STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME CORRECTED COPY	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(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 657	Continued From page 52 #3 (Licensed Practical Nurse), when asked if the side rails should be care planned, LPN #3 stated that they should be. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if the side rails should be care planned, she stated that they should be. On 6/28/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing) made aware of the findings. No further information was provided by the end of the survey.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident representative interview, staff interview and clinical record review, it was determined that the facility staff failed to ensure treatment and care was provided in accordance with professional standards of practice, and the comprehensive person-centered care plan provide care for one of 26 residents in the survey sample, Resident #22. The facility staff failed to rinse Resident #22's	F 684		

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F 684	Continued From page 53 mouth with mouth wash twice daily, per physician's order. The findings include: Resident #22 was admitted to the facility on 9/25/17. Resident #22's diagnoses included but were not limited to muscle weakness, high blood pressure and repeated falls. Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/19, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded Resident #22 as requiring extensive assistance of one staff with personal hygiene. On 6/25/29 at 9:57 a.m., an interview was conducted with Resident #22's representative (RR). The RR stated Resident #22 had been seen by the dentist and has gingivitis. The RR voiced concern that the facility staff was not rinsing Resident #22's mouth per the dentist's recommendation. Review of Resident #22's clinical record revealed a nurse's note dated 5/9/19 that documented, "Out to Dentist at 12:30 pm with (name of RR) accompany her, transported via (name of facility) van. Returned at 3 pm. Consultations (sic) states oral care twice a day and removal of partial." A nurse's note dated 5/10/19 documented, "Resident to have mouth wash twice daily and to use electric tooth brush. Rp (Responsible party [same as representative]) made aware and will make (sic) bring electric tooth brush in, Added to mar (medication administration record) and TAR	F 684	F 684 1. Mouth care was pushed to CNA touchscreen. R#22 is no longer a resident of Covenant Woods. 2. All residents with diagnosis of gingivitis and orders for mouth wash rinse may be affected. 3. Nurses will be re-educated by MDS Coordinator or designee on the process for order entry with push to CNA touchscreen for documentation of care. CNAs will be re-educated by MDS Coordinator or designee on documenting ADL care per physician ordered plan of care. 4. Unit manager or designee will audit 100% of physician's orders for mouth wash monthly to ensure order is reflected on touchscreen for 3 months. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations.	27-Jun-19 11-Aug-19 11-Aug-19 11-Aug19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 54 (treatment administration record). Will continue to monitor." A physician's order dated 5/10/19 documented, "1. Electric Tooth (daily brushing teeth- if possible). 2. Mouth wash BID (twice a day) (rinse & spit) (Listerine or any available)." Review of the May 2019 and June 2019 MARs, TARs and ADL (activities of daily living) documents, and May 2019 and June 2019 nurses' notes for Resident #22 failed to reveal evidence that facility staff rinsed the resident's mouth with mouth wash twice a day. Resident #22's comprehensive care plan with an effective date of 6/3/19 documented, "(Name of Resident #22) will have oral hygiene, hair combed, and other personal hygiene needs met daily." On 6/26/29 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked how nurses ensure residents' mouths are rinsed with mouthwash per physician's orders. LPN #1 stated, "We make sure we have everything she needs. The CNAs (certified nursing aides) do but I go back behind them to make sure it's getting done." When asked how this should be evidenced, LPN #1 stated, "It should be showing up on the TAR. We sign off on the TAR to evidence it's done." On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 6/27/19 at 8:02 a.m., an interview was	F 684		

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F 684	Continued From page 55 conducted with ASM #2. ASM #2 stated the physician order for mouthwash was placed on the CNA ADL documentation during the previous day. ASM #2 was asked how staff could evidence that the mouthwash was being provided to Resident #22 prior to the previous day if it was not documented for staff to provide. ASM #2 stated the social worker interviewed staff and they said they had been providing the mouthwash but ASM #2 confirmed she could not provide evidence it was done each day. The facility policies titled, "Verbal Orders" and Telephone Orders" failed to document specific information regarding following physician's orders. No further information was presented prior to exit.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement safety precautions to prevent accidents for two of 26 residents in the survey sample, Residents #17 and #22.	F 689		

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F 689	Continued From page 56 1. a. The facility staff failed to transfer Resident #17 properly with a mechanical sit to stand lift per physician's order, which resulted in a fall on 6/18/19. 1. b. The facility staff failed to ensure the right, quarter bed rail for Resident #17's was maintained in a safe manner. 2. The facility staff failed to implement interventions to prevent falls after Resident #22 fell on 2/1/19, 2/11/19 and 2/17/19. The findings include: 1. a. The facility staff failed to transfer Resident #17 properly with a mechanical sit to stand lift per physician's order, which resulted in a fall on 6/18/19. Resident #17 was admitted to the facility on 6/10/17. Resident #17's diagnoses included but were not limited to urinary tract infection, muscle weakness and heart failure. Resident #17's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 4/11/19, coded the resident's cognition as severely impaired. Section G coded Resident #17 as requiring extensive assistance of two or more staff with transfers. Review of Resident #17's clinical record revealed a physician's order dated 7/5/18 for a sit to stand lift for transfers. Resident #17's comprehensive care plan with an effective date of 5/16/19 documented, "(Name of Resident #17) will complete transfers with the assistance of 1-2 people/lift devices as required..."	F 689	F 689 1. Resident #22 is no longer a resident at Covenant Woods. Grab bars for R#17 were repaired. Staff was educated on the use of the mechanical lift for R#17. 2. Residents requiring use of grab bars and residents with falls may be affected. Residents requiring use of mechanical lift transfers may be affected. 3. CNA's are being re-educated to check CNA touchscreen prior to doing resident care to verify resident equipment needs to prevent falls. Residents with new orders for grab bars will be reviewed daily at morning clinical meeting to ensure care plans have been updated timely.	26-Jun-19 26-Jun-19 11-Aug-19

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F 689	Continued From page 57 Further review of Resident #17's clinical record revealed a nurse's note dated 6/18/19 that documented, "Resident had a fall this evening. Agency CNA (certified nursing aide) (name) stated that she was attempting to toilet resident and stated that resident sad (sic) that he could stand up. Per CNA stated that resident with her assistance stood up with him holding onto the bathroom side rails. CNA stated that resident stated that his legs where (sic) giving out so she lowered him to the floor with her knees in his back. So CNA came to nurses station telling writer that & other CNA (name) about the incident and that she needed help lifting him up off the floor in the bathroom. When we arrived he had pillows placed underneath for comfort. Assisted off of the floor by writer and no open areas to skin only but red areas to back at the time of incident. Maybe about 10 minutes later CNA (name) came to nurses station stating that resident had a skin tear to (L) (left) outer leg. Writer also observed discoloration to (L) outer arm and to (L) lower shin. Pt. (Patient) did call daughter (name) before writer could r/t (relate to) incidence. Daughter (name) called about 8pm & spoke with writer concerning incidence stating that she would be talking to the Unit Manager (name) and that father hasn't stood up in about 2 years and that she should read his chart before attending to care. Cleaned with normal saline, Steri strips applied to keep skin in place." The CNA who improperly transferred Resident #17 on 6/18/19 was not available for interview during the survey. On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2; regarding Resident #17's transfer status. LPN #2	F 689	F 689 4. Weekly audits of residents who have orders for lift transfers will be conducted for one month, then every two weeks for 1 month. Resident grab bars will be audited monthly with bed checks and as needed. Documentation for residents with falls will be audited during weekly clinical meeting to ensure grab bars and mechanical lifts were used properly. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations.	11-Aug-19

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F 689	Continued From page 58	F 689		

stated Resident #17 is supposed to be transferred by two people with a sit to stand lift and his transfer status has been that way as long as she has been employed at the facility (for one year). LPN #2 was asked how residents' transfer requirements are communicated to CNAs. LPN #2 stated the nurses give agency and new CNAs a quick rundown regarding residents' transfer requirements and the assistance required.

On 6/26/19 at 2:10 p.m., an interview was conducted with CNA #1; regarding Resident #17's transfer status. CNA #1 stated Resident #17 is supposed to be transferred with a sit to stand lift and his transfer status has been that way as long as she has been employed at the facility (since November 2018). CNA #1 was asked how residents' transfer requirements are communicated to CNAs. CNA #1 stated the CNAs usually get report from the nurses and information about basis care is documented in the computer system.

On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "SAFE LIFTING GUIDELINES" documented, "1. (Name of facility) direct care staff has the responsibility to: * Use mechanical lifting devices and other approved resident handling aids for residents handling and movement tasks, except when absolutely necessary, such as in a medical emergency. * Use mechanical lifting devices and other handling aids that have been assessed as appropriate to meet the mobility needs of the individual resident..."

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F 689	Continued From page 59 1. b. The facility staff failed to ensure the right, quarter bed rail for Resident #17's was maintained in a safe manner. Review of Resident #17's clinical record revealed a physician's order dated 7/5/18 for 1/2 side rails (bed rails) up when in bed to assist with repositioning and independence. Resident #17's comprehensive care plan with an effective date of 5/16/19 failed to document information regarding bed rails. On 6/24/19 at approximately 7:45 p.m., Resident #17 was observed in his room voicing concern to an unidentified staff member about a loose bed rail. On 6/25/19 at 9:38 a.m., an interview was conducted with Resident #17. The resident voiced concern regarding his right bed rail. Resident #17 stated the bed rail was loose and dangerous and stated it may make him fall. At this time, observation of the right, quarter bed rail was conducted. The bed rail was up and in a locked position. The bed rail moved approximately one inch to the left (facing the bed) and approximately one inch out from the bed when pulled. On 6/26/19 at 7:50 a.m., observation of Resident #17's right bed rail revealed the rail remained loose when up and in the locked position. On 6/26/19 at 10:38 a.m., an interview was conducted with OSM (other staff member) #2 (the maintenance manager). OSM #2 was asked to describe the role the maintenance department plays regarding the maintenance of bed rails.	F 689		

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F 689	Continued From page 60	F 689		

OSM #2 stated, "We get work orders that something goes wrong. We will immediately dispatch a maintenance person there to make a repair or order a part." OSM #2 was asked if he had received any work orders regarding Resident #17's bed rail. OSM #2 stated he would look.

On 6/26/19 at 11:22 a.m., OSM #2 presented a work order dated 6/25/19 at 8:35 a.m. The work order documented Resident #17's right "grab bar" on the bed was loose and hanging down on the side of the bed. OSM #2 stated this was the only work order regarding Resident #17's bed rail. OSM #2 stated the work order was received on the previous day at 8:35 a.m. OSM #2 stated a maintenance employee had tightened the bed rail. OSM #2 was made aware that at 7:50 a.m. on this date the bed rail was not repaired and was asked why the bed rail had not been repaired if the work order was received on 6/25/19. OSM #2 stated the assigned maintenance employee did not get to the bed rail for repair until this morning.

On 6/26/19 at 1:52 p.m., another interview was conducted with OSM #2. OSM #2 was asked if Resident #17's loose bed rail posed a safety risk. OSM #2 stated he did not physically see the bed rail and that the employee who repaired the bed rail stated it was loose and was tightened with three to four turns of a screwdriver. OSM #2 stated he could not say if the bed rail posed a risk because he did not see the bed rail.

On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if Resident #17 uses his bed rails. LPN #2 stated the resident uses his bed rails for turning and positioning. LPN #2 was asked if a loose bed rail posed a safety risk. LPN

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F 689	Continued From page 61 #2 stated, "Yes, because it's not. It's supposed to be for mobility and they may use for transfers. If loose, possibly not tight enough, it could give and drop on them and cause them to fall." On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy regarding side rails (bed rails) failed to document information regarding the maintenance of bed rails. No further information was presented prior to exit. 2. The facility staff failed to implement interventions to prevent falls after Resident #22 fell on 2/1/19, 2/11/19 and 2/17/19. Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/19, in Section J coded the resident as sustaining two or more falls with no injury. Review of Resident #22's clinical record revealed a fall risk assessment dated 6/1/19 that documented the resident was at high risk for falls. Further review of Resident #22's clinical record and fall investigations revealed the following falls: 2/1/19- Resident #22 was observed on the floor beside the bed. 2/11/19- Resident #22 was observed on the floor in the living room area. 2/17/19- Resident #22 sustained a fall from the bed.	F 689		

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F 689	Continued From page 62 Review of nurses' notes dated 2/1/19, 2/11/19 and 2/17/19, and fall investigations dated 2/1/19, 2/11/19 and 2/17/19, and Resident #22's comprehensive care plan dated 10/6/17 failed to reveal interventions to prevent futures falls were addressed and/or implemented after the 2/1/19, 2/11/19 and 2/17/19 falls. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the facility process regarding resident falls. LPN #1 stated a different intervention is implemented after each fall and the type of intervention depends on the cause of the fall; what has occurred with the fall and what facility staff can do to prevent future falls. On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "FALL PREVENTION" documented, "5. In the event of a resident fall, a Fall Investigation will be completed to identify the reason for the fall. Appropriate interventions to prevent reoccurrence will then be implemented..." No further information was presented prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		

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F 695	Continued From page 63 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide respiratory care and services for one of 26 residents in the survey sample, Resident #37. The facility staff failed to ensure a physician's order was in place for the use of an incentive spirometer (1), and failed to store an incentive spirometer in a sanitary manner for Resident #37. The findings include: Resident #37 was admitted to the facility on 2/13/19 with the diagnoses of but not limited to acute respiratory failure with hypoxia (2), urinary tract infection, benign prostatic hyperplasia without lower urinary tract symptoms, and high blood pressure. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 5/23/19, coded the resident as scoring a 10 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. On 6/25/19 at 9:43 AM and 6/26/19 at 8:26 AM, an observation was made of Resident #37. An incentive spirometer was observed sitting on the bedside table uncovered during each observation. A review of the clinical record failed to reveal a	F 695	F 695 1. R#37 incentive spirometer resident unable to use was discarded. 2. The DON made rounds and determined there were no incentive spirometers in other resident rooms. 3. Equipment will be obtained after order in place and stored per protocol. 4. Rounds will be conducted daily by nurse or designee to validate proper storage of and alert clinical supervisor or designee of presence of incentive spirometer. 5. Clinical Supervisor or designee will conduct 24 hr chart check to validate physician order for use of incentive spirometer. 6. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations.	26-Jun-19 26-Jun-19 26-Jun-19 26-Jun-19 26-Jun-19 11-Aug-19

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 64	F 695		

physician's order for an incentive spirometer for Resident #37.

On 6/26/19 at 1:09 PM, an interview with LPN (Licensed Practical Nurse) #3 was conducted. LPN #3 was asked if there should be a physician's order for the use of an incentive spirometer. LPN #3 stated, "Well, if we have a physician's order, he should have an incentive spirometer. But we have residents who bring things up on the floor and some have things in their rooms that are not ordered and we have to make rounds and remove things that are not ordered." LPN #3 was asked about the process staff follows for storing a resident's incentive spirometer. LPN#3 stated "Typically, we have to store it in a bag, whether a zip lock bag, just so it is covered." LPN #3 was asked if an uncovered incentive spirometer could potentially for be contaminated. LPN #3 stated, "Certainly, you would need to get another one cause of infection control." LPN #3 was informed Resident #37 had an uncovered incentive spirometer with no physician's order. She stated, "I will call hospice and see if they want it. If not, then I will remove it."

6/26/19 at 13:46 PM, LPN #3 stated, "The resident's daughter brought in the incentive spirometer because she thought it would help him. I am still going to speak with hospice. I will take it out of his room."

A review of the facility's policy "Departmental (Respiratory Therapy) - Prevention of Infection" documented in part, "Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents

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F 695	Continued From page 65	F 695		

and staff ..." The policy documented under "General Guidelines," "Equipment and Supplies ...1. Appropriate equipment/supplies necessary for ordered therapy ..." Under the section "Infection Control Considerations Related to Oxygen Administration" documented in part, " ...Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use ..." Under the section "Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol" documented in part, " ...Store the circuit in plastic bag, marked with date and resident's name, between uses ..." There was no other documentation in the policy that specifically indicated the requirement for a physician's order.

On 6/26/19 at 4:15 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings.

No further information was provided by the end of the survey.

(1) Incentive Spirometer: An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000451.htm

(2) Acute respiratory failure with hypoxia: When

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F 695	Continued From page 66 not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 695		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for seven of 26 residents in the survey sample; Residents #46, #249, #22, #41, #17, #10 and	F 700		

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F 700	Continued From page 67 #35. The findings include: 1. The facility staff failed to ensure, risks versus benefits were explained to Resident #46 and/or the resident representative, and failed to ensure a risk for entrapment assessment was conducted, and a signed consent was obtained prior to the installation/use of side rails for Resident #46. Resident #46 was readmitted to the facility on 5/30/19; diagnoses included but are not limited to, Parkinson's disease, spinal stenosis, diabetes, high blood pressure, osteoarthritis, and chronic lower back pain. The Admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 6/6/19, coded Resident #46 as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, hygiene, toileting, dressing, and transfers; limited assistance for eating; and was frequently incontinent of bowel and bladder. On 6/25/19 at 1:45 PM and 6/26/19 at 8:55 AM, observations were made of Resident #46's room. The resident was not in the room. The bed was noted with quarter-length sized side rails on the bed in the up position. Review of the clinical record revealed a physician's order, dated 5/30/19, for "1/2 siderails (Sic.) up when in bed to assist with repositioning and independence." A review of the clinical record revealed a "Side Rail Evaluation" dated 6/1/19, which documented	F 700	F 700 1. Risk/benefits assessments for entrapment and/or consents were obtained for R#17 on 6/25/19, R#41 on 7/8/19; and R#35, 46, 249 and 10 on 7/19/19. R#22 is no longer a resident of Covenant Woods. 2. All residents with grab bars may be affected. 3. A system was implemented to ensure that resident assessments for use of side rails, including the risks/benefits and risk of entrapment was completed on admission, readmission, quarterly, and with a significant change. Physician orders will be obtained per side rail assessment. Consents for use of grab bars will be obtained with initial physician order and use of the side rails. 4. A bed safety inspection will be conducted annually by facility director or designee. A bed safety inspection will also be completed by facility director or designee for any bed or mattress change. Grab bars will be removed if not applicable for resident upon assessment.	19-Jul-19 19-Jun-19 11-Aug-19

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F 700	Continued From page 68 15 questions and resident responses regarding the use of side rails. The "Recommendations" section documented, "Recommendations: Side Rails....Half Rails....Bilateral." This form did not include documentation regarding the risks versus benefits of the use of side rails or specify if there was any entrapment risk. Further review of the clinical record failed to reveal any signed consents for the use of the side rails for Resident #46. A review of the baseline care plan dated 5/30/19 included a section for "Restraints/Alarms/Side Rails: ___No restraints, alarms, or side rails used....___Restraint(s) used....___Alarm(s) used..... ___Side rail(s) used....." Each line item contained a box to the left of the type of restraint, to check if that type was required, and three lines after each line item for writing in specific details. The box next to "No restrains, alarms, or side rails used" was checked. A review of the comprehensive care plan, with an "Effective Date" of 6/11/19, revealed one, undated, for "Turning/positioning in bed (bed mobility). (Resident #46) requires extensive assistance." This care plan included the intervention, undated, "While in bed, assist (Resident #46) to turn/reposition self. Use pillows and foam wedges to maintain position." This care plan did not document that the use of bedrails was appropriate for this resident. A second care plan, undated, for "Impaired Bed Mobility" also did not document the use of bedrails was appropriate for this resident. The resident was not care planned for the use of side	F 700	F 700 5. DON or designee will audit 100% of resident with Grab bars to ensure compliance with system- physician order, assessment, consent, and care plan x 3 months. 6. Administrator or designee will audit annual bed safety inspection compliance with bed safety policy. 7. Administrator or designee will audit monthly for bed safety inspections for 3 months and as needed based on changes in bed or mattress. Education will be provided for any discrepancies noted. Results will be tracked and trended and presented at QAPI for further recommendations	11-Aug-19 11-Aug-19 11-Aug-19

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F 700	Continued From page 69 rails. On 6/26/19 at 10:33 AM, in an interview with LPN #3 (Licensed Practical Nurse), when asked if the side rails were on the bed, was there the potential that the staff or family may utilize them and put them in the up position with the resident in bed. She stated that there is a potential if it is on the bed. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked about the facility process regarding bed rails. LPN #1 stated bed rails are usually used for a resident that needs more help with pulling up and who is a little more independent, but needs assistance with getting in and out of bed. LPN #1 stated that prior to bed rail use, a physician's order is obtained, the facility staff makes sure the bed rails are safe for the resident and discusses the use of bed rails with the resident or family. LPN #1 stated the resident and/or family is made aware of the dangers of bed rails and consent is obtained and the use of side rails should be care planned. LPN #1 was asked if there was a risk of bed rails being used if they were on a resident's bed, even if the resident does not have a physician's order for bed rails. LPN #1 stated, "Yes." On 6/28/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing) made aware of the findings. They were asked that if the side rails were present on the beds, then was there the potential that staff or family may utilize them and put them in the up position with the resident in bed. They stated that there was a potential.	F 700		

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F 700	Continued From page 70 A review of the facility document "Pivoting Assist Device" documented, "An optimal bed system assessment should be conducted on each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed's system entrapment guidance, including the clinical guidance for the assessment and implementation of side rails....The assist device is intended for use as an aid in entering or exiting the bed sleep area, as well as a stable handhold during self-positioning within the bed sleep area...The assist device is only one part of your healthcare bed system. Proper combinations of bed, mattress, head/foot panels and assist rails are needed to minimize the risk of entrapment...." A review of the facility policy, "Restraints (Including Side Rails) was conducted. The policy referred to the use of full side rails in the context of being a restraint and did not address the criteria for half or quarter sized side rails for the purposes of aiding residents' independence with moment in the bed. No further information was provided by the end of the survey. 2. The facility staff failed to review the risks and benefits and obtain informed consent, prior to the presence of and use of bed rails for Resident #249. Resident #249 was admitted to the facility on 6/14/19; diagnoses included but are not limited to	F 700		

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F 700	Continued From page 71	F 700		

high blood pressure, retention of urine, adult failure to thrive, anxiety disorder, and major depressive disorder. The most recent MDS (Minimum Data Set), an initial admission assessment, with no ARD (Assessment reference date), no BIMS (Brief Interview for Mental Status) score indicating the Resident's ability for daily decision-making.

On 6/24/19 at 7:010 PM and 6/25/19 at 1:54 PM, an observation was made of Resident #249's room. The resident was observed in the bed. His bed was noted to have 2 quarter-length side rails (one on each side) and the side rails were up at each observation. The side rails were present, in the up position, and available for use by the resident while he was in bed.

A review of the clinical record revealed a undated "Side Rail Evaluation" form that documented in part, "Instructions: Check YES or NO, as appropriate, to answer each question. Provide additional information where requested." This form contained a series of questions.
"Has the resident expressed a desire to have side rails raised while in bed for their own safety?" "Yes" response was entered. "Resident states the side rails help with changing positions."
"Does the resident have fluctuations in levels of consciousness or a cognitive defect?" "Yes" response was entered. "Periods of forgetfulness."
"Does the resident have any visual defects? If yes, explain." "Yes" response was entered. "Wears glasses daily."
"Is the resident able to get in / out of bed? "No" response was entered.
"Is the resident able to get in / out of bed safely?" "No" response was entered.

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"Does the resident have a history of falls?" "Yes" response was entered.
"Is the resident having problems with balance or poor trunk control?" "No" response was entered.
"Does the resident use the side rail for positioning or support?" "Yes" response was entered.
"Does the side rail help the resident rise from a supine position to a sitting / standing position?" "Yes" response was entered.
"Does the resident have a history of postural hypotension?" "No" response was entered.
"Is there a possibility the resident will climb over the side rail? "No" response was entered.
"Is there evidence (reason to believe) the resident has (or may have) a desire or reason to get out of bed? If yes, explain." "No" response was entered.
"Does the resident receive any medications that would require safety precautions? If yes, explain." "No" response was entered.
"Is there a risk to the resident if side rails are used? If yes, explain." "No" response was entered.
"Do the side rail alternatives / interventions create more risk that side rail use? If yes, explain." "No" response was entered.
This form contained a section identified as "Interventions," dated 6/16/19. This section contained the following: "Reminder to use call light." This form contained a section identified as "Recommendations." This section contained the following documentation: "This resident has requested Side Rails while in bed."

A review of the clinical recorded revealed a physician's order dated 6/16/19, documented in part, "1/2 side rails up when in bed to assist with repositioning and independence."

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F 700	Continued From page 73 A review of the clinical record revealed a baseline care plan, dated 6/14/19. The base line care plan included a section for "Restraints/Alarms/Side Rails: ___No restraints, alarms, or side rails used ...___Restraint(s) used ...____Alarm(s) used ...___Side Rail(s) used ..." Each line item contained in a box to the left of the type of restraint, to check if that type was required, and three lines after each item for writing in specific details. The box next to "Side Rail(s) used" was checked. Further review of the clinical record failed to reveal the risks and benefits for the use of side rails were reviewed with Resident #249 and or the residents responsible party and failed to evidence a signed informed consent for the use of bed rails was obtained prior to the use of bed rails for the resident. On 6/26/19 at 4:15 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Suprapubic: A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000145.htm (2) An indwelling catheter is a tube that drains urine from the bladder to a bag outside of the body. This information was obtained from the	F 700		

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F 700	Continued From page 74 website: https://medlineplus.gov/ency/patientinstructions/000140.htm 3. The facility staff failed to review risks and benefits, and obtain informed consent for Resident #22's use of bed rails. Resident #22 was admitted to the facility on 9/25/17. Resident #22's diagnoses included but were not limited to muscle weakness, high blood pressure and repeated falls. Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/19, coded the resident's cognitive skills for daily decision making as moderately impaired. Section G coded Resident #22 as requiring extensive assistance of one staff with bed mobility and transfers. A side rail (bed rail) evaluation dated 1/7/19 documented Resident #22 used side rails for positioning and support. The evaluation further documented no risk to the resident if side rails are used. Review of Resident #22's clinical record failed to reveal a physician's order for bed rails. Further review of Resident #22's clinical record failed to reveal the risks and benefits of bed rails was explained to Resident #22 and/or the resident's representative or evidence that informed consent was obtained for the use of bed rails. Resident #22's comprehensive care plans dated 10/6/17 and 6/3/19 failed to document information regarding bed rails. On 6/26/29 at 2:55 p.m., Resident #22 was	F 700		

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F 700	Continued From page 75 observed lying in bed. Both quarter bed rails were up. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked about the facility process regarding bed rails. LPN #1 stated bed rails are usually used for a resident that needs more help with pulling up and who is a little more independent but needs assistance with getting in and out of bed. LPN #1 stated that prior to bed rail use, a physician's order is obtained, the facility staff makes sure the bed rails are safe for the resident and discusses the use of bed rails with the resident or family. LPN #1 stated the resident and/or family is made aware of the dangers of bed rails and consent is obtained. LPN #1 was asked if there was a risk of bed rails being used if they were on a resident's bed, even if the resident does not have a physician's order for bed rails. LPN #1 stated, "Yes." On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 4. The facility staff failed to review risks and benefits, and obtain informed consent for Resident #41's use of bed rails. Resident #41 was admitted to the facility on 1/16/18. Resident #41's diagnoses included but were not limited to high blood pressure, asthma and urinary tract infection. Resident #41's most recent MDS (minimum data set), a quarterly	F 700		

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assessment with an ARD (assessment reference date) of 6/5/19, coded the resident's cognitive skills for daily decision making as independent. Section G coded Resident #41 as requiring extensive assistance of two or more staff with bed mobility and transfers.

Review of Resident #41's clinical record revealed a side rail (bed rail) evaluation dated 9/12/18 that documented the resident was not at risk if side rails are used. A physician's order dated 5/29/19 documented an order for 1/2 side rails (bed rails) up when in bed to assist with repositioning and independence. Resident #41's comprehensive care plan with an effective date of 6/1/19 failed to document information regarding the resident's use of bed rails.

Further review of Resident #41's clinical record failed to reveal the risks and benefits of bed rails was explained to Resident #41 and/or the resident's representative or evidence that informed consent was obtained.

On 6/26/19 at 7:54 a.m., Resident #41's quarter bed rails were observed in an upright position.

On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the facility process regarding bed rails. LPN #1 stated bed rails are usually used for a resident that needs more help with pulling up and who is a little more independent but needs assistance with getting in and out of bed. LPN #1 stated that prior to bed rail use, a physician's order is obtained, the facility staff makes sure the bed rails are safe for the resident and discusses the use of bed rails with the resident or family. LPN #1 stated the resident

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and/or family is made aware of the dangers of bed rails and consent is obtained.

On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if Resident #41 uses her bed rails. LPN #2 stated the resident uses her bed rails for turning and positioning.

On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

5.a. The facility staff failed to ensure Resident #17's right, quarter bed rail was maintained in a safe manner.

Resident #17 was admitted to the facility on 6/10/17. Resident #17's diagnoses included but were not limited to urinary tract infection, muscle weakness and heart failure. Resident #17's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 4/11/19, coded the resident's cognition as severely impaired. Section G coded Resident #17 as requiring extensive assistance of one staff with bed mobility and as requiring extensive assistance of two or more staff with transfers.

Review of Resident #17's clinical record revealed a physician's order dated 7/5/18 for 1/2 side rails (bed rails) up when in bed to assist with repositioning and independence. Resident #17's comprehensive care plan with an effective date of 5/16/19 failed to document information regarding

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F 700	Continued From page 78 the resident's use of bed rails. On 6/24/19 at approximately 7:45 p.m., Resident #17 was observed in his room voicing concern to an unidentified staff member about a loose bed rail. On 6/25/19 at 9:38 a.m., an interview was conducted with Resident #17. The resident voiced concern regarding his right bed rail. Resident #17 stated the bed rail was loose and dangerous and stated it may make him fall. At this time, observation of the right, quarter bed rail was conducted. The bed rail was up and in a locked position. The bed rail moved approximately one inch to the left (facing the bed) and approximately one inch out from the bed when pulled. On 6/26/19 at 7:50 a.m., observation of Resident #17's right bed rail revealed the rail remained loose when up and in the locked position. On 6/26/19 at 10:38 a.m., an interview was conducted with OSM (other staff member) #2 (the maintenance manager). OSM #2 was asked to describe the role the maintenance department plays regarding the maintenance of bed rails. OSM #2 stated, "We get work orders when something goes wrong. We will immediately dispatch a maintenance person to make a repair or order a part." OSM #2 was asked if he had received any work orders regarding Resident #17's bed rail. OSM #2 stated he would look. On 6/26/19 at 11:22 a.m., OSM #2 presented a work order dated 6/25/19 at 8:35 a.m. The work order documented Resident #17's right "grab bar" on the bed was loose and hanging down on the	F 700		

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side of the bed. OSM #2 stated this was the only work order regarding Resident #17's bed rail. OSM #2 stated the work order was received on the previous day at 8:35 a.m. OSM #2 stated a maintenance employee had tightened the bed rail. OSM #2 was made aware that at 7:50 a.m. on this date the bed rail was not repaired. OSM #2 was asked why the bed rail had not been repaired if the work order was received on 6/25/19. OSM #2 stated the assigned maintenance employee did not get to the bed rail for repair until this morning.

On 6/26/19 at 1:52 p.m., another interview was conducted with OSM #2. OSM #2 was asked if Resident #17's loose bed rail posed a safety risk. OSM #2 stated he did not physically see the bed rail and that the employee who repaired the bed rail stated it was loose and was tightened with three to four turns of a screwdriver. OSM #2 stated he could not say if the bed rail posed a risk because he did not see the bed rail.

On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if Resident #17 uses his bed rails. LPN #2 stated the resident uses his bed rails for turning and positioning. LPN #2 was asked if a loose bed rail posed a safety risk. LPN #2 stated, "Yes, because it's supposed to be for mobility and they may use for transfers. If loose, possibly not tight enough, it could give and drop on them and cause them to fall."

On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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F 700	Continued From page 80 The facility policy regarding side rails (bed rails) failed to document information regarding the maintenance of bed rails. No further information was presented prior to exit. 5. b. The facility staff failed to review risks and benefits, and obtain informed consent for Resident #17's use of bed rails. Review of Resident #17's clinical record revealed a side rail (bed rail) evaluation dated 6/10/17. The evaluation documented there was no risk to the resident if side rails are used. A physician's order dated 7/5/18 documented an order for 1/2 side rails (bed rails) up when in bed to assist with repositioning and independence. Resident #17's comprehensive care plan with an effective date of 5/16/19 failed to document information regarding bed rails. Further review of Resident #17's clinical record failed to reveal the risks and benefits of bed rails was explained to Resident #17 and/or the resident's representative or evidence that informed consent was obtained. On 6/25/19 at 9:38 a.m., the bed rails on Resident #17's bed were observed in an upright position. On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if Resident #17 uses his bed rails. LPN #2 stated the resident uses his bed rails for turning and positioning. On 6/26/19 at 3:36 p.m., ASM (administrative	F 700		

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F 700	Continued From page 81 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 6. The facility staff failed to obtain consent and review risk and benefits prior to the installation/use of bed rails for Resident #10. Resident #10 was admitted to the facility on 6/12/18. Resident #10's diagnoses included but were not limited to muscle weakness, arthritis (inflammation of joints) and high blood pressure. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/20/19, coded Resident #10 with no cognitive impairment. Section G coded Resident #10 as requiring extensive assistance of one staff member with bed mobility. Review of Resident #10's clinical record revealed a physician order dated 06/20/18 which documented, "Side rails to be on both sides of bed at all times" and a facility document titled, "Side Rail & Entrapment Risk Evaluation," completed 5/06/19. Further review of Resident #10's clinical record failed to reveal documented consent or documentation that risk and benefits were reviewed with Resident #10 (or the resident's representative) prior to the resident's use of bed rails. On 6/25/19 at 11:45 a.m., Resident #10 was observed sitting in her wheelchair watching television. Both quarter rails were in a raised	F 700		

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F 700	Continued From page 82	F 700		

position. Resident #10 was asked if she used the half rails at any time. Resident #10 stated, "I use them to move around sometimes."

On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the facility process regarding bed rails. LPN #1 stated bed rails are usually used for a resident that needs more help with pulling up and who is a little more independent but needs assistance with getting in and out of bed. LPN #1 stated that prior to bed rail use, a physician's order is obtained, the facility staff makes sure the bed rails are safe for the resident and discusses the use of bed rails with the resident or family. LPN #1 stated the resident and/or family is made aware of the dangers of bed rails and consent is obtained. LPN #1 was asked if there was a risk of bed rails being used if they were on a resident's bed, even if the resident does not have a physician's order for bed rails. LPN #1 stated, "Yes."

On 6/28/19 at 12:15 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to the end of the survey.

7. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the installation/use of bed rails for Resident #35.

Resident #35 was admitted to the facility on 5/10/18. Resident #35's diagnoses included but were not limited to high blood pressure, blindness and osteoporosis (a bone disease). Resident

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F 700	Continued From page 83 #35's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/17/19, coded Resident #35 with no cognitive impairment. Section G coded Resident #35 as requiring limited assistance of one staff member with bed mobility. Review of Resident #35's clinical record revealed a facility document titled, "Side Rail & Entrapment Risk Evaluation", completed 5/06/19. Further review of Resident #35's clinical record failed to reveal documented consent, a physician order or documentation that risk and benefits were reviewed with Resident #35 (or the resident's representative). On 6/25/19 at 11:50 a.m., Resident #35 was observed sitting on her bed in the room. Both quarter rails were in a raised position. Resident #35 was asked if she used the half rails at any time. Resident #35 stated, "I use the rails sometimes because I am blind. My bed remote hangs from it." On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the facility process regarding bed rails. LPN #1 stated bed rails are usually used for a resident that needs more help with pulling up and who is a little more independent but needs assistance with getting in and out of bed. LPN #1 stated that prior to bed rail use, a physician's order is obtained, the facility staff makes sure the bed rails are safe for the resident and discusses the use of bed rails with the resident or family. LPN #1 stated the resident and/or family is made aware of the dangers of bed rails and consent is obtained. LPN #1 was	F 700		

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F 700	Continued From page 84 asked if there was a risk of bed rails being used if they were on a resident's bed, even if the resident does not have a physician's order for bed rails. LPN #1 stated, "Yes." On 6/27/19 at 4:00 p.m., ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing) were asked that if the side rails were present on the beds, then was there the potential that staff or family may utilize them and put them in the up position with the resident in bed. They stated that there was a potential. On 6/28/19 at 12:15 p.m., ASM #1 and ASM #2 were made aware of the above concern. No further information was presented prior to the end of the survey.	F 700		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete annual CNA (certified nursing aide) performance reviews for three of five CNA record reviews. The facility staff failed to complete annual	F 730		

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F 730	Continued From page 85 performance reviews for CNA #2, CNA #3 and CNA #4. The findings include: Review of CNA #2's record revealed the last performance review was completed on 3/25/17. Review of CNA #3's record revealed no performance review. Review of CNA #4's record revealed a performance review with no date. On 6/26/19 at 2:14 p.m., an interview was conducted with OSM (other staff member) #3 (the director of human resources). OSM #3 was asked about the facility process for CNA performance reviews. OSM #3 stated performance reviews were conducted quarterly in 2018 and changed to being conducted twice a year in the beginning of 2019. OSM #2 stated the new nursing manager misunderstood the process and thought half of the reviews could be conducted in March and the other half of reviews could be conducted in August. OSM #3 was made aware of the above concerns and stated she could not present any further information. On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. An excerpt from the facility handbook documented, "(Name of facility) reviews employee performance on a continuing basis and also periodically on a formal basis to assist the employee in attaining maximum development. The first evaluation is completed in the third month of employment and semi-annually	F 730	F 730 1. Performance reviews completed on CNAs #2, 3, and 4 by DON. — 11-Aug-19 2. A 100% review of CNA personnel records will be completed by 18-Jul--19. Any reviews out of compliance will be completed by DON or designee. — 11-Aug-19 3. Review of evaluation process and training provided to DON by HR staff. — 12-Jul-19 4. Nursing department will submit all 90-day evaluations and semi-annual evaluations to HR upon completion. HR will audit evaluations against list of new-hires and last evaluation x90 days. Education will be provided for any discrepancies noted. Results will be tracked and trended and presented at QAPI for further recommendation. — 11-Aug-19	

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F 730	Continued From page 86 thereafter..." No further information was presented prior to exit.	F 730		
F 732 SS=C	Posted Nurse Staffing Information 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	F 732		

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F 732	Continued From page 87 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post all required information on the daily nursing staff form. The facility staff failed to ensure the daily nursing staff form contained the total number of RNs (registered nurses), LPNs (licensed practical nurses) and CNAs (certified nursing aides) directly responsible for resident care per shift. The findings include: On 6/25/19 at 12:21 p.m., observation of the daily nursing staff form posted at the elevator on the C wing was conducted. The form contained the hours of RNs, LPNs and CNAs but failed to document the total number of RNs, LPNs and CNAs directly responsible for resident care per shift. On 6/26/19 at 9:54 a.m., an interview was conducted with ASM (administrative staff member) #3 (the executive assistant). ASM #3 was asked what information should be documented on the daily nursing staff form. ASM #3 stated, "The census and the CNA, LPN and RN hours for each shift." ASM #3 was asked if the form should include the total number of CNAs, LPNs and RNs. ASM #3 stated, "I don't know. It can. I can make it like that." On 6/26/19 at 3:36 p.m., ASM #1 (the	F 732	F 732 1. Posting staff hours document updated to include number of people in addition to hours worked. 2. May have affected residents who benefit from having hours converted. 3. The format of the document has been changed to identify all required elements. 4. Daily posted information will be updated as changes occur. Discrepancies will be reported to the DON.	26-Jun-19 26-Jun-19 11-Aug-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	C 06/27/2019

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F 732	Continued From page 88 administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 6/26/19 at 4:27 p.m., ASM #3 stated she corrected the daily nursing staff form and presented a revised version to include the total number of CNAs, LPNs and RNs directly responsible for resident care per shift. The facility policy titled, "POSTING OF STAFFING INFORMATION" documented, "The health care center will post, on a daily basis and for each shift, the current facility census and the number of nursing personnel by category, that are responsible for providing direct care to the residents..." No further information was presented prior to exit.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		

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F 755	Continued From page 89 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure medications were available for administration as prescribed for one of 26 residents in the survey sample, Resident #149. The facility staff failed to ensure Resident #149, physician prescribed medications, Aspercreme (1) 4% topical patch, albuterol sulfate (2) 90 micrograms/actuation aerosol inhaler, and diclofenac (3) 1% topical gel, were available for administration on 6/19/19. The findings include: Resident #149 was admitted to the facility on 6/18/19. Resident #149's diagnoses included but were not limited to urinary tract infection, shortness of breath and hearing loss. Resident #149's MDS (minimum data set) assessment was not complete. An admission nursing assessment dated 6/18/19 documented the resident was alert	F 755	F 755 1. R#149 is no longer a current resident at Covenant Woods. 2. LPN #1 and nurses working 7-3 and 3-11 were educated by the DON on the process for obtaining meds. 3. 100% review of new admission resident MARS will be completed to ensure meds are available and being administered as ordered by resource nurse or designee 3 times per week starting on July 15. 4. Nurses will be re-educated by Remedi Pharmacy representative on the process for obtaining meds on admissions per Remedi policy/procedure. 5. DON or designee will audit 100% of all new admission MARS for 1 month and then 50% of all new admission MARs for 2 months to confirm meds are available and administered as ordered. Education will be provided for any discrepancies noted. Results will be tracked and trended and presented at QAPI for further recommendations	26-Jun-19 15-Jul-19 11-Aug-19 11-Aug-19

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F 755	Continued From page 90 and oriented times three (person, place and time). Review of Resident #149's clinical record revealed the following physician's orders: 6/18/19 Aspercreme (1) 4% topical patch- apply one patch to left chest daily. 6/18/19 albuterol sulfate (2) 90 micrograms/actuation aerosol inhaler- two puffs two times a day. 6/18/19 diclofenac (3) 1% topical gel- two grams four times daily. Review of Resident #149's June 2019 MAR (medication administration record) revealed the above medications were not administered during the morning medication pass on 6/19/19 because the facility staff was awaiting for arrival of the medications from the pharmacy. In addition, the diclofenac was not administered during the lunch medication pass on 6/19/19 because the facility staff was awaiting for arrival of the medication from the pharmacy. A nurse's note dated 6/19/19 at 12:00 p.m. documented, "Medications given this am awaiting a few from pharmacy due to arrive today..." Resident #149's baseline care plan dated 6/18/19 documented, "MEDICATION/TREATMENT ORDERS. See MAR/TAR (treatment administration record)..." Review of the facility STAT box list revealed Aspercreme, albuterol sulfate and diclofenac were not available in the STAT box (a box containing various medications that can be accessed when a resident's medications are not available).	F 755		

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F 755	Continued From page 91 On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse caring for Resident #149 during the 6/19/19 morning and lunch medication passes). LPN #1 confirmed Resident #149's Aspercreme, albuterol sulfate and diclofenac did not arrive during her shift on 6/19/19 so the medications were not administered to the resident. LPN #1 stated she called the pharmacy and the technician said the medications would arrive on the early pharmacy run around 3:00 p.m. LPN #1 was asked what should be done if a resident's medications have not arrived from the pharmacy when they are due for administration. LPN #1 stated in most cases, the medications could be obtained from the STAT box or nurses try to get the medications sent STAT/right away from the pharmacy. LPN #1 stated medications can be sent from a backup pharmacy but that does not always happen. On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "DRUGS-PHARMACEUTICAL SERVICES" documented, "All new medication orders shall be transcribed on the physician's order sheet or the telephone order form by the nurse taking the order from a person lawfully authorized to prescribe...Any new medication order required before the next regular delivery will be called and faxed immediately to the pharmacy..." No further information was presented prior to exit.	F 755		

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F 755	Continued From page 92 (1) Aspercreme is used to treat arthritis pain. This information was obtained from the website: https://www.mayoclinic.org/diseases-conditions/osteoarthritis/in-depth/pain-medications/ART-20045899?p=1 (2) Albuterol sulfate is used to treat shortness of breath. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682145.html (3) Diclofenac is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a611002.html	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		

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F 756	Continued From page 93 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, facility document review and clinical record review, it was determined that the facility staff failed to ensure a monthly drug regimen review was completed for one of 26 residents in the survey sample, Resident #17. The facility staff failed to ensure the pharmacist completed Resident #17's April 2019 drug regimen review. The findings include: Resident #17 was admitted to the facility on 6/10/17. Resident #17's diagnoses included but were not limited to urinary tract infection, muscle weakness and heart failure. Resident #17's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 4/11/19, coded the resident's	F 756	F 756 1. The April, 2019 drug regimen review for resident #17 was conducted by the consultant pharmacist on 4/16/19 and has now been made part of the resident's medical record. 2. The deficient practice, i.e., the failure of the consultant pharmacist to document in the medical record that a drug regimen review was conducted, has the potential to affect all residents. 3. At the time of each visit, the consultant pharmacist, using a facility census report, will cross check that every resident's medical record contains a note indicating the date the drug regimen review was completed. 4. The pharmacy's lead consultant will audit 50% of the current residents' medical records monthly x 2 to determine if the consultant pharmacist has documented their reviews per this plan of correction. All results will be tracked and trended and presented at QAPI for further recommendations.	15-Jul-19 24-Jul-19 11-Aug-19

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F 756	Continued From page 94 cognition as severely impaired. Review of Resident #17's clinical record failed to reveal a monthly drug regimen review completed by a pharmacist in April 2019. On 6/26/19 at 2:37 p.m., a telephone call to the consultant pharmacist was made. There was no answer. On 6/26/19 at 3:11 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked about the facility process for monthly medication drug regimen reviews. ASM #2 stated the pharmacist is supposed to come once a month and normally comes between the first and second weeks of the month. ASM #2 stated a pharmacist would also come to review a newly admitted resident's chart. On 6/26/19 at 3:36 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Drug Regimen Review/Medication Regime Review" documented, "3) The Consultant Pharmacist will perform a drug/medication regimen review [DRR/MRR] for every resident in the facility. 4) Routine reviews will be done monthly..." No further information was presented prior to exit.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		

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F 761	Continued From page 95 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure proper storage of narcotics per the requirements in one of 2 medication storage rooms, Wing C medication storage room. The facility staff failed to ensure the Wing C medication refrigerator lock was secured and that the narcotic box in the refrigerator was permanently affixed. The findings include:	F 761	F 761 1. The lock on the medication refrigerator on Wing C was repaired on 06/26/19.The narcotic box in the refrigerator on Wing C was permanently affixed. The refrigerator on Wing A was examined and was noted to have functioning lock. 2. Nurses were educated by the DON on proper storage of narcotics. Nurses will be re-educated on the proper storage of narcotics. 3. Unit manager or designee will round on the med rooms on each unit weekly to ensure proper storage of narcotics. Results of rounding audits will be tracked and trended and presented at QAPI for further recommendations	11-Aug-19 26-Jun-19 26-Jun-19 11-Aug-19 11-Aug-19

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F 761	Continued From page 96 On 6/24/19 at 6:30 p.m., a tour of Wing C was conducted. While inspecting the Wing C medication storage room, LPN (licensed practical nurse) #7 was asked to open the refrigerator. LPN #7 then pulled the refrigerator door open. LPN #7 was asked if the refrigerator contained narcotics. LPN #7 stated, "Yes, here they are." LPN #7 then pointed to a box which contained narcotics. The box was easily removed from the refrigerator and did not contain a lock to secure narcotics. The refrigerator door was not locked at time of inspection. On 6/24/19 at 6:40 p.m., an interview was conducted with LPN #7. LPN #7 was asked about the process staff follows for ensuring proper narcotic storage. LPN #7 stated, "Narcotics should be double locked, behind a locked door in a locked refrigerator or inside of locked box inside of the refrigerator." LPN #7 was made aware that the refrigerator containing narcotics was not locked. LPN #7 stated, "I know. We've been having problems with the lock so the refrigerator was left unlocked so we could easily access the medications inside and the narcotics when needed." LPN #7 was asked if it had been reported to anyone that the lock was broken on the refrigerator in the Wing C medication storage room. LPN #7 stated, "Yes, it has been reported." On 6/25/19 at 3:00 p.m., a second inspection of Wing C medication storage room was completed. The refrigerator in the medication storage room was noted to be locked and required use of a key to be opened. 06/25/19 at 4:03 p.m., an interview was conducted with OSM (other staff member) #2 (the maintenance manager). OSM #2 was asked the	F 761		

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F 761	Continued From page 97 process for initiating a maintenance work order. OSM #2 stated, "Maintenance work orders are done via email. Once received, I assign them to maintenance staff." OSM #2 was asked if there was a work order to repair the lock on the medication storage refrigerator. OSM #2 stated, "I would have to look." OSM #2 provided this surveyor with a maintenance work order (#383135) dated 5/23/19 that documented, "The lock on the fridge that the nurses use is not working, still." Further review of the document noted that that the lock on the refrigerator was repaired on 5/23/19. OSM #2 was asked if there were additional work order sent to repair the lock on the medication storage refrigerator. OSM #2 stated, "None that I'm aware of." On 6/28/19 at 12:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. A review of the facility policy titled, "Controlled Substances" documented, "5. Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents." No further information was presented prior to the end of the survey.	F 761		
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	F 842		

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F 842	Continued From page 98 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. §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	F 842	F 842 1. R#22 is no longer a resident in Covenant Woods. 2. All residents with previous falls may be at risk for missing documentation in their medical record. 3. Nurses will be educated by the DON or designee on fall documentation process to include description of fall, resident assessment, vital signs, any injury sustained, neuro checks, if applicable, notification to MD and RP, interventions, and follow up of fall documentation for 72hrs. 4. Unit manager or designee will audit 100% of all falls on an ongoing basis to ensure appropriate documentation of resident falls. Results will be tracked and trended and presented at QAPI for further recommendations	19-Jul-19 11-Aug-19 11-Aug-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 842	Continued From page 99 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 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 26 residents in the survey sample, Resident #22. The facility staff failed to document Resident #22's fall that occurred on 2/17/19 in the clinical record. The findings include: Resident #22 was admitted to the facility on 9/25/17. Resident #22's diagnoses included but	F 842		

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	495419	A. BUILDING _____ B. WING _____	C 06/27/2019

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F 842	Continued From page 100 were not limited to muscle weakness, high blood pressure and repeated falls. Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/19, coded the resident's cognitive skills for daily decision making as moderately impaired. Section G coded Resident #22 as requiring extensive assistance of one staff with bed mobility and transfers. Section J coded the resident as sustaining two or more falls with no injury. A fall investigation dated 2/17/19 revealed Resident #22 sustained a fall from the bed on that date. Review of Resident #22's clinical record failed to reveal documentation regarding the 2/17/19 fall. On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses should document resident falls in the clinical record. LPN #2 stated, "Yes." When asked why, LPN #2 stated, "Because they just had an incident." On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Charting and Documentation" documented, "3. All incidents, accidents, or changes in the resident's condition must be recorded..." No further information was presented prior to exit.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 101 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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:	F 880	F 880 1. Infection control tracking is current for June 2019. 2. Unit manager or designee will complete surveillance logs weekly, communicate issues/concerns to DON, and provide DON with weekly data for tracking and trending. 3. Facility DON will maintain a current and effective infection control tracking, trending, and surveillance program on a monthly basis. Infection control surveillance and tracking will be submitted monthly by DON or designee for clinical operations report review with interdisciplinary team. 4. Administrator or designee will audit infection control surveillance data monthly x3 months to ensure compliance and timeliness with infection control program. 5. Data from infection control program will be tracked and trended and presented at QAPI for further recommendations	27-Jun-19 27-Jun-19 27-Jun-19 11-Aug-19 11-Aug-19

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F 880	Continued From page 102 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an infection control program, as evidenced by no infection control tracking, trending, and surveillance logs for January 2019 through May 2019. The facility staff failed to maintain tracking, trending, and surveillance logs for facility infections. There were no infection control	F 880		

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F 880	Continued From page 103 tracking, trending, and surveillance logs for January 2019 through May 2019 The findings include: The facility staff failed to maintain tracking, trending, and surveillance logs for facility infections. There were no infection control tracking, trending, and surveillance logs for January 2019 through May 2019 On 6/26/19 at 4:00 PM, the infection control tracking logs was requested from ASM #2 (Administrative Staff Member, the Director of Nursing DON). On 6/27/19 at 8:15 AM, a review of the logs was conducted. The logs were for the current month of June 2019 only. On 6/27/19 at 8:21 AM, in an interview with ASM #2, she stated that she had started employment at the facility in the middle of May 2019, and started the tracking logs. She stated that there were no tracking, trending, and surveillance logs prior to June 2019. On 6/27/19 at 8:55 AM, ASM #2 provided an infection control logbook for the calendar year of 2018. However, she was still not able to provide evidence of infection control tracking, trending, and surveillance for January 2019 through May 2019, a 5 month time period with no tracking, trending and surveillance. A review of the facility policy, "Infection Control" documented, "Policy: The primary purpose of	F 880		

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F 880	Continued From page 104 (facility) infection control policies and procedures are to establish guidelines for providing a safe and sanitary environment and to help prevent the development and transmission of disease and infection, while maintaining the residents' comfort, dignity and rights. Procedures: ....2. The objectives of our infection control policies and procedures are to: *Identify, investigate, control and prevent infections in the facility. *Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; *Establish guidelines for the implementation of isolation precautions; *Maintain records of incidents and corrective actions related to infections. *Establish guidelines to follow in implementing Standard Precautions for the handling of blood, body fluids, secretions, excretions, mucous membranes and nonintact skin. 3. It shall be the responsibility of the Quality Assurance Committee, through the Infection Control Sub-Committee; to approve infection control policies and procedures and to ensure that they are implemented and followed....5. The Governing Board, through the Quality Assurance and the Infection Control Sub-Committees, has adopted our infection control policies and procedures, as those that best reflect the needs and operational requirements of this facility in the prevention of transmission of infections and communicable diseases as set forth in current (multiple agencies listed) guidelines and recommendations...." On 6/27/19 at 9:07 AM, ASM #1 (the Administrator) was made aware of the findings. No further information was provided by the end of the survey.	F 880		