STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

(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 on 7/23-25/2019. The facility was in substantial compliance with 42 CFR Part 483.73 Requirements for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey	E 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/23/19 through 07/25/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 174 certified bed facility was 163 at the time of the survey. The survey sample consisted of 63 resident reviews.	F 000	federal and state laws requires it. This Plan of Correction serves as the facility's allegation of compliance. **F578 Request/ Refuse/ Dscontnue Trmnt, Formite Adv Dir.**	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578	1. Resident #94 suffered no adverse effects from medical record not being updated timely. Resident no longer resides in the facility. 2. Social services director/designee will complete a 100% quality review of current residents' code status components to ensure accuracy. 3. ED/designee will re-educate the staff on ensuring the components of code status are accurate. 4. SSD/designee will conduct a quality review 1x a week for 1 month of resident's code status components to ensure accuracy. Quality improvement monitoring findings to be reported to the QAPI committee for a period of 2 months for compliance and/or revisions. 9/8/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	08/23/2019

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 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to maintain an accurate medical record in regards in advance directives rights for one Resident (Resident #94) in a survey sample of 63 Residents. The findings included: Resident #94 was admitted to the facility on 5/28/19. Resident #94's diagnoses included but were not limited to: schizophrenia, hypertension, vitamin D deficiency, and muscle weakness.	F 578		

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F 578	Continued From page 2 Review of Resident #94's electronic medical record on 7/24/19 revealed on the main screen for Resident #94, code status was noted as "Full Code," which indicated, in the event of cardiopulmonary arrest CPR (cardiopulmonary resuscitation) would be provided. Review of Resident #94's physician orders revealed an active order, with an effective date of 5/28/19 that read, "Full Code," Resident #94's careplan read, "[Resident name] has advanced directives r/t [related to] full code." Review of Resident #94's paper chart on 7/25/19 revealed an undated document, titled "Advance Directives Discussion Document." The form stated, "please indicate your wishes regarding the following: Cardiopulmonary Resuscitation:" the withhold box was checked and "DNR" (do not resuscitate) was written beside it. Resident #94 had signed the document. On 7/25/19 an interview was conducted with LPN C. LPN C was asked about Resident #94's code status, she looked at the document titled "Advance Directives Discussion Document" and stated, "he is a DNR." No further information was provided.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		

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F 584	Continued From page 3 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 2 floors and for 2 (Residents	F 584	**F 584 SS-E Safe/ Clean/ Comfortable /Homelike Environment** A. What actions will be accomplished for those residents found to have been affected by this practice? 1. No residents suffered any adverse effects in relation to the window pane being cracked by a pebble. However, no loose or hanging glass was noted to that window. 2. No residents suffered any adverse effects in relation to AC unit dripping condensation. 3. Resident #87 did not suffer any adverse effects in relation to her ceiling being discolored.	

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F 584	Continued From page 4 #87, #43) of 63 sampled residents. The findings included: 1. On 7/23/2019 at 3:00 PM Surveyor B reported seeing a broken window in the first floor dayroom. A closer examination revealed that the second window from the left upon entering the dayroom had a broken window with a loose piece of glass hanging in the frame. 2. On 7/23/2019 at 11:45 AM Surveyor E noticed a hallway air conditioning unit at ground level was leaking water and towels were on the floor to keep the flow of water from the walkway. On 7/24/2019 at 8:38 AM the situation was noted to be the same. On 7/24/2019 at 11:00 AM an interview was conducted with Employee F, Maintenance Director. He stated that he was too busy to repair the air conditioning unit and would get to it "next week". 3. The facility staff failed to ensure that Resident #87's ceiling was not leaking on her bed. Resident #87 was a 55-year-old who was admitted to the facility on 3/5/19. Resident #87's diagnoses included Heart Failure, Major Depressive Disorder, and Hypertension. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/12/19, coded Resident #87 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.	F 584	B. How the facility will identify other residents having the potential to be affected by the same practice. 1. Residents residing in the center have the potential to be affected. 2. Residents residing in the center have the potential to be affected. 3. Residents residing in the center have the potential to be affected. C. What measures will be put in to place or what systemic changes will be made. 1. ED/Designee will conduct a 100% audit of window panes to ensure that there are not damaged. 2. ED/Designee will perform quality review of maintenance log on routine declogging the line so that condensation does not drip onto the floor. 3. ED/Designee will perform quality review of maintenance room checks to ensure that the ceiling is free of condensation and/or discoloration.	

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F 584	Continued From page 5 On 7/23/19 at 4:04 P.M., an interview was conducted with Resident #87 in her bedroom. She was in bed, with the head of her bed elevated. Resident #87 stated that she was fearful of getting injured because of the ceiling leaking on her bed. She stated that at times the ceiling leaks and wets her bed. She believed that the ceiling could fall on her. The Assistant Administrator (Employee H) walked into the room. When asked to describe the condition of the ceiling above Resident #87's bed, the Assistant Administrator stated, "It looks like dried ketchup." The ceiling was observed to have dried stains that were black-brown in color. In addition, some of the tiles surrounding the sprinkler head were damaged. The tiles in the hallway were also warped and had stains on them. On 7/23/19 a review was conducted of facility documentation, revealing a Repair Requisition dated 7/7/19. It stated that the ceiling was leaking in Resident #87's room. Another Repair Requisition dated 7/11/19 stated that the ceiling was leaking in the hallway on Resident #87's unit. On 7/24/19 at approximately 9:00 A.M., an interview was conducted with the Director of Maintenance (Employee F) in the conference room. The Director of Maintenance stated, "The ceiling was leaking due to a crack in the reservoir pan on the air conditioning unit. We have a lot of separate units and they are old and leak condensation. It is important to residents to have a home like environment." When asked to describe the ceiling tiles on Resident #87's unit, the Director of Maintenance stated that some of the tiles were warped and needed to be	F 584	D. How the facility plans to monitor its performance. 1. ED/Designee will conduct weekly random audits on windows in resident common areas and resident rooms for 1-month and the findings will be reported to QAPI committee for 2 months. 2. ED/Designee will conduct weekly random audits for 1-month of radiator drains and the findings will be reported to QAPI committee for 2 months. Thereafter, further action plans as needed. 3. ED/Designee will conduct weekly random audits for 1-month and the findings will be reported to QAPI committee. Thereafter, further action plans as needed. 9/8/2019	

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F 584	Continued From page 6 replaced." No further information was received. 4. For Resident #43, the facility staff failed to ensure that the armrests on her wheelchair were repaired. Resident #43 was a 69-year-old who was admitted to the facility on 1/18/19. Resident #43's diagnoses included Epilepsy, Schizophrenia, Bipolar Disorder, and Major Depressive Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference date of 5/11/19 was reviewed. Resident #43 was coded as having a Brief Interview of Mental Status Score on 12, indicating mild cognitive impairment. On 7/23/19 at approximately 3:30 P.M., an observation was made of Resident #43 sitting in her wheelchair in the activity room. The material covering the armrests on her wheelchair was ripped off, exposing sponge-like cushion, which was soiled. Resident #43 stated that she wanted her armrests to be repaired. On 7/24/19 at approximately 9:00 A.M., an interview was conducted with the Director of Maintenance (Employee F) in the conference room. The Director of Maintenance stated that nursing staff were responsible for submitting a requisition for wheelchair repairs. No further information was received.	F 584		

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F 600 F 600 SS=G	Continued From page 7 Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed for 1 resident (Resident #210) of 63 sampled residents to ensure that they were free of abuse and neglect. Resident #210 was abused by Resident #68, resulting in facial and scalp contusions and being rendered unconscious on the floor. This is harm for Resident #210. The Findings included: Resident #210 was a 69 year old who was admitted to the facility on 4/6/19 and expired at the facility on 6/10/19. Resident #210's diagnoses included Delirium, Dementia, Hypertension and Schizophrenia. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 4/13/19 was reviewed.	F 600 F 600	**F 600 Free from Abuse and Neglect** A. What actions will be accomplished for those residents found to have been affected by this practice? 1. Resident #210 received minor injuries and was sent to the hospital and was returned the same day. 2. Resident #86 had no adverse reactions related to the complaints from daughter. However, the nurse's note on the day mentioned, the staff addressed the resident's care, status, and lack of distress noted. Resident was admitted to the facility with a wound that has healed under the care of the facility staff.	

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F 600	Continued From page 8 Resident #210 was coded as having a Brief Interview of Mental Status Score of 0, indicating severe cognitive impairment. In addition, she was coded as requiring a walker for ambulation. Resident #68 was a 61 year old who was admitted to the facility on 12/31/16. His diagnoses included Anxiety Disorder, Wedge Compression Fracture of T 9-T 10 Vertebra Sequela, and Schizophrenia. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/4/19 was reviewed. Resident #68 was coded as having a Brief Interview of Mental Status Score of 5, indicating moderately impaired cognition. He was coded as being able to understand and be understood by others. According to his clinical record, Resident #68 had a history of inappropriate behaviors. A nurse's note dated 10/29/18 read, "Resident became verbally aggressive and stated,"If I knock the hell out of you, I can get out of here." An excerpt from a Progress Note dated 8/6/18 read, "resident exposed himself to the receptionist downstairs." On 7/23/19 a review was conducted of facility documentation, revealing an investigation of an altercation between Resident #210 and Resident #68. The witness statement, which was written by Registered Nurse D on behalf of Certified Nursing Assistant I was reviewed. Certified Nursing Assistant (CNA I) was the witness. An excerpt read, "I heard [Resident #68] ask [Resident #210] about 5 times to remove her hand off his wheelchair, and when she didn't that's when he hit her. I removed [Resident #68] from the site immediately. [Resident #210] was unresponsive for awhile."	F 600	B. How the facility will identify other residents having the potential to be affected by the same practice. 1. Residents residing in the center have the potential to be affected. A 100% audit will be conduct to review diagnosis and behaviors to ensure residents are appropriately assessed. 2. Residents residing in the center have the potential to have complaints; facility will continue to address concerns voiced. C. What measures will be put in to place or what systemic changes will be made. 1. The ED/Designee will conduct training on abuse. The re-education will be conducted focus on recognize signs agitation, burn-out, and reporting of the 7-types of abuse. D. How the facility plans to monitor its performance. 1. ED/Designee will conduct weekly random audits 3 x a week for 1month. The findings will be reported to QAPI committee for 2 months for further action plans as needed. 9/8/2019	

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F 600	Continued From page 9 On 7/24/19 an interview was conducted with CNA I in a second floor office. She stated that she thought that Resident #210 was unconscious for 2-3 minutes. She said, "He [Resident #68] hit her [Resident #210] because she had her hands on his wheelchair. He asked her several times to remove her hands from his wheelchair. She was known to be like that even with other residents, wandering in and out of their rooms. I removed him from the area and I yelled down the hall for someone to come. She laid on the floor for 2 or 3 minutes before anyone came to help her. It happened in the dining room on the secure unit." He [Resident #68] can be a handful to deal with. He is anxious, always talking loud at others." On 7/24/19 at 11:30 A.M. an interview was conducted in the conference room with Registered Nurse D, who conducted the investigation. She stated, "The CNA [CNA I] stated at the time that [Resident #68] hit [Resident #210], and that [Resident #210] was unresponsive on the floor for an unknown amount of time." A nurse's note dated 4/12/19 was reviewed. An excerpt read, "Resident [Resident #210] was holding the handle of another residents [Resident #68] wheelchair, the other resident asked her to leave his chair alone 2 x and then he hit her, resident lost her balance at that time and fell to the floor. Resident [#210] assessed and has a lump to the left side of forehead and complains of a headache. MD notified and resident is being sent to the ER [emergency room]." On 7/24/19 a review was conducted of facility documentation, revealing a hospital Discharge Summary dated 4/12/19. An excerpt read, "Facial	F 600		

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F 600	Continued From page 10 & Scalp Contusions. 1. Apply Ice packs, 2. take Tylenol 3. apply antibiotic cream" The follow-up report to the incident that occurred on 4/12/19 was reviewed. It read, "4/16/19. Findings: Upon completion of the investigation of the allegation of resident to resident abuse between [Resident #68], and [Resident #210], the facility is substantiating these allegations of abuse." In addition the report stated that Resident #68 was placed on 1:1 observation, and staff was educated regarding aggressive behaviors and interventions. On 7/24/19 an interview was conducted with the facility Administrator (Employee A) in the conference room. She stated that Resident #68's "arm went up in the air and hit her, he didn't intentionally do it." The Administrator was asked why then did the facility substantiated the allegation of abuse and put Resident #68 on 1:1 observation, as well as the other interventions, including staff education regarding managing aggressive behaviors. She stated, "...I would not have written it that way... ." The Physical Therapy notes were reviewed. Resident #68 was independent in bed mobility and being able to propel his wheelchair. There was no documentation in his record of a neurological disease that caused involuntary movements such as muscle spasms, twitches, jerking or writhing movements. On 7/24/19 at 3:00 P.M. an interview was conducted with the Director of Nursing (Employee B). When asked to state her understanding of the therapy notes, she stated, "His arms were fine	F 600		

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F 600	Continued From page 11 and had full strength." The facility Abuse, Neglect, Exploitation & Misappropriation Policy dated 11/28/17 was reviewed. An excerpt read, "It is inherent in the nature and dignity of each resident that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property." No further information was received.	F 600		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640	**F 640 SS-D Encoding/Transmitting Resident Assessments** 1. Resident # 94 suffered no adverse reactions from his admission modification assessment reference date of 6/4/2019 not being submitted to CMS timely. Resident # 94 admission modification assessment reference date of 6/4/2019 was submitted to CMS. 2. MDS/designee will review completed assessments for current residents in the facility with a focus to ensure MDS are submitted per RAI Guidelines. 3. ED/designee will re-educate the MDS department Registered Nurses to ensure that the MDS(s) are submitted to CMS per RAI guidelines. 4. MDS/designee will conduct a quality monitoring on 20 residents weekly x 4 weeks to ensure MDS(s) are submitted timely. Quality improvement monitoring findings to be reported to the QAPI committee for a period of 2 months for compliance and/or revisions. 9/8/2019	

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F 640	Continued From page 12 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed to transmit a Resident assessment to the CMS system for one Resident (Resident #94) in a survey sample of 63 Residents. The findings included: Resident #94 was admitted to the facility on 5/28/19. Resident #94's diagnoses included but were not limited to: schizophrenia, hypertension, vitamin D deficiency, and muscle weakness. Review of Resident #94's MDS (Minimum Data	F 640		

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F 640	Continued From page 13 Set) assessment history revealed a modification to the MDS with an ARD (assessment reference date) of 6/4/19, which was coded as an admission assessment. The correction/modification was completed on 7/2/19 as indicated on the MDS in section X1100E. The MDS modification, which was completed on 7/2/19, had not been transmitted to the CMS system as indicated by the electronic medical record, as of 7/25/19. On 7/25/19 at 9:45am an interview was conducted with RN A, the MDS Coordinator and she indicated they use the RAI (resident assessment instrument) manual as their policy and directive on when they complete MDS and transmit them to the CMS. On 7/25/19 at 12:40pm an interview was conducted with RN B, the MDS Director who stated, they have up to 7 days upon completion of an MDS to transmit it. She confirmed they go by the RAI manual. In the table on page 5-4 of the RAI manual, it indicated a MDS modification must be transmitted within 14 days of the X1100E date. No further information was provided.	F 640		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to	F 644	**F 644 SS- Coordination of PASARR and Assessment** A. What actions will be accomplished for those residents found to have been affected by this practice?	

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F 644	Continued From page 14 avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility staff failed to incorporate the recommendations from the PASARR level II into the careplan for one resident (Resident #94) in a survey sample of 63 residents. The findings included: Resident #94 was admitted to the facility on 5/28/19. Resident #94's diagnoses included but were not limited to: schizophrenia, hypertension, vitamin D deficiency, and muscle weakness. Review of the Level II PASARR (pre-admission screening and resident review) completed 4/8/19 revealed the following recommendations on page 4 of the document: "basic grooming, restorative nursing, psychiatric consultation, crisis intervention, psychotropic medication management, psychosocial rehabilitation, targeted case management."	F 644	1. Resident #94 suffered no adverse affects in relation to PASARR Level II not being completed and/or followed. B. How the facility will identify other residents having the potential to be affected by the same practice. 1. Facility will conduct an audit of residents' PASARRs to ensure accuracy and/or implementation. C. What measures will be put in to place or what systemic changes will be made. 1. MDS/SSD/Designee will ensure that the issues that lead to the failure to implement the specifications of Level II will not occur again. MDS/ SSD/ Designee will conduct random audits. D. How the facility plans to monitor its performance. 1. MDS/SSD/Designee will conduct weekly random audits 2 x a week for 1 month. The findings will be reported to QAPI committee for 2 months for further action plans as needed. 9/8/2019	

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F 644	Continued From page 15 Review of the careplan for Resident #94 revealed no mention of restorative nursing, psychiatric consultation, crisis intervention, psychosocial rehabilitation or targeted case management. Review of the entire clinical record for Resident #94 revealed no indication that the Resident was being followed by psychiatry or the CSB (community services board) for the recommended services. No further information was provided.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645	**F 645 SS-D PASARR Screening for MD & ID** 1. Resident's #43, #14, #75, and #26 had no adverse reaction from remaining in facility without having a PASARR prior to admission. Identified residents had a PASARR completed to reflect current diagnosis. 2. SSD/Designee will perform a quality review of resident's PASARR to ensure all resident's have PASARR on record. BDC will ensure that new residents have a PASARR completed prior to admission. 3. ED/designee will re-educate SSD/SSM/BDC on obtaining PASARR prior to admission. 4. SSD/BDC/Designee will perform quality audits to ensure new admissions have a complete PASARR prior to admission 3 xs per week for 1 month. Quality improvement monitoring findings to be reported to the QAPI committee for 2 months for compliance or revisions. 09/08/19	

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F 645	Continued From page 16 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an	F 645		

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F 645	Continued From page 17	F 645		

intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility staff interview, and clinical record review, the facility staff failed, for three residents (Resident #43, #14, #75) to obtain a Level 1 PASARR prior to admission to the facility.

The Findings included:

For Resident #43, the facility staff failed to obtain a Level 1 PASARR until approximately five months after admission.

Resident #43 was a 69-year-old who was admitted to the facility on 1/18/19. Resident #43's diagnoses included Epilepsy, Schizophrenia, Bipolar Disorder, and Major Depressive Disorder.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference date of 5/11/19 was reviewed. Resident #43 was coded as having a Brief Interview of Mental Status Score on 12, indicating mild cognitive impairment.

On 7/24/19 a review was conducted of Resident #43's clinical record, revealing a Level 1 PASARR that was dated 6/10/19. The Assessment was done by the facility Director of Social Services (Employee E).

On 7/24/19 at approximately 2:00 P.M., an interview was conducted with the Director of Social Services. When asked why the PASARR had not been obtained prior to admission, she

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F 645	Continued From page 18 stated. "We just realized it in a recent audit, then I completed one for the resident." No further information was received. 2. For Resident #14, the facility staff failed to ensure the Resident had a Level I PASARR screening prior to admission to the facility. Resident #14, a 57 year old woman admitted to the facility on 8/7/18 with diagnoses of but not limited to delusional disorder, anxiety disorder, Bipolar disorder, Diabetes, Major Depressive Disorder, Psychotic disorder with Hallucinations. Resident #14's most recent MDS dated 4/20/19 codes Resident #14 as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. On 7/24/19 doing the clinical record review it was discovered Resident # 14's PASARR Screening was dated 3/26/19. On 7/25/19 during an interview with Social Worker, employee E she stated "When we discovered that some Residents did not have PASARR's completed prior to admission we had to catch up on the ones who didn't have them." On 7/25/19 the facility Administrator was made aware and no further information was provided. 3. For Resident # 75, the facility staff failed to obtain a Level I PASARR screening prior to admission to the facility.	F 645		

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F 645	Continued From page 19 Resident #75, a 52 year old man admitted to the facility on 9/21/17 with diagnoses of but not limited to Seizure disorder, temporal sclerosis, Aphasia, cognitive communication deficit, Symbolic Dysfunction, Major Depressive Disorder, Anxiety Disorder, and injury of head. On 7/23/19 during clinical record review it was discovered that the Resident had a PASARR dated 6/11/19. On 7/25/19 during an interview with Social Worker, employee E she stated "When we discovered that some Residents did not have PASARR's completed prior to admission we had to catch up on the ones who didn't have them." On 7/25/19 the facility Administrator was made aware and no further information was provided.	F 645		
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 required under §483.24, §483.25 or §483.40; and	F 656	**F656 SS-E Develop/ Implement Comprehensive Care Plan** 1. Resident #113, #136, and #410 suffered no adverse effects from care plans not being patient centered or having measurable goals. Residents' #113 and #136 activity care plans were updated to reflect the resident's current social needs. Resident # 410 discharged from facility. 2. MDS/designee will review care plans for current residents in the facility with a focus to address activities social needs.	

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F 656	Continued From page 20 (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 observation, Resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to develop or implement a person-centered care plan for two residents (Resident #33 and Resident #113) in a survey sample of 63 Residents. The findings included: 1. For Resident #33, the facility staff failed to implement the care plan by providing assistance	F 656	3. MDS/designee will re-educate the activities department to enter the appropriate and specific interventions to address the residents' social needs for activities. 4. MDS/designee will conduct a quality monitoring on 20 residents weekly x 4 weeks for review of social needs during activities. Quality improvement monitoring findings to be reported to the QAPI committee for a period of 2 months for compliance and/or revisions. 9/8/2019	

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F 656	Continued From page 21 with transfers to prevent a fall. Resident #33 was admitted to the facility on 10/13/17. His diagnoses included but were not limited to: hemiplegia affecting left side. Resident #33's most recent MDS [minimum data set] [an assessment tool] with an ARD [assessment reference date] of 5/6/19 was coded as a quarterly assessment. Resident #33 was coded as requiring extensive assistance of two staff members for transfers. Resident #33 was evaluated by an occupational therapist on 4/17/19 and in the OT [occupational therapy] initial evaluation form, the following was noted: "transfers: maximal assistance; PLOF [prior level of functioning] maximal assistance." Also included in this document was the following: "Precautions include: Fall risk." On 7/23/19 during a review of Resident #33's nursing notes it was revealed an entry on 7/8/19 at 11:07pm that read, "resident was lowered to floor this shift, CNA stated that while transferring resident from his wheelchair to his bed, she lost her balance, no injuries were noted." On 7/24/19, when the Administrator was asked to provide the investigation for Resident #33's incidents for the month, the Administrator stated, "when he threw himself in the floor?" During review of the "Fall Root Cause Investigation Report" it was revealed that Resident #33 was listed with a transfer status of "stand & pivot" and was being "transferred to bed from wheelchair" with the assistance of one staff member. Under the "resolution/intervention for minimizing future occurrences: the following information was	F 656		

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F 656	Continued From page 22 written, "education on transfers and equipment." Review of the incident report dated 7/9/19 revealed Resident #33 was being assisted to bed by a stand and pivot transfer by one staff member. Review of Resident #33's careplan revealed a careplan that read "[Resident #33's name] has an ADL self-care performance deficit r/t [related to] hemiplegia, impaired balance, hx [history] stroke, pain, sickle cell disease, decreased ROM [range of motion] to L [left] upper and lower extremity. He req [sic] [requires] extensive to total assist with bed mobility, transfers..." Interventions read as follows: "hoyer lift times two staff members" with an initiation date of 2/7/19. Another intervention read, "requires mechanical lift with 2 staff assistance for transfers." No further information was provided. 2. For Resident #113, the facility staff failed to develop a care plan with measurable objectives and timeframes with regards to activities. Resident #113 was admitted to the facility on 1/9/19. Resident #113's diagnoses included but were not limited to: type 1 diabetes mellitus, hypertension, muscle weakness, and seizures. Review of Resident #113's careplan for activities read: "[Resident #113] is dependent for meeting emotional, intellectual, physical, and social needs r/t [related to] physical limitations." Review of the goal for Resident #113's activity	F 656		

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F 656	Continued From page 23 careplan read, "Staff will continue to encourage [Resident #113] to participate in group activities." On 7/25/19 at approximately 3:28pm an interview was conducted with Employee J, the Activities Director. When the Activities Director was asked to explain how the care plan goal is measured and the time frame for completion. The activities director stated, "I didn't put a time frame on there..." No further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657	**F 657 SS-D Care Plan timing and Revision** 1. Resident # 26 had no adverse effects from care plan not being revised with significant change related to weight loss. Resident #26 has a significant change assessment opened for an assessment reference date of 8/16/2019. 2. MDSC/designee will perform a quality review of current resident's with the IDT to ensure that significant changes will be conducted on residents the have significant changes in two or more areas. 3. ED/designee will re-educate Clinical and MDSC on completing significant changes when needed. 4. MDSC/designee will perform quality audits to ensure significant changes are completed when needed 5 x weeks for 4 weeks. Quality improvement monitoring findings to be reported to the QAPI Committee for a period of 2 months for compliance and/or revisions. 9/8/2019	

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F 657	Continued From page 24 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation the facility staff failed to review and revise the care plan to reflect changes for 1 Resident (#26) in a survey sample of 63 Residents. The findings included: For Resident #26 the facility staff failed to update care plan to include weight loss. Resident #26 a 66 year old man admitted to the facility on 7/29/15 with diagnoses of but not limited to cognitive communication deficit, major depressive disorder, bipolar disorder, and Hx (history) of stroke. Resident #26's last MDS (Minimum Data Set) dated 5/2/19 coded Resident as having a (Brief Interview of Mental Status) BIMS score of 11 indicating moderate cognitive impairment. On 7/25/19 during clinical record review it was discovered that Resident #26's care plan read: FOCUS: [Resident #26] is at risk for imbalanced nutrition & hydration d/t [due to] multiple comorbidities, Hx [history] of weight change, Hx of noncompliance with care plan, Hx of skin impairments, & p/u's [pressure ulcers], Hx of wt. change & smoker. Date initiated - 1/9/19 Revised - 3/14/19	F 657		

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F 657	Continued From page 25 GOAL: [Resident #26] will maintain adequate nutritional status as evidenced by maintaining weight w/o significant change through next review date. Date initiated: 1/4/19 Revision date: 7/18/19 INTERVENTIONS: Planned wt. loss - date initiated 4/30/19 Prepare and serve diet as ordered & according to resident's preferences- resident prefers mech. soft breakfast Date initiated- 1/4/19 RD to monitor and f/u as necessary Date initiated -1/4/19 Weigh as indicated- honor Resident right to refuse. Date initiated -1/4/19 According to the clinical record the Resident's weight went from 178.2 lbs. on 1/21/19 to 123 lbs. on 7/19/19. On 7/25/19 at 9:00 AM and interview was conducted with Unit Manager LPN B who stated the weights must be incorrect. Staff obtain new weight via mechanical lift scale and the weight was 143.0 on 7/25/19 at 9:30 AM, this represents a weight loss of 20% in 6 Months. After the Re-weighing of the Resident, an interview was conducted with Unit Manager LPN B who stated "He [Resident #26] was care planned for weight loss 4/30/19 but that changed on 7/18/19." When asked if the care plan was	F 657		

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F 657	Continued From page 26 reviewed and revised to reflect that change she stated that she felt it could have been more specific. On 7/25/19 the Administrator was notified of the findings and no further information was provided.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to provide an ongoing program to support Resident's choice of activities through facility-sponsored group, individual activities, and independent activities for one Resident (Resident #136) in a survey sample of 63 Residents. The findings included: Resident #136 was admitted to the facility on 12/4/18. Resident #136's diagnoses included but were not limited to: chronic embolism and thrombosis of unspecified deep veins of lower extremity, pain, major depressive disorder, insomnia, and spinal stenosis.	F 679	**F679 – Activities Meet Interest/ Needs Each Resident** A. What actions will be accomplished for those residents found to have been affected by this practice? 1. Resident #136 suffered no adverse effects in relation to participating in activities as the resident prefers to self direct. B. How the facility will identify other residents having the potential to be affected by the same practice. 1. Facility will conduct a 100% audit of current residents that self direct activities to ensure we offer some activities that meet their areas of interest.	

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F 679	Continued From page 27 Resident #136 was observed on numerous occasions (in excess of 6) during the survey period of 7/23/19-7/25/19 and was noted to be in bed, watching television each time. The only other forms of activity pursuits to be present were: a spiral notebook for writing and a cell phone. On 7/24/19 an interview was conducted with Resident #136 and he stated he doesn't attend the activities at the facility due to waiting on a wheel chair cushion that has been ordered. On 7/25/19 at 10:43am an interview was conducted with CNA B who stated "I've never seen him up and out of bed." Review of Resident #136's Activities Evaluation which was completed 12/4/18, indicated 14 areas of interest where the Resident liked small groups. Of those 14 areas 12 were coded as being very important to the Resident, they included but were not limited to: animals/pets, arts/crafts, bingo, board games, cooking, and educational programs. Review of Resident #136's careplan for activities read: "[Resident #136] is dependent for meeting emotional, intellectual, physical, and social needs." Review of the goal for Resident #136's activity careplan read, "The recreational team will continue to encourage [Resident #136] to participate in group activities." On 7/25/19 at 9:15am a request was made to provide copies of Resident #136's activity	F 679	C. What measures will be put in to place or what systemic changes will be made. 1. Activities Director/Designee will ensure that activities attempt to meet the needs of residents by assessing interest. D. How the facility plans to monitor its performance. 1. Activities Director/Designee will conduct weekly random audits of residents that self direct activities 2 x a week for 1 month. The findings will be reported to QAPI committee for 2 months for further action plans as needed. 9/8/2019	

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F 679	Continued From page 28 attendance. On 7/25/19 at approximately 11am an interview was conducted with Employee J, the activities director. Although a request had been made for Resident #136's activity attendance records, Employee J brought in the Resident's careplan and a progress note dated 4/16/19 which stated, "[Resident #136] is dependent for meeting emotional, intellectual, physical and social needs. He has a personal tablet and cell phone that he watches movies family bring [sic] in snacks for him at times, he has bags of food at bedside on night stand. He remains in bed most of the time." When asked about Resident #136's attendance in group activities, the activities director stated, "he refuses, I have it careplanned and in my notes." She was asked if they document his refusals and the activities director replied, "no and it's not a regulation that we have to." Another request was made to provide the survey team with documentation of Resident #136's activity attendance. Review of the facility policy titled, "Documentation/Participation Record" with a revision date of 5/29/19 read, "1. Participation records will provide a system for identifying residents to be targeted for each group according to the person-centered plan of care. 2. Participation will reflect each resident's attendance at specific programs and level of involvement (active, passive, refusal or inability to participate) in accordance with the resident's person-centered care plan." On 7/25/19 at 4:30pm at the conclusion of the survey, the facility provided no documentation	F 679		

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F 679	Continued From page 29 with regards to Resident #136 being offered any activity programing with regards to his previously stated interests other than television, cell phone and food. No further information was provided.	F 679	**F 689 Free from Accident Hazards /Supervision/Devices**	
F 689 SS=G	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 observation, resident interview, staff interview, facility documentation review, Hospital record review, and clinical record review, the facility staff failed ensure an accident and hazard free environment for 1 resident, (Residents #211) of 63 residents in the survey sample, resulting in harm. The findings included: 1. For Resident #211, the facility staff failed to supervise a Resident with a known exit seeking behavior, and failed to secure windows resulting in the Resident falling 10 feet from a window, and fracturing his neck. Resident #211, was admitted to the facility on 4-9-19. His diagnoses included a history of "head injury", from an assault with no fractures, chronic	F 689	1. Resident #211 was immediately sent to the hospital status post climbing out of the window for evaluation and treatment of any sustained injuries. The resident no longer resides in the facility. 2. Residents that reside in the facility have the potential to be affected; therefore, a quality review of the windows in resident common areas and resident rooms will be rechecked to ensure that the windows remain unable to open greater than 4 inches. Follow up based on findings 3. ED/designee will reinforce education for on ensuring windows remain unable to open greater than 4 inches. 4. ED/Designee will complete Quality Improvement Monitoring of windows to ensure that the windows remain unable to open greater than 4 inches 5xs weekly for 1 month. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations for 2 months. Monitoring schedule modified based on findings. 9/8/2019	

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F 689	Continued From page 30 blood clots, major depression, schizophrenia, bipolar disorder, hypertension, and seizures. Resident #211's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4-16-19 was coded as a full admission. Resident #211 was coded with a BIMS (Brief Interview of Mental Status) score of 7/15 which indicated moderate cognitive impairment. Resident #211 was coded as needing one staff limited assistance for dressing eating and hygiene, and only supervision for transferring, bed mobility and toileting. The Resident was independently ambulatory with a walker. The Director of Nursing (DON), and Administrator were asked for copies of all physician progress notes, nursing progress notes, the care plan, MDS, physician's orders, medication and treatment administration records, all assessments, social work notes, medical diagnosis sheet, face sheet, discharge summary, and any investigations for this Resident. The request was for all documents from the time of admission to the time of discharge. The documents were supplied, and the DON stated this is everything we have. A review of Resident #211's clinical record revealed nursing progress notes documenting that from 4-19-19, the Resident stated he wanted to move to another room, and was "agitated with his room mate". The notes stated the Resident was pacing in the hallway. On 4-24-19 the nursing note describes the Resident as making "false accusations", however, does not describe what those are, and "asks repeated questions about the same topics."	F 689		

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F 689	Continued From page 31 From the date of admission to the facility, the Resident's family, and the Resident, requested to be moved back to the tidewater area to be closer to his family. On 4-28-19 the family came to the facility and took the Resident on an outing at 11:30 a.m., and he returned at 2:00 p.m. At 10:30 p.m. that night the Resident stated he did not want his room mate and called his family and wanted to go to the hospital. Staff documented that they told him this was not a valid reason to go to the hospital, and they would pass the concern on to the day shift the next day. The next day on 4-29-19, the nursing notes documented that the Resident talked with his family several times, and that staff had referred him to have a psychiatric evaluation as he stated he was "Sad sometimes and wants to go home." Nursing notes documented the following: On 4-30-19 Resident was "agitated with room mate and not wanting to be in room. On phone with family throughout the evening. Has been pacing the hallway and sitting in the front lobby. Took belongings in a bag and carried them to the lobby. Encouraged to go back to room, but refused. Currently sitting in lobby with head phones on and eyes closed." At 10:00 p.m., that night the Resident refused his medications. On 5-1-19 at 2:30 p.m., the Resident refused to go to his room and sat in the lobby. At 6:30 p.m. that night the Resident was agitated and wanted to leave the facility, and was placed on 15 minute checks.	F 689		

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F 689	Continued From page 32 On 5-2-19 the resident refused his shower and stated he wanted to leave the facility. The Resident tried to exit the building at the beginning of the 3:00 p.m., to 11:00 p.m. shift and was stopped by an employee. The note also documented that the Resident stayed in the lobby "the majority of the shift". On 5-3-19 the Resident remained on 15 minute checks and was in the lobby at 7:43 a.m. At 7:26 p.m., the Resident was on 15 minute checks for "elopement risk" and the Resident was documented as "in the hallway for first half of shift", .and then after dinner took a shower and went to bed." Later that night, at 1:23 a.m., (5-4-19) "The Resident refused to sleep in his bed, and was sitting in the lobby, and stayed there all night until 6:00 a.m. when he went to bed. On 5-5-19 at 7:55 a.m., that the Resident was agitated and confused and sitting in the lobby on 15 minute elopement checks. At 8:19 p.m., the Resident was sitting in the lobby. At 9:30 p.m. the Resident had opened the window in the first floor day room and threw his walker, coat, and cell phone charger out of the window, and jumped out of the window himself. The staff found him on the ground in the shrubbery beneath the day room window. The Resident arrived via ambulance at the hospital emergency room at 10:22 p.m., and was diagnosed there with traumatic spinal cord injury requiring surgery, and resulted in the previously ambulatory Resident being paralyzed and Quadriplegic. After complications from the injury and surgery, the Resident received a tracheostomy in his neck to breathe, and a feeding tube, as the Resident could no longer eat.	F 689		

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F 689	Continued From page 33 Social work notes were reviewed and revealed no indication that the Resident had agitation, or exit seeking behaviors. There were only 4 notes in the clinical notes in the record and that documented that staff were aware that the family was involved with the Resident's care and that the family and the Resident wanted him moved closer to family. Physician progress notes were reviewed and revealed that the Resident was seen by the facility medical director's practice on 4-9-19, 4-11-19, 4-15-19, 4-19-19, and a last visit on 4-24-19. On 4-9-19 the physician's note documented "consult for psychiatry is indicated", due to diagnoses, and medications. The physician's notes all revealed documentation of no family involvement, no agitation, no anxiety, monitor for changes in mental status, and no depression. The note dated 4-15-19 documented "monitor him for falls and impulsive behavior." None of the physician notes indicated that the doctor was ever made aware of the Resident's agitation, statements of sadness, pacing, statements of wanting to go home, desire for a room change, agitation with the Resident's room mate, and exit seeking behaviors. The care plan was reviewed and revealed no care plan for the Resident's feelings of agitation, anxiety, sadness and wanting to move closer to family. No psychiatric evaluation was ever care planned or obtained, after the doctor stated in his progress note that it was indicated. Only 2 areas in the care plan address the Resident's desire to leave the facility, and those follow; 1. FOCUS: "Resident (name) has a behavior	F 689		

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F 689	Continued From page 34 problem related to bipolar and schizophrenia: history of refusing pneumonia vaccine, false accusations, repetitive questions, pacing the hallway, sitting in the front lobby with belongings, refuses showers." Initiated 4-16-19. The interventions were; "Administer medications as ordered. Monitor document for side effects. Anticipate and meet resident needs. Explain all procedures to the resident before starting and allow the resident to adjust to changes." 2. FOCUS: "Resident (name) is an elopement risk related to pacing the hallway, sitting in the front lobby, Taking belongings in a bag and carrying them to the lobby, 15 minute checks." Initiated 5-1-19. The interventions were; "Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, encourage to go back to room for rest/sleep." None of the care plan interventions for behaviors or elopement were ever documented as having been used except for returning the Resident to his room, and no behaviors were ever documented on the medication and administration records for the Resident's stay. A "Report of Resident Exit Seeking/Wandering:" "Missing from Facility", 5 page document was reviewed. The form revealed that the document was completed on 5-6-19, the day after the Resident exited from the window and fell. The document described the Resident as "observed outside in the landscape shrubbery beneath a window. Last known location lobby, No security alarm at facility, was assessment for exit seeking/wandering completed before this event yes, was an assessment for exit	F 689		

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F 689	Continued From page 35 seeking/wandering completed prior to this event no, an assessment for exit seeking/wandering was completed after this event, no resident monitoring device." The document goes on to say that the doctor and family were made aware of the fall from the window. On 7-24-19 at approximately 2 pm, interviews were conducted with two nursing the maintenance director. The interview with the unit 2 nursing staff revealed that the windows in the day room, at the end of that hall, were not screwed shut until the day after the Resident fell, and could be opened completely before he fell. They went on to say "how could a 200 pound grown man push a walker and himself out of a window that would not open." The interview with the maintenance director revealed that the windows were not screwed shut until the day after the Resident fell, as he stated "We put the screws in to keep the windows from opening immediately the next day after he fell." No social work support was evident, no monitoring device was applied, physician notes indicated the doctor was unaware of the Residents agitation, sadness, wandering, and exit seeking, supervision was insufficient, and even though the staff knew for many days that the Resident was wandering and exit seeking, the windows on the first floor day room were not made safe from elopement. The windows in the unit 2 day room were examined during survey, and revealed that the windows all had metal screws, screwed into the window frame, so that the windows could not be opened more than 4 inches.	F 689		

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	495327	A. BUILDING _____ B. WING _____	C 07/25/2019

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F 689	Continued From page 36 The facility Administrator and DON were made aware of the findings on 7-26-19. No further information was provided.	F 689		
F 690 SS=D	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 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	F 690	**F 690 Bowel/ Bladder Incontinence, Catheter, UTI** 1. Resident #28 suffered no adverse effects from Foley catheter bag touching the floor. Resident remains free of any signs or symptoms of infection at this time. 2. DON/designee will conduct 100% quality monitoring of residents with catheters to ensure that none are touching the floor. 3. DON/designee will re-educate nursing staff on the importance of the catheter not touching the floor and infection prevention methods. 4. DON/designee to complete Quality Improvement monitoring on catheters to ensure no violation of infection control are violated 3xs weekly for 30 days. Findings will be reported to the QAPI Committee for 2 months and updated as indicated. Quality monitoring schedule modified based on findings. 9/08/19	

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F 690	Continued From page 37 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed, for 1 residents (Resident #28) to operate in a manner to prevent infection. The Findings included: 1. For Resident #28, the facility staff failed to ensure that his catheter bag did not drag along the floor as he was being pushed down the hallway in his wheelchair. Resident #28 was a 72 year old who was admitted to the facility on 3/26/19. Resident #23's diagnoses included Unspecified Urethral Stricture, Retention of Urine, and Encounter for Attention to Cystostomy. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 5/16/19 was reviewed. It coded Resident #28 as having a Brief Interview of Mental Status Score of 7, indicating moderately impaired cognition. On 7/23/19 at 3:57 P.M. an observation was made of a facility staff member pushing Resident #28 down the hallway with his catheter bag dragging along the floor. The staff person was dressed in a blue uniform like the other female Certified Nursing Assistants. She very quickly left Resident #28 before she could be identified. Another CNA (CNA G) stated that she wanted to assist Resident #28. She discreetly pointed to the catheter bag and stated, "His catheter is on the	F 690		

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F 690	Continued From page 38 floor. It's a health issue because he wanders all over and there are germs all over the floor." On 7/24/19 a review was conducted of Resident #28's clinical record, revealing a care plan. An excerpt from the care plan read, "4/4/19. Suprapubic Catheter d/t [due to] Obstruction Urapathy and Urinary Obstruction. Change catheter bag as needed. To wear leg bag during the day when out of bed as tolerated." On 7/24/19 a review was conducted of facility documentation, revealing a Catheter Care Policy dated 9/5/17. An excerpt read, "Reattach catheter securement device. Return to proper place. Perform hand hygiene." No further information was received.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure oxygen was administered as ordered for one Resident (Resident #30) in a survey sample of 63 Residents.	F 695	**F 695 SS-D Respiratory/ Tracheostomy Care and Suctioning** 1. Resident #30 suffered no adverse reactions from oxygen not being on the correct settings per MD order. The settings were corrected following order validation. Resident remains stable at present time. 2. Residents that reside in the facility receiving oxygen have the potential to be affected; therefore, a 100% quality review of residents receiving oxygen has been conducted to ensure oxygen is being administered per MD order. Follow up based on findings.	

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F 695	Continued From page 39 The findings included: Resident #30 was not receiving oxygen on 7-23-19, and 7-24-19 per the physician's order. Resident #30 was admitted to the facility on 7-15-19, and was a new admission and had only been in the facility 8 days. Diagnoses included; Acute and chronic respiratory failure with hypoxia, COPD/ chronic obstructive pulmonary disease, diabetes, diabetes, anxiety, hypertension and shortness of breath. Resident #30's most recent Minimum Data Set Assessment was in progress, however, the Resident was interviewed and found to be alert, and oriented to; person, place, time, and situation. The Resident was able to make all of his needs known. The Resident was in a wheel chair and required assistance from staff for all activities of daily living (ADLs) care. Resident #30 was first observed on 7-23-19 during initial tour of the facility at approximately 11:45 a.m. in his room laying on his back with one leg amputated above the knee, in a low bed, with an oxygen concentrator approximately 6 feet from him infusing oxygen. The resident was interviewed and stated he was tired and weak, and he felt that his oxygen didn't feel like it was on. The oxygen concentrator was plugged in and turned on, and was infusing via a nasal cannula at 0.5 liters per minute. The corporate registered nurse was called into the room and asked to look at the oxygen and find out what the physician's order was for the Resident's infusion She looked at the oxygen and stated "this is not right, he has an order for 2 liters per minute I think, I will find out." She returned to the room and corrected the	F 695	3. DON/designee will educate nursing staff on following MD orders to include oxygen administration. 4. DON/designee to complete Quality Improvement Monitoring to ensure oxygen is being administered per MD order 5x a weekly for 1 month. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations for 2 months. Monitoring schedule modified based on findings. 9/08/19	

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F 695	Continued From page 40 flow meter to read 2 liters per minute, as per the order. On 7-24-19 at 3:00 p.m., the Resident was again observed, in the hallway in a wheel chair with a portable oxygen tank, and he stated "my oxygen is out, can you help me?" The tank was inspected, and was indeed empty. he stated he had told a nurse and she said she would get him a tank. A second surveyor was standing in the hallway observing and stated she had been timing the situation, which was now at 15 minutes since the Resident ran out of oxygen. The 2 surveyors approached the nursing station on the unit 1 hall and the nurse stated she was waiting for an oxygen carrying cart. The cart arrived after about 5 minutes and within 10 minutes more the new tank was being applied. The Resident did not exhibit shortness of breath, pallor, nor symptoms of oxygen deprivation. A pulse oximeter was applied to the Resident who registered an SP02 of 93% on the device, which was low. Review of the physician's orders revealed an order for continuous oxygen at 2 liters per minute via nasal cannula. On 7-24-19 The Director of Nursing was made aware of findings. No further information was provided by the facility.	F 695		
F 755 SS=E	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	F 755	**F 755 SS-E Pharmacy Services/ Procedures/Pharmacist Records** 1. Residents #28, #108, #154, #145, #88, and #61 suffered no adverse effects related to the narcotic sheet not being signed off at the time of medication administration.	

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F 755	Continued From page 41 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an accurate record of controlled medications for 6 residents (Resident #28, Resident #108, Resident #154, Resident #145, Resident #88, and Resident #61) in a survey sample of 63 Residents. The findings included. For Resident #28, Resident #108, Resident #154,	F 755	2. DON/designee will conduct 100% quality monitoring of narcotic sheets signed off during medication pass, as residents receiving narcotic medication have the potential to be affected. Follow up will be conducted based on the findings. 3. DON/designee will re-educate nurses on the guidelines to medication administration guidelines. 4. DON/designee to complete Quality Improvement monitoring on signing narcotic sheets at the time of administration 3 x week for 30 days. Finding will be reported to the QAPI Committee monthly and updated as indicated for 2 months. Quality monitoring schedule modified based on findings. 9/08/19	

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F 755	Continued From page 42 Resident #145, Resident #88, and Resident #61, the facility staff failed to maintain an accurate account of controlled medications. On 7/23/19 at approximately 12:30, an inventory of controlled medication was conducted on the medication cart located on Wing 3 and assigned to LPN A. The Controlled Medication Utilization Record was compared to the actual medication count and there were a total of 7 discrepancies found as follows: Resident #28, lorazepam, count per record=18, actual count=17 Resident #108, gabapentin, count per record=29, actual count=28 Resident #154, Lyrica, count per record=11, actual count=10 and Vimpat, count per record=10, actual count=9 Resident #145, lorazepam, count per record=44, actual count=43 Resident #88, lorazepam, count per record=6, actual count=5 Resident #61, lorazepam, count per record=9, actual count=8 LPN A confirmed she was the medication nurse responsible for these Resident's and stated, "I passed these [medications] at 9 this morning, I just didn't mark them off in the book, I know I should have, do you want me to do that right now?". An interview was conducted with LPN B, Charge Nurse for Wing 3 and she stated, "When you pull it [the controlled medication], you sign it, you mark it off the inventory immediately to show an accurate count".	F 755		

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F 755	Continued From page 43 The Facility Administrator (Employee A) was informed and no further information was received.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758	**F 758 SS-D Free From Unnecessary Psychotropic Med/PRN Use** 1. Resident #75 suffered no adverse effects from having PRN psychotropic/ antianxiety medication ordered for >14 days. Resident received only one PRN dose of medication during the month, per the review. No adverse reactions were noted. 2. DON/designee will conduct a 100% quality review of residents receiving PRN antianxiety medications. Discrepancies noted will be followed up with a notification to the physician for clarification and implementation of new orders, as given. 3. DON/designee provided re-education to ~~all~~ licensed nurses on PRN anti-anxiety medications being ordered for 14 days or less. 4. DON/designee to complete Quality Improvement monitoring on medication orders for appropriate time frame. Monitoring will be conducted 5 x weekly for 1 month. Finding will be reported to the QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 9/08/19	

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F 758	Continued From page 44 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview clinical record review and facility documentation the facility staff failed to ensure 1 Resident (# 75) in a survey sample of 63 Residents received as needed (PRN) Psychotropics medication for no more than 14 days. The findings included: For Resident #75 the facility staff failed to ensure that he was free from unnecessary Psychotropics and ordering an as needed (PRN) medication for more than 14 days. Resident #75, a 52 year old man admitted to the facility on 9/21/17 with diagnoses of but not limited to Seizure disorder, temporal sclerosis, Aphasia, cognitive communication deficit, Symbolic Dysfunction, Major Depressive Disorder, Anxiety Disorder, and injury of head. On 7/25/19 during clinical record review it was noted that Resident # 75 had the following orders	F 758		

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F 758	Continued From page 45 written on his (Medication Administration Record) MAR. Lorazepam (Generic for ATIVAN-an Anti-Anxiety) Intensol Concentrate 2 mg/ ml give 1 ML every 2 hours as needed for anxiety :Start date 5/21/19 give until 7/23/19 Lorazepam solution Intramuscularly 2 mg/ ml give 1 ML every 2 hours as needed for seizures Start date 5/21/19 give until 7/23/19 Both of the Lorazepam orders were Re-Ordered on 7/23/19 as follows: Lorazepam Intensol Concentrate 2 mg/ ml give 1 ML every 2 hours as needed for anxiety give until 11/21/19 Start date 7/23/19 Lorazepam solution Intramuscularly 2 mg/ ml give 1 ML every 2 hours as needed for seizures give until 11/21/19. Start date 7/23/19 On 7/25/19 at 3:07 PM an interview was conducted with the DON. When asked if she was aware of the regulation on 14 day limit for PRN Psychotropic medications including anti-anxiety medications like Lorazepam she stated "I understand the 14 days and I have addressed it with him. Because of this patients history he gave what he gave." According to the Facility " Medication Management Psychotropic Medications Policy" Page 1-Procedure #7 - PRN physician order(s) for psychotropic medications are limited to 14 days. Except if the	F 758		

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F 758	Continued From page 46 physician or prescribing practitioner believes that it is appropriate to extend beyond 14 days and documents the rationale in the medical record. The administrator was made aware and no further information was provided.	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to distribute food in a sanitary manner on one unit in a survey sample of four units. The findings included: On 07/24/19 at 08:59 AM CNA B and CNA C	F 812	**F 812 Food Procurement, Storage/ Prepare/Serve-Sanitary** 1. No residents were affected by the unlabeled, untested, requested test tray being left on the tray cart with other trays. This tray was not assigned to a resident. 2. DON/designee will conduct quality monitoring rounds to ensure sanitation is maintained during tray delivery. 3. DON/designee will re-educate employees to ensure that there are no trays returned to carts containing clean trays. 4. DON/designee will conduct quality monitoring review during meal service to ensure proper food handling and sanitation is maintained 3xs a week for 1 month. Quality improvement monitoring findings to be reported to the QAPI committee for a period of 2 months for compliance and/or revisions. 9/8/2019	

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F 812	Continued From page 47 were both observed going into Resident's rooms, removing breakfast trays and bringing them into the hall of the 200 unit and placing the used trays onto the rack; which still contained trays of food that Residents had not been served yet. On 07/24/19 at 09:02 AM CNA A removed the uneaten/unserved tray off the rack and took it to the Resident in room 215. No further information was provided.	F 812		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a functional call system for 2 of 4 nurses stations (affecting 21 of 76 resident rooms) and 1 of 63 residents (Resident #33) who resided on the 200 unit. The findings included: 1. The call system operated intermittently in the nursing stations. An assessment of the Resident call system was conducted on 7/25/2019. Resident call systems are designed to provide a means of rapid	F 919	**F919 – Resident Call System** A. What actions will be accomplished for those residents found to have been affected by this practice? 1. Residents suffered no adverse affects in relation to the call system not functioning. B. How the facility will identify other residents having the potential to be affected by the same practice. 1. Facility will conduct a 100% audit of the call bell system to ensure functionality.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 48 communication between residents and staff members in case of an emergency or otherwise. Call systems usually provide a light over residents' doors to alert staff walking in the hallways. There is also a central panel at each nursing station which tells staff where the alarm is coming from. A chime of buzzer will sound when a call bell is activated. On 7/25/2019 an interview was conducted with Employee A, Administrator who stated that the call bell system was installed in 1972 and it is difficult to find someone to fix it. It was noted that the system was not a wireless system, but uses wires that run through the ceiling making diagnosis and repair difficult if not impossible. In all nursing stations the call bell box is located approximately 3 feet above the desk where a nurse would sit. It is not located in a place where the alarm would be easily seen. In the nursing station outside the memory unit, the lights over residents' doors would come on when the call bell was activated in all rooms. There were no chimes activated and the lights at the box in the nurses' station were inoperative. Lights outside rooms 101 and 109 were not operable. Chimes did not work at this panel in the nurses' station. All lights worked on Wing 1, but there was no audible chime when the call bell was activated, thus staff would not be quickly alerted to a resident problem.	F 919	C. What measures will be put in to place or what systemic changes will be made. 1. Maintenance Director/Designee will ensure that the call bell system is functioning properly to meet the needs of residents. D. How the facility plans to monitor its performance. 1. Maintenance Director/Designee will conduct weekly random audits 2xs a week for 1month. The findings will be reported to QAPI committee for 2 months for further action plans as needed. 9/8/2019	

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F 919	Continued From page 49	F 919		

2. Resident #33's call light didn't indicate it was on at the nursing station or outside of the door.

On 07/24/19 at 09:55 AM during an interview with Resident #33, the Resident stated his call bell didn't work. This writer, Surveyor E, was accompanied by Surveyor G, to the room of Resident #33. The call light was activated and it didn't indicate it was on at the nursing station or outside of the door.

At the nursing station was LPN E and she stated they could hear an auditory alarm and knew it was Resident #33's room because it has been like that for a while.

On 7/24/19 at approximately 10:00am review of the maintenance work order book revealed no repair requisition for the room of Resident #33 to notify maintenance of the light not working.

On 7/24/19 at 10:30am an interview was conducted with the Maintenance Director, Employee F. The maintenance director stated, "they are passing out cow bells now, I am aware of problem, I just hadn't made it upstairs to fix it yet."

Review of the facility policy titled "Maintenance" stated, "the facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair."

No further information was provided.