resident's current status was accurately assessed on this MDS.	F 641	• The DON and/or QA Coordinator will audit 4 assessments per week x 8 weeks for section I of MDS to validate accuracy of coding of diagnosis for Bipolar/Manic Depression. Discrepancies will be immediately corrected with 1:1 education with MDS nurse entering the coding of inaccurate diagnosis. • Weekly audits will be submitted to the QA Coordinator who will analyze data submitted and present a report of areas of non-compliance to the QAPI Committee for discussion and further recommendations.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

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F 656	Continued From page 3 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for two of 28 residents in the survey sample, Residents # 26 and 63, to develop a person-centered plan of care. For Resident # 26, the facility failed to develop a person-centered plan of care to address behaviors. For Resident # 63, the facility failed to develop a person-centered plan of care to address anxiety and/or depression.. The findings were:	F 656	F tag 656 **Corrective Action:** • The care plan for resident #26 was updated on 6/13/2019 to reflect resident behaviors and resident centered approaches. The television and radio have been placed in the resident's room. Interventions to assist in minimizing behaviors have been communicated to direct care staff. • The care plan for resident #63 was updated on 6/13/2019 for diagnosis of anxiety and depression and resident centered approaches were added to the care plan. • LPN #1 corrected the MDS for resident #63 on 5/29/2019 to remove diagnosis of Bipolar. The assessment has been transmitted and accepted. • LPN #1 has been educated on PASAAR. 6/20/2019 • RN #4 has been educated on the development of resident centered care plans on 6/13/2019.	7/12/19

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F 656	Continued From page 4 1. Resident # 26 was admitted to the facility on 6/30/14, and most recently readmitted on 11/27/18 with diagnoses that included hypertension, hyperlipidemia, Non-Alzheimer's dementia, seizure disorder, depression, arthritis, dysphagia, chronic atrial fibrillation, cerebrovascular disease, unilateral inguinal hernia, and artificial left hip joint. According to the most recent Minimum Data Set, an Annual with an Assessment Reference Date of 3/4/19, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15. Under Section E (Behaviors), the resident was assessed as having behaviors that significantly interfered with his care. At 11:45 a.m. on 5/28/19, during the orientation tour on the Second Floor Unit, the surveyor heard a resident yelling out in an intermittent, non-sensical manner. The resident yelling was identified as Resident # 26. At the time the resident was yelling, there were several staff in the hall where the resident's room was located. None of the staff went to the resident's room to see if he needed assistance, or to see if he could be redirected in order to stop his yelling. While on the tour, a resident whose room was near that of Resident # 26 was interviewed. Asked if the resident's yelling bothered him, the resident said, "He was yelling last night (5/27/19). He woke me up and I couldn't go back to sleep." Review of Resident # 26's plan of care revealed the following:	F 656	Identification of others: Any resident with behaviors and/or diagnosis of depression and anxiety could be at risk for not having an individualized resident centered care plan. Care plans are being reviewed for residents with behaviors and diagnosis of depression and anxiety to validate and update the care plan is individualized and has resident centered approaches.	

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F 656	Continued From page 5 Problem: LTC (Long Term Care) Behavioral Symptoms Outcomes: (Name of resident) will understand as much as possible events in accuracy; (Name of resident) will have less yelling episodes; MDS (Minimum Data Set) Nurse Reviewed. Interventions: Provide care with smile, gentle touch, voice, reassurance; Evaluate for signs of pain during care and intervene; Collaborate to determine causes for pain and intervene; Notify provider if hallucinations or delusions present; Remind (name of resident) when he is being cared for we will ask to touch him and the difference between hit/touch; Orient (name of resident) daily and encourage staff to re-assure him when they pass by room; Behavior Plan Development; Radio or TV on for comfort while awake. At the time the resident was observed, there was no radio or television on in his room. During an end of day meeting at 4:30 p.m. on 5/29/19, that included the Administrator, Interim Director of Nursing (DON), and the survey team, the DON was advised of the observations regarding Resident # 26 yelling out, the lack of staff intervention, and his disturbing the sleep of another resident. At approximately 9:30 a.m. on 5/30/19, the DON was asked who was responsible for developing care plans. The DON stated that the Clinical Coordinators (Unit Managers) on the unit develop care plans. At 11:00 a.m. on 5/30/19, RN # 4 (Registered	F 656	System Changes: • Interdisciplinary team will be educated on development of resident centered care plans on 6/20/2019. This will include discussion of care planning for diagnosis of depression, anxiety and behaviors. • During care plan meetings each week, the care plans of residents with behaviors, diagnosis of depression and anxiety will be validate to reflect individualized problems, goals and approaches. • Any resident that receives a new diagnosis of depression, anxiety and/or behaviors will have a care plan developed with input by the interdisciplinary team.	

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F 656	Continued From page 6 Nurse), who identified herself as a Clinical Coordinator (Unit Manager) on the Second Floor Unit, was interviewed regarding care plans. When asked how care plans are developed, RN # 4 said there was "...a section in Cerner (the Electronic Health Record computer program used by the facility) where we can check off items for the care plan." Asked about a resident's name appearing in the care plan, RN # 4 said they (staff) are able to add a resident's name on some items. RN # 4 went on to say that, "We involve the resident and family to find out their preferences." RN # 4 was given Resident # 26's care plan for Behavioral Symptoms and asked to review it. After reviewing it, RN # 4 was specifically asked if Resident # 26's care plan for behavioral symptoms was a person-centered plan of care. RN # 4 replied, "Yes." No further information and/or documentation was presented prior to the exit conference on 5/30/19 at 5:00 PM. 2. Resident #63 admitted to the facility on 4/25/17. Diagnoses for this resident included, but were not limited to: high blood pressure, PVD (peripheral vascular disease), diabetes mellitus, increased lipids, thyroid disorder, arthritis, anxiety, depression, manic depression, morbid obesity, right BKA (below the knee amputation), history of venous thrombosis and embolism. Resident #63 had an MDS trigger in the LTCS (long term care software) process for "No PASAAR II with diagnosis. The resident's most current MDS (minimum data set) was annual assessment dated 4/11/19. The	F 656	Monitoring: • A weekly audit of 4 care plans x8 weeks will be completed by the DON or designee following care plan conferences to validate the presence of individualized care plans for residents with behaviors and diagnosis of depression and anxiety. Areas of non-compliance will be immediately addressed with the revision of the care plan. • The weekly audits will be submitted to the QA Coordinator who will present a report of areas of noncompliance to the QAPI committee for discussion and further recommendations.	

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F 656	Continued From page 7 resident did not trigger for anything in Section A1500. Preadmission Screening and Resident Review and did not trigger for anything in Section A.1510 Level II Preadmission Screening and Resident Review Conditions. This MDS did reveal that the resident had a documented diagnosis of anxiety, depression and manic depression (bipolar) in Section I. Active Diagnoses. The resident's CAAS (care area assessment summary) section of this MDS was reviewed. The resident did not trigger for mood, behaviors or psychosocial well being. The resident had CAAS worksheets for mood and psychosocial well being, which were reviewed. The CAAS worksheet documented under mood state on the MDS, "...relapse of an underlying mental health problem, anxiety disorder, depression (other than bipolar), and manic depression (bipolar)..." The resident's CCP (comprehensive care plan) was reviewed and did not document anything regarding anxiety, depression or manic depression (bipolar). On 05/29/19 at 4:08 PM, LPN (Licensed Practical Nurse) #1 (who was the MDS coordinator) was interviewed regarding the above findings, specifically related to a PASAAR Level II for this resident. LPN #1 was made aware of a possible MDS discrepancy. LPN #1 stated that she did not know anything about the PASAAR. LPN #1 pulled the information up on the computer and stated that a diagnosis of bipolar would trigger for a Level II and stated that this would be an error for this resident. The LPN stated that this resident does have depression and anxiety, but not bipolar. LPN #1 stated, "Ok, this is my	F 656		

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F 656	Continued From page 8 mistake I marked manic depression (bipolar) by accident. She does not have that, she has anxiety and depression, but not bipolar, I will have to fix that." LPN #1 was then asked about the resident's CCP for anxiety and depression. LPN #1 stated that the unit managers, clinical leaders, and DON (director of nursing) usually do the care plans. On 5/30/19 at approximately 3:45 PM, the DON was asked about the care plan for this resident regarding the above information. The DON stated that the resident should have a care plan for those things (anxiety/depression) and went on to say the unit managers and clinical leaders add those in, but additionally stated that the it is a check off. The DON was made aware that the care plans reviewed were exactly that, a check off and consisted of a sentence, were not descriptive or individualized for the resident and were generic. The DON agreed. No further information and/or documentation was presented prior to the exit conference on 5/30/19 at 5:00 PM to evidence a CCP was developed for this resident in the area of anxiety and depression.	F 656		
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	F 684		

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F 684	Continued From page 9 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 staff interview, medication pass and pour observation, and clinical record review, facility staff failed to follow physician orders for five of 28 residents in the survey sample, Residents #56, #91, #350, #61, #37; and also failed to timely assess vital signs for one of 28 residents in the survey sample, Resident #150. 1. Facility staff failed to follow physician orders for obtaining weekly vital signs and obtaining left leg, vascular assessments every eight hours for Resident #56. 2. Facility staff failed to follow physician orders for obtaining weekly vital signs and monthly weights for Resident #91. 3. Resident #350 was ordered 400 mg of Amiodarone by mouth every day. LPN (licensed practical nurse) #5 administered 200 mg in error. This resulted in a medication error rate of 3.13% (one error/32 opportunities). 4. Facility staff failed to follow physician orders for the use of TED stockings for Resident #61. 5. The facility staff failed to obtain monthly weights for Resident #37 as ordered by the physician. 6. Facility staff failed to timely assess vital signs for Resident #150.	F 684	F tag 684 **Corrective Action:** 7/12/19 • The attending physician for resident #56 was notified regarding the weekly vital signs being inconsistently obtained and the vascular assessments ordered every 8 hours for the left leg had not been completed as ordered. New orders received on — 6/14/2019 to discontinue weekly vital signs and left leg vascular assessment. RP notified. • The attending physician and RP for resident #91 were notified that weekly vital signs and monthly weights were inconsistently documented. New orders received to continue monthly weights and weekly vital signs. The resident's weight was obtained on 6/17/2019 and weekly vital signs are being obtained and documented in the medical record. RP notified of new orders.	

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F 684	Continued From page 10 Findings included: 1. Resident #56 was originally admitted to the facility on 04/17/2006 and readmitted on 08/17/2012 with diagnoses including, but not limited to: Diabetes, Arthritis, Dementia, Hemiplegia, Parkinson's Disease, Convulsions, and Spiral Tibia Fracture. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 04/05/19. Resident #56 was assessed as severely impaired in her short and long term memory and daily decision making skills. The clinical record of Resident #56 was reviewed on 05/29/19 at 10:00 a.m. Resident #56's POS (physician order sheet) dated May 2019 included: "...07/24/18...Neurovascular assessment-Leg, Left, every 8 hours, Start 07/24/18...11/17/18...Vital signs-weekly (Sun.), 3 365 Day(s), Start: 11/17/18. No neurovascular assessments were located in the clinical record. Vital signs were recorded on 11/27/18, 12/17/18, 12/28/18, 1/11/19, 1/15/19, 1/22/19, 1/29/19, 2/1/19, 2/5/19, 2/8/19, 2/19/19, 2/27/19, 3/15/19, 3/19/19, 4/1/19, 4/2/19, 4/3/19, 4/12/19, 4/15/19, 5/8/19. The DON (director of nursing) was interviewed during a meeting with the survey team on 05/29/19 at approximately 6:00 p.m. on the location of neurovascular assessments, vital sign documentation and what she considers vital signs. The DON stated, "I will have to look in the record and get back with you. I consider vital signs to be temperature, pulse, respirations, blood pressure and an O2 sat." On 05/30/19 at	F 684	• The attending physician was notified on 5/29/2019 that resident #350 was given 200 mg of Amiodarone during medication pass instead of the ordered 400 mg. New orders were received on 5.29.2019 to go ahead and give the second 200 mg dose. LPN #5 will be re-educated on administering accurate dosage of medication. • The attending physician and RP were notified of TED hose not being applied to resident #61's legs as ordered. Nurses responsible for ensuring the TED hose were in place have been counselled by the DON regarding the responsibility of following physician orders.	

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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 684	Continued From page 11 approximately 1:00 p.m., the DON stated, "I did not find any neurovascular assessments and you are right in that the vital signs are sporadic and incomplete." No further information was received by the survey team prior to the exit conference on 05/30/19. 2. Resident #91 was originally admitted to the facility on 04/21/06 and readmitted on 11/05/18 with diagnoses including, but not limited to: Anemia, Cerebral Palsy, Dementia, Seizures, Contractures, Gastrostomy Tube. The most recent MDS was a quarterly assessment with an ARD of 05/01/19. Resident #91 was assessed as moderately impaired in her cognitive status with a total cognitive score of 08 out of 15. Resident #91's clinical record was reviewed on 05/29/19 at 11:00 a.m. The physician order sheet (POS) dated May 2019 included: "...11/05/18...Weigh Patient- every week x4; then once a month. Start: 11/05/18...11/18/18...Vital signs-weekly (Sun.), x 365 Day(s), Start: 11/18/19..." Subsequent review of documented vital signs and weights included documentation on the following dates: Vital signs: 12/30/18, 2/17/19, 3/3/19, 3/31/19, 4/7/19, 4/28/19, 5/5/19, 5/12/19, 5/19/19. Weights: 12/2/18, 2/18/19, 3/6/19, 5/16/19. No weights were recorded for the months of January or April. The DON was interviewed during a meeting with the survey team on 05/29/19 at 6:00 p.m. The DON stated, "I consider vital signs to be	F 684	Application and removal of the TED hose will be documented in the medical record. • The attending physician was notified regarding monthly weights not being completed as ordered for resident #37. The restorative aides, who are responsible for the obtaining resident weights have been counselled by the DON. The Clinical Coordinator responsible for ensuring weights were completed and documented was counselled by the DON. Resident #37's weight was obtained on 6/18/2019 and documented in the medical record. • Resident #150 expired on 11/22/2018. The nurse who failed to document an assessment of vital signs is was terminated from employment at TCH.	

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	495177	A. BUILDING _____ B. WING _____	05/30/2019

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F 684	Continued From page 12 temperature, pulse, respirations, blood pressure and O2 sats." On 05/30/19 at approximately 1:00 p.m., the DON stated, "I did not find any other weights and you are right in that the vital signs are sporadic and incomplete." No further information was received by the survey team prior to the exit conference on 05/30/19. 3. A medication pass and pour observation was conducted on 05/29/2019 beginning at approximately 8:00 a.m. on the first floor of the facility. LPN #5 was observed preparing medications for Resident #350. The medications were in single dose packages. LPN #5 checked the electronic MAR (medication administration record) and then pulled each medication from the med cart drawer. The unopened medications were handed to the surveyor to record, and were then placed on top of the medication cart. After all the medications were pulled and recorded the total number of pills written down by the surveyor were counted and compared with the number of pills on top of the medication cart. A total of seven pills were counted by the surveyor and verified by LPN #5, this included one 200 mg Amiodarone tablet. After the count LPN #5 opened each pill and placed them in a medication cup for administration. When the medication pass was completed the medications were reconciled with the clinical record. Observed on the physician order sheet and the MAR were orders for "Amiodarone 400 mg, Tab PO [by mouth], daily, X [times] 365 Day(s)." LPN #5 administered Amiodarone 200 mg during the medication pass observation. LPN #5 awas interviewed at approximately 9:10 a.m. The box of Amiodarone belonging to	F 684	**Identification of others:** Any resident residing in facility could have been at risk for physician orders not being fully implemented. A 100% audit of current residents will be done to ensure that monthly weights for June have been obtained and documented in the medical record. Staff will be re-educated on the importance of obtaining and documenting weekly vital signs as ordered by the physician. Licensed nursing staff will be re-educated on accurate medication administration and documentation. A 100% audit of residents with orders for TED hose will be completed to ensure that staff know who is to have TED hose and how to document application / removal of the hose. A 100% audit of current resident's code status will be completed to ensure that the code status is clearly identified in the resident's medical record.	

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F 684	Continued From page 13 Resident #350 was pulled from the medication cart. Observed on top of the box was a sticker that read: "CAUTION DOSAGE STRENGTH DIFFERENT FROM ORDER, USE APPROPRIATE AMOUNT". The label on the box also contained the following: [name of Resident] AMIODARONE HCL 200 MG TABL [tablets] TAKE 2 TABLETS [underlined in black marker] (400 MG) BY MOUTH DAILY...QTY [quantity] 32". LPN #5 stated, "I see that, I thought I gave two pills." LPN #5 was asked if she remembered counting the pills with this surveyor prior to administration and agreeing with the count. She stated, "Yes." LPN #5 counted the remaining pills left in the box. There were 13, and per the medication label, 32 had been dispensed. LPN #5 stated, "There should be an even number since we are giving them two at a time." LPN #5 was asked what she was going to do. She stated, "I'm still in my window, I'll give it or call the doctor and ask him if he just wants her to have one." During an end of the day meeting with the DON (director of nursing) and the administrator the above information was discussed. The DON stated, "She gave the other pill." A copy of the facility policy regarding medication pass administration was requested. The facility policy "PREPARING AND ADMINISTERING MEDS & USE OF DRUG CART" was presented on 05/30/2019. Per the facility policy: Remember the 5 R's-Right: Patient, Medication, Route, Dose, and Time..." No further information was obtained prior to the exit conference on 05/30/2019.	F 684	**System Changes:** • Licensed nurses will be re-educated on responsibility in receiving, transcribing and following physician orders. • Licensed nurses will be re-educated on the 6 rights of medication administration. • Education with licensed nurses regarding code status orders, obtaining physician orders, how to enter orders into EMR and honoring resident's choice for code status will be done. • New code status orders are to be entered on 24 hour report. For new admissions, the Clinical Coordinators will validate the presence of the code status order within 24 hours of admission. • Clinical Coordinators or other persons designated by the DON will be responsible for ensuring vital signs and weights are obtained per physician's orders. • Licensed nurses will be re-educated on vital sign protocol, application of TED hose and assessment of new admissions per facility protocol and documentation of assessments and care as ordered.	

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F 684	Continued From page 14 4. Resident #61 was admitted to the facility on 6/22/18. Diagnoses for Resident #61 included; Diabetes, heart failure, osteoporosis, chronic pulmonary edema. The most current MDS (minimum data set) was a initial assessment with an ARD (assessment reference date) of 5/9/19. Resident #61 was assessed with a score of 13 indicating cognitively intact. On 5/28/19 at 3:00 PM an interview was conducted with Resident #61. During the interview it was observed that Resident #61 did not have compression hose in place. After the interview, Resident #61's record was reviewed. A physician's order dated 5/19/19 documented "Intermittent venous compression hose knee length, legs, both, start 05/19/19." On 05/29/19 at 9:11 AM, Resident #61 was observed sitting in her room without compression hose in place. Resident #61 was interviewed regarding compression hose. Resident #61 verbalized that she (Resident #61) used to wear compression hose years ago, but hasn't worn any for a long time, and stated that her ankles have been swelling lately. On 05/29/19 at 10:02 AM, Registered nurse (RN) #4 was asked to look for Resident #61's compression hose in the room were Resident #61 resided. The compression hose were not located. On 05/29/19 at 10:12 AM, license practical nurse (LPN) #2, assigned to Resident #61, was interviewed regarding compression hose. LPN #2 stated that she had just been made aware that Resident #61 has an order for compression hose.	F 684	• The protocol for obtaining weekly vital signs will be reviewed and revised as indicated by the DON and medical director. **Monitoring:** • Medication administration observations will be done with 4 nurses per week for 4–8 weeks, then 2 per week for 4 weeks. A report of medication pass observations will be submitted weekly to the DON for analysis and trending. If variances are observed the nurse will be immediately re-educated. • Clinical Coordinators will submit a monthly weight report to the DON who will analyze for areas of non-compliance. Missing weight will be obtained and documented in the medical record. • A review will be completed to identify all residents with ongoing orders for weekly weights. A weight report will be submitted to the DON weekly for analysis and trending for areas of non-compliance. Missing weight will be obtained and documented in the medical record	

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F 684	Continued From page 15 On 05/29/19 at 5:08 PM, the above finding was presented to the director of nursing and administrator. No other information was presented prior to exit conference on 5/30/19. 5. Resident #37 was admitted on 03/27/18 with diagnoses that included dementia, hypertension, joint pain, stage IV sacral pressure ulcer, gastronomy - Peg-tube placement, and cerebrovascular infraction - stroke. The most recent minimum data set (MDS) dated 03/18/19 was an annual assessment and assessed Resident #37 as having long and short term memory problems, moderately impaired for daily decision making and having periods of fluctuating inattention. Resident #37's electronic medical record (EMR) was reviewed on 05/29/19 at 8:00 a.m. Observed was an order for monthly weights with a start date of 06/08/18. A review of Resident #37's (EMR) did not document weights monthly as ordered by the physician. For the period of June 7, 2018 through May 29, 2019, there were no weights documented for the months of November 2018, December 2018, January 2019, February 2019 and March 2019. On 05/29/19 at 5:08 p.m., during a meeting these findings were reviewed with the administrator & DON. The DON stated she would check in the care tracker system for additional documentation and provide the information the next day. On 05/30/19 at 10:15 a.m., the DON provided a printed copy of Resident #37's weights. The copy documented weights for the months of June	F 684	• QA Coordinator will review Care Tracker weekly for documentation of application of TED hose. Areas of non-compliance will be addressed immediately. Visual observations of 4 residents with orders for TED hose will be done weekly x 8 weeks by the Clinical Coordinator / designee; findings of variances will be investigated, corrected as appropriate, and responsible staff re-educated. Findings of the weekly observations will be submitted to the DON / designee for trending and analysis. • 4 records of residents will be reviewed weekly x 8 weeks by the Clinical Coordinator / designee to ensure there is clear and accurate identification of the resident's code status. If variances are found, they will be immediately corrected. The weekly audits will be submitted to the QA Coordinator for trending and analysis. • A report of areas of non-compliance for medication pass, application of TED hose, and obtaining weights and vital signs will be presented to the QAPI committee for discussion and further recommendations.	

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F 684	Continued From page 16 2018, July 2018, October 2018, April 2019 and May 2019. There were no monthly weights documented for the months of November 2018, December 2018, January 2019, February 2019 and March 2019. The DON stated these were all that could be found in the electronic system. On 05/30/19 at 10:25 a.m., the Registered Dietitian (OS #5) who routinely follows Resident #37 was interviewed. OS #5 stated she routinely follows Resident #37 as the resident receives peg-tube feedings and pleasure foods by mouth. OS #5 was interviewed regarding the physician ordered weights for Resident #37. OS #5 stated she started employment in February 2019 and Resident #37 did not have weights documented for the months of November 2018 through March 2019. OS #5 continued and stated from her understanding Resident #37 was on comfort care for a brief period and weights were not obtained and/or documented during that time. OS #5 was asked if there was a physician order for the comfort care. OS #5 stated no there was no written order for the comfort care. OS #5 stated staff thought a conversation had taken place about comfort care, and possibly a verbal order had been given, however the actual order was not written. OS #5 stated from her review of the records Resident #37 had not lost any weight and was currently stable at 109# for this month. No additional information was received by the survey team prior to the exit on 05/30/19 at 5:00 p.m. 6. Resident # 150 was admitted to the facility on 10/30/18, and most recently readmitted at approximately 1:00 p.m. on 11/21/18 with diagnoses that included acute and chronic diastolic heart failure, acute and chronic hypoxic	F 684		

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

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F 684	Continued From page 17 respiratory failure secondary to congestive heart failure, pulmonary fibrosis, emphysema, pulmonary hypertension, diabetes mellitus, history of hypertension, and oxygen dependence. A thorough review of the resident's Electronic Health Record (EHR) failed to reveal any instructions for the resident's care, any Nurse's Notes regarding the resident's condition on admission, any Nurse's Notes documentation of his vital signs, or any Nurse's Notes of his condition up to, and including, the time of his death. On 5/30/19 at approximately 8:50 a.m., speaking the to the lack of nurse's notes documentation, the Interim Director of Nursing (DON) said, "The previous DON did not have staff document (a narrative) in the Clinical Notes (Nurse's Notes). She only had them use the check-off boxes in Cerner (the Electronic Health Record computer program)." Resident # 150's vital signs were documented in two area in Cerner, Bedside Data and Vitals, and iView, neither of which were readily available for review by staff. At approximately 5:00 p.m. on 11/21/18, the vital signs for Resident # 150 were recorded in both Bedside Data and Vitals, and iView as follows: Oral temperature 35.6 (Centigrade) on Bedside Data and Vitals, 35.9 (Centigrade) on iView; Pulse 109; Blood Pressure 116/96; Respiration Rate 24; O2 Sats 91%. The resident was noted on iView as receiving oxygen via nasal cannula at 4 liters per minute.	F 684		

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F 684	Continued From page 18 The next set of vital signs for Resident # 150 were taken 7 (seven) hours later at approximately Midnight (0000 to 0029 on 11/22/18). His vital signs were recorded under Bedside Data and Vitals, and iView as follows: Oral temperature 36.9 (Centigrade)/98.4 (Fahrenheit); Pulse 72; Blood Pressure 92/66; Respiration Rate 24; O2 Sats 90%. The resident was noted on iView as receiving oxygen via nasal cannula at 4 liters per minute. The following "Significant Event Note, Final Report" was located in the Clinical Notes section of Resident # 150's Cerner EHR: 11/22/18 0 7:54 a.m. "This writer made aware by CNA (Certified Nursing Assistant) (Name) Mr. (Name of Resident # 150) was (gone). [sic] I went down to the room with the vitals machine and found resident had no vitals of life. Resident was white and nail beds were cyanotic upon beginning of my shift. Body was still, cool to touch. I then came back to the desk and made and proceeded to make my phone calls to resident's contacts. Prior to the resident's passing I and the CNA (Name) had been checking o [sic] him due to his low o2 [sats]. I was told at the beginning of the shift that the resident had to wear an E-Pap device at all times due to his sits [sic] being in the 60's so we did keep close tabs on him for theis [sic] reason." (NOTE: EPAP, or Expiratory Positive Airway Pressure, is used to create pressure during the exhalation process, providing smoother breathing. Ref. www.epap.net.) A "Final Report - Discharge by Death." dated	F 684		

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F 684	Continued From page 19 11/22/18 at 4:14 a.m., located in the Cerner EHR, noted the following: "Writer called by staff LPN (Licensed Practical Nurse), (Name), @ (at) 0240 (2:40 a.m.). Stated resident had passed and needed RN (Registered Nurse) pronouncement. Writer arrived to pronounce and was informed by staff LPN that CNA had been present at time this occurrence was noted. Writer in to assess resident. Resident presented with epap in place and functioning. Vital signs were checked. He was absent of all, no BP (Blood Pressure), pulse or respirations. No SPO2 (Pulse Oximetry). Resident appears with mouth open, pale in color with cyanotic nail beds to hands/feet. Apical pulse checked = absent, lung sounds checked = absent, bowel sounds checked = absent. Skin temp is cold to touch. This writer pronounced TOD (Time Of Death) @ 0345 (3:45 a.m.). Staff LPN (Name), CNA (Name) present @ bedside. Dr. (Name), MD was notified by staff LPN (Name)...." At 1:15 p.m. on 5/30/19, the condition of Resident # 150 as noted in the "Final Report - Discharge by Death," dated 11/22/18, was reviewed with RN # 1, the Quality Assurance Nurse. Asked if she thought Resident # 150's condition as described was irreversible, RN # 1 said, "Yes." At approximately 1:30 p.m. on 5/30/19, the code status of Resident # 150 was discussed with the Interim DON. Advised that the surveyor was unable to locate the resident's code status in Cerner, the Interim DON said, "He (Resident # 150) had an established code status, but it wasn't captured by Cerner."	F 684		

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F 686 SS=G	Continued From page 20 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure two of 28 residents did not develop pressure ulcers, and failed to ensure one of 28 residents had prevalon boots in place as ordered by the physician. 1. Resident #24 developed full thickness skin loss to her first (thumb) and fourth finger on her left hand. This was identified as harm by the survey team. 2. Resident #5 did not have weekly skin assessments completed by the nursing staff. On 02/01/2019 a Stage III pressure ulcer was discovered on her left heel. This was identified as harm by the survey team. 3. Resident #2 was not wearing physician ordered prevalon boots.	F 686 F 686	F tag 686 **Corrective Action:** • Resident #24 is receiving treatment as ordered to the wound on her left hand. The wound is showing signs of improvement. Treatments are being administered and documented per physician order. Resident continues to be treated by OT. • Restorative nursing assistants have been counselled regarding continuing services of Restorative Nursing Program until rehab has initiated evaluation and treatment, at which time an order will be obtained to discontinue restorative. • The physician will be notified that resident did not receive restorative or occupational therapy from 3/21/2019 until 3/28/2019. • A thorough head to toe assessment was completed on resident #5 on 6/7/2019. No new areas of skin impairment were noted. The wound on resident #5's heel was resolved on 5/8/2019. Prevalon boots are being applied and documented as ordered.	7/12/19

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F 686	Continued From page 21 Findings include: 1. Resident #24 was originally admitted to the facility on 04/08/2005. Her diagnosis included but were not limited to: Hypertension, anxiety, diabetes mellitus, congestive heart failure, and chronic Atrial fibrillation. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 03/04/2019 assessed Resident #24 as having problems with short term memory and daily decision making skills. Initial tour of the facility was conducted on 05/28/2019 at approximately 11:30 a.m. Resident #24 was observed lying in bed. Her left hand was wrapped in gauze. LPN (licensed practical nurse) #4 was in the hallway and was asked about the dressing. She stated, "She had an injury...there was some exposed bone. We are doing dressing changes on it...I'm pretty sure we did an X-ray and nothing was broken." The clinical record was reviewed from 05/28/2019 through 05/30/2019. Observed on the POS (physician order sheet) was an order dated 04/12/2019, "Cover left thumb with hydrofera blue foam and pad between fingers and palm-Change Q [every] 3 days." A wound team progress note dated 04/12/2019 contained the following information: "Visit Information: Called to ck [check] for breakdown of fingers..Pain: Patient response screams out when touch [sic] either hand and fights nurse attempting care. Left thumb-thumb may be broken-bone protruding at middle joint-soft-no	F 686	• Prevalon boots are now being applied and documented to resident #2. Assigned nurses are responsible for validating the placement of the boots as ordered. The care plan has been updated to reflect the use of the boots. **Identification of others:** All residents could have been at risk. Current residents have had skin observations completed and documented; new findings have been reported to the resident's physician. An audit of residents with orders for Prevalon boots will be conducted to ensure that resident has Prevalon boots and that application of the boots is being documented in the medical record.	

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F 686	Continued From page 22 tone to upper thumb area-all fingers thin and contracted-Some light bleeding at area shown above [referring to picture of injury] and also finger crossing has open tissue. Will need to talk with Dr. about possible X-ray of area and develop plan of care. Cleaned and covered with hydrofera foam and secured..." The care plan for Resident #24 included: "LTC Skin Intergrity" Outcomes included but were not limited to: "Skin Integrity Maintained; [Name] will not have further issues from moisture; Minimize risk for skin breakdown r/t [related to] pressure or moisture thru next review"; Interventions included but were not limited to: "Apply moisture as needed for dryness; Change dressing to 1st and 4th finger each shift as ordered (Discontinued); Hydrofera blue dsg [dressing] to 1st finger wound on Rt [hand] (Discontinued); Hydrofera blue dsg to Lt [left thumb] every 3 days". On 05/29/2019 at approximately 10:00 a.m., the DON [director of nursing] was in the conference room to speak with the survey team. She was asked to let the wound nurse know that this surveyor needed to see the dressing change to Resident #24's left hand when it was done. The DON left the room and returned a few minutes later. She stated, "The dressing was done early this morning...it is only done every three days and is very painful for the resident, if you want to see it we will do it again." The DON was asked if the dressing could be done the following morning [05/30/2019]. She stated she would let the wound nurse know. On 05/29/2019 at approximately 2:00 p.m., the wound nurse, LPN (licensed practical nurse) #6 came to the conference room to discuss the	F 686	**System Change:** • A full house head to toe skin sweep was completed on 5/31/2019. No new pressure areas were identified. Another full house skin sweep is scheduled be completed the first week of July 2019. • The DON has reviewed and revised the schedule for weekly skin assessments for the completion of weekly skin assessments. • The licensed nurses have been re-educated on completion of skin assessments per schedule and how to complete a skin assessment. • The Clinical Coordinators will be educated on their role in ensuring the skin assessments have been completed and assisting with completion as needed. • Nursing assistants will be educated on their role and responsibility for preventing pressure ulcer, reporting change in resident's skin, and implementation of preventive interventions including use of protective boots, wedge/positioning device, care of splints/braces, etc.	

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F 686	Continued From page 23 wound on Resident #24's left thumb. She was accompanied by the DON. LPN #6 stated that occupational therapy had been working with Resident #24 in her room doing range of motion to her hand and had informed her that there was a wound present. She stated that she looked at the wound and initiated dressing changes. It was requested that the occupational therapist that had worked with Resident #24 be brought into the conversation. The COTA (certified occupational therapy assistant) that worked with Resident #24 came to the conference room. She stated, "We [occupational therapy] picked her up around the end of March for contracture management. At that time her hand was stuck in a fisting position...I first saw her on April 2nd...the skin of her thumb and fingers had fused together...I was working with her and she pulled away...her fingers became unstuck and were open at the knuckle of her thumb...it looked like bone...nursing was informed and they started the dressing changes then." The COTA was asked about an order on the POS dated 01/07/2019 for "RNP [restorative nursing] -PROM [passive range of motion] in BUE [bilateral upper extremities] in all planes as tolerated by patient". The COTA stated, "She had been getting that, but it stopped when therapy came back in." It was requested that the Restorative aide be brought into the conversation. The CNA (certified nursing assistant) #4 who provided restorative nursing care to Resident #24 came to the room. She was asked about Resident #24's left hand. She stated, "We got her back in restorative around the end of December or the first part of January...I did Passive range of	F 686	• Licensed nursing staff will be educated on prevention, assessment, treatment and documentation of pressure ulcers. • Nursing staff is being re-educated on the use of **prevalon boots.** • Clinical Coordinators observed each resident in the facility for presence of contractures to ensure there is no area of skin impairment associated with the condition. • New areas of skin impairment and rehab orders will be communicated on the 24 hour report. • Licensed nurses will be re-educated on their responsibility in obtaining, transcribing and implementation of new orders. **Monitoring:** • Clinical Coordinators will observe the placement of Prevalon boots each day. Areas of non-compliance will be immediately corrected and addressed with appropriate staff • Clinical Coordinators will do a daily validation of skin assessments from the prior day being completed. 1:1 education will be done with staff who did not complete assessment as assigned.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 24 motion to her uppers, her arms and hands...when I was working with her there wasn't nothing wrong with her left hand like open areas or anything...her hand was contracted but I could get it open by rubbing it and putting lotion on it to loosen it up...I could move her thumb out and get to her palm, it wasn't stuck in a fist" CNA #4 was asked when she stopped providing services. She left the room and returned with documentation. She stated, "Here is the referral...we got that on January 7...I saw her three times a week starting January 10...my last visit with her was March 21...therapy was coming in and we can't do restorative if the resident is getting therapy." The COTA was asked when Occupational therapy started. She stated, "The evaluation was done on March 28...it looks like the request was made on March 20 for her to be evaluated for an orthotic for that hand...usually after we get the request it's done in the next day or two...It must have gotten overlooked. The therapist that did the evaluation was a traveler and she is not here any more." The COTA and the Restorative CNA were asked what services Resident #24 received to treat her left hand contractures from 03/21/2019, the day of the last restorative visit until the date of the evaluation, 03/28/2019. Neither could provide an answer. The evaluation completed on 03/28/2019 was presented by the COTA. Per the evaluation: "Range of Motion...UE ROM [Upper extremities range of motion]: RUE ROM = Impaired (contractures and deformities present at all joints, able to grasp items); LUE ROM = Impaired (contractures and joint deformities present at all joints of hand, with flexion. Patient's hand contracted in flexion)...Joints: Shoulder = WFL	F 686	• The Clinical Coordinators will validate treatment orders and implementation of those orders. • The DON, QA Coordinator, or designee will conduct 4 skin observations weekly x 8 weeks and compare those observations to completed weekly skin assessments to ensure accuracy in completion of the weekly assessments. Findings from these weekly audits will be submitted to the DON for trending, analysis, and any additional education or action. • The DON, QA Coordinator, or designee will conduct resident observations of 4 residents x 8 weeks to ensure that pressure ulcer interventions are being applied correctly. If variances are discovered the responsible staff will receive 1:1 education and	

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F 686	Continued From page 25 [within functional limits]; Elbow/Forearm = WFL, Wrist = WFL; Hand = Impaired; Shoulder = WFL; Elbow/Forearm = Impaired (contracted in elbow flexion); Wrist = Impaired (contracted in extension); Hand = Impaired (all digits and joints contracted and deformities present, in flexed position). The COTA was asked what a flexed position meant. She stated, "Her hand was fixed in a fist." A previous evaluation from OT dated 11/26/2018 was also presented by the COTA. The assessment summary contained the following description of Resident #24, "Functional Limitations as a result of Contractures: Patient presents with multiple contractures to her bilateral wrists and digits. Her right wrist contracted in a flexed position and left contracted in a position of extension. Patient exhibits swan neck deformity to digits bilaterally..." The COTA was asked what a swan neck deformity was. She stated, "Her fingers turned up on the ends." She was asked if there was a decline between the two evaluations. She stated, "Yes." The COTA was asked what could have been done to keep Resident #24's hand from becoming fixed in a fist and her fingers stuck together. She stated, "Hand hygiene...if you are cleaning the hand and massaging it to help the contractures, the skin won't fuse between the fingers and cause pressure as they rest on each other." She was asked how long it would take for Resident #24's hand to be in that condition if hand hygiene wasn't performed. She stated, "Just a couple of days." The COTA was asked if the wound on Resident #24's hand was from pressure. She stated, "Yes, from her fist being contracted and fixed." She was asked if she thought it was avoidable. She stated, "Yes, if hand hygiene was provided that would have kept	F 686	interventions will be applied. Findings from these weekly observations will be submitted weekly to the DON for trending, analysis, and any additional education or other action. • Reports of areas of non-compliance will be presented to the QAPI committee by the DON or QA Coordinator for discussion and further recommendations.	

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F 686	Continued From page 26 her fingers from being stuck together." One of the therapy technicians, (OS #10) came into the conference room during the interview. She and the COTA were asked how long they had been doing their jobs and had they ever seen anything like this before. The COTA stated, "I've been doing this since 2018, I've never seen it happen before." OS #10 stated, "I've been doing this for ten years, I've never seen this happen before." After the interviews discussed above, the DON was asked to present any additional information regarding the pressure area to Resident #24's left thumb. Further review of the clinical record was conducted. A skin integumentary note dated 04/04/2019 contained the following: "1st and 4th finger full thickness skin loss. Yellow and pink tissue noted to both areas. Depth noted to first finger. Resident fighting with staff while trying to assess. Foam dressing applied. Bleeding noted. MD aware. Stated to have treatment nurse address." On 04/12/2019 after the wound nurse evaluated Resident#24, a recommendation was made to send her to the emergency room. Transfer comments on the facility transfer note included: "Resident sent to ER due to possible bone exposure to left thumb..." The emergency room visit note dated 04/12/2019 included the following: "...Patient presents for wound evaluation...open wound of left thumb. Patient digits are significantly contracted. Pt is non-verbal but it is apparent that the area is causing her pain...Musculoskeletal: Upper extremities: All digits malformed due to contractures. Exposed bone to IP joint of left	F 686		

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F 686	Continued From page 27	F 686		

thumb, medial aspect...area is extremely tender when manipulated..." An X-ray was obtained. The report included: "Two fingers of he left hand were stuck together. When they were separated the fingers, a sore was noted which exposed the bone of the left thumb. Given the degree of the contraction, the left thumb is very limitedly assessed. No gross abnormalities of thumb are noted. There does appear to be a pencil in cup type deformity involving the 5th PIP joint suggesting psoriatic arthritis. Impression: The hand is severely contracted. The left thumb is visualized. No gross abnormalities of the thumb are noted..."

An orthopedic consult was obtained on 04/15/2019, and contained the following: "...Patient is extremely demented...Patient have [sic] deep laceration on dorsal aspect of the thumb. The thumb is deformed and curled up most probably from chronic arthritis. All fingers are deformed...At this point I recommend to continue daily dressing changes. I attempted to call patient's son who is POA [power of attorney]....we discussed her treatment options. I suggested attempt to primarily close the laceration versus amputation of the thumb. The thumb is completely nonfunctional because of the significant deformity. The thumb is curled up under the index finger. Open wound can lead to infection and amputation might be better option with 97-year-old female patent having complete dementia and significant deformity of the thumb. The son wanted to see if there is any chance for wound will heal by itself. I stated that we can continue daily dressing change and check again within 1 week. If infection develops or wound worsens, then we can consider surgical treatment otherwise will continue daily dressing change by

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F 686	Continued From page 28 nurse..." A follow-up orthopedic appointment on 04/17/2019 contained the following information: "...Examination of the left thumb IP joint is difficult given the patient's dementia and combativeness when attempting to examine her left thumb given the amount of pain. The wound was examined by the wound care specialist ...she feels minor granulation is starting. She has redressed the wound with hydrofera Blue and has agrees to continue watch and dressing changes every three days..." During an end of the day meeting on 05/29/2019 with the DON and the administrator, concerns were voiced that per interviews conducted with staff, Resident #24's hand was not fixed in a fist when restorative nursing was working with her. The hand could be opened and the thumb moved. Restorative was discontinued on 03/21/2019. There are no documented interventions from 03/21/2019 until 03/28/2019 when occupational therapy reevaluated her. When the COTA came in the room to do therapy on 04/04/2019, the fingers were stuck together and when Resident #24 pulled away, they became unstuck with resulting full thickness wounds. They were informed that the injury was being investigated at a harm level. A dressing change was observed on 05/30/2019 with LPN #6. An additional staff member was in the room to assist. LPN #6 used good technique to remove the old dressing. The wound on the left thumb was difficult to visualize as the resident pulled away from the nurse stabilizing her arm. The area that could be seen was open and bright red.	F 686		

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F 686	Continued From page 29 At approximately 1:30 p.m., LPN #7 was asked if she could pull the bath record for Resident #24 and ascertain who bathed her from 03/21/2019 through 03/28/2019. She stated that the baths were divided up per shift on the unit. Resident #24 was bathed on the night shift. She pulled the requested information up on the computer. Per the documentation, Resident #24 received a bed bath every night and had one whirlpool bath during that time frame. LPN #7 stated, "She has never been in the whirlpool, I don't know why that's there." She was asked if she could tell who bathed her. She stated she would try to run a report and bring the information to the conference room. On 05/30/2019 at approximately 2:55 p.m., the DON, the administrator and the QA (Quality Assurance) nurse came to the conference room to discuss Resident #24. The DON stated, "We can't explain what happened from March 21 through March 28, there is no documentation showing what, if anything, was being done with her hand...but we have information that the therapist and the nurses were working together to treat her after that." The DON was informed that there were no issues with the treatment documented before March 21 or after the evaluation on March 28, the concern based on staff interviews, was the time frame after restorative was discontinued and the evaluation done seven days later by occupational therapy. The DON stated that she understood. The DON was asked who should have been providing hand hygiene to Resident #24. She stated, "The CNA doing her bath should be doing that." The name and phone number of the CNA who had bathed Resident #24 on the night shift was requested.	F 686		

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F 686	Continued From page 30 At approximately 3:45 p.m., the requested information for the CNA (CNA #22) who bathed Resident #24 on the night shift for five of seven nights between 03/21/2019 and 03/28/2019 was received. She was contacted via telephone at approximately 4:00 p.m. and interviewed regarding Resident #24. She was asked if she had cared for Resident #24 during the week of 03/21/2019 through 03/28/2019. She stated, "Yes." She was asked what care she had provided. She stated, "I turn her, I get her something if she needs it and I bathe her." CNA #22 stated, "I start at her face and go down. I wash her face, her neck, her chest her arms, her hands, and work my way down all the way to her feet." CNA #22 was asked if she had washed Resident #24's hand. She stated, "Yes, I run the wash cloth between her fingers." She was asked if she had done range of motion on Resident #24's left hand. She stated, "I run the washcloth in and out between her fingers." She was asked if she had been able to open Resident #24's left hand at all or move her thumb. She stated, "I run the washcloth in and out between her fingers." No further information was obtained prior to the exit conference on 05/30/2019. 2. Resident #5 admitted to the facility on 03/10/2017. Her diagnoses included but were not limited to: Dementia, contracture of the hip joint, lumbar spine osteoarthritis, anxiety and depression. The a quarterly MDS (minimum data set) with an ARD (assessment reference date of 05/18/2019, assessed Resident #24 as being severely impaired in her cognitive status, with a summary	F 686		

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F 686	Continued From page 31 score of "05". The clinical record was reviewed on 05/29/2019 at approximately 10:30 a.m. The POS (physician order sheet) did not contain any orders for pressure ulcer care. The quarterly MDS of 05/18/2019 documented that Resident #5 was "at risk" for pressure ulcers. The integumentary section of the clinical record was reviewed. On 02/01/2019, the following was documented: "Stage III, 2.2 cm length, 2 cm width, Pressure Ulcer Bed description: Granulation tissue, non-granular, pale, pink, yellow; Pressure Ulcer Exudate Description: Serosanguinous, Small amount, Moderate Amount, Odor absent, Other: dried." The care plan for Resident #5 was reviewed and contained the following: "LTC [long term care] Skin Integrity". Outcomes included but were not limited to: "Skin Integrity Maintained". Interventions included but were not limited to: "Monitor skin condition every shift." On 05/29/2019 at approximately 3:00 p.m., the wound nurse, LPN (licensed practical nurse) #6 was interviewed regarding the pressure ulcer on Resident #5's heel. She stated, "We found it [the pressure ulcer] at a Stage three." LPN #6 was asked how often skin assessments were done by the nurses. She stated, "They are suppose to be done weekly." She was asked how an area could be found at a stage three if weekly skin assessments were done. She stated, "That's what we wondered when it was found." LPN #6 was asked to pull up the weekly skin assessments done prior to 02/01/2019. She looked in the computer and stated, "There was	F 686		

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one done on 12/05/2018 that documents her contractures and one on 01/02/2019 that documented an abnormality, but that's all that I see." She was asked what the abnormality on 01/02/2019 was. She stated, "I can't tell." LPN #6 stated, "She was admitted to us with contractures...her left leg crosses over her right at the hip...her legs are crossed scissorlike from the top of her leg...she has prevalon boots and we float her heels but she still got that place on her heel...it's all healed up now."

During an end of the day meeting on 05/29/2019 with the DON and the administrator, concerns were voiced that there was no documentation of weekly skin assessments and a pressure ulcer had been found on Resident #5's heel at a stage III. The DON was asked if other than the integumentary screen, was there any place else the weekly skin assessments would be documented. She stated she would look.

On 05/30/2019 at approximately 7:30 a.m., LPN #3 was interviewed. She stated that Resident #5's skin was assessed on the night shift. She stated she had documented that abnormality in regard to the resident's thighs. She stated, "Her legs are twisted..I was documenting about the way her thighs are pushed together...I don't always have her."

On 05/30/2019 at approximately 11:15 a.m., Resident #5 was observed with LPN #6. Resident #5 was lying in bed on her back. When the covers were pulled back, her legs were crossed at the hip level, her left foot was on her right side and her right foot was on the left side. She was wearing bilateral prevalon boots. She stated, "What are you doing momma? Don't touch my

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feet momma." LPN #6 explained what she was going to do, she removed the prevalon boot and lifted the left foot revealing the heel which was healed.

On 05/30/2019 at approximately 2:45 p.m., the DON was in the conference room. Concerns were voiced regarding the identification of the pressure area discovered at a Stage III on Resident #5's foot. She stated, "I know...we had a mock survey in April. They identified problems with the staging of pressure ulcers and weekly skin assessments. I am working on the plan of correction and we have done some education but we aren't done yet. The DON was asked if there was any additional documentation as the survey team was identifying the pressure ulcer as harm. She stated, "We don't have anything else.

No further information was obtained prior to the exit conference on 05/30/2019.

3. Resident #2 was admitted to the facility on 01/03/2012. Her diagnoses included but were not limited to: Diabetes Mellitus, Hemiplegia, hypertension, dementia, depression, and anxiety.

A quarterly MDS (minimum data set) was an ARD (assessment reference date) of 02/18/2019, assessed Resident #2 as severely impaired in her cognitive status, with a summary score of "05".

On 05/28/2019 at approximately 12:00 p.m., Resident #2 was observed lying in bed. She was tearful and when asked what was wrong she stated, "My foot hurts and my leg...I sprung it...I fell in a hole last night." LPN (licensed practical nurse) #4 was in the hallway and was assigned to Resident #2. She was asked if Resident #2 had

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F 686	Continued From page 34	F 686		

any recent falls. She stated, "No." She was asked if she knew what had happened to Resident #2's leg and foot. She stated, "It looked bruised to me earlier today when I looked at it...she crosses one foot over the other." Resident #2 was observed with LPN #4. LPN #4 lifted the covers, exposing Resident #2's legs. Resident #2 had her right foot resting on top of left foot. A discolored area was observed on top of the left foot. A Skin tear and bruising were noted on the right shin. Steri strips were in place over a skin tear on the left shin. LPN #4 was asked about Resident #2's legs. She stated, "Her skin is very fragile...they [CNAs] can tear it when they are taking her clothes off." She was asked what the facility was doing to protect/prevent that from happening. She stated, "I can probably get her some protectors to put over them." LPN #4 stated "She has an order for prevalon boots... I am going to put them on her after she eats lunch". LPN #4 then pointed to her computer screen and the order for the prevalon boots, "...Prevalon boots as tolerated..." LPN #4 was asked if they were to be on all the time, she stated, "Yes." She was asked if she had offered them to her. She stated, "I didn't ask her earlier, I don't know about the CNA [certified nursing assistant]....I usually try to go through all my orders when I get here, but I haven't gotten to that yet."

At approximately 12:35 p.m., CNA #23 was interviewed regarding Resident #2's prevalon boots. She stated, "I offered to put her socks on today and she didn't want them...I didn't offer the prevalon boots...she usually won't let you put them on her."

Resident #2 was observed with her prevalon

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F 686	Continued From page 35 boots in place after lunch. At approximately 3:22 p.m., LPN #4 stated, "I really don't think that is a bruise on [Name of Resident #2] left foot, I think that is a site of an old skin tear." LPN #4 was asked why Resident #2 was ordered to have prevalon boots. She stated, "To keep her from getting breakdown on her heels and to help protect her legs." The POS (physician order sheet) was reviewed on 05/28/2019 at approximately 4:00 p.m. The following order was observed: "02/05/2019 Skin care: Site: Left Site: Rt [right] heel, Prevalon booties/booties as tolerated, check for placement every shift..." The care plan for Resident #2 was requested and received. The following information was observed: "LTC [long term care] Skin Integrity"; Outcomes included but were not limited to: "Skin Integrity Maintained". Interventions included but were not limited to: "Apply skin moisturizer for dryness; Monitor skin condition every shift." There was no mention of the prevalon boots on the care plan. Resident #2 was observed with her prevalon boots on bilaterally throughout the day on 05/29/2019. During an end of the day meeting on 05/29/2019 with the DON (director of nursing) and the administrator, the above information was discussed. The DON was asked if there was a treatment record that the nurse's used to remind them to check for things like whether or not the prevalon boots were in place. She stated, "No."	F 686		

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F 686	Continued From page 36 No further information was obtained prior to the exit conference on 05/30/2019.	F 686	F tag 688 **Corrective Action:**	
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, the facility staff failed to provide services to prevent an avoidable decline in range of motion for one of 28 residents, Resident #24. Resident #24 suffered an increase in the contractions of her left hand. Restorative nursing was being provided three times per week and was stopped on 03/21/201 pending an evaluation by occupational therapy for a hand orthotic. The evaluation was not done until 03/28/2019. At the time of the evaluation on 03/28/2019, Resident #24's hand had contracted into a fixed fist and the	F 688	• Resident #24 continues to receive occupational therapy treatments. The restorative nursing assistant was re-educated regarding continuation of restorative treatment until rehab has initiated evaluation and treatments and to request nurse to obtain order to discontinue restorative nursing treatment at this time. • Resident has an appointment with the orthotist on 5/20/2019. **Identification:** Any resident residing in the facility could have been at risk for having contractures with a delay in the initiation of treatment by OT. PT or OT representatives will conduct a screening on current residents to determine the need for services or interventions to maintain and/or improve the resident's range of motion. If the screening identifies residents in need, the resident's physician will be contacted for orders.	7/12/19

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F 688	Continued From page 37 skin on her fingers had fused together. This was identified as harm by the survey team. Findings were: Resident #24 was originally admitted to the facility on 04/08/2005. Her diagnosis included but were not limited to: Hypertension, anxiety, diabetes mellitus, congestive heart failure, and chronic Atrial fibrillation. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 03/04/2019 assessed Resident #24 as having problems with short term memory and daily decision making skills. Initial tour of the facility was conducted on 05/28/2019 at approximately 11:30 a.m. Resident #24 was observed lying in bed. Her left hand was wrapped in gauze. LPN (licensed practical nurse) #4 was in the hallway and was asked about the dressing. She stated, "She had an injury...there was some exposed bone." The clinical record was reviewed from 05/28/2019 through 05/30/2019. Observed on the POS (physician order sheet) was an order dated 04/12/2019, "Cover left thumb with hydrofera blue foam and pad between fingers and palm-Change Q [every] 3 days". The care plan for Resident #24 included the following: "LTC ADL [long term care activities of daily living] Function Rehab" Outcomes included but were not limited to: "Resident Will Not Have a Decline in Level of ADL Function"; Interventions included	F 688	**System Changes:** • Rehab will educate nursing staff on contracture identification management, cleaning of contracted areas and observation for changes in the skin. • Care plans are being reviewed and updated to reflect contractures, contracture care, devices and cleaning of the contracted area. • Clinical Coordinators will be responsible for observing residents with contractures to validate the proper placement of devices and hygiene care provided per orders. • Licensed nurses will be re-educated on their responsibility in obtaining, transcribing, and implementation of physician orders. • Licensed nurses will be re-educated on use of the 24 hour report to communicate new orders and identification of residents with onset of limitation in range of motion of fingers, hands and other extremities. • Clinical Coordinators will be re-educated on the updating of care plans with resident centered problems, goals and approaches for the management and care of contractures.	

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F 688	Continued From page 38 but were not limited to: " RNP-PROM BLE in all planes as tolerated." "LTC Musculoskeletal" Outcomes included but were not limited to: "[Name} will not have further decline of her bilateral hand contractions'; [Name} will allow staff to clean, move her bil. hands to prevent further declin in contracture." Interventions included but were not limited to: "Position [Name] upper extremities, hands for comfort and to prevent immobility complications." On 05/29/2019 at approximately 2:00 p.m., the wound nurse, LPN (licensed practical nurse) #6 came to the conference room to discuss Resident #24's left thumb. She was accompanied by the DON. LPN #6 stated that occupational therapy had been working with Resident #24 in her room doing range of motion to her hand and had informed her that there was a wound present. It was requested that the occupational therapist that had worked with Resident #24 be brought into the conversation. The COTA (certified occupational therapy assistant) that worked with Resident #24 came to the conference room. She stated, "We [occupational therapy] picked her up around the end of March for contracture management. At that time her hand was stuck in a fisting position...I first saw her on April 2nd...the skin of her thumb and fingers had fused together...I was working with her and she pulled away...her fingers became unstuck and were open at the knuckle of her thumb...it looked like bone...nursing was informed and they started the dressing changes then." The COTA was asked about an order on the POS dated 01/07/2019 for "RNP [restorative nursing] -PROM [passive range	F 688	**Monitoring:** • Clinical coordinator / designee will observe 4 residents weekly x 8 weeks who have contractures and/or orders for contracture management to ensure that physician orders are being implemented, that devices are appropriately applied and that the resident's skin shows no signs of irritation or impairment from use of the device. If variances are identified the responsible staff will be re-educated and the resident's physician will be notified of any potential need of change to the resident's plan of care. • Findings from weekly observations will be submitted to the DON who will analyze reports and present a report of areas of non-compliance to the QAPI committee for discussion and further recommendations.	

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F 688	Continued From page 39 of motion] in BUE [bilateral upper extremities] in all planes as tolerated by patient". The COTA stated, "She had been getting that, but it stopped when therapy came back in." It was requested that the Restorative aide be brought into the conversation. The CNA (certified nursing assistant) #4 who provided restorative nursing care to Resident #24 came to the room. She was asked about Resident #24's left hand. She stated, "We got her back in restorative around the end of December or the first part of January...I did Passive range of motion to her uppers, her arms and hands...when I was working with her there wasn't nothing wrong with her left hand like open areas or anything...her hand was contracted but I could get it open by rubbing it and putting lotion on it to loosen it up...I could move her thumb out and get to her palm, it wasn't stuck in a fist" CNA #4 was asked when she stopped providing services. She left the room and returned with documentation. She stated, "Here is the referral...we got that on January 7...I saw her three times a week starting January 10...my last visit with her was March 21...therapy was coming in and we can't do restorative if the resident is getting therapy." The referral contained the following information: "Restorative Nursing Program Referral...Program: PROM [checked]. Goals to Maintain Resident's Current Functional Status: 1. PROM to BUE [bilateral upper extremities] in all planes as tolerated by patient.; Frequency: 3 X week/ 12 weeks [3 times per week for 12 weeks]; Start Date: 1-10-19." The form was signed by CNA #4 and the traveling OT who was no longer at the facility. The COTA was asked when Occupational therapy	F 688		

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started. She stated, "The evaluation was done on March 28...it looks like the request was made on March 20 for her to be evaluated for an orthotic for that hand...usually after we get the request it's done in the next day or two...It must have gotten overlooked. The therapist that did the evaluation was a traveler and she is not here any more." The COTA and the Restorative CNA were asked what services Resident #24 received to treat her left hand contractures from 03/21/2019, the day of the last restorative visit until the date of the evaluation, 03/28/2019. Neither could provide an answer.

The evaluation completed on 03/28/2019 was presented by the COTA. Per the evaluation: "Range of Motion...UE ROM [Upper extremities range of motion]: RUE ROM = Impaired (contractures and deformities present at all joints, able to grasp items); LUE ROM = Impaired (contractures and joint deformities present at all joints of hand, with flexion. Patient's hand contracted in flexion)...Joints: Shoulder = WFL [within functional limits]; Elbow/Forearm = WFL, Wrist = WFL; Hand = Impaired; Shoulder = WFL; Elbow/Forearm = Impaired (contracted in elbow flexion); Wrist = Impaired (contracted in extension); Hand = Impaired (all digits and joints contracted and deformities present, in flexed position). The COTA was asked what a flexed position meant. She stated, "Her hand was fixed in a fist."

A previous evaluation from OT dated 11/26/2018 was also presented by the COTA. The assessment summary contained the following description of Resident #24, "Functional Limitations as a result of Contractures: Patient presents with multiple contractures to her bilateral

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F 688	Continued From page 41 wrists and digits. Her right wrist contracted in a flexed position and left contracted in a position of extension. Patient exhibits swan neck deformity to digits bilaterally..." The COTA was asked what a swan neck deformity was. She stated, "Her fingers turned up on the ends." She was asked if there was a decline between the two evaluations. She stated, "Yes." The COTA was asked if the delay in the evaluation and lack of restorative during that time could have contributed to the decline. She stated, "Yes." The COTA was asked what could have been done to keep Resident #24's hand from becoming fixed in a fist and her fingers stuck together. She stated, "Hand hygiene...if you are cleaning the hand and massaging it to help the contractures, the skin won't fuse between the fingers and cause pressure as they rest on each other." She was asked how long it would take for Resident #24's hand to be in that condition if hand hygiene wasn't performed. She stated, "Just a couple of days." The COTA was asked if the wound on Resident #24's hand was from pressure. She stated, "Yes, from her fist being contracted and fixed." She was asked if she thought it was avoidable. She stated, "Yes, if hand hygiene was provided that would have kept her fingers from being stuck together." One of the therapy techs, (OS #10) came into the conference room during the interview. She and the COTA were asked how long they had been doing their jobs and had they ever seen anything like this before. The COTA stated, "I've been doing this since 2018, I've never seen it happen before." OS #10 stated, "I've been doing this for ten years, I've never seen this happen before." During an end of the day meeting on 05/29/2019 with the DON and the administrator, concerns	F 688		

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F 688	Continued From page 42 were voiced that per interviews conducted with staff, Resident #24's hand was not fixed in a fist when restorative nursing was working with her. The hand could be opened and the thumb moved. Restorative was discontinued on 03/21/2019. There were no documented interventions from 03/21/2019 until 03/28/2019 when occupational therapy reevaluated her. When the COTA came in the room to do therapy on 04/04/2019, the fingers were stuck together and when Resident #24 pulled away, they became unstuck with resulting full thickness wounds. On 05/30/2019 at approximately 2:55 p.m., the DON, the administrator and the Quality Assurance nurse came to the conference room to discuss Resident #24. The DON stated, "We can't explain what happened from March 21 through March 28, there is no documentation showing what if anything was being done with her hand...but we have information that the therapist and the nurses were working together to treat her after that." The DON was informed that there were no issues with the treatment documented before March 21 or after the evaluation on March 28, the concern based on staff interviews, was the time frame after restorative was discontinued and the evaluation done seven days later by occupational therapy. The DON stated that she understood. The DON was asked who should have been providing hand hygiene to Resident #24. She stated, "The CNA doing her bath should be doing that." The name and phone number of the CNA who had bathed Resident #24 on the night shift was requested. At approximately 3:45 p.m., the requested information for the CNA (CNA #22) who bathed	F 688		

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F 688	Continued From page 43 Resident #24 on the night shift for five of seven nights between 03/21/2019 and 03/28/2019 was received. She was contacted via telephone at approximately 4:00 p.m. and interviewed regarding Resident #24. She was asked if she had cared for Resident #24 during the week of 03/21/2019 through 03/28/2019. She stated, "Yes." She was asked what care she had provided. She stated, "I turn her, I get her something if she needs it and I bathe her." CNA #22 stated, "I start at her face and go down. I wash her face, her neck, her chest her arms, her hands, and work my way down all the way to her feet." CNA #22 was asked if she had washed Resident #24's hand. She stated, "Yes, I run the wash cloth between her fingers." She was asked if she had done range of motion on Resident #24's left hand. She stated, "I run the washcloth in and out between her fingers." She was asked if she had been able to open Resident #24's left hand at all or move her thumb. She stated, "I run the washcloth in and out between her fingers." No further information was obtained prior to the exit conference on 05/30/2019.	F 688		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		

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F 690	Continued From page 44 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for bladder irrigation for one of 28 residents in the survey sample: Resident # 59. Findings include: Resident # 59 was admitted to the facility 4/17/18 with diagnoses to include, but were not limited to: dementia, neurogenic bladder, and coronary artery disease. The most recent MDS (minimum data set) was	F 690	**F tag 690** **Corrective Action:** The attending physician for resident #59 has been notified regarding the inconsistent documentation of completion of bladder irrigations. Resident #59 experienced no negative outcomes related to the bladder irrigations. Licensed nursing staff will be educated on the importance of following physician order and the technique for completing bladder irrigations. **Identification:** Any resident with a Foley catheter and orders for irrigations could have been at risk for the lack of documentation indicating irrigation has been done. A 100% audit of current residents will be conducted to identify residents with orders for bladder irrigations and licensed nursing staff will be re-educated on techniques for completing bladder irrigations. Physician will be notified if physician orders for bladder irrigation have not been completed as ordered and clarification orders will be obtained.	7/12/19

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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 690	Continued From page 45 an annual assessment dated 4/8/19 and had the resident coded with moderate cognitive impairment with a total summary score of 08 out of 15. The clinical record was reviewed 5/30/19 at approximately 8:00 a.m. The current POS (physician order summary) included an order carried forward from 9/11/18 for "Bladder Irrigation: Intermittent. Solution: Normal Saline, Volume 500 ml mixed with 30 cc's of vinegar Monday/Wednesday/Friday." Further review of the clinical record failed to reveal any documentation of the treatment. On 5/30/19 beginning at 10:35 a.m. during a meeting with facility staff, including the IT (information technology) staff, the survey team expressed the difficulty in locating needed information for the survey process. The IT staff was asked for assistance in locating the documentation for Resident # 59's bladder irrigations, and was told it could be "in a couple of different places, depending where staff may have documented" and that the information may also be in a clinical note. The DON (director of nursing) then stated "You [survey team] are not going to find any nursing notes; the previous DON told staff they did not have to do any narrative notes, just to do the check offs in the system. I have changed that, and told the staff to do nursing notes, but I have only been in this position about 2 weeks." The IT staff then provided guidance on where to locate the information for the bladder irrigations, but the forms were blank. The IT staff, who was also an RN (registered nurse) stated "That's where the documentation should be; as you know, if it's not documented, it's not done." There were no	F 690	**System Changes:** • Licensed nurses will be re-educated on their responsibility in obtaining, transcribing and following physician orders for catheters irrigations and documentation of procedure being done. • The DON will review and revise the procedure for bladder irrigations if indicated. Licensed nursing staff will be re-educated in the facility procedure for bladder irrigations.	

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F 690	Continued From page 46 nursing narrative notes of the bladder irrigation done. On 5/30/19 at 12:00 p.m. the DON and LPN (licensed practical nurse) # 7, who was the unit manager, were interviewed about the treatment. The DON stated "I tried to catch up with the second shift nurse yesterday to ask her about that, but I could never catch up with her; I was here until 8:00 p.m." LPN # 7 stated she had also looked for the documentation, and was unable to find it. The DON provided the phone number for the nurse who worked second shift 5/29/19. On 5/30/19 at 12:15 p.m. LPN # 9 was interviewed via phone. She stated "I do not do [name of Resident # 59]; that is done on day shift. I do have one bladder irrigation I do on 3-11 shift, but it's not her.." Interviews with staff on unit 1 failed to reveal if the treatment had been being done for Resident # 59. No further information was provided prior to the exit conference.	F 690	**Monitoring:** • The Clinical Coordinators will monitor the documentation of completion of bladder irrigations weekly x 8 weeks. Areas of non-compliance will be immediately addressed by 1:1 education with the responsible nurse. • Clinical coordinator / designee will observe bladder irrigation and documentation of the treatment for 1 resident per week x 8 weeks. Areas of non-compliance will be immediately addressed with 1:1 educations • Findings from the weekly audits and observations will be submitted to the DON or designee for analysis of areas of non-compliance. • The DON or designee will submit a report to the QAPI committee for discussion and further recommendations.	
F 691 SS=E	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 691		

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F 691	Continued From page 47 review, the facility staff failed to follow physician orders for flushing a nephrostomy tube for one of 28 residents in the survey sample: Resident # 73. Findings include: Resident # 73 was admitted to the facility 7/17/13 with diagnoses to include, but were not limited to: acute renal failure, high blood pressure, anemia, and multiple sclerosis. The most recent MDS (minimum data set) was an annual assessment dated 4/22/19 and had the resident coded with moderate cognitive impairment with a total summary score of 11 out of 15. The clinical record was reviewed 5/30/19 at approximately 8:00 a.m. The current POS (physician order summary) included an order carried forward from 11/19/17 for "Nephrostomy tube, daily, flush nephrosotomy tube with 10 cc of normal saline." Further review of the clinical record failed to reveal any documentation of the treatment. On 5/30/19 beginning at 10:35 a.m. during a meeting with facility staff, including the IT (information technology) staff, the survey team expressed the difficulty in locating needed information for the survey process. The IT staff was asked for assistance in locating the documentation for Resident # 73's nephrostomy flushes, and was told it could be "in a couple of different places, depending where staff may have documented" and that the information may also be in a clinical note. The DON (director of nursing) then stated "You [survey team] are not going to find any nursing notes; the previous DON	F 691	**F tag 691** **Corrective Action:** The attending physician for resident #73 has been notified regarding the inconsistent documentation of completion of nephrostomy flushes. Resident # 73 experienced no negative outcomes related to the nephrostomy flushes. Resident #73's nephrostomy tube is being flushed and documented in the medical record per physician order. **Identification:** There is one additional resident residing in the facility with nephrostomy tubes in place. There are no flush orders for the tube at this time. **System Changes:** • Licensed nurses will be re-educated on their responsibility in obtaining, transcribing and following physician orders for nephrostomy flushes and documentation of procedure being done. • The DON will review and revise the procedure for nephrostomy flushes if indicated.	7/12/19

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F 691	Continued From page 48 told staff they did not have to do any narrative notes, just to do the check offs in the system. I have changed that, and told the staff to do nursing notes, but I have only been in this position about 2 weeks." The IT staff then provided guidance on where to locate the information for the bladder irrigations, but the forms were blank. The IT staff, who was also an RN (registered nurse) stated "That's where the documentation should be; as you know, if it's not documented, it's not done." There were no nursing narrative notes of the nephrostomy tube flushes done. On 5/30/19 at 12:00 p.m. the DON and LPN (licensed practical nurse) # 7, who was the unit manager, were interviewed about the treatment. The DON stated "I tried to catch up with the second shift nurse yesterday to ask her about that, but I could never catch up with her; I was here until 8:00 p.m." LPN # 7 stated she had also looked for the documentation, and was unable to find it. The DON provided the phone number for the nurse who worked second shift 5/29/19. On 5/30/19 at 12:15 p.m. LPN # 9 was interviewed via phone. She stated "I do not do [name of Resident # 73]; that is done on day shift. I do have one bladder irrigation I do on 3-11 shift, but it's not her flushes.." Interviews with staff on unit 1 failed to reveal if the treatment had been being done for Resident # 73. No further information was provided prior to the exit conference.	F 691	**Monitoring:** • The Clinical Coordinators will monitor the documentation of completion of nephrostomy flushes weekly x 8 weeks. Areas of non-compliance will be immediately addressed by 1:1 education with the responsible nurse. • A report will be submitted to the DON or designee for analysis of areas of non-compliance. • The DON or designee will submit a report to the QAPI committee for discussion and further recommendations. **F tag 692** **Corrective Action:** Resident #45's Groshong catheter is currently intact and IV fluids are being administered and documented as ordered. Licensed nursing will be re-educated on proper management of central lines and IV sites as well as administration of IV fluids.	7/12/19
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

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F 692	Continued From page 49 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to ensure sufficient fluid intake to maintain proper hydration for one of 28 residents in the survey sample, Resident #45. Resident #45 was admitted to the hospital with a primary diagnoses of dehydration due to not receiving physician ordered fluids to keep hydrated. This was identified as harm. The Findings Include: Resident #45 was admitted to the facility on 9/24/16. Diagnoses for Resident #45 included; Anemia, chronic kidney disease, crohn's disease,	F 692	**Identification:** There is no other resident with an IV line in place for hydration. **System Changes:** • Licensed nurses will be re-educated on their responsibility in obtaining, transcribing and following physician orders. Education to include their responsibility in notifying physician immediately of a change of status related to the use of the IV line or malfunctioning of the IV line with inability to provide IV hydration as ordered to resident and have a documented request for alternative method of hydration or transfer resident to the emergency Room. Licensed nurses will demonstrate competency in the management of central lines and IV sites including administration of IV fluids. • Licensed nurses will be re-educated on the use of the 24 hour report as a communication tool for all changes in functional status of IV lines and ability to hydrate residents.	

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F 692	Continued From page 50 and dumping syndrome. The most current MDS (minimum data set) was a initial assessment with an ARD (assessment reference date) of 3/7/19. Resident #45 was assessed with a score of 15 indicating cognitively intact. On 5/29/19 at 8:45 AM Resident #45 was interviewed. During the interview Resident #45 was asked about being admitted to the hospital. Resident #45 stated that she had recently been admitted to the hospital twice, one time for infection the other time because of dehydration. A central line (Peripherally Inserted Central Catheter [PICC] line) inserted into the chest area was observed. When asked about the PICC line, Resident #45 stated the PICC line was inserted because of receiving fluids each night so that she doesn't get dehydrated. Resident #45 stated that she has dumping syndrome and if she eats or drinks too much at one time the fluids and food dump out into a colostomy without being absorbed. On 5/29/19 Resident #45's clinical chart was reviewed. A nursing note dated 2/20/19 documented "Blue lumen [line] PICC torn, red line patent and flushes without difficulty. On call MD [name of nurse practitioner] notified. Advised to call ER [emergency room] to see if someone is available to replace. Call placed to ER nurse in ER states no one available to replace PICC tonight. States infusion can be run in red lumen. ER nurse stated by being a two line PICC nothing will come out of the blue line because it is a separate line. Staff will secure blue line until able to replace in am. DON [director of nursing] notified." Another clinical note dated 2/23/19 by the	F 692	• Licensed nurses will be re-educated on the use and assessment of Groshong catheters, signs and symptoms of dehydration and physician notifications. • Licensed nurses will be re-educated updating of care plans for hydration needs of residents with IV lines.	

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F 692	Continued From page 51 emergency department documented "Patient has a hx [history] of dumping syndrome and receive around a liter of fluids everyday. Her [Resident #45] PICC line has a hole in it so it can not [sic] be used until it is fixed. She [Resident #45] has not received fluids for 3 days. C/O [complaint of] dehydration, no appetite, HA [headache], stomach pain. A surgery consult dated 2/25/19 evidenced that Resident #45 had a surgical procedure performed (replacement of PICC line) due to a " [...] malfunctioning Groshong [central line] catheter and the patient was unable to use get [sic] IV [intravenous] fluids and is dehydrated on admission [...]" The hospital records also included an image of the torn PICC line and documentation that read "note tape on line-there is damage and line is split - port not in use needs replacement of Hickman [central line] split in tubing [...] continues with heavy producing ileostomy which requires fluid replacement. [...]" Note the image showed that there were 2 lines (ports of entry) to the central line (indicating if one line can't be used then the other line can be). A hospital discharge summary evidenced that Resident #45 was discharged back to the facility on 2/27/19 with a diagnoses of dehydration. Resident #45's physician orders were reviewed for the month of February 2019 and evidenced an order was in place for Resident #45 to receive "Sodium Chloride 1,000 ML [milliliters] IV bedtime, [...] use rate of 125 ML per hour [...]" Resident #45 medication administration record	F 692	**Monitoring:** • The 24 hour report will be reviewed on a daily basis to identify any issues with the use of IV lines or malfunctioning of lines and validation of physician notification and orders in place for an alternative method of hydration if Groshong catheter is identified as malfunctioning. • Any areas of non-compliance will be addressed immediately with physician notification for new orders and 1:1 counselling and/or disciplinary action if indicated with the involved nurse. • Areas of non-compliance will be addressed with the QAPI committee for discussion and further recommendations. • 1 licensed nurse will be observed weekly x 8 weeks for proper care, management, and administration of IV fluids. Variances will be immediately addressed with 1:1 education. The weekly observations will be submitted to the DON / designee weekly for trending and analysis. A report of the weekly audits will be submitted to the QAPI committee for discussion and further recommendation.	

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F 692	Continued From page 52	F 692		

(MAR) for the month of February 2019 was then reviewed. The MAR evidenced that Resident #45 did not receive IV fluids via central line on 2/20/19, 2/21/19, and 2/22/19 documenting "no iv access [sic]." This documentation was written by three different nurses (a different nurse for each day).

Resident #45's care plan (for the time period in question) was then reviewed. A care plan for "Dehydration/Fluid Maintenance" had been initiated with interventions that included encourage fluids and to give IV fluids nightly.

On 05/30/19 at 11:15 AM, license practical nurse (LPN) #9, identified as one of the nurses who were assigned to Resident #45 and did not give IV fluids on one of the nights identified above, was interviewed via telephone. LPN #9 was asked about Resident #45 not receiving fluids during a shift that LPN #9 had worked. LPN #9 stated that the PICC line was torn and couldn't be used. LPN #9 was asked if the second line could be accessed. LPN #9 stated that she thought that there was only one line. It was explained to LPN #9 that according to documentation and an image of the PICC line, there were two access points. LPN #9 stated that she really could not remember but if there were two access lines, then she would have used the other line unless that line could not be accessed.

The other nurses that did not give IV fluids were unavailable to interview. One of the nurses no longer worked at the facility and the other nurse was a part-time nurse on an as needed basis and unable to be contacted.

On 5/30/19 at 11:45 AM, the director of nursing

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F 692	Continued From page 53 (DON) was informed of the above concern and was asked to present any additional information regarding physician notification of the fluids being stopped due to torn PICC line or any physician orders regarding the PICC line. The DON presented a nursing note dated 2/25/19 (indicating a late entry) that read "provider updated on care status: MD [Medical Doctor] was notified due to central line was not in use and resident is on iv fluids. MD gave orders to hold fluids until line is replaced. The date of when the physician was notified was given as 2/21/19. There was no evidence provided that an actual physician order was placed in Resident #45's clinical record to stop the IV fluids, and the MAR did not evidence that the IV fluids had been placed on hold. On 05/30/19 at 3:10 PM the administrator and DON, were informed of concerns about the nursing note indicating that the physician was informed on 2/21/19 and that the physician stated to stop the IV fluids without any indication when a new PICC line was going to be replaced or any order regarding how Resident #45 was going to receive sufficient fluid intake to ensure hydration. The DON stated that the clinical coordinator should have certainly followed up on stopping the fluids and when a PICC line was going to be replaced. On 05/30/19 at 3:21 PM, Resident #45's physician was interviewed via telephone. The physician stated that he was aware that the PICC line could not be use and also stated this has happened before and it usually only takes a day to get a Resident into the hospital so that a new	F 692		

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F 692	Continued From page 54 PICC line can be placed. The physician stated that he was aware of Resident #45's dumping syndrome but by encouraging the Resident to drink fluids then there was usually no concern for dehydration for a day but would not be appropriate for a long period of time. The physician stated that he had never seen a PICC line take a long time to be scheduled to get replaced and would think that staff would have let him know that the Resident had not had IV fluids for 3 days. The physician also stated that he was not aware of Resident #45's condition until Resident #45 was admitted to the hospital. The physician stated this was a lesson learned. On 05/30/19 at 3:40 PM, Resident #45 was interviewed regarding going to hospital due to dehydration. Resident #45 stated that the staff didn't give her fluids for 3 evenings and she became dehydrated. Resident #45 stated that she has been dehydrated before and when the feeling comes on then she goes down hill fast. When asked if the staff were giving oral fluids, Resident #45 stated she can't drink that much fluid because she has just a small section of colon and the fluids don't get absorbed and go right through due to dumping syndrome. Resident #45 was asked how long the PICC line had been in place. Resident #45 stated it had been in place since she was admitted to the facility and that it really helps with hydration. No other information was presented prior to exit conference on 5/30/19.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		

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F 695	Continued From page 55 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 and staff interview, the facility staff failed to ensure on oxygen was administered per physician's orders for one of 28 residents, Resident #98. Findings include: Resident #98 admitted to the facility on 5/6/19. Diagnoses included, but were not limited to: diabetes mellitus, high blood pressure, chronic lymphocytic leukemia, of b-cell type, anxiety disorder, renal failure with chronic hemodialysis, retinal disorder (legally blind), left BKA (below the knee amputation), atrial fibrillation, and CHF (congestive heart failure). The most current MDS (minimum data set) was a five day admission assessment with an ARD (assessment reference date) of 5/13/19. This MDS assessed the resident with a cognitive score of 14, indicating the resident is cognitively intact for daily decision making skills. The resident was assessed on this MDS as receiving oxygen while are resident and while not a resident (within the last 14 days). Resident #98 was observed on 05/28/19 at 11:53 AM with O2 (oxygen) at 3 LPM 9liteers per minute). Resident #98 was coughing and stated	F 695	**F tag 695** **Corrective Action:** Resident #98's oxygen flow rate has been corrected to infuse at 2L/min via nasal cannula as ordered. Attending physician was notified on 6/19/2019 regarding oxygen infusing between 2 ½ and 3 L/min instead of 2 L/min as ordered, and that the flow rate has now been adjusted to the correct rate. Resident #98 experienced no negative outcome related to flow rate. **Identification:** Any resident receiving oxygen could be at risk for oxygen to be set at a rate other than the physician's prescribed rate. An audit of oxygen flow rates is being conducted to determine the ordered flow rate with a validation of oxygen infusing at the correct rate. Any areas of discrepancy will be immediately corrected with 1:1 education with the nurse involved.	7/12/19

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F 695	Continued From page 56 that she didn't feel good and that she had a cold. LPN #2 overheard this conversation and gave the resident cough medicine. The resident's oxygen was not checked and was remained at 3 LPM. Resident #98 was observed again on 5/28/19 at 12:45 PM with O2 at 3 LPM. On 05/29/19 at 9:37 AM, Resident #98 was observed laying in bed with oxygen at 2.5 LPM. On 05/29/19 at 5:25 PM, Resident #98 was observed again with oxygen set to 2.5 LPM. The resident's current POS (physician's order set) was reviewed and included an order for, "Nasal Cannula, LPM 2.0, continuous, Start 5/6/19." The resident's current care plan was reviewed and documented, "...O2 at 2.0 LPM per NC continuous..." On 05/30/19 at 12:12 PM, Resident #98 was observed with oxygen set at 2.5 LPM. The resident was asked how her breathing was and she stated that her breathing was ok. On 05/30/19 at 12:15 PM, LPN (Licensed Practical Nurse) #7 (also known as the unit manager) was asked who was responsible for checking and managing oxygen administration. LPN #7 stated that the nurses are and further stated that they check it when the oxygen saturations are checked. LPN #7 was made aware of the above observations and that the resident had an order for oxygen at 2 LPM and that it had not been at 2 LPM on any of the observations and was currently set on 2.5 LPM. LPN #7 stated, "Ok, thank you."	F 695	**System Changes:** • Licensed nurses will be re-educated on their responsibility in obtaining, transcribing, implementing and following physician's orders as it relates to oxygen therapy. • Licensed nurses will be educated on the use of oxygen as a drug to include that only nurses can adjust the flow rate; and how to adjust the oxygen regulator. • Licensed nurses will observe oxygen settings during each med pass to validate accuracy and for documentation purposes. • Any new order for oxygen flow rates will be communicated on the 24 hour report. Licensed nurses will be re-educated on the use of the 24 hour report as a communication tool. **Monitoring:** • Charge nurses are responsible for observing oxygen during med pass to validate accurate flow rate. • Clinical Coordinators will monitor 4 residents receiving oxygen 2 x per week x 8 weeks to validate flow rates. Areas of discrepancy will be immediately corrected with 1:1 education with the responsible nurse. • A weekly report of areas of non-compliance will be submitted to the DON or designee for analysis and trending. A report will be presented to the QAPI committee for discussion and further recommendations.	

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	495177	A. BUILDING _____ B. WING _____	05/30/2019

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F 695	Continued From page 57 No further information and/or documentation was presented prior to the exit conference on 5/30/19 at 5:00 PM.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, a resident group interview and staff interview, the	F 725	**F tag 725** **Corrective Action:** Staff Development RN and administrator provided education on 6/19/2019 to ~~all~~ facility staff on promptly answering call lights. The DON, QA Coordinator, and/or administrator will meet with Resident's #43, and #58 and offer apology for call bells not being answered timely and discuss changes that will made to ensure more timely response to call bells. Resident #350 discharged from facility to home on 6/4/2019. **Identification:** Any resident who has the ability to use their call bell could be at risk for not having their call light answered promptly.	7/12/19

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F 725	Continued From page 58 facility staff failed to respond to call bells in a timely manner. Residents, the resident council group and family members reported lengthy call bell response with waiting between 30 minutes and up to 1 hour for staff response. The findings include: Resident #43 who was admitted on 05/08/07 with diagnoses of hypertension and hemiparesis and hemiplegia. The most recent minimum data set (MDS) dated 03/22/19 was a quarterly assessment & assessed Resident #43 as cognitively intact for daily decision making with a score of 15. On 05/28/19 during the initial tour Resident #43 was interviewed at 12:18 p.m. regarding quality of life in the facility. Resident #43 stated "this past weekend which was Memorial Weekend was the worse. We had 3 CNAs (certified nursing assistants) on this entire second floor, but because the census on the first floor was more and they had staff call outs, one of our CNAs had to go downstairs to help out. Sometimes I've waited three or four hours before I actually see my assigned shift CNA. The nurses will come in but they are so busy they can't get to us all." Resident #43 stated "we are short-staffed mostly on the weekends and on third (night) shift. I am incontinent and I try not to complain, but sometimes I have to wait a couple hours before anyone can get to me for a brief change." Resident #43 stated things just seem like they are getting worse with staffing. On 05/28/19 during the initial tour at approximately 12:30 p.m., two other residents were interviewed separately regarding call bell	F 725	**System Changes:** • All facility staff re-educated on promptly answering call lights. • The facility will implement a "No Pass Zone" program which requires any staff member to answer a call light. If the staff member is unable to address the resident's request, the person answering the call light will go get someone who can assist the resident. This program will be implemented across all departments and disciplines. • Staff will be educated that call lights can only be turned off in the resident rooms. • Resident Council meetings will be held weekly for 8 weeks to solicit resident feedback to determine if the residents are experiencing improved satisfaction in regard to call light response time. **Monitoring:** • The activity Director or the Social Services Director or designee will interview 4 alert and oriented residents 2 times per week for 8 weeks to	

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F 725	Continued From page 59 response and time. One resident who was newly admitted stated "my only issue is they need more staff." A visiting family member of the resident stated "the weekends are the worst. We've had to wait up to 30 minutes before a CNA has come in to help getting her back to bed." The family member stated "I just keep ringing the bell and/or go up the hall until I find someone to come help." The second resident who was observed eating lunch stated "I know they can't get to all of us at the same time, but having to wait 30-45 minutes for toileting assistance doesn't make sense. I need assistance getting on and off the toilet because I don't want to fall. The staff often tells me ring the bell, but then they either come and turn it off or say I'll be right back and it takes a long time for them to get back.Sometimes I just keep ringing the bell or will call out for someone to come help me." Resident #350 was admitted to the facility on 05/15/2019 with diagnoses of hypertension and ventricular tachycardia. There was no MDS completed on this resident at the time of the survey. An interview was conducted on 05/28/2019 at approximately 12:00 p.m. with Resident #350 and her daughter. They were asked about call bell response time. Resident #350 stated, "I probably shouldn't say anything, but yesterday when I came back from therapy, they [therapy] left me in my wheelchair and didn't put the call bell over here where I can reach it ...I was tired, they had worked me pretty hard in therapy ...the nurses never came to check on me and I couldn't call them because I didn't have my call light. I called her [pointing to her daughter] and asked her to call the nurses station and tell them to come put	F 725	determine if call light response time is acceptable to them. • Activity Director or Social Services Director will submit a weekly report to administrator of resident interviews in regard to call light response time satisfaction. Additional follow up with individual residents will be made and documented as appropriately. • The administrator will report findings of all audits monthly to the QAPI committee for discussion and further recommendations. • Unit Secretaries /designee will audit and document response time to 10 call lights 3 times per week x 8 weeks. These audits will be conducted across each shift. Findings from the weekly audits will be submitted to the administrator for response time shows an improvement. • The administrator will provide a summary reports of the audits to the Resident Council monthly x 2 months and analysis of the audits to the QAPI Committee for additional discussion and recommendation.	

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F 725	Continued From page 60 me in the bed. They [the nurse/CNA (certified nursing assistant)] came down here and helped me back to bed. The nurse said therapy never told them I was back. I understand that therapy didn't tell them and therapy didn't put my call bell where I could reach it but I sat here for two hours ...I would think somebody would come down here and at least check to see..." Resident # 58 was admitted to the facility on 8/25/18 with diagnoses that included high blood pressure, hemiplegia, hemiparesis, pain, obesity, and heart failure. The most recent minimum data set (MDS) dated 04/18/19 was a quarterly assessment & assessed Resident #58 as cognitively intact for daily decision making with a score of 15. Resident #58 was interviewed on 05/29/19 at 4:19 p.m. Resident #58 stated that she has been here a year, two years in August and the problem is that in the CNA (certified nursing assistant) [named] is "getting cocky with me." The resident was asked what that meant and the resident stated that "the CNAs don't answer you when you ask a question and they (CNAs) just stare at you, don't answer. They just say roll over, roll over while changing. I feel they don't have patience and they just don't care and they are short staffed." Resident #58 stated that she didn't think they have enough help, and that she has had to wait in here in her bed soaking wet for 45 minutes waiting on them to change her. The resident stated that they are understaffed and that is the problem. Resident #58 stated that this is normally on the early morning shift, when she has to wait for long periods. The resident stated, "It shouldn't take them that long, I know they have 25 other people to get to-but this is my time." The	F 725		

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F 725	Continued From page 61 resident stated that when the CNAs come in to work on 3-11 shift, they already have a look on their face, they don't want to work and again stated that they, "just don't have enough help." On 05/29/19 at 1:30 p.m. a group interview with conducted with 12 cognitive residents in attendance. Residents in the group meeting were asked about call bell response time in the facility. Comments from the group included: "I have waited up to for an hour for someone to come and assist me with going to the bathroom. My daughter has had to call the nurses' station to get someone to assist me." "They (CNA) will come in the room, turn off the call bell, ask what you need, tell you they will be back and they never come back until you ring the call bell again." "I had to wait almost 40 minutes before anyone came to help get me off the toilet after I had finished my business." "They (nurses) don't like to see or hear those call bells lights going off, so the any of the staff will come in and turn off the call bell, ask what you want, tell you they will be back or get the right person to help you, but never come back to let you know if and when someone will be in to assist you." "I've missed my regular scheduled showers and have to take it the next day because the CNAs will say they are short-staffed or tired." A review of the resident council minutes for the months of March 2019, April 2019 and May 2019	F 725		

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F 725	Continued From page 62 documented concerns with call bell response. On 05/29/19 at 5:08 p.m., these findings were shared with the administrator and director of nursing. On 05/30/19 at 1:55 p.m., the director of nursing (DON) was interviewed regarding staffing and call bell response time. The DON stated the reasonable expectation was for staff to respond to a call bell within 3-5 minutes. The DON stated if the staff person who responded to the call bell was not able to provide the required assistance then they should locate someone immediately to assist the resident. The DON stated residents should not have to wait 30 or more minutes for assistance or for follow-up assistance. On 05/30/19 at 2:30 p.m., the quality assurance/staff development nurse (RN #1) was interviewed regarding training on call bell response and customer service. RN #1 stated since the survey in 2018, the facility had provided in-services on call light response times. RN #1 provided copies of the in-service forms dated 6/1/18, 6/19/18, and 6/27/18. RN #1 stated the facility recognized there had been a concern with call light response times and has instructed all staff to respond to a call bell and if they can not meet the need of the resident, they are to locate someone who can assist the resident and follow-up with the resident to let them know a staff member will be with them as soon as possible. No additional information was received by the survey team prior to exit on 05/30/19 at 5:00 p.m.	F 725		
F 732	Posted Nurse Staffing Information	F 732		

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F 732 SS=C	Continued From page 63 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732	F 732 Nurse staffing 1. The daily staffing sheets are being posted on both first and second floors. 2. Any resident residing in the facility did not have access to staffing numbers. No resident experienced a negative outcome as a result of the daily staffing sheets not being posted. 3. The Program Support Assistant, Clinical Coordinators and Licensed Nurses were inserviced on posting of daily nurse staffing sheets. The Program Support Assistant will post the staffing hours Monday through Friday. In the event that she is absent, the Clinical Coordinators will post the hours. The weekend Clinical Coordinator will post the staffing hours on Saturdays and Sundays. The Licensed Nurses will be responsible for updating the sheets for changes that occur on their perspective shifts. 4. DON or designee will perform documented observation audits for the posting of daily staffing hours 3 times a week for 8 weeks. Identified variances will be immediately corrected. DON or designee will report findings of the audits to monthly QAPI committee for tracking and trending purposes for any further discussion.	7/12/19

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F 732	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post daily nurse staffing in a visible area in the facility. The findings include: On 05/29/19 at 4:00 p.m., a tour of the facility nursing stations was conducted. There were no posted daily nurse staffing observed on the second floor. Observed on first floor in a plastic sheet protector was a daily nurse staffing sheet partially filled out with only the facility census for first and second shifts and dated 5/24/19. On 05/29/19 at 4:18 p.m., the licensed practical nurse (LPN #2) who routinely provides care on the second floor was interviewed regarding the daily nurse staff postings. LPN #2 stated the nurse staffing is not posted, rather it is keep on a clipboard at the nurses' station. LPN #2 presented a clipboard which had a copy of the weekly electronic work schedule. LPN #2 was asked if the facility posted the daily nurse staffing anywhere for public access and viewing. LPN #2 stated no, we only have the schedule on this clipboard here at the nurses' station. On 05/29/19 at 5:08 p.m., these findings were reviewed with the administrator and director of nursing (DON). The administrator and DON were asked if the daily nurse staffing was posted on each unit where the residents and public could view. The director of nursing stated no, the weekly schedule was kept on a clipboard at each nurses' station. The DON was presented with a copy of the partially filled out daily nurse staffing form dated 5/24/19 which was observed on the	F 732		

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F 732	Continued From page 65 first floor on 05/29/19. The DON stated she did not know who was responsible for posting the daily nurse staffing. No further information was received by the survey team prior to exit on 05/30/19 at 5:00 p.m.	F 732	F tag 774 **Corrective Action:** • The person centered care plan to address Lewy Body dementia has been developed for resident #14. • The person centered care plan to address Non-Alzheimer's dementia has been developed for resident #82 **Identification of others:** • A 100% audit has been completed to identify residents with a diagnosis of Lewy Body dementia and Non-Alzheimer's dementia. • A resident centered care plan has been developed for each resident who has a diagnosis of dementia. **System Changes:** • Education with Interdisciplinary team in regard to developing resident centered care plans to include residents with dementia. • The Interdisciplinary team will participate in education on caring for residents with dementia. • The interdisciplinary team will complete and implement the resident centered care plan for residents with Lewy Body dementia and Non-Alzheimer's dementia upon completion of the comprehensive MDS.	7/12/19
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for two of 28 residents in the survey sample, Residents # 14 and 82, to develop a person-centered plan of care to address dementia care. For Resident # 14, the facility failed to develop a person-centered dementia plan of care to address Lewy Body dementia. For Resident # 82, the facility failed to develop a person-centered plan of care to address Non-Alzheimer's dementia. The findings were: 1. Resident # 14 was admitted to the facility on 12/29/16, and most recently readmitted on 2/27/19 with diagnoses that included Lewy Body dementia, abdominal aortic aneurysm, allergic rhinitis, anxiety, dysphagia, glaucoma, hypertension, hypokalemia, breast cancer, scoliosis, upper GI (gastrointestinal) bleed, chronic back pain, and generalized weakness. According to the most recent Minimum Data Set	F 744		

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F 744	Continued From page 66 (MDS), a Quarterly review with an Assessment Reference Date (ARD) of 2/27/19, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 03 out of 15. Resident # 14 had the following orders for psychotropic medications: Citalopram (Celexa) 10 mg (milligrams) tablet, 1 by mouth once a day. (Citalopram [Celexa] is an antidepressant used in the treatment of major depressive disorders, with an unlabeled use for anxiety. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 263.) Haloperidol 0.125 mg liquid, by mouth once a day. (Haloperidol is a neuroleptic antipsychotic used in the treatment of psychotic disorders. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 579.) Olanzapine 7.5 mg tablet, 1 by mouth once a day. (Olanzapine is a neuroleptic antipsychotic used in the treatment of acute agitation. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 873.) Trazodone 50 mg tablet, 1 by mouth at bedtime. (Trazodone is an antidepressant used in the treatment of anxiety. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 1189.) Review of Resident # 14's plan of care revealed the following: Problem: LTC (Long Term Care) Psychotropic Medication Use	F 744	**Monitoring:** • The DON or designee will review 4 care plans of resident with dementia x 8 weeks completed each week to validate residents with dementia have appropriate resident centered approaches on the care plan. Areas of non-compliance will be addressed with appropriate care plan approaches and communicated with staff. Areas of concern will be addressed with the interdisciplinary team and the plan of care will be revised to reflect resident centered care.	

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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 744	Continued From page 67 Outcomes: MDS (Minimum Data Set) Nurse Reviewed; Decreased inappropriate behaviors; Minimal side effects from psychotropic treatment. Interventions: Collaborate with pharmacist regarding dose adjustments; Notify provider regarding medication response, side effects; Psychotropic medication review; Haldol as ordered; Citalopram, Trazodoen, Olanzapine, Alprazolam as ordered. (NOTE: As of the date of record review, 5/29/30, the resident was no longer taking Alprazolam.) 2. Resident # 82 was admitted to the facility on 4/25/19 with diagnoses that included Non-Alzheimer's dementia, hypertension, anemia, anxiety disorder, dysphagia, malignant neoplasm of the breast, osteoporosis, and arthritis. According to an Admission MDS, with an ARD of 5/2/19, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15. Resident # 28 had the following psychotropic medication order: Mirtazapine 15 mg tablet, 1 by mouth at bedtime. (Mirtazapine is an antidepressant used in the treatment of depression. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 800.) Review of Resident # 14's plan of care revealed the following: Problem:	F 744	• Areas of non-compliance will be reported by the Don or designee in the monthly QAPI meeting for discussion and further recommendations. • The DON, QA Coordinator, or designee will conduct 4 resident validation observations weekly x 8 weeks to ensure that the resident centered care plan interventions for residents with dementia are being implemented. If variances are identified, they will be investigated and appropriate corrective action will be taken. A report of the weekly validation observations will be submitted to the QA Coordinator for trending and analysis. A summary report of the weekly validation observations will be submitted to the QA Committee for further discussion or recommendation.	

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F 744	Continued From page 68 LTC (Long Term Care) Psychotropic Medication Use Outcomes: MDS (Minimum Data Set) Nurse Reviewed; Decreased inappropriate behaviors; Minimal side effects from psychotropic treatment. Interventions: Collaborate with pharmacist regarding dose adjustments; Notify provider regarding medication response, side effects; Mirtazapine as ordered; Psychotropic medication review. At approximately 9:30 a.m. on 5/30/19, the Interim Director of Nursing (DON) was asked who was responsible for developing care plans. The DON stated that the Clinical Coordinators (Unit Managers) on the unit develop care plans. At 11:25 on 5/30/19, RN # 3 (Registered Nurse), who identified herself as a Clinical Coordinator (Unit Manager), and as the person responsible for developing the care plans for Residents # 14 and # 82 was interviewed. Asked how the care plans for dementia were developed, RN # 3 said, "Some things we key in from the computer (Cerner program) and other things we add. It's kind of a mixture." RN # 3 did not comment as to the person-centered nature of the care plans.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		

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F 756	Continued From page 69 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to act on a pharmacy recommendation for a gradual dose reduction (GDR) for two of 28 residents in the survey sample: Resident # 81 and Resident # 9.	F 756	F 756 Pharmacy Recommendations 1. Pharmacy Recommendation for resident #81 has been resubmitted to the physician and has been acted upon for gradual dose reduction. Pharmacy recommendation for resident #9 has been re-submitted to the physician and awaiting response. 2. All residents residing in the facility are at risk of pharmacy recommendations not being acted upon in particular for gradual dose reductions. The DON has reviewed pharmacy recommendations for the last 90 days to identify any other pharmacy recommendations that may not have been ad-dressed. The attending physician will be contacted regarding outstanding pharmacy recommendations for intervention. 3. A letter is being sent to each attending physician regarding F756 and acting upon pharmacy recommendations regarding deficiency received during annual survey ending 05/30/2019 for F756.	7/12/19

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F 756	Continued From page 70 The physician did not provide clinical justification for not attempting a requested GDR by the pharmacy. Findings include: 1. Resident # 81 was admitted to the facility 12/3/15 with a readmission date of 12/13/18. Diagnoses for Resident # 81 included, but were not limited to: anxiety, depression, and diabetes. The most recent MDS (minimum data set) was a quarterly review dated 4/29/19 and had the resident scored as cognitively intact with a total summary score of 15 out of 15. The electronic medical record (emr) was reviewed 5/29/19 at approximately 2:45 p.m. A pharmacy recommendation dated 5/7/19 was noted in the record. The review documented: "LTC (long term care) Drug Regimen Review Note. Type of Review: Monthly. Medication Regimen Review Findings: Dosage of meds adjustment recommended. Regimen Medication # 1: Alprazolam 1 mg at bedtime (anxiety). Recommendation to Physician: Review behaviors, consider dosage adjustment (Comment: Please review resident's condition and consider a GDR at this time, possibly to: Alprazolam 0.5 mg at bedtime for anxiety, or provide documentation for no change, thank you." Further review of the emr did not reveal a response from the physician. On 5/29/19 at 4:00 p.m. LPN (licensed practical nurse) # 7 was asked for assistance in locating the physician response to the recommendation for Resident # 81. LPN # 7 stated "We [nurses]	F 756	4. A copy of the facility policy for management of pharmacy recommendations and a copy of F 756 regulation will be attached to the letter. The letter will outline the facility expectations for physician compliance in adhering to regulations in providing appropriate response and documentation to re-quests. The licensed nurses will be educated on the process for pharmacy recommendations in particular as it relates to gradual dose reductions. 5. The DON/designee will audit all pharmacy recommendations monthly to validate that they have been acted upon and if not that a clinical rationale has been provided by the physician. The DON will contact the physician by phone if necessary. The DON/designee will report finding of monthly audits to QAPI for tracking and trending purposes with follow up actions to be determined by the committee. Trends of non-compliance by a physician will be addressed by the administrator and Medical Director.	

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F 756	Continued From page 71	F 756		

aren't involved in that anymore. Pharmacy does the reviews and any recommendation is emailed directly to the physician; the only way we know if a medication has been reduced/changed is if we get a new prescription for a resident...but we don't know it's due to a pharmacy recommendation, or to be observant for any increase in a resident's behavior."

The pharmacist who did the recommendation came to the nurses' station, and stated "I can show you where the physician has uploaded and signed that he received the recommendation, but I am unable to open the document. I can tell you the doctors do not always provide any documentation or a clinical rationale for not attempting a requested GDR. For example, the resident you are looking at is still on the same dose of Alprazolam, so I know he did not change that medication."

The DON (director of nursing) then came to the nurses' station, and as she listened to the pharmacist, stated "I have been saying since I got this position that I don't like the current process; it totally takes me and the nursing staff out of the loop." The pharmacist then stated "I send a copy of the recommendation via email to you and the administrator." The DON verbalized she was not aware of that, and was unsure where in the computer system those emails were. She further stated "I have always been used to getting the pharmacy recommendations, putting them in a folder for the doctor, he does what he needs to do with them, and then I make sure any changes are taken care of by nursing. This current process is certainly not conducive to nursing involvement; and I have not seen the document you are referencing that the physician signed and

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F 756	Continued From page 72 uploaded in the system." On 5/29/19 during a meeting with facility staff beginning at 5:05 p.m. the DON was asked if there was a way to retrieve the document the physician had uploaded in the system to determine if he had provided any documentation. She stated she would speak to the IT (information technology) staff to see if they could print it. On 5/30/19 at 9:45 a.m. the DON and IT staff presented the requested document. The DON stated "This indicates the physician signed the recommendation that he acknowledged he received it, but he did not provide the clinical rationale for not changing the medication; he simply signed it." No further information was provided prior to the exit conference. 2. Resident #9 was admitted to the facility on 8/22/18. Diagnoses for Resident #9 included; Dementia, anxiety disorder, and depression. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/22/19. Resident #9 was assessed with a score of 14 indicating cognitively intact. On 5/30/19 Resident #9's medical record was reviewed. A physician's order dated 8/22/18 documented "QUEtiapine [Seroquel] 25 MG [milligrams] PO [by mouth] bid [twice a day...]" Resident #9's pharmacy regimen reviews were reviewed and evidenced a pharmacy recommendation dated 3/19/19 asking the physician to review Resident #9's condition to determine if a GDR for Seroquel would be	F 756		

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F 756	Continued From page 73 acceptable. Documentation evidenced that the attending physician received notification asking for a GDR of Seroquel on 3/24/19. Resident #9's medical record did not evidence that a rational from the physician was documented to continue Resident #9 on Seroquel at the same dosage or agree with a GDR. On 05/30/19 at 10:16 AM, the director of nursing (DON) was interviewed regarding GDR for Resident 9's Seroquel. The DON verbalized that documentation evidenced a pharmacy recommendation for a GDR for Seroquel. DON verbalized that physician was aware of the recommendation but did not act on the recommendation. The DON also verbalized that the recommendation is faxed directly to the physician by the pharmacist and a lot of times the nursing staff are unaware that a recommendation has been sent and can be had to track with the system that is put in place. No other information was presented prior to exit conference on 5/30/19.	F 756		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

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F 842	Continued From page 74 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842	**F tag 842** **Corrective Action:** The MDS Coordinator corrected the incorrect documentation in resident #26's medical record. **Identification:** Any resident who has an entry into their medical record could be at risk for having an incorrect entry made into their medical record. Clinical notes in the EMR for June will be reviewed to ensure that a resident's medical record does not contain confidential information about another resident. If variances are identified, the medical record will be corrected according to facility policy. **System Changes:** • Licensed nurses will be re-educated on verifying that entries into the clinical notes of resident's medical records are being entered into the correct medical record.	7/12/19

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F 842	Continued From page 75 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 clinical record review and staff interview, the facility failed to maintain the integrity of the clinical record for one of 28 residents in the survey sample, Resident # 26. Information related to another resident was contained in the Clinical Notes section of Resident # 26's Electronic Health Record. The findings were: Resident # 26 was admitted to the facility on 6/30/14, and most recently readmitted on 11/27/18 with diagnoses that included hypertension, hyperlipidemia, Non-Alzheimer's dementia, seizure disorder, depression, arthritis, dysphagia, chronic atrial fibrillation, cerebrovascular disease, unilateral inguinal hernia, and artificial left hip joint. According to the most recent Minimum Data Set (MDS), an Annual with an Assessment Reference Date of 3/4/19, the resident was assessed under Section C	F 842	**Monitoring:** • The DON, MDS Coordinator, Staff Development Coordinator and / or the Clinical Coordinators will review the clinical notes of 4 residents weekly for 8 weeks to validate the information was documented in the correct medical record. Variances will be immediately corrected per facility policy and responsible staff will be re-educated. Findings from the weekly audits will be submitted to the DON for analysis, trending and additional action as needed. • The DON will submit a report to the QAPI committee for discussion and further recommendations.	

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F 842	Continued From page 76 (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15. During review of Resident # 26's Electronic Health Record the following entry related to another resident was found in the Clinical Notes section: 3/4/19 - 3:49 p.m. "MDS Section G0110 C1 and C2 corrected to reflect activity did not occur. (Name of female resident) is non-ambulatory. MDS Section H1 corrected to reflect (name of female resident) is dependent with eating, receives Peg tube feeding as ordered. MDS Section G0110 J1 corrected to reflect (name of female resident) is dependent with personal hygiene." During an end of day meeting at 4:30 p.m. on 5/29/19, that included the Administrator, Interim Director of Nursing (DON), and the survey team, the finding of the co-mingled record was presented.	F 842		
F 880 SS=C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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F 880	Continued From page 77 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 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	F tag 880 **Corrective Action:** Facility Engineering revised the mapping diagram for the facility's water system and identified areas of potential Legionella growth or other waterborne pathogens. The EOC committee met to review and update The Hundley Center Water Management Plan on 6/15/2019. Deficiencies were corrected at the meeting. The Infection Preventionist revised the Legionella infection control policy to be more specific to the risks of Legionella and changes were made to surveillance for clinical assessment to include residents of high risk and favorable conditions for Legionella. **Identification of others:** Any resident, staff or visitor entering the facility could be at risk if the facility's water system was contaminated with Legionella or other waterborne pathogen.	7/12/19

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F 880	Continued From page 78 §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 staff interview and facility document review, the facility staff failed to develop a water management program for the prevention of legionella or other waterborne pathogens. Findings include: On 05/29/19 at 11:32 AM, the maintenance manager presented the water management program. The information did not include a mapping diagram for the facility's water system and did not identify area of potential legionella growth or other waterborne pathogens. The maintenance manager was made aware that the some of the components were not provided. The maintenance manager stated that he would bring in the requested information. The facility policy documented, "Water Management...reduce the risk of disease from legionella and other waterborne pathogens...measures put in place to limit the growth and spread of Legionella and other waterborne pathogens...control limits: maximum	F 880	**System Change:** • Revised mapping diagram to be revised and attached to The Hundley Center Water Management plan. • Facility Engineering will monitor and log temperature of hot water storage every p.m. In the event that the temperature drops below 110 degrees, the cause will be determined and temperature would be brought back to 110 degrees. • The EOC Water management Committee will meet quarterly to review hot water storage temperatures • Infection Preventionist will track and monitor infectious disease laboratory findings for the residents in healthcare and will identify residents who may be at risk for Legionella. • Infection Preventionist will review the risk assessment for Legionella yearly and revise as needed in collaboration with Facility Engineer. • Infection Preventionist / designee will educate licensed nursing staff on signs / symptoms of Legionella.	

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

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	495177	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970

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F 880	Continued From page 79 value, minimum value...range of values that are acceptable for control measures...locations of water systems where a control measure can be applied...reaction to control measures...steps taken to return control measures...comprehensive risk assessment...identify...cooling towers, hot and cold water storage tanks...electronic faucets/showers...hot tubs, eye wash stations...decorative fountains...medical devices/equipment...heater-cooling units...CPAP machines...documentation of control measures...computerized preventative...system...boiler logs...outside contractors...sterile processing records...eye wash/shower test logs...infection prevention monitoring processes's..." On 5/30/19 at 9:50 AM, the director of facilities, along with the maintenance manager were made aware of the missing components of the facility water management program. The director of facilities presented a hand drawn map that listed basic information, city water main, whirl pools, kitchen dishwasher, hot water heater and domestic hot and cold. This map did not identify the areas of potential growth of legionella and did not identify any holding tanks or other water storage. The director of facilities and maintenance manager were made aware and were asked for the temperature control management log information for potential areas of concern. The maintenance manager stated that he checks temperatures in the resident rooms and does ice machine and hot water heater maintenance. The director of facilities and maintenance manager were made aware that the areas of concern have to be identified and monitored and documented. The director of facilities stated that based on the risk assessment	F 880	**Monitoring:** • The Director of Facility Engineering/Designee will keep a daily temperature log of hot water storage areas for The Hundley Center. • Daily temperature logs will be submitted to the Administrator of The Hundley Center weekly along with a report of any discrepancies and solution for discrepancies. • The Administrator will submit a monthly report to the QAPI committee for discussion and further recommendations.	

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F 880	Continued From page 80 the facility was deemed minimal risk for legionella and did not need to do any environmental testing or monitoring, other than what is already being done. The director of facilities and maintenance manager were made aware that the facility risk assessment did not identify areas of potential legionella growth or other water borne pathogens. The director of facilities stated that the infection control specialist had additional information. On 05/30/19 at 1:30 PM, the infection control specialist was asked about legionella testing and water management program, the infection control specialist stated that would be the man from the hospital and that he has a book and would bring his book. The infection control specialist was made aware that the information had been presented and did not have the required components for an effective water management program for the prevention of legionella. The infection control specialist was made aware of the missing information and that there were not areas listed as being checked for appropriate temperatures controls for growth of legionella and other waterborne pathogens. The infection control specialist stated, "they are not checking temperatures." No further information and/or documentation was presented prior to the exit conference on 5//30/19 at 5:00 PM.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		

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F 881	Continued From page 81 a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based staff interview and facility document review, the facility staff failed to establish an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. Findings include: On 5/29/19 at 10:03 AM, a review of facility's antibiotic stewardship was conducted. The policy did not include written antibiotic protocols for prescribing, including documentation for indications of use, dosage and duration of the antibiotic. There was not any type of tracking or documentation that would describe how tracking will be completed and/or accomplished. A folder was presented with information labeled LTC [long term care] with with typed entries for four months. These entry's were listed by month, no specific dates, which included the resident's name, the symptoms (if any), antibiotic used and some included the duration. These entries did not include the physician prescribing information or additional required information, such as the start date, or stop date. Some of these entries identified the organism, but did not identity how the organisms were identified [i.e. labs, etc]. Some of the entries documented that antibiotics were or were not prescribed, and did not correlate the documented information for justification of the use or non use. There was a blank sheet in the back of the folder titled "Appendix 9. Loeb's	F 881	F tag 881 **Corrective Action:** • An Antibiotic Stewardship policy is in the process of development and will be completed and approved by the Antibiotic Stewardship Committee which includes representatives from nursing, physician, and pharmacy by 7/12/2019. • No resident has experienced a negative outcome as a result of antibiotic therapy. **Identification of others:** Any resident residing in facility could have been at risk for receiving an antibiotic in the absence of meeting LOEB criteria. **System Changes:** • Education with licensed nurses on Antibiotic Stewardship and LOEB criteria for infection identification will be completed. 7/12/19 RECEIVED JUN 24 2019 VDH/OLC	

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F 881	Continued From page 82 minimum criteria for initiating antibiotic therapy". This sheet had an area for a resident's name, location, date of infection, date of review, and if evaluated or criteria met. Additionally on this form, it listed infections such as UTI [urinary tract infections], respiratory tract infection, skin and soft tissue infection and "fever where the focus of infection is unknown." The information did not have specific supporting information to correctly identify and track. Additionally there was also a blank sheet titled nursing home antimicrobial stewardship guide, that provided an area for name, room number, dates, type of infections, results (labs, x-rays), name of clinician, antibiotic name, duration, date, dose and if a change has been made. This information was blank, and id not provide supporting information for any the residents/infections listed. A policy titled, "antibiotic stewardship policy" documented, "4/29/19 date/reviewed/revised 4/29/19...a separate Antibiotic Stewardship program will be formed to include antibiotic use protocols and systems for monitoring antibiotic use...based on evidence to meet such goals as set forth...will meet quarterly and review the policy annually or as needed...staff will have clear guidance and education on the principal of optimal and judicious use of antibiotics for residents...minimize...consequences...establishm ent of an antibiotic stewardship committee...two staff members if possible...DON (director of nursing)...pharmacist...administrator, attending physician, nurse, nurse aide, allied health professional, resident or family...procedure to support and promote antibiotic use protocols, using the Loeb...specifying dose, duration, and indications for use, along with clinical justification, develop and maintain a system to monitor	F 881	• Attending physicians will be provided a copy of the Antibiotic Stewardship policy along with LOEB criteria, which has been adopted as the facility standard. • The Antibiotic Stewardship committee has been established. Members include a physician, DON, QA Coordinator, pharmacist, administrator and a minimum of one Clinical Coordinator at each meeting. An initial Antibiotic Stewardship committee meeting was conducted on 6/19/2019. An Infection preventionist was appointed. Committee meetings will be held monthly. • A letter is being sent to each facility attending physician regarding the Antibiotic Stewardship Program and LOEB criteria. A copy of the Antibiotic Stewardship policy will be attached to the letter. • An antibiotic tracking log was implemented in March 2019. The log form was reviewed in the Antibiotic Stewardship meeting with no revisions indicated T • The QA Coordinator or designee will collect data for antibiotic use, diagnosis, appropriate order and LOEB criteria.	

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F 881	Continued From page 83 antibiotic use, develop and maintain a system to monitor resistance data." This information in this policy could not be located. On 05/29/19 at 1:44 PM, the infection control specialist was interviewed. The infection control specialist stated that she does infection control for acute and LTC (long term care) and stated that the policy is a "working copy" of our antibiotic stewardship, and further stated that the policy has not been approved or signed. The infection control specialist was asked what the facility is currently using if they don't have a policy. The infection control specialist stated that she could provide a copy of the hospital policy, but stated, management told us we couldn't use the hospital policy. The infection control specialist stated that this policy just needs to be signed by the administrator and stated that they have done a lot of work on this. The infection control specialist stated that this is just getting underway and that she wished she would have known about this sooner (antibiotic stewardship program). The infection control specialist stated that this program is just getting started and that she has been educating, but the members have not been identified as of yet and they have not met regarding this. The infection control specialist was informed that the antibiotic stewardship requirements have been in effect since November 2017. The infection control specialist stated that we were under the hospital umbrella and this is brand new for us. The infection control specialist stated that we have been separate from the hospital since 2017. The infection control specialist stated that they have been following the policy and went on to say, "we are still working on it."	F 881	**Monitoring:** • The Antibiotic Stewardship Committee will meet monthly and review the data collection and analysis of the prior month. This committee will monitor trends and provide feedback to the prescribers on unnecessary antibiotic use. A summary of the Antibiotic Stewardship Committee meeting will be provided to QAPI committee for discussion and further recommendations. • The Medical Director and/or pharmacist will address unnecessary antibiotic use with attending physicians as needed.	

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F 881	Continued From page 84 On 05/30/19 at 10:02 AM, the infection control specialist was interviewed again and stated that this information will be taken quarterly to the QA [quality assurance] meeting, and stated that the administrator voiced that this is the policy that the facility will use if it is deemed ok. The infection control specialist stated, that before this policy they were using the hospital policy, it had the facility name, but was not specific to the facility. The infection control specialist stated that the antibiotic stewardship program was brought to her in April of 2019 to develop a program for this facility alone, separate from the hospital and stated, "I am starting to educate on the tracking and trending, the documentation and educating the physicians, the physicians have just received the tool for antibiotic use." The infection control specialist stated that there will be a pharmacy staff on the committee, but they have not developed an actual committee and have not actually had any meetings. No further information and/or documentation was presented prior to the exit conference on 5/30/19 at 5:00 PM to evidence that the facility had developed and/or implemented an antibiotic stewardship programs that addressed the required components for appropriate use, prescribing, and tracking.	F 881		