STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NASSAWADOX	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/04/19 through 08/08/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/4/19 through 8/8/19. An extended survey was conducted on 8/6/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during survey. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 134 at the time of the survey. The standard survey sample consisted of 48 current resident reviews and 8 closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical	F 557	**F557** **Corrective Action(s):** Resident #124 is now draped in the appropriate fashion to prevent body exposure during the provision of care and treatment. L.P.N. #9 and C.N.A. #6 were inserviced on maintaining resident dignity and privacy during the provision of care and treatment. This includes proper precautions to prevent body exposure during care. A facility Incident & Accident form was completed for this incident.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Susan Parks Administrator 8/28/19

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F 557	Continued From page 1	F 557		

record review and facility document review the facility staff failed to provide draping to prevent exposure of body parts and maintain dignity during the provision of care for 1 of 56 residents in the survey sample, Resident #124.

The findings include:

Resident #124 was admitted to the facility on 9/20/18 with diagnoses to include but not limited to, stroke and diabetes. The current MDS (Minimum Data Set) an annual with an assessment reference date of 7/1/19 assessed the resident as having long and short term memory deficits. The resident required extensive assistance of two staff for bed mobility and was dependent for transfers. Under section M. Skin Conditions the resident was coded as having a stage IV pressure injury (defined in the MDS as-full thickness tissue loss with exposed bone, tendon, or muscle. Slough, eschar may be present on some parts of the wound bed).

On 8/7/19 at 12:33 p.m., an observation of the sacral dressing change was conducted. The facility wound nurse (Licensed Practical Nurse-LPN #9) preformed the dressing change with Certified Nursing Assistant (CNA #6) providing assistance with maintaining the resident on her side. Upon the surveyor entering the room, the resident was in the bed, laying on her right side and completely naked. The CNA stated she had just provided incontinent care to the resident. The curtains were not completely closed facing the B bed side, the roommate was not in the room at the time, and the door was left open. During the dressing change the resident stated, "my hiney"...the CNA stated, "you got enough people seeing your hiney..." A staff member

Identification of Deficient Practices & Corrective Action(s):
All other residents receiving wound care may have potentially been affected. The DON, ADON and/or unit managers will conduct 100% audit of all residents receiving wound care to identify residents at risk. Any/all negative findings identified will be corrected at the time of discovery. An Incident and Accident form will be completed for each negative finding.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes warranted at this time. All nursing staff will be inserviced by the DON and/or social services director on maintaining resident dignity and privacy during the provision of care and treatment. To include maintaining dignity and privacy during wound care and preventing exposure of unnecessary body parts.

Monitoring:
The wound Care Nurse is responsible for maintaining compliance. DON and/or Unit Managers will complete 3 random weekly treatment audits to monitor for compliance. Any negative findings will be corrective at time of discovery and disciplinary action will be taken as required. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.
Completion Date: 9/20/19

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F 557	Continued From page 2	F 557		

knocked on the door and the resident stated, "no men." The resident remained naked during the course of the dressing change which lasted approximately 20 minutes. After the dressing change, CNA #6 was interviewed. She was asked why the resident was not provided draping/covering to prevent exposure of body parts during the dressing change. The CNA stated, "I wasn't thinking."

On 8/8/19 at 9:47 a.m., the observation concern of the resident not being provided draping during the dressing change was shared with the wound nurse. The wound nurse stated "She usually has a gown on...she should have had a sheet covering her," when asked why she stated, "Dignity."

8/8/19 at 12:48 p.m., the resident was observed eating lunch in bed. She was asked if it would be okay if I asked her a question, her response was, "I hope I can answer it." The resident was then asked how she felt being left completely naked yesterday during the dressing change, she stated, "I didn't like being naked."

On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing (DON). The DON stated, "I definitely don't think that is a common practice, she should have have taken a sheet and covered the resident."

The facility policy titled Quality of Life-Dignity revised August 2016 read, in part:
Policy Statement-Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.
Policy Interpretation and Implementation:

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F 557	Continued From page 3 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during the assistance with personal care and during treatment procedures.	F 557		
F 584 SS=D	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. 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;	F 584	**F584** **Corrective Action(s):** Resident #78's Broda Chair has been replaced. A facility Incident and Accident form was completed for this incident.	

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F 584	Continued From page 4 §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, staff interview, and clinical record review the facility staff failed to ensure medical equipment was maintained in good repair for 1 of 56 residents in the survey sample, Resident #78. Resident #78's mobility chair was observed to have areas that were ripped, torn and a piece of the foam arm rest was missing. The findings include: Resident #78 was admitted to the facility on 2/20/14 with diagnoses to include but not limited to, seizures, traumatic brain injury, and spastic hemiplegia (Spastic hemiplegia is a neuromuscular condition of spasticity that results in the muscles on one side of the body being in a constant state of contraction) affecting the right side. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 6/11/19 coded the resident as scoring a 12 out of a 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had moderately impaired cognition. The resident required extensive assistance of two staff for bed mobility and transfers. The resident was chair bound. Based on the Resident's abnormal posture and for the prevention of falls the resident was ordered a Broda chair (a seating, positional	F 584	**Identification of Deficient Practice(s) and Corrective Action(s):** All other resident wheelchairs may have potentially been affected. A complete documented environmental review of all facility wheelchairs will be conducted by the administrator, and/or Maintenance Director to identify any resident wheelchairs in need of cleaning and/or repair/replaced. All resident wheelchairs identified as needed repairs or replaced will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director and/or Environmental Director will provide inservices to all staff on facility policy and procedure on the notification system to use when cleaning and/or repairs are needed to facility and resident equipment throughout the facility. **Monitoring:** The Administrator and Maintenance Director are responsible for maintaining compliance. Documented wheelchair rounds will be completed weekly to monitor compliance. The administrator will review the wheelchair audits weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date: 9/20/19**	

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F 584	Continued From page 5 mobile chair). On the initial tour of the right side unit on 8/4/19 and at 4:29 p.m., the resident was observed sitting up in the Broda chair at the bedside. The chair was observed as follows: the left side vinyl panel was ripped and torn, the right adjustable wing for upper lateral support had multiple cracked areas in the vinyl located in proximity of where the resident face can make contact, and the right black foam arm rest was missing a piece that had been torn/ripped off measuring approximately 1.5 inches by 2 inches. The resident was observed sitting in the Broda chair each of the following days of the survey 8/5/19, 8/6/19 and 8/7/19, the Broda chair remained in the same condition. On 8/7/19 at 10:55 a.m., the right side unit manager was interviewed. She was asked about Resident #78's Broda chair in need of repair. She stated she was not made aware of it. She stated if medical equipment needs repair the request is placed into the maintenance computer system named TELS or sent to the therapy department depending on what is needed, she stated, "I can't always get into that system (TELS), so then I just tell them (maintenance)." She was asked to accompany this surveyor to the resident's room to look at the Broda chair. After noting the areas she stated to the resident, "Looks like you'll be getting a new chair." On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing. The Administrator stated, "...we do have additional Broda chairs." She stated she would have expected the front line staff to have informed the	F 584		

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F 584	Continued From page 6 unit manager. No additional information was provided to the survey team prior to exit.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, it was determined that the facility failed to develop and implement an abuse policy to include conducting a reference screening for one (1) prospective employee out of 25 records reviewed. Review of personnel records obtained from facility revealed that no verification of reference screenings was conducted for a current employee, Certified Nursing Assistant (CNA) #9. The findings included: On 8/8/2019 at approximately 1:20 p.m., the Human Resource (HR) Director was asked to provide evidence of reference screenings for CNA #9. The HR Director stated, "I don't have one for her" and "I was not working here then."	F 607	**F607** **Corrective Action(s):** C.N. A. #9 has had their reference check forms reviewed by the HR director and all references have been obtained. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other employees may have been potentially affected. The Human Resources department will audit 100% of all active employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident Report will be completed for any/all negative findings.	

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F 607	Continued From page 7 Facility policy on Abuse Prevention Program documented in part, the following: "...2. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, or exploitation, mistreatment of residents or misappropriation of resident property." Facility policy did not incorporate procedures for prospective employee reference checks.	F 607	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. Administrative Staff, Department Managers and the HR department will be inserviced on the policy & procedure regarding abuse prevention and pre-employment procedures by the Administrator. Administrative Staff and Department Heads extending employment without meeting the requirements of the facility policy & procedure will receive disciplinary action. Perspective employees will not be allowed to work until all required documentation has been obtained and reviewed by the appropriate department manager. **Monitoring:** The Human Resources Manager is responsible for maintaining compliance. The Human Resources Director and/or designee will conduct monthly audits of all new hire employee files for each month to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 9/20/19**	
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622	**F622** **Corrective Action(s):** The facility staff failed to ensure the comprehensive care plan goals were submitted to the receiving hospital for Residents #101 on 1/18/19, 3/25/19, 7/18/19 and 7/21/19 when transferred to the hospital. A facility Incident & Accident Form has been completed for these incidents.	

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F 622	Continued From page 8 endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record	F 622	The facility staff failed to ensure the comprehensive care plan goals were submitted to the receiving hospital for Residents #61 on 2/11/19 when transferred to the hospital. A facility Incident & Accident Form has been completed for these incidents. The facility staff failed to provide the receiving Hospital with contact information for the attending physician, contact information for the Resident Representative, Advance directive information, or comprehensive care plan goals for Resident #128 on 6/1/19, 6/16/19, and 6/21/19. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The DON, ADON and/or Unit Managers will conduct a 100% audit of all residents who have been discharged and/or transferred from the facility in the past 30 days to identify residents that did not have the required documentation submitted to the receiving facility. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice facility licensed staff on the documentation required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outside health care facility.	

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F 622	Continued From page 9 must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and facility document review, the facility staff failed to send the comprehensive care plan goals upon transfer to the hospital for 3 of 56 residents in the survey sample (Residents #101, #61, and #128).	F 622	**Monitoring:** The DON/designee will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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F 622	Continued From page 10	F 622		

The findings included:

1. Resident #101 was originally admitted to the facility on 2/28/14 and was re-admitted on 7/30/19 with diagnoses to include but not limited to Functional Quadriplegia and End Stage Renal Disease.

Resident #101's most recent Minimum Data Set (MDS) is a Quarterly with an Assessment Date (ARD) of 6/20/19. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #101 is cognitively intact and capable of daily decision making.

Resident #101's Detail Discharge Report was review and is documented in part, as follows:
1/18/19 Discharge to Hospital.
3/25/19 Discharge to Hospital.
5/7/19 Discharge to Hospital.
7/18/19 Discharge to Hospital.
7/21/19 Discharge to Hospital.
7/26/19 Discharge to Hospital.

A medical record review indicated no documentation that comprehensive care plan goals were sent on 1/18/19, 3/25/19, 7/18/19, and 7/21/19 upon Resident #101's transfers to the hospital.

On 8/8/19 at 11:30 A.M. an interview was conducted with the Director of Nursing regarding Resident #101's comprehensive care plan goals not being sent upon transfer to the hospital. The Director of Nursing stated, "The care plan is a part of the Transfer Discharge Summary in the computer and I cannot find documentation for these dates. I was not aware that we had to

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HERITAGE HALL NASSAWADOX	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

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document that the care plan goals were sent when we send a resident out."

On 8/7/19 at 3:00 a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

2. Resident #61 was admitted to the facility on 08/20/12 and readmitted to the facility on 02/14/19. Diagnoses for Resident #61 included but not limited to Alzheimer's disease and anxiety disorder.

The current Minimum Data Set (MDS), was a discharge assessment with an Assessment Reference Date (ARD) of 02/11/19. Staff assessment of mental status coded the resident as having short term memory problems.

The Discharge MDS assessments was dated for 02/11/19 - discharge return anticipated; re-admitted to the facility on 02/14/19.

On 02/11/19, according to the facility's documentation, "EMS (Emergency Medical Services) exited the facility with (Resident #61) for transport to the hospital."

On 08/08/19 the policy entitled Transfer or Discharge, Emergency was reviewed and included the following:
Policy Statement: Emergency Transfers or discharges may be necessary to protect the health and/or well being of the residents. Policy Interpretation and Implementation: #4 Reads: Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement

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the following procedures: Prepare a transfer form to send with the resident.

On 08/08/19 at approximately 3:00 PM a pre-exit interview was conducted with the Administrator and Director of Nursing they were informed of the above findings. They were asked what should have been done? The DON commented, "We send the care plan but we were not documenting it in the nurses note."

3. Resident #128 was admitted to the facility on 6/4/2018, with transfers to the hospital occurring on 6/1/2019, 6/16/2019 6/21/2019 and 7/21/2019. Diagnoses included, but not limited to, type 2 diabetes mellitus with diabetic neuropathy, diastolic heart failure, respiratory failure with hypoxia, stage 4--chronic kidney disease, hypokalemia, chronic ischemic heart disease, pseudocyst of pancreas, and morbid obesity.

Resident #128's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/9/19. Resident #128 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam.

There was no evidence that the required documentation; physician contact information, responsible party contact information, advanced directives, or the care plan goals were sent with the resident at the time of transfer on 6/1/2019, 6/16/2019, and 6/21/2019.

On 8/8/2019 at approximately 3:20 p.m. an interview was conducted with ASM (administrative staff member) #3, the ADON (Assistant Director

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of Nursing), requesting evidence, upon transfer, of advanced directives, instructions for ongoing care, care plan goals physician contact information, responsible party information; yielded a transfer summary for a hospital transfer that occurred on 7/21/2019.

There was no additional documentation submitted by ASM #3. Additionally, clinical record reviews conducted yielded no evidence that the referenced, required information was sent upon transfer to the hospital on 6/1/2019, 6/16/2019, and 6/21/2019.

Heritage Hall policy on Transfer or Discharge Documentation (revised December 2016) includes:

(4) When a resident is transferred or discharged from the facility, the following information will be documented in the medical record:
a. The basis for the transfer or discharge;
(1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include:
(a) the specific resident needs that cannot be met;
(b) this facility's attempt to meet those needs; and
(c) the receiving facility's service(s) that are available to meet those needs.
b. That an appropriate notice was provided to the resident and/or legal representative;
c. The date and time of the transfer or discharge;
d. The new location of the resident;
e. The mode of transportation;
f. A summary of the resident's overall medical, physical, and mental condition;
g. Disposition of personal effects;
h. Disposition of medications;

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F 622	Continued From page 14 i. Others as appropriate or as necessary; and j. The signature of the person recording the data in the medical record. 7. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: a. The basis for transfer or discharge; (1) If the resident is being transferred or discharge because his or her needs cannot be met at the facility, documentation will include: (a) the specific resident needs that cannot be met; (b) this facility's attempt to meet those needs; and (c) the receiving facility's service(s) that are available to meet those needs. b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance Directive information; e. All special instructions or precautions for ongoing care, as appropriate; f. Comprehensive care plan goals; and g. All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625	**F625** **Corrective Action(s):** Resident #101 and their RP have been notified that the facility failed to review and offer notice of bed-hold when Resident #101was transferred to the hospital on 1/18/19, 3/25/19, 5/7/19, 7/18/19, 7/21/19, and 7/26/19. An Incident and Accident form has been completed for this resident.	

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F 625	Continued From page 15 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and facility document review the facility staff failed to send Bed Hold Notices upon transfer to the hospital for 4 of 56 residents in the survey sample, Residents #101, #61, #129 and #128. The findings included: 1. Resident #101 was originally admitted to the facility on 2/28/14 and was re-admitted on 7/30/19 with diagnoses to include but not limited to Functional Quadriplegia and End Stage Renal Disease. Resident #101's most recent Minimum Data Set	F 625	Resident #61 and their RP have been notified that the facility failed to review and offer notice of bed-hold when Resident #61 was transferred to the hospital on 2/11/19. An Incident and Accident form has been completed for this resident. Resident #129 and their RP have been notified that the facility failed to review and offer notice of bed-hold when Resident #129 was transferred to the hospital on 7/28/19. An Incident and Accident form has been completed for this resident. Resident #128 and their RP have been notified that the facility failed to review and offer notice of bed-hold when Resident #128 was transferred to the hospital on 6/1/19, 6/16/19, 6/21/19, and 7/21/19. An Incident and Accident form has been completed for this resident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed staff have been inservicedby the administrator and/or Social Services director on the bed-hold requirement and the proper use and notification of the Bed-Hold policy.	

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F 625	Continued From page 16 (MDS) is a Quarterly with an Assessment Date (ARD) of 6/20/19. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #101 is cognitively intact and capable of daily decision making. Resident #101's Detail Discharge Report was review and is documented in part, as follows: 1/18/19 Discharge to Hospital. 3/25/19 Discharge to Hospital. 5/7/19 Discharge to Hospital. 7/18/19 Discharge to Hospital. 7/21/19 Discharge to Hospital. 7/26/19 Discharge to Hospital. A medical record review indicated no documentation that Bed Hold Notices were sent on 1/18/19, 3/25/19, 5/7/19, 7/18/19, 7/21/19 and 7/26/19 upon Resident #101's transfers to the hospital. On 8/8/19 at 11:30 A.M. an interview was conducted with the Director of Nursing regarding Resident #101's Bed Hold Notices not being sent upon transfer to the hospital on 1/18/19, 3/25/19, 5/7/19 7/18/19, 7/21/19 and 7/26/19. The Director of Nursing stated, "Our Bed Hold Notice is in our green transfer packet that we sent with the resident on discharge. I was not aware that we had to document that the Bed Hold Notice was sent when we send a resident out." On 8/7/19 at 3:00 a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided. 2. Resident #61 was admitted to the facility on 08/20/12 and readmitted to the facility on	F 625	**Monitoring:** The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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02/14/19. Diagnoses for Resident #61 included but not limited to, Alzheimer's disease and Anxiety Disorder.

The current Minimum Data Set (MDS), was a discharged assessment with an Assessment Reference Date (ARD) of 02/11/19. Staff assessment of mental status coded the resident as having short term memory problems.

The Discharge MDS assessments was dated for 02/11/19 - discharge return anticipated; re-admitted to the facility on 02/14/19.

On 08/08/19 at approximately 3:00 PM a pre-exit interview was conducted with the Administrator and Director of Nursing they were informed of the above findings. They were asked what should have been done? The DON commented, "We do issue the bed hold notice, but we were not documenting it in the nurses note."

3. Resident #129 was originally admitted to the facility for skilled services on 7/5/19 following a fall at home resulting in a left hip fracture and then readmitted on 8/1/19 after a hospitalization with diagnosis of Foley related sepsis Urinary Tract Infection (UTI), other diagnoses included neurogenic bladder (a dysfunction of the bladder) and dementia. The current MDS (Minimum Data Set) a 14 day with an assessment reference date of 7/19/19 coded the resident as having long and short term memory deficits and severely impaired cognitive skills for daily decision making.

The clinical record face sheet evidenced the resident was not his own responsible party. The resident representative was listed as a son.

The resident was sent out to the emergency room

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and admitted to the hospital for a change in condition on 7/28/19. The resident was re-admitted to the facility on 8/1/19.

There was no evidence in the clinical record that the written notice which describes the bed-hold policy was provided to the resident representative at the time of transfer to the hospital on 7/28/19.

On 8/6/19 at 4:15 p.m., the two nurses on the right side unit were interviewed (Licensed Practical Nurse/LPN #7 & #8). They were asked about the transfer process and bed hold policy written notification. LPN #8 stated they attempt to get the notice signed before the resident is transferred and if not the facility gets it signed as soon as possible. When asked about the policy they stated they do not document in the record that it was provided.

On 8/8/19 at 3:00 p.m., during the pre-exit meeting with the Administrator and the Director of Nursing the above findings was shared. They stated that the bed hold policy and the care plan do go with the resident upon transfer, however could not provide evidence that the policy was sent.

No additional information was provided prior to exit.

4. Resident #128 was admitted to the facility on 6/4/2018, with transfers to the hospital occurring on 6/1/2019, 6/16/2019 6/21/2019 and, 7/21/2019. Diagnoses included, but not limited to, type 2 diabetes mellitus with diabetic neuropathy, diastolic heart failure, respiratory failure with hypoxia, stage 4-chronic kidney disease, hypokalemia, chronic ischemic heart disease,

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F 625	Continued From page 19 pseudocyst of pancreas, and morbid obesity. Resident #128's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/9/19. Resident #128 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. On 8/8/19 at approximately 10:40 a.m. a face-to-face interview conducted with Licensed Practical Nurse (LPN) when asked when bedholds were submitted, stated, "the nurses send the bedholds." On 8/8/2019 at approximately 3:35 p.m. upon inquiry regarding documentary evidence of bedhold notification to the receiving provider, the Assistant Director of Nursing (ADON) responded, "We were not aware that bedhold notification is sent with the residents upon transfer." Clinical record reviews conducted yielded no evidence that the required bedhold information was sent upon transfer to the hospital on 6/1/2019, 6/16/2019, 6/21/2019 and 7/21/2019. Facility policy on Transfer or Discharge Documentation (revised December 2016) states: 7. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: a. The basis for transfer or discharge; (1) If the resident is being transferred or discharge because his or her needs cannot be met at the facility, documentation will include: (a) the specific resident needs that cannot be	F 625		

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F 625	Continued From page 20 met; (b) this facility's attempt to meet those needs; and (c) the receiving facility's service(s) that are available to meet those needs. b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance Directive information; e. All special instructions or precautions for ongoing care, as appropriate; f. Comprehensive care plan goals; and g. All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. Facility policy on Bed-Holds and Returns (revised March 2017) states: Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. 3. Prior to a transfer written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer).	F 625		
F 638	Qrtly Assessment at Least Every 3 Months	F 638		

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F 638 SS=D	Continued From page 21 CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review the facility staff failed to ensure that a Quarterly Review Assessment was submitted no less than once every three months for 3 of 56 residents in the survey sample, (Residents #2, #3 and #4). The findings included: 1. Resident #2 was admitted on 10/12/18 with diagnoses to include but not limited to Type II Diabetes Mellitus and Cerebrovascular Disease. Upon completing the Resident Assessment Task is was noted that Resident #2 was triggered for a Minimum Data Set (an assessment tool) that was greater than 120 days late. Resident #2's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 6/25/19. The Brief Interview for Mental Status was a 10 out of a possible 15 indicating that Resident #2 was moderately cognitively impaired but capable of some daily decision making. Under Section Z Assessment Administration: Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was signed on 8/1/19.	F 638	**F638** **Corrective Action(s):** A facility Incident and Accident form has been completed for Residents #2, #3 & #4 for completing and transmitting a quarterly MDS assessment late. Resident #2, #3 & #4 have had their comprehensive care plan revised to reflect resident specific approaches and interventions to address their specific needs. **Identification of Deficient Practice and Corrective Action(s):** All other residents may have potentially been affected. A 100% review of resident assessments will be done by the RCC and/or designee to ensure that all residents requiring a quarterly MDS have had one completed in the last 92 days or transmitted late. Any/all negative findings will be reported to the resident care coordinator at time of discovery for immediate correction. Comprehensive care plans will be revised as needed to reflect resident specific measurable objectives and interventions. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The RCC has been inserviced by the Regional Nurse Consultant on scheduling and completing MDS assessments per the Resident Assessment Instrument (RAI) manual guidelines.	

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F 638	Continued From page 22 The CMS (Center for Medicare Services) Submission Report MDS 3.0 NH (Nursing Home) Final Validation Report for Resident #2's Quarterly MDS with the ARD of 6/11/19 was reviewed and is documented in part, as follows: Submission Date/Time: 8/1/2019 15:50:08 (3:05 P.M.) Accepted: Name: (Resident #2) Target Date: 6/25/19 Warning: Assessment Completed Late: (assessment completion date) is more than 14 days after A2300 (assessment reference date). The last Quarterly assessment submitted to CMS was on 3/18/19, which is over 4 months between quarterly assessments being completed for Resident #2. On 8/7/19 at 1:33 P.M. an interview was conducted with the MDS Coordinator regarding Resident #2's Quarterly assessments being submitted greater than 3 months apart. The MDS Coordinator stated, "We just submitted his (Resident #2's) quarterly MDS on 8/1/19, it was submitted late. We have been short in the MDS department and since I got here in June we have been trying to catch up." The MDS Coordinator was also asked how often quarterly assessment should be submitted for residents. The MDS Coordinator stated, "MDS's should be completed and submitted according to the RAI (Resident Assessment Instrument) Manual." On 8/8/19 at 2:13 P.M. an interview was conducted with the Administrator regarding Resident #2's late quarterly MDS. The Administrator stated, "I feel our MDS's were late	F 638	**Monitoring:** The RCC is responsible for compliance. The RCC and/or designee weekly MDS audits coinciding with the MDS calendar to monitor for timely completion of MDS assessments per the RAI guidelines. Any/all negative findings will be reported to the DON and the RCC will make corrections at the time of discovery. Aggregate findings of the audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 9/20/19	

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	495277	A. BUILDING _____ B. WING _____	C 08/08/2019

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because we have some new MDS staff and the have difficulty with time management. I expect for the MDS's be be current and submitted on time."

On 8/7/19 at 3:00 a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

2. Resident #3 was admitted to the facility with diagnoses to include but not limited to Dementia and Anxiety Disorder.

Upon completing the Resident Assessment Task is was noted that Resident #3 was triggered for a Minimum Data Set that was greater than 120 days late.

Resident #3's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 6/10/19. The Brief Interview for Mental Status indicated that Resident #3 has long and short term memory deficits and was severely cognitively impaired for daily decision making. Under Section Z Assessment Administration: Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was signed on 8/2/19.

The CMS (Center for Medicare Services) Submission Report MDS 3.0 NH (Nursing Home) Final Validation Report for Resident #3's Quarterly MDS with the ARD of 6/10/19 was reviewed and is documented in part, as follows:

Submission Date/Time: 8/2/2019 17:32:12 (5:32 P.M.)

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Accepted:
Name: (Resident #3)
Target Date: 6/10/19
Warning: Assessment Completed Late: (assessment completion date) is more than 14 days after A2300 (assessment reference date).

The last Quarterly assessment submitted to CMS was on 3/8/19, which is over 4 months between quarterly assessments being completed for Resident #3.

On 8/7/19 at 1:33 P.M. an interview was conducted with the MDS Coordinator regarding Resident #3's Quarterly assessments being submitted greater than 3 months apart. The MDS Coordinator stated, "We just submitted his (Resident #3's) quarterly MDS on 8/2/19, it was submitted late. We have been short in the MDS department and since I got here in June we have been trying to catch up." The MDS Coordinator was also asked how often quarterly assessment should be submitted for residents. The MDS Coordinator stated, "MDS's should be completed and submitted according to the RAI (Resident Assessment Instrument) Manual."

On 8/8/19 at 2:13 P.M. an interview was conducted with the Administrator regarding Resident #3's late quarterly MDS. The Administrator stated, "I feel our MDS's were late because we have some new MDS staff and the have difficulty with time management. I expect for the MDS's be be current and submitted on time."

On 8/7/19 at 3:00 a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to

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F 638	Continued From page 25	F 638		

exit no further information was provided.

3. Resident #4 was admitted to the facility on 4/11/16 with diagnoses to include but not limited to Type II Diabetes Mellitus and Hypertension.

Upon completing the Resident Assessment Task is was noted that Resident #4 was triggered for a Minimum Data Set that was greater than 120 days late.

Resident #4's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 6/11/19. The Brief Interview for Mental Status indicated that Resident #4 has long and short term memory deficits and was severely cognitively impaired for daily decision making. Under Section Z Assessment Administration: Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was signed on 8/7/19.

The CMS (Center for Medicare Services) Submission Report MDS 3.0 NH (Nursing Home) Final Validation Report for Resident #4's Quarterly MDS with the ARD of 6/11/19 was reviewed and is documented in part, as follows:

Submission Date/Time: 8/7/2019 14:13:05 (2:15 P.M.)
Accepted:
Name: (Resident #4)
Target Date: 6/11/19
Warning: Assessment Completed Late: (assessment completion date) is more than 14 days after A2300 (assessment reference date).

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F 638	Continued From page 26 The last Quarterly assessment submitted to CMS was on 3/28/19, which is over 4 months between quarterly assessments being completed for Resident #4. On 8/7/19 at 1:33 P.M. an interview was conducted with the MDS Coordinator regarding Resident #4's Quarterly assessments being submitted greater than 3 months apart. The MDS Coordinator stated, "We just submitted her (Resident #4's) quarterly MDS today, it was submitted late. We have been short in the MDS department and since I got here in June we have been trying to catch up." The MDS Coordinator was also asked how often quarterly assessment should be submitted for residents. The MDS Coordinator stated, "MDS's should be completed and submitted according to the RAI (Resident Assessment Instrument) Manual." On 8/8/19 at 2:13 P.M. an interview was conducted with the Administrator regarding Resident #4's late quarterly MDS. The Administrator stated, "I feel our MDS's were late because we have some new MDS staff and the have difficulty with time management. I expect for the MDS's be be current and submitted on time." The facility Policy titled :Resident Assessment Instrument" last revised September 2017 was reviewed and is documented in part, as follows: Policy Interpretation and Implementation: 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessment and reviews according tot he following schedule: c. At least quarterly.	F 638		

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F 638	Continued From page 27 On 8/7/19 at 3:00 p.m. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure an MDS (Minimum Data Set-an assessment tool) was accurate for 1 of 56 residents in the survey sample, Resident #121. Section E. Behaviors was not accurate for the quarterly MDS with an assessment reference date of 7/10/19. The findings include: Resident #121 was admitted to the facility on 11/6/12 with diagnoses to include but not limited to, unspecified dementia without behavioral disturbance, major depressive disorder, recurrent with severe psychiatric symptoms. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 7/10/19 coded the resident as having long and short term memory deficits and severely impaired daily decision making skills. Under behaviors Section E. 0200 A. the resident was coded as not exhibiting any physical behavioral symptoms directed towards others (e.g., hitting, kicking,	F 641	**F641** **Corrective Action(s):** Resident #121 has had their most recent MDS modified to accurately code section E, Behaviors. Resident #121's comprehensive care plan has been reviewed and revised to include current behaviors being exhibited. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all residents current MDS assessments will be completed by the RCC and/or designee to ensure that sections E of the MDS are coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS. **Systemic Change(s):** The Resident Interdisciplinary Care Team has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data.	

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F 641	Continued From page 28 pushing, scratching, grabbing). Resident #121 required extensive assistance of two staff for toileting needs and personal hygiene and was dependent for bathing. Review of the Medication Administration Record for July 2019 evidenced the resident was administered Ativan (an anti-anxiety drug) 1 mg PRN (as needed) for the following identified behaviors that were not coded on the 7/10/19 MDS: July 9th at 9:08 a.m.-hitting, kicking, scratching, grabbing July 10th at 9:43 a.m.-hitting, scratching, grabbing Review of the quarterly MDS Section Z. Assessment Administration evidenced the Social Worker's signature as having completed section C, D, E and Q. Section Z. reads in part: "I certify that the accompanying information accurately reflects resident information for this resident..." On 8/8/19 at 12:21 p.m., the above findings was shared with the MDS Coordinator. She stated, "Section E.0200 A was coded incorrectly by the Social Worker" and "we will be completing a modification of the MDS for Section E. and submit it once it is completed." On 8/8/19 at 3:00 p.m., during the pre-exit meeting with the Administrator and the Director of Nursing the above findings was shared. The facility policy title Resident Assessment Instrument revised September 2017 reads, as follows in part: 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment	F 641	**Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, andrecommendations for change in facility policy, procedure, and/or practice. **Completion Date**: 9/20/19	

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F 641	Continued From page 29 Team conduct timely resident assessments and reviews according to the following schedule: c. At least quarterly 7. All persons who have completed any portion of the MDS Resident Assessment Form must sign such document attesting to the accuracy of such information.	F 641		
F 657 SS=E	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. (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	F 657	**F657** **Corrective Action(s):** Resident #80's comprehensive care plan has been reviewed and revised to reflect Resident 80's left pinky finger blister was caused by trauma, not a burn on 7/2/19 or that it was now healed on 7/11/19. A Facility Incident & Accident Form was completed for this incident. Resident #134's comprehensive care plan has been reviewed and revised to reflect resident #134's fall with a fracture and the appropriate interventions and approaches to address the fracture. A Facility Incident & Accident Form was completed for this incident. Resident #121's comprehensive care plan has been reviewed and revised to reflect resident #121's current behaviors of hitting, kicking, scratching, or grabbing during ADL care. As well as the nonpharmacological approaches to used prior to psychotropic medication being used. A Facility Incident & Accident Form was completed for this incident.	

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by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to revise the care plan for three of 56 residents in the survey sample, Resident #80, #134, and #121.

The findings included:

1. Facility staff failed to revise the care plan when it was determined her left pinky blister was caused from trauma rather than a burn on 7/2/19; and failed to revise the care plan when the blister had healed on 7/11/19.

Resident #80 was admitted to the facility on 6/22/16 with diagnoses that included but were not limited to, Parkinson's disease, convulsions, and Schizophrenia. Resident #80's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/2/19. Resident #80 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview of Mental Status) exam.

Review of Resident #80's clinical record revealed that Resident #80 obtained a blister on 6/30/19. The following nursing notes were written:

6/30/19 at 7:20 a.m.: "resident (sic) came up to nursing station stating that she spilled coffee on L (left) pinky finger. L pinky finger was red, blister noted. Resident is her own RP (responsible party). (Name of Medical Doctor) made aware. resident (sic) given tylenol. skin blanches. area is closed and not weeping."

6/30/19 2:03 p.m., "Intact blister to left hand oinky

Identification of Deficient Practices & Corrective Action(s):
Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified.

Systemic Changes:
The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in resident condition.

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F 657	Continued From page 31 (sic) finger, silvadene (1) applied per order." 7/1/19 1:23 p.m.: "Wound assessment done by nurse: Resident was seen by wound care nurse for blister noted to left pinky finger. Spoke to resident concerning origin of non-intact blister, resident stated, "I think I hit it on my w/c (wheelchair)" When asked again within 5 minutes resident stated "I hit my hand between the door and the wheelchair" When asked if she had spilled coffee on herself resident stated "no (sic) I think I hit my hand on door with my w/c" Area dry no bleeding no drainage noted area 2 cm (centimeters) x 0.5 cm red in color with pigmented skin layer absent at this time." Review of Resident #80's July POS (physician order summary) revealed her wound care treatment was changed to the following order: "Clean L (left) pinky with dermal wound cleanser, pat dry, and apply polymem (2) every three days prn (as needed) until healed." This order was discontinued on 7/19/19. Review of the facility's investigation related to Resident #80's blister revealed that her blister was obtained from trauma rather than a burn. Further review of Resident #80's clinical record revealed that the wound care physician had evaluated Resident #80 later that day on 7/1/19. The following note was written: "64-year old female with non-intact blister on her left 5th finger. Patient uncertain as to cause. She described to nurse a wheelchair injury. When questioned my (sic) MD (medical doctor) , she reported catching her finger against door jam. She then said it may have been a burn. When I questioned her as to the source of the burn, she	F 657	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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was unclear. Given patient's medical history and changing story, etiology unreliable. The wound is superficial, with a non-intact blister with mildly reddened intact skin underneath blister, which is inconsistent with a burn and inconsistent with a crush injury. Given current appearance of the wound, etiology most likely an abrasion due to unknown cause...Plan: 1. Leave wound open to air..."

Review of Resident #80's skin assessments failed to document when her abrasion/non-intact blister had healed.

Review of Resident #80's care plan dated 6/30/18 documented the following: "At Risk for Impaired Skin integrity r/t (related to) history of burn to pinky finger...Change dressing as per orders. Ensure resident had lid on coffee. Monitor site for s/s (signs/symptoms) of infections and report any to MD (medical director)."

The care plan was not revised once it was determined that her blister was caused from trauma rather than a burn. The care plan was also not revised once her blister was healed.

On 8/8/19 at 10:39 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the wound care nurse. When asked the cause of Resident #80's blister, LPN #1 stated that it was from trauma and that the facility had conducted an investigation and interviewed staff and the resident regarding her blister. When asked the purpose of the care plan, LPN #1 stated the purpose of the care plan was to address the needs of each resident. When asked if it was important that it was accurate, LPN #1 stated that it was. When asked who was responsible for

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revising the care plan, LPN #1 stated that she did not revise the care plan that MDS was responsible for revising the care plan. When asked how MDS is made aware of any change with a resident's condition, LPN #1 stated that the floor nurses tell MDS. This writer showed LPN #1 Resident #80;s care plan. When asked if her care plan should have been revised to reflect that her blister was from trauma and not burns, LPN #1 stated that it should have been. When asked if Resident #80 still had a blister, LPN #1 stated that she did not. When asked when her blister had healed, LPN #1 stated that she wasn't sure but had to check Resident #80's clinical record. This writer made LPN #1 aware that a note could not be found in Resident #80's clinical record. LPN #1 stated that she would try to find a note.

On 8/8/19 at 1:32 p.m., further interview was conducted with LPN #1. LPN #1 showed this writer her personal notepad. LPN #1 stated that Resident #80's wound had healed on 7/11/19, but that she forgot to document this assessment in the clinical record. When asked if Resident #80's care plan should have also been revised to reflect that her blister had healed, LPN #1 stated that the care plan should have been revised.

LPN #1 gave this writer a late entry progress note dated 8/8/19 that documented in part, the following: "Late Entry for 7/11/19: Resident pinky finger was assessed by wound nurse. At this time area light pink in color no open area noted no bleeding no drainage noted. Area blanchable at this time. Area presents as healed at this time."

On 8/8/19 at 3:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the ADON (Assistant Director of Nursing) were made

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F 657	Continued From page 34 aware of the above concerns. No further information was presented prior to exit. (1) Silvadene- topical antimicrobial used to prevent infections from burn wounds. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2935806/. (2) Polymem-dressing that is designed to facilitate healing, relieve pain and reduce inflammation. https://polymem.com. 2. Facility staff failed to revise the care plan after a fall with fracture on 6/30/18 for Resident #134. Resident #134 was admitted to the facility on 2/13/13 with diagnoses that included but were not limited to Alzheimer's disease, dementia, high blood pressure and cerebral aneurysm. Resident #134's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/3/18. Resident #134 was coded as being severely impaired in cognitive function scoring 00 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #134 was coded as requiring extensive assistance with two plus persons with transfers. Resident #134 was also coded in Section G (functional status) as "Not Steady, only able to stabilize with staff assistance" with surface to surface transfers (transfer between bed and chair or wheelchair." Review of Resident #134's clinical record revealed that she had a fall on 6/30/18. It was revealed that Resident #134 had fallen because	F 657		

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she got up unassisted. The following was documented in a nursing note: "While CNA (certified nursing assistant) was moving chair to assist into chair. (sic) resident stood up and fell on fall mat. resident (sic) has complaints of L (left knee) pain. no (sic) swelling noted. resident does have some pain with movement. motrin (1)(sic) given."

Review of Resident #134's care plan dated 5/2/16 revealed that Resident #134 had the following fall preventive interventions in place prior to her fall on 6/30/18: "pressure alarm at all times, Hi/low bed with fall mat..."

Review of Resident #134's nursing kardex (care plan for nursing aides) revealed the following fall preventive interventions were in place as of 6/11/18: "Pressure alarm at all times, gel pommel cushion to wheelchair, alarming seatbelt while in wheelchair, Hi/low bed with fall mat."

Further review of Resident #134's clinical record revealed that Resident #134 sustained a fracture from the fall on 6/30/18. Review of Resident #134's physician orders revealed that she was ordered an ACE (2) wrap on 6/30/18. The following order was documented: "N.O. Ace wrap left extremity loosely from mid thigh to ankle."

Review of Resident #Resident #134's nursing notes revealed that she had went out to the hospital on 7/2/18 for an Ortho (orthopedic) evaluation. Resident #134 arrived back to the facility on 7/2/18 with the following order: "Patient's splint needs to be removed twice a day and assess skin for breakdown." Patient should continue to be non weight bearing on left lower

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extremity. Continue use of wheelchair."

Review of Resident #134's July 2018 TAR (treatment administration record) revealed that staff were implementing the order for her splint.

Further review of Resident #134's care plan dated 5/2/16, failed to reflect her fractured femur and new orders for splint care.

On 8/8/19 at 10:18 a.m., an interview was conducted with OSM (other staff member)#1, the MDS nurse. When asked who was responsible for updating care plans, OSM #1 stated that MDS updates the care plans now, but was not sure who updated the care plans back in 2018. When asked when the care plan was updated, OSM #1 stated that the care plan was updated for any new orders, change in condition, quarterly etc. When asked if a resident had a fall and obtained a fracture, if she would expect to see the care plan revised to reflect that fall and fracture, OSM # 1 stated that she would. When asked if she would expect to see care for the new fracture on the care plan, OSM #1 confirmed that she would. OSM #1 confirmed that Resident #134's fractured femur was not reflected on her comprehensive care plan and the care required for her fracture i.e. splint instructions etc.

On 8/8/19 at 3:18 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the ADON (Assistant Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

(1) Motrin (ibuprofen) NSAID (non-steroidal I anti-inflammatory drugs) used to treat pain. This information was obtained from The National

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Institutes of Health.https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=26cd56b0-edbb-74f3-e054-00144ff8d46c.
(2) ACE wrap is an elastic bandage used to stabilize joints and to reduce swelling. This information was obtained from https://www.acebrand.com/3M/en_US/ace-brand/about-ace-brand/our-story/.

Complaint Deficiency.
3. The facility staff failed to ensure the care plan was revised for identified behaviors and failed to include non-pharmacological approaches designed to meet the individual needs of Resident #121.

Resident #121 was admitted to the facility on 11/6/12 with diagnoses to include but not limited to, unspecified dementia without behavioral disturbance, major depressive disorder, recurrent with severe psychiatric symptoms. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 7/10/19 coded the resident as having long and short term memory deficits and severely impaired daily decision making skills. Under behaviors the resident was assessed as not exhibiting any physical or verbal behaviors or potential indicators for psychosis and the resident was not exhibiting any rejection of care. Resident #121 required extensive assistance of two staff for toileting needs and personal hygiene and was dependent for bathing.

Review of the Medication Administration Records (MAR's) for June 2019, July 2019 and August 2019 evidenced the resident was administered Ativan (an anti-anxiety drug) 1 mg PRN (as needed) as follows without implementation of

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F 657	Continued From page 38 non-pharmacological approaches prior to administration for these identified behaviors: June 9th at 8:09 a.m.-combative with staff, attempting to get up without assistance. June 12th at 12:50 p.m.-hitting, kicking, scratching, grabbing July 9th at 9:08 p.m.-hitting, kicking, scratching, grabbing July 10th at 9:43 a.m.-hitting, scratching, grabbing July 14th at 9:48 a.m.-combative during ADL care (activities of daily living) July 23rd at 8:29 a.m.-resident attempted to get out of bed, pacing the hallway July 24th at 10:31 a.m.-hitting, kicking, scratching, grabbing, cursing July 27th at 10:14 a.m.-hitting, kicking, scratching, cursing July 28th at 9:58 a.m.-hitting, kicking, scratching, grabbing, combative during care July 29th at 9:38 a.m.-hitting, kicking, scratching, grabbing, combative during ADL care July 30th at 10:13 a.m.-hitting, kicking, scratching, grabbing, cursing July 31st at 9:15 a.m.-hitting, kicking, scratching, grabbing, combative during ADL care August 1st at 9:13 a.m.-hitting, kicking, scratching, grabbing, combative during ADL care August 5th at 9:15 a.m.-hitting, kicking, scratching, grabbing, combative during ADL care A review of the Comprehensive Person Centered Care Plan dated 11/17/2015 for Resident #121, evidenced it was not revised to include the resident's behaviors of hitting, kicking,scratching, or grabbing during ADL care, nor did it include individualized approaches to minimize or reduce the use of the psychotropic drug Ativan.	F 657		

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On 8/8/19 at 11:33 a.m., Licensed Practical Nurse (LPN #8) was interviewed as she was identified as the nurse who had administered each of the PRN Ativan doses for June, July and August 2019. She stated the resident does not want to be bothered stating, "She would rather be in bed than get up...she gets agitated during ADL care." When asked if non-pharmacological approaches were implemented prior to administration she stated, "Yes, we try to wait or offer snacks." When asked where the documentation of the non-pharmacological interventions are she stated, "I didn't document them." When asked if the care plan had been revised to include a behavioral care plan with individualized non-pharmacological approaches to be attempted prior to the administration of PRN Ativan, she stated, "No". When asked how long an order is good for with PRN psychotropic drugs, she stated, "Fourteen days." The LPN was shown the order and stated it should have had a stop date and the care plan should have been revised.

On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing (DON). The DON concurred that the care plan should have been revised to include the resident's behaviors and non-pharmacological approaches.

No additional information was provided prior to exit.

The facility Policy titled Care Plans, Comprehensive Person-Centered revised December 2016 reads in part:
13. Assessment of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement the physician's recommendations for treatment to a non-intact blister; failed to document when the non-intact blister had healed in the clinical record; and continued to treat the non-intact blister when it was already healed for one of 56 resident in the survey sample, Resident #80. The findings included: Resident #80 was admitted to the facility on 6/22/16 with diagnoses that included but were not limited to Parkinson's disease, convulsions, and Schizophrenia. Resident #80's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/2/19. Resident #80 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview of Mental Status) exam. Review of Resident #80's clinical record revealed that Resident #80 obtained a blister on 6/30/19. The following nursing notes were written: 6/30/19 at 7:20 a.m.: "resident (sic) came up to nursing station stating that she spilled coffee on L	F 658	**F658** **Corrective Action(s):** Resident #80's attending physician has been notified that the facility staff did not administer a physician ordered treatment to a non-intact blister, failed to document when the non-intact blister had healed and continued to treat the non-intact blister after it had healed. Resident #80's physician orders have been reviewed to ensure all treatment orders are accurate. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving physician ordered wound care treatments may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident's wound care and treatment orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered wound care and treatments per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for wound and treatment administration per physician order.	

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F 658	Continued From page 41 (left) pinky finger. L pinky finger was red, blister noted. Resident is her own RP (responsible party). (Name of MD (Medical Doctor) made aware. resident (sic) given tylenol (1). skin blanches. area is closed and not weeping." 6/30/19 2:03 p.m., "Intact blister to left hand oinky (sic) finger, silvadene (2) applied per order." 7/1/19 1:23 p.m.: "Wound assessment done by nurse: Resident was seen by wound care nurse for blister noted to left pinky finger. Spoke to resident concerning origin of non-intact blister, resident stated, "I think I hit it on my w/c (wheelchair)" When asked again within 5 minutes resident stated "I hit my hand between the door and the wheelchair" When asked if she had spilled coffee on herself resident stated "no (sic) I think I hit my hand on door with my w/c" Area dry no bleeding no drainage noted area 2 cm (centimeters) x 0.5 cm red in color with pigmented skin layer absent at this time." Review of Resident #80's July POS (physician order summary) revealed her wound care treatment was changed to the following order: "Clean L (left) pinky with dermal wound cleanser, pat dry, and apply polymem (3) every three days prn (as needed) until healed." This order was discontinued on 7/19/19. Review of the facility's investigation related to Resident #80's blister revealed that her blister was obtained from trauma rather than a burn. Further review of Resident #80's clinical record revealed that the wound care physician had evaluated Resident #80 later that day on 7/1/19. The following note was written: "64-year old	F 658	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will observe 3 treatment pass observations weekly to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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female with non-intact blister on her left 5th finger. Patient uncertain as to cause. She described to nurse a wheelchair injury. When questioned my (sic) MD (medical doctor) , she reported catching her finger against door jam. She then said it may have been a burn. When I questioned her as to the source of the burn, she was unclear. Given patient's medical history and changing story, etiology unreliable. The wound is superficial, with a non-intact blister with mildly reddened intact skin underneath blister, which is inconsistent with a burn and inconsistent with a crush injury. Given current appearance of the wound, etiology most likely an abrasion due to unknown cause...Plan: 1. Leave wound open to air..."

Review of Resident #80's physician orders revealed that facility staff failed to implement the wound care physician's recommendations to leave her abrasion/non-intact blister open to air.

Review of Resident #80's July 2019 TAR (treatment administration record) revealed that facility staff continued dressing her abrasion/non-intact blister with a polymen dressing until 7/19/19, when the order was discontinued.

Review of Resident #80's skin assessments failed to document when her abrasion/non-intact blister had healed.

On 8/8/19 at 10:39 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the wound care nurse. When asked the process (how an order is implemented from the physician's recommendations), LPN #1 stated that she was the nurse responsible for writing

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orders from the wound care physician's recommendations. LPN #1 stated that the wound care physician's recommendations should be considered an order. LPN #1 stated that she had made the nurses aware of the new order verbally but that she forgot to write the order. LPN #1 stated that she didn't recall seeing a dressing on Resident #80's finger after the wound care physician's evaluation. When asked what check marks meant on the TAR, LPN #1 stated that check marks meant a treatment was administered. LPN #1 confirmed that Resident #80's July 2019 TAR revealed that staff were dressing her wound until 7/19/19. LPN #1 stated that the nurses could have just documented that they completed the dressing but didn't really do the dressing. When asked if it was okay to document that a treatment or medication was given when it was not, LPN #1 stated that it was not okay to document care that was not provided. When asked when Resident #80's wound had healed, LPN #1 stated that she would have to check her clinical record. This writer made LPN #1 aware that a note could not be found in Resident #80's clinical record. LPN #1 stated that she would try to find a note.

On 8/8/19 at 11:36 a.m., interview was conducted with RN (Registered Nurse) #2, a floor nurse. When asked what check marks meant on the MAR (medication administration record)/TARs, RN #2 stated that check marks meant a medication and/or treatment was administered. When asked if it was okay to document that a treatment was administered when it was not administered, RN #2 stated that it was not okay to falsify records.

On 8/8/19 at 11:49 a.m., an attempt was made to

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reach the nurse who documented that she administered the polymen treatments on 7/16/19 and 7/19/19. She could not be reached for an interview.

On 8/8/19 at approximately 1:30 p.m., an interview was conducted with Resident #80. Resident #80 stated that she remembered having a dressing but was not sure how long she had the dressing to her finger.

On 8/8/19 at 1:32 p.m., further interview was conducted with LPN #1. LPN #1 showed this writer her personal notepad. LPN #1 stated that Resident #80's wound had healed on 7/11/19 but that she forgot to document this assessment in the clinical record. LPN #1 confirmed that Resident #80's July 2019 TAR reflected that staff were still treating her wound on 7/16/19 and 7/19/19 even though her wound had healed on 7/11/19. LPN #1 gave this writer a late entry progress note dated 8/8/19 that documented in part, the following: "Late Entry for 7/11/19: Resident pinky finger was assessed by wound nurse. At this time area light pink in color no open area noted no bleeding no drainage noted. Area blanchable at this time. Area presents as healed at this time."

On 8/8/19 at 3:18 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the ADON (Assistant Director of Nursing) were made aware of the above concerns. CSM (Corporate staff member) #1 stated that the facility used Lippincott and/or their policies as a professional standard.

Facility policy titled, "Medication and Treatment Orders" documents in part, the following:

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F 658	Continued From page 45 "Medications shall be administered only upon the written order...Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart." No further information was presented prior to exit. (1) Tylenol Tablet 325 mg (Acetaminophen)- Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details. (2) Silvadene- topical antimicrobial used to prevent infections from burn wounds. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2935806/. (3) Polymem-dressing that is designed to facilitate healing, relieve pain and reduce inflammation. https://polymem.com.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686	**F686** **Corrective Action(s):** Resident #124's attending physician was notified that the facility staff failed to assess, measure, implement preventative devices to promote the healing of a Stage 1 pressure injury. A facility Incident & Accident form was completed for this incident.	

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F 686	Continued From page 46 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to provide the necessary care and treatment to prevent and promote healing of a pressure injury for 1 of 56 residents in the survey sample, Resident #124. The findings include: Resident #124 was admitted to the facility on 9/20/18 with diagnoses to include but not limited to, stroke and diabetes. The current MDS (Minimum Data Set) an annual with an assessment reference date of 7/1/19 assessed the resident as having long and short term memory deficits. The resident required extensive assistance of two staff for bed mobility and dependent for transfers. Under section M. Skin Conditions the resident was coded as at risk for developing pressure ulcers/injuries and having a stage IV pressure injury (defined in the MDS as a full thickness tissue loss with exposed bone, tendon, or muscle. Slough, eschar may be present on some parts of the wound bed). On 8/7/19 at 12:33 p.m., an observation of the sacral dressing change was conducted. The resident was on a low air loss mattress. The facility wound nurse (Licensed Practical Nurse-LPN #9) performed the dressing change with Certified Nursing Assistant (CNA #6) who was providing assistance with maintaining the resident on her side. During the dressing change this surveyor observed that the resident's left heel was red. After completing the dressing change the wound nurse was asked about the residents	F 686	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with wound care prevention and treatment orders may have potentially been affected. The DON, ADON, Wound nurse and/or Unit Manager will conduct 100% skin audit and a 100% audit of all Pressure injury prevention orders to identify any residents at risk for alterations in skin integrity without proper monitoring, assessment and tracking and missing prevention items. Any negative findings will be corrected at the time of discovery and disciplinary action taken as indicated. A facility Incident and Accident form will be completed each negative finding. **Systemic Change(s):** The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the Wound Care Nurse and/or the DON on the facility's Pressure Ulcer Treatment and Prevention Policy and Procedure. The training will include the weekly skin assessment process and the application of physician ordered pressure relieving devices.	

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F 686	Continued From page 47 left heel. She assessed the heel and it was found to have redness, the tissue was boggy and was not blanchable in the middle. The wound nurse stated she was not aware of this pressure injury and that the resident was utilizing the specialty "heel float" boots, and there had been a previous order for skin prep. The wound nurse assessed the left heel and documented that during the dressing change the resident was noted to have a reddened area to the left heel. The area was boggy, measuring 3.1 cm (centimeters) in length x 2.8 cm wide with no depth. The area was blanchable closer to the outer edges and "...the center of area blanches with difficulty." The wound nurse ordered skin prep to be applied to the left heel every shift until healed as there had not been a treatment initiated. Further clinical record review evidenced the last documented skin inspection report by the nursing staff was 10/11/18. There was no documentation in the clinical record of the left heel pressure injury on 8/5/19, 8/6/19, or 8/7/19. The wound care physician had assessed the resident's sacral pressure ulcer on 8/5/19, the notes indicated the left lower extremity was normal. On 8/8/19 at 9:47 a.m., an interview with the wound nurse was conducted. She was asked to clarify what she meant by on her assessment that the area "blanches with difficulty," she stated, "It's a stage I non-blanchable...someone should have seen it before you saw it yesterday." She stated the skin inspections should be filled out weekly. She stated the weekly skin assessment schedule	F 686	**Monitoring:** The DON is responsible for compliance. The DON, ADON and/or Wound nurse will review all residents weekly skin inspection sheets to identify any residents with a potential skin alteration that requires assessment, measuring, tracking and monitoring. The DON, ADON and/or Unit Managers will complete 3 random rounds weekly to monitor for physician ordered preventive pressure injury devices are in place. Any/all negative findings will be addressed at time of discovery and additional inservice training and/or disciplinary with will be administered at that time. The results of the audits will be sent to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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F 686	Continued From page 48 should be posted at the nurses station, she further stated, "...since we have had turn over it may not have been conveyed." When asked who had oversight of the weekly wound assessment schedule to ensure they are being conducted she stated, "The unit managers." The wound nurse stated during the resident shower days if the certified nurse aide (CNA) finds a skin concern she is to document it on the CNA Skin Check Form and then report the area found to the charge nurse. The charge nurse will then go and do an assessment of the area. The assessment should include a description of the area in the clinical record, if it is a pressure injury this is relayed to the wound nurse so that she can assess the wound. The wound nurse stated the floor nurses do not stage pressure injuries she does. A stage I pressure ulcer/injury is defined in the MDS as: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. On 8/8/19 at 10:20 a.m., a review of the CNA Skin Check Form completed on 8/5/19 evidenced CNA #7 had identified reddened areas to Resident #124 heels. The nurse (Licensed Practical Nurse #8) who was assigned to care for the resident that shift was asked if she was notified or had reviewed the CNA Skin Check Form dated 8/5/19, she stated, "No, I didn't see it." The nurse was asked where the weekly skin assessment schedule was located, she stated she did not know. The right side unit manager was asked where the weekly skin assessment schedule was posted for the nurses. She stated, "I am in the process of making one now, I have to create a calendar." When asked where would I	F 686		

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F 686	Continued From page 49 find in the clinical record the weekly skin assessments conducted by a licensed nurse, she stated, "Honestly, I'm going to tell you that it has probably not been done." On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing. The facility policy titled Prevention of Pressure Ulcers/Injuries revised July 2017 reads in part: Purpose-The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Risk Assessment: 1. Assess the resident on admission for existing pressure ulcer/injury risk factor. Repeat the risk assessment weekly and upon any changes in condition. The National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Australia; 2014. Page 17 reads, in part: 4. Include a comprehensive skin assessment as part of every risk assessment to evaluate any alterations to intact skin. 5. Document all risk assessments.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689	**F689** **Corrective Action(s):** Resident #8's attending physician has been notified that facility staff failed to serve her coffee with a protective lid on 8/6/19. A facility incident and accident form has been completed for this incident.	

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F 689	Continued From page 50 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, staff interviews, clinical record review and facility document review the facility staff failed to provide a physician ordered safety device (a lidded cup) to promote safety for 1 of 56 residents in the survey sample, Resident #8. The findings include: Resident #8 was admitted to the facility on 5/6/11 with diagnoses to include but not limited to, legal blindness and history of major depressive disorder, recurrent, severe with psychotic symptoms. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 7/8/19 coded the resident as scoring a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident was coded as requiring limited assistance with one person physical assist with eating, and transfers, and extensive assistance with one person physical assist with bed mobility, personal hygiene and dressing. The resident had limited range of motion to both upper and lower extremities. The Comprehensive Person Centered Plan of Care dated 4/29/16 identified the resident had risk of injury due to visual impairment diagnosis	F 689	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered protective lids for hot liquids may have been affected. The DON, ADON and/or Unit Manager will conduct a 100% review of all residents with physician ordered protective lids to hot liquids to identify residents at risk. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all Licensed Nursing staff regarding residents and their use of hot liquids. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform twice weekly inspections of all residents with physician ordered lids for hot liquids to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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F 689	Continued From page 51	F 689		

of legal blindness. One of two goals was to ensure the resident would not have injuries thru the next review. One of the interventions was listed as: Keep the resident's environment free of small objects on the floor, very hot liquids and toxic liquids. The care plan did not include a hot safety beverage device such as a lidded cup.

On 8/5/19 at 1:19 p.m., the resident was observed asleep in bed, the head of the bed was elevated. The bedside table was positioned over the resident's torso. The resident's gown was visibly wet from spilled coffee on the chest area. A regular mug of coffee without a lid was observed on the lunch tray almost empty.

A nurses noted dated 8/5/19 entered at 6:11 p.m., read: "Late entry for 1330 (1:30 p.m.): CNA (certified nursing assistant) reported that today at lunch resident spilled her coffee on her front of her gown. Nurse went in and immediately assessed resident's skin to her chest and abdomen, no redness or discoloration was noted. Resident asked about this and she stated, "oh my coffee wasn't hot, it was cool, I am fine." MD (Medical Doctor) and RP (Representative Party) notified. Hot liquids safety evaluation done and resident is at risk for injury from spills of hot liquids. New order obtained for lidded cup for all hot liquids." This nurses note was entered by the Director of Nurses (DON).

On 8/6/19 at 9:30 a.m., this surveyor and surveyor #1 observed the resident was in bed, awake. The resident was asked if she had eaten breakfast or drank her coffee already. She stated, "No, I couldn't get the lid off (coffee cup)." The resident stated she would like another cup of coffee. The two surveyors went to the nurses

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station (right side) and informed the staff of the resident's request. At this time CNA #5 stated she would get the resident a cup of coffee. The CNA came back from the kitchen with a cup of coffee, she stopped at the nurses station and asked if the resident needed a special cup for the coffee, she stated the staff did not respond to her. CNA #5 continued to the resident's room. Once inside the room the CNA stated she was not sure if the resident was to have the coffee in a regular mug, she questioned it and stated to the surveyor that the resident was blind and probably needed a lidded cup. When asked why, she stated, "Because she is blind...so she doesn't spill it on herself and burn herself." The CNA stated, "I don't normally work with her, it should be on the Closet Care Plan which is taped inside the resident's closet." The Resident's closet was opened and the CNA Care Plan was reviewed by surveyor and CNA. There was no reference for a lidded cup for all hot liquids. The CNA then proceeded to place sugar in the coffee and then handed the coffee to the resident. Once the coffee cup reached the resident's lips, the resident stated, "It's too hot!" The CNA then took the cup and was going to add cold water to it. At this time, this surveyor asked the CNA to hold off until the coffee temperature was obtained. Surveyor #1 then entered the room accompanied by the Dietary Manager, the coffee temperature was obtained, the thermometer reading stopped between the 152 degree mark and the 154 degree mark, indicating the coffee was 153 degrees Fahrenheit. The CNA was asked if the kitchen staff had obtained the coffee temperature prior to handing it off to her, she stated, "No". The Dietary Manager stated the kitchen staff should have obtained the resident's coffee temperature prior to it leaving the kitchen, he

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further stated coffee should not be higher than 150 degrees Fahrenheit when released to the floors. The Dietary Manager stated the kitchen had received a new order yesterday evening for the resident to be served all hot beverages in a lidded cup. CNA #5 stated she was not aware of this new order. At this time both surveyors went to the kitchen. Two kitchen staff were interviewed. Food Service Worker #10, who was in the process of washing dishes stated she had placed on the tray a lidded cup with coffee to be served to the resident this morning for breakfast. Food Service Worker #11, who handed the coffee in a regular mug to CNA #5 stated she was not told nor did she ask who the coffee was for. She also stated she did not temp the coffee before it left the kitchen. The Dietary Manager was asked how many lidded cups were in the facility and stated, "We have 7 lidded cups and 3 residents that use them currently, including Resident #8."

The facility policy titled Safety of Hot Liquids revised 10/2014 was reviewed. The policy indicated a Hot Liquid Safety Evaluation was be to completed on all residents upon admission, readmission and on change in condition. A Hot Liquid Safety Evaluation had never been done for Resident #8. The policy further reads, in part:
1. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions.
4. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include:
a. Maintaining a hot liquids serving temperature of not more than 150 degrees Fahrenheit;

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F 689	Continued From page 54 b. Serving hot beverages in a cup with a lid; 5. Food service staff will monitor and maintain foods temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. Table 1. Time and Temperatures Relationship to Serious Burns-Time Required for a 3rd Degree Burn to Occur for temperatures between 148 and 155 degrees Fahrenheit is 1-2 seconds. Referenced from http://www.bt.cdc.gov/masscasualties/burns.asp The facility Incident Report dated 8/6/19 for Resident #8 read in part and was signed by the right side unit manager: Narrative of description of injuries (use additional pages, if needed): Resident received lidded cup (with) her coffee on breakfast tray-resident received another cup of coffee in a regular cup. On 8/6/19 at approximately 10:50 a.m. the Administrator and Director of Nursing were informed of the findings.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757	**F757** **Corrective Action(s):** Resident #128's attending physician has been notified that the facility administered the incorrect dose of Humalog insulin on 8/6/19. A facility medication error form has been completed for this incident. RN # 2 has received one on one education regarding medication administration which included a focus on the accurate administration of sliding scale insulin	

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F 757	Continued From page 55 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure one of 56 residents (Resident #128) in the survey sample was free from unnecessary medication; specifically excess units of insulin. The findings included: Resident #128 was admitted to the facility on 6/4/2018, with the most recent readmission on 7/30/2019. The resident was on hospice care as of 8/4/2019. The latest diagnoses included, but not limited to, type 2 diabetes mellitus with diabetic neuropathy, and pseudocyst of pancreas, and morbid obesity. Resident #128's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/9/19. Resident #128 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. A review of Resident #128's comprehensive care	F 757	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving sliding scale insulin may have potentially been affected. A 100% audit of all residents with sliding scale insulin orders will be conducted to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action and inservice training will be administered as warranted. An Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed Nursing staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of sliding scale insulin per physician order. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will perform 2 random weekly Medication Pass audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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plan dated 8/1/2019 revealed, in part, the following documentation: "Problem / Need. Risk for hyper/hypoglycemia (high/low blood sugar) r/t (related to) diabetes. Resident #128 will remain free from complications associated with Diabetes through next review. Approaches include: Continue diet as ordered; Monitor intake and encourage dietary compliance; Monitor for thirst, excessive appetite, and excessive voiding; Monitor blood sugars as ordered and notify MD (medical doctor) per order; Administer medications as ordered.

A review of Resident #128's physician orders, dated 7/30/2019, revealed in part, the following order related to the treatment of diabetes:

"Humalog (1) 10 units/ml. Generic: Insulin Lispro Kwikpen inject subq (subcutaneous) ac (with meals) & hs (at bedtime) per sliding scale:
100-125=2u (units)
126-200=4u
201-249=6u
250-299=8u
300-349=10u
350-400=12u
>401=14u"

Review of Resident #128's August 2019 medication administration record (MAR) revealed that on 8/6/19, Resident #128's blood glucose level measured 163 at 7:30 a.m.. The nurse gave 10 units of sliding scale insulin which was 6 extra units of insulin.

Further review of Resident #128's clinical record revealed no negative outcome from this deficient practice. Resident #128's blood sugar measured 171 at 11:30 a.m.

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	495277	A. BUILDING _____ B. WING _____	C 08/08/2019

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HERITAGE HALL NASSAWADOX	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

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F 757	Continued From page 57	F 757		

On 8/8/19 at 11:36 a.m., a phone interview was conducted with RN (Registered Nurse) #2, the nurse who administered the 6 extra units of insulin. RN #2 was asked what the check marks indicate on the MAR. RN #2 stated, "Check marks mean that it was given". When asked, what it means to administer medications on a sliding scale, RN #2 stated, "Those are units given per order." When asked regarding the 10 units of Humalog administered on 8/6/2019 for a blood glucose level of 163, RN #2 stated, "I don't recall that." When asked what are the negative outcomes of administering the wrong number of units of Humalog, staff #2 responded, "sugar would drop, go into a coma."

On 8/8/19 at approximately 2:20 p.m., a phone interview was conducted with other staff member (OSM) #5, the pharmacist. When asked if there would be any negative side effects for administering 10 units, vs the ordered 4 units of Humalog for a blood sugar of 163, OSM #5 stated, "10 units is not that high, should have checked 30 minutes after administration; could become hypoglycemic; a significant med error."

There was no record of a blood sugar check 30 minutes after the administration of 10 units of Humalog on 8/6/2019.

On 8/8/19 at 3:18 p.m., an interview was conducted with administrative staff member (ASM) #2, the ADON (assistant director of nursing). When asked the side effects of administering 10 units of Humalog vs. the ordered 4 units for a blood sugar reading of 163, ASM #2 stated that six extra doses was not significant but that resident could possibly

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F 757	Continued From page 58 become hypoglycemic. On 8/8/19 at 3:18 p.m., ASM #1, the administrator and ASM #2, the ADON (Assistant Director of Nursing) were made aware of the above concerns. Heritage Hall policy on Administering Medications (revised December 2016) states: (3). Medications must be administered in accordance with the orders, including any required time frame. (20). As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. (1) HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from The National Institutes of Health.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758	**F758** **Corrective Action(s):** Resident #121's attending physician has been notified that the facility staff failed to implement non-pharmacological approaches prior to administration of PRN Ativan and failed to obtain a stop date for PRN Ativan. A Facility Incident & Accident Form has been completed for this incident.	

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F 758	Continued From page 59 §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 §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	F 758	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving PRN psychotropic medications may have been potentially affected. The DON,ADON, and/or Pharmacy consultant will review the medication orders of all residents receiving PRN psychotropic medication to identify all others that do not indicate non-pharmacological approaches to be attempted prior to administration or that do not have stop dates. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant for proper administration and monitoring of psychotropic medication to include ensuring gradual dosage reduction recommendations are being addressed by the attending physician. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will complete weekly physician orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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F 758	Continued From page 60 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 staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 56 residents in the survey sample was free from unnecessary psychotropic drugs, Resident #121. The facility staff failed to implement non-pharmacological approaches prior to administration of the anti-anxiety drug Ativan and failed to obtain a stop date for as needed (PRN) Ativan. The findings include: Resident #121 was admitted to the facility on 11/6/12 with diagnoses to include but not limited to, unspecified dementia without behavioral disturbance, major depressive disorder, recurrent with severe psychiatric symptoms. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 7/10/19 coded the resident as having long and short term memory deficits and severely impaired daily decision making skills. Under behaviors the resident was assessed as not exhibiting any physical or verbal behaviors or potential indicators for psychosis. And that the resident was not exhibiting any rejection of care. Resident #121 required extensive assistance of two staff for ADL care (activities of daily living) to include toileting needs and personal hygiene. The resident was dependent on staff for bathing.	F 758		

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F 758	Continued From page 61	F 758		

A review of the Comprehensive Person Centered Care Plan identified psychotropic drug use as a potential for injury related to the use of these medications as ordered for anxiety, and major depressive disorder. The approaches did not include any individualized behavioral interventions or non-pharmacological approaches to prevent/minimize usage of as needed Ativan prior to or during the provision of care.

On the August 2019 Medication Administration Record (MAR) was an order for Ativan 1 milligram one tablet by mouth PRN (as needed) every eight hours for anxiety. There was no 14 day stop date for this psychotropic drug order. The resident received a PRN dose of Ativan on 8/1/19 at 9:13 a.m., and another dose on 8/5/19 at 9:15 a.m., without non-pharmacological interventions prior to administration. The behaviors for the Ativan were documented as hitting, kicking, scratching, and grabbing during ADL (activities of daily living) care.

Further review of the MAR's for June 2019 and July 2019 evidenced the resident was administered Ativan 1 mg PRN without implementation of non-pharmacological approaches prior to administration with identified behaviors as follows:
June 9th at 8:09 a.m.-combative with staff, attempting to get up without assistance
June 12th at 12:50 a.m.-hitting, kicking, scratching, grabbing
July 9th at 9:08 a.m.-hitting, kicking, scratching, grabbing
July 10th at 9:43 a.m.-hitting, scratching, grabbing
July 14th at 9:48 a.m.-combative during ADL care

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F 758	Continued From page 62 (activities of daily living) July 23rd at 8:29 a.m.-resident attempted to get out of bed, pacing the hallway July 24th at 10:31 a.m.-hitting, kicking, scratching, grabbing, cursing July 27th at 10:14 a.m.-hitting, kicking, scratching, cursing July 28th at 9:58 a.m.-hitting, kicking, scratching, grabbing, combative during care July 29th at 9:38 a.m.-hitting, kicking, scratching, grabbing, combative during ADL care July 30th at 10:13 a.m.-hitting, kicking, scratching, grabbing, cursing July 31st at 9:15 a.m.-hitting, kicking, scratching, grabbing, combative during ADL care On 8/8/19 at 11:33 a.m., Licensed Practical Nurse #8 was interviewed as she was identified as the nurse who had administered each of the PRN Ativan doses for June, July and August 2019. She stated the resident does not want to be bothered stating, "She would rather be in bed than get up" and "She gets agitated during ADL care." When asked if non-pharmacological approaches were implemented prior to administration she stated, "Yes, we try to wait or offer snacks." When asked where the documentation of the non-pharmacological interventions were she stated, "I didn't document them." When asked if the care plan had been revised to include a behavioral care plan with individualized non-pharmacological approaches to be attempted prior to the administration of PRN Ativan, she stated, "No." When asked how long an order is good for with PRN psychotropic drugs, she stated, "Fourteen days." The LPN was shown the order and stated it should have had a stop date and the care plan should have been revised.	F 758		

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F 758	Continued From page 63 The facility could not provide supporting documentation to evidence that individualized, non-pharmacological approaches were implemented or had failed prior to the administration of PRN Ativan for fourteen of fourteen doses administered from June 9, 2019 through August 5, 2019. On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing (DON). The DON stated the non-pharmacological interventions should have been attached with the physician order. When asked if they were attached, she stated, "No." The facility policy titled Antipsychotic Medications revised December 2016 addressed PRN psychotropic drugs however, it did not address non-pharmacological approaches prior to the administration of a PRN psychotropic. No additional information was provided prior to exit.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure one of 56 residents was free from a significant medication error, Resident #128.	F 760	**F760** **Corrective Action(s):** Resident #128's attending physician has been notified that the facility administered the incorrect dose of Humalog insulin on 8/6/19. A facility medication error form has been completed for this incident. RN # 2 has received one on one education regarding medication administration which included a focus on the accurate administration of sliding scale insulin	

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F 760	Continued From page 64 The findings included: Resident #128 was admitted to the facility on 6/4/2018, with the most recent readmission on 7/30/2019. The Resident was placed on hospice care as of 8/4/2019. The diagnoses included, but not limited to, type 2 diabetes mellitus with diabetic neuropathy, pseudocyst of pancreas, and morbid obesity. Resident #128's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/9/19. Resident #128 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. A review of Resident #128's comprehensive care plan dated 8/1/2019 revealed, in part, the following documentation: "Problem / Need. Risk for hyper/hypoglycemia (high/low blood sugar) r/t (related to) diabetes. (Resident #128) will remain free from complications associated with Diabetes through next review. Approaches include: Continue diet as ordered; Monitor intake and encourage dietary compliance; Monitor for thirst, excessive appetite, and excessive voiding; Monitor blood sugars as ordered and notify MD (medical doctor) per order; Administer medications as ordered. A review of Resident #128's physician orders, dated 7/30/2019, revealed, in part, the following order related to the treatment of diabetes: "Humalog (1) 10 units/ml. Generic: Insulin Lispro Kwikpen inject subq (subcutaneous) ac (with	F 760	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving sliding scale insulin may have potentially been affected. A 100% audit of all residents with sliding scale insulin orders will be conducted to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action and inservice training will be administered as warranted. An Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed Nursing staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of sliding scale insulin per physician order. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will perform 2 random weekly Medication Pass audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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F 760	Continued From page 65 meals) & hs (at bedtime) per sliding scale: 100-125=2u (units) 126-200=4u 201-249=6u 250-299=8u 300-349=10u 350-400=12u >401=14u" Review of Resident #128's August 2019 medication administration record (MAR) revealed that on 8/6/19, Resident #128's blood glucose level measured 163 at 7:30 a.m.. The nurse gave 10 units of sliding scale insulin which resulted in 6 extra units of insulin being administered. Further review of Resident #128's clinical record revealed no negative outcome from this deficient practice. Resident #128's blood sugar measured 171 at 11:30 a.m. On 8/8/19 at 11:36 a.m., a phone interview was conducted with RN (Registered Nurse) #2, the nurse who administered the 6 extra units of insulin. RN #2 was asked what the check marks indicate on the MAR. RN #2 stated, "Check marks mean that it was given." When asked, what it means to administer medications on a sliding scale, RN #2 stated, "Those are units given per order." When asked regarding the 10 units of Humalog administered on 8/6/2019 for a blood glucose level of 163, RN #2 stated, "I don't recall that." When asked what are the negative outcomes of administering the wrong number of units of Humalog, staff #2 responded, "sugar would drop, go into a coma." On 8/8/19 at approximately 2:20 p.m., a phone interview was conducted with other staff member	F 760		

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F 760	Continued From page 66	F 760		

(OSM) #5, the pharmacist. When asked if there would be any negative side effects for administering 10 units, vs the ordered 4 units of Humalog for a blood sugar of 163, OSM #5 stated, "10 units is not that high, should have checked 30 minutes after administration, could become hypoglycemic. A significant med error."

There was no record of a blood sugar check 30 minutes after the administration of 10 units of Humalog on 8/6/2019.

On 8/8/19 at 3:18 p.m., an interview was conducted with administrative staff member (ASM) #2, the ADON (Assistant Director of Nursing). When asked the side effects of administering 10 units of Humalog vs. the ordered 4 units for a blood sugar reading of 163, ASM #2 stated that six extra doses was not significant but that resident could possibly become hypoglycemic.

On 8/8/19 at 3:18 p.m., ASM #1, the Administrator and ASM #2, the ADON were made aware of the above concerns.

Heritage Hall policy on Administering Medications (revised December 2016) states:

(3). Medications must be administered in accordance with the orders, including any required time frame.

(20). As required or indicated for a medication, the individual administering the medication will record in the resident's medical record:
a. The date and time the medication was administered;
b. The dosage;

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F 760	Continued From page 67 c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. (1) HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f . Review of Davis's Drug Guide for Nurses 11th edition documents in part, the following: "High Alert: Insulin -related medication errors have resulted in patient harm and death...Check type, dose, and expiration date with another licensed nurse...Toxicity and Overdose: Overdose is manifested by symptoms of hypoglycemia. Mild hypoglycemia may be treated by ingestion of oral glucose. Severe hypoglycemia is a life-threatening emergency; treatment consists of IV (intravenous) glucose, glucagon, or epinephrine...symptoms of hypoglycemia (anxiety; restlessness; tingling in hands, feet, lips or tongue; chills, cold sweats, confusion, cool, pale skin; difficulty in concentration; drowsiness...rapid heart rate, tremor, weakness, unsteady gait."	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 68 §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, staff interview, and facility document review, it was determined that facility staff failed to store and prepare food in a sanitary manner in the facility kitchen. The findings included: On 8/4/19 at 12:40 p.m., observation of the facility kitchen was conducted. On 8/4/19 at 1:10 p.m., an open container of ham was found in the reach-in refrigerator. The open date labeled on the container of ham documented "7/22/19." A second date on the container of ham documented "7/26/19." On 8/4/19 at 1:10 p.m., a pitcher that was half way full of tomato juice was also observed in the	F 812	**F812** **Corrective Action(s):** The open container of ham with 2 dates written on the container and the outdated half full container of Tomato Juice was removed from the reach-in refrigerator and disposed of. A facility Incident and Accident form was completed for this incident. The two metal ceiling vents over the food prep area that were accumulating condensation have been replaced with plastic ceiling vents to reduce condensation building up, the thermostat control now has a locking cover to prevent the staff from adjusting the temperature down and increasing the condensation in the kitchen. The tray line prep area has been reviewed and tray cart locations have been adjusted to prevent carts from being under the ceiling vents in the kitchen. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will randomly monitor the kitchen preparation area before, during and after meals to identify any negative findings. The freezers and refrigerators in the kitchen will be monitored daily for proper storage of food items. Any expired food or unlabeled or undated food items identified in the kitchen freezers, refrigerators or dry storage area will be corrected at time of discovery and appropriate disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding identified.	

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F 812	Continued From page 69 reach in refrigerator. "7/27/19" was the date labeled on the pitcher. On 8/4/19 at 1:11 p.m., an interview was conducted with OSM (other staff member) #7, the cook. When asked about the second date labeled on the ham, OSM #7 stated that the 7/26/19 date was the use by date and that the ham should have been thrown away. OSM #7 then stated that the ham was either old or staff labeled the wrong dates on the container. OSM #7 then threw the container away. When asked about the tomato juice, OSM #7 stated that it was probably made that day and would be used by the end of the day. When asked why the date on the pitcher documented "7/27/19," OSM #7 stated that the wrong date must have been written on the pitcher. OSM #7 could not say for certain if the tomato juice was new or old. On 8/6/19 at 10:10 a.m., a second observation of the facility kitchen was conducted. Two vents in the ceiling were observed over the food prep station. The vents were accumulating condensation from the A/C (air conditioning) units. Water droplets were observed coming off the first vent and onto a tray full off hot dog buns. The tray was covered in plastic wrap. Water droplets were also observed dripping from the second vent onto the food rack that contained trays of sandwiches. The sandwiches were also covered in plastic wrap. Unidentified black spots were observed on the vents. There was also a puddle of water observed on the floor underneath the food tray rack. On 8/6/19 at approximately 10:15 a.m., an interview was conducted with OSM (other staff member) #8, the maintenance director. When	F 812	The Maintenance Staff will monitor the kitchen for condensation and proper maintenance of the temperature in kitchen area to prevent condensation building up. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The Dietary Manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, to include ensuring all expired foods items are removed from distribution and that the temperatures are in the appropriate range for the refrigerator and freezer. All Dietary staff will be inserviced on the revised layout of the tray line prep and set up area for proper meal tray set up in a sanitary fashion. **Monitoring:** The Dietary Manager and the DON are responsible for maintaining compliance. The Dietary manager will complete the Dietary food storage audit tool daily to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The maintenance staff will perform weekly Kitchen audits to monitor for compliance with condensation and temperature in the kitchen. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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F 812	Continued From page 70	F 812		

asked where the condensation on the vents was coming from, OSM #8 stated that the condensation was coming from the air conditioner. OSM #8 stated that the staff in the kitchen like to turn up the A/C causing it to work harder. OSM #8 stated that the door between the dining room and kitchen was also kept open at times making the A/C unit work harder. OSM #8 stated it was currently 68 degrees (Fahrenheit) in the kitchen but at times he will notice the thermostat in the 50's. OSM #8 stated he had placed a sign up in the kitchen asking staff to not touch the thermostat. When asked if water from the vents should be dripping on the food trays, OSM #8 stated that it should not. When asked why water from the vents should not be dripping on the food trays, OSM #8 stated, "I wouldn't want water on my food." When asked if the water from the vents was clean, OSM #8 stated that he didn't know. When asked what the black spots on the vents were, OSM #8 stated that he didn't know. When asked if it was mold, OSM #8 stated again that he didn't know.

On 8/6/19 at 10:20 a.m., an interview was conducted with OSM #9, the dietary manager. When asked how long the vents were dripping water, OSM #9 stated that he never paid attention or "any mind" to the dripping water so he was not sure how long the water had been "dripping like that."

On 8/8/19 at 3:18 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the ADON (Assistant Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

Facility policy titled, "Covering, Labeling, Dating

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F 812	Continued From page 71 Food," documents in part, the following: "Refrigeration Storage: 1. All foods must be covered, labeled and dated with a date label. All food should be monitored each day to be assured that the foods will be used, consumed, or discarded by the use by date or expired date...All leftover food (previously prepared on site) food must be used or discarded within 3 days. The count begins the day the food was prepared. 4. All food items that are not secured in their original containers must be stored in closed containers and secured. The label must identify the common name of food, if food cannot easily be identified. The label must have the date the food was packaged, received or prepared and/or an expiration date. Expiration dates may be used or the food storage chart guideline may be used to determine the expiration date." Complaint Deficiency.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to maintain the facility dumpster in a manner to prevent pests for one of two facility dumpsters. The findings included: On 8/4/19 at 1:15 p.m., observation of the facility dumpster was conducted with OSM #7, the cook. One of two facility dumpsters had the doors open	F 814	**F814** **Corrective Action(s):** The area around the dumpsters was cleaned and all the dumpster doors were closed. A Facility Incident & Accident Form has been completed for this incident. **Identification of Corrective Deficient Practice(s) & Corrective Action(s):** All other garbage disposal and storage areas have the potential to be affected. The Maintenance Director and Environmental Services Director will inspect all garbage storage areas to identify risk. Any/All negative findings will be corrected at time of discovery.	

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F 814	Continued From page 72 to the front and back of the dumpster. The dumpster was over full with trash. When asked who was responsible for maintaining the facility dumpster; ensuring it was shut and free from surrounding debris, OSM #7 stated that everyone (all staff) should make sure the dumpsters are shut and the surrounding area was clean, but that it was ultimately dietary's responsibility. When asked why the dumpster should be shut, OSM #7 stated to prevent pests from getting into the trash especially the feral cats that have been spotted in the area. OSM #7 confirmed that the dumpster was not shut. On 8/8/19 at 3:18 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the ADON (Assistant Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Disposal of Garbage and Refuse," documents in part, the following: "Refuse containers and dumpster kept outside the facility should have tightly fitting lids and should be covered when not being loaded. Dumpster should be emptied according to the facility contract; garbage should not accumulate or be left outside the dumpster."	F 814	**Systemic Change(s):** The facility policy & procedure for the storage and disposal of refuse was reviewed and no changes are warranted at this time. The Maintenance Director and/or Environmental Services director will provide in-services to all staff on the proper techniques for the collection, storage, and disposal of refuse. The inservice training will include disposing of all refuse inside supplied dumpsters. **Monitoring:** The Environmental Services Director is responsible for maintaining compliance. The Maintenance Director and/or Environmental Services Director will complete rounds of dumpster areas weekly to monitor and maintain compliance. Any negative findings will be corrected immediately. The results of these rounds will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	**F880** **Corrective Action(s):** LPN #1 involved in the Treatment Observation for Resident's #12 has received one-on-one inservice training on proper infection control practices to be followed during a dressing change. A Facility Incident & Accident form was completed for this incident. Resident #129's foley catheter drainage system has been changed and the resident's attending physician has been notified of the incident. A Facility Incident & Accident form was completed for this incident	

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F 880	Continued From page 73 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who receive a dressing change and all residents who have foley catheters may have potentially been affected. The DON, ADON and/or Unit Manager will conduct a 100% audit of all dressing change treatments on all licensed nursing staff to observe proper infection control practices and proper hand washing during the treatment pass administration procedures. Any negative findings will be addressed immediately, and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. The infection preventionist will conduct a 100% audit of all residents with foley catheters to determine those at risk. Any negative findings will be addressed immediately, and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed staff will be inserviced on the facility policy and procedure for proper infection control practices during treatment procedures and when foley catheters are in use by the DON and/or Regional Nurse Consultant. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will perform 2 random weeklyTreatment Pass audits to monitor nursing staff for compliance. The infection preventionist will conduct visual audits 3 times weekly of all residents with foley catheter to monitor for compliance.	

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F 880	Continued From page 74 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to maintain infection prevention for 2 of 56 residents in the survey sample. For Resident #12 the facility staff failed to perform wound care in a manner to prevent infection; and for Resident #129 the facility staff failed to maintain Foley catheter tubing and bag in a manner in accordance with infection control standards and practices. . The findings included: 1. Resident #12 was originally admitted to the facility 08/19/10 and readmitted on 04/08/11. Resident #12's diagnoses included Diabetes Mellitus without complications and Essential Hypertension. The Quarterly Revision Minimum Data Set (MDS)	F 880	Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/20/19**	

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assessment with an assessment reference date (ARD) of 04/16/19 coded the resident as having short term and long term memory problems.

In section "G" (Physical functioning) the resident was coded as needing limited physical assistance bed mobility, limited assistance with transfers, supervision with locomotion, limited assistance with dressing, limited assistance with eating, one person physical assistance with toileting, personal hygiene and bathing.

On 08/07/19 at approximately 9:48 AM Resident #12 was receiving wound care to his right heel by LPN (Licensed Practical Nurse) #1. As she removed the soiled kerlix dressing the resident's right heel rested on the resident's bed sheet. LPN #1 then asked Resident #12 if he was ok, he stated "yes." She received assistance from CNA #7, to help raise up resident's right foot She then preceded to clean his right heel wound without difficulty.

On 8/07/19 at approximately 10:10 AM with LPN #1 concerning the above issue. She stated "There should have been a pad placed under him when I removed the dressing and should have placed a pad under his foot."

A review of physician orders read as follows: Cleanse right heel wound with DWC pat dry, lightly pack with dakins moistened gauze wrap with rolled kerlix gauze every day and as needed.

On 08/08/19 at approximately 4:22 PM an interview was conducted with LPN #10. She was asked if she was providing wound care on a resident's heel how would she proceed with it? "I would have someone assist me to elevate the

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resident's heel." "I would rest their heel on a drape."

Wound Care Policy: Purpose: The purpose is to provide guidelines for the care of wounds to promote healing. Preparation: Assemble the equipment and supplies as needed. Equipment and Supplies: Disposable cloths, as indicated. Steps in the Procedure: #3 Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites.

On 08/08/19 at approximately, 3:00 PM a pre-exit interview was conducted. Present were DON and Administrator. No comments were made.

2. Resident # 129 was originally admitted to the facility for skilled services on 7/5/19 following a fall at home resulting in a left hip fracture and then readmitted on 8/1/19 after a hospitalization with diagnosis of Foley related sepsis Urinary Tract Infection (UTI), other diagnoses included neurogenic bladder (a dysfunction of the bladder) and dementia. The current MDS a 14 day with a assessment reference date of 7/19/19 coded the resident as having long and short term memory deficits and severely impaired cognitive skills for daily decision making. The resident was coded as having an indwelling Foley catheter (a plastic tube inserted into the bladder to drain urine).

The Person Centered Plan of Care dated 8/1/19 for Resident #129 identified that the resident was at risk for injury related to the presence of an indwelling catheter related to neurogenic bladder, the resident removes his catheter securement device and pulls at catheter. The interventions did not include approaches to handle the tubing

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or Foley drainage bag in a manner to prevent catheter-associated urinary tract infections.

08/4/19 at 4:04 p.m., observed during the initial tour and again on 8/5/19 at 10:26 a.m., 11:43 a.m., 1:12 p.m. and 1:33 p.m. the Foley drainage bag was attached to the side of the bed, the bed was being maintained in the low position due to the resident's fall risk, the drainage bag and tubing were observed on the floor. On 8/6/19 at approximately 9:15 a.m., and 4:00 p.m., the resident was observed in bed in low position with the Foley catheter tubing and drainage bag on the floor. On 8/7/19 at 9:50 a.m., the resident was observed in a wheelchair being transported to the rehab therapy room by the private sitter. The Foley bag was observed to be in contact with the floor during the transport. At 4:06 p.m., the resident was observed sitting up in the wheelchair in front of the nurses station. The Foley drainage bag was attached under the wheelchair seat but not high enough to prevent it from making contact with the floor.

On 8/8/19 at 10:13 a.m., the resident was observed asleep in bed, the Foley drainage bag and tubing were on the floor. At this time the right side unit manager was asked to come into the room. When asked if the Foley catheter bag and tubing should be making contact with the floor she stated, "Absolutely not." When asked why, she stated, "Because of the germs." She then stated, "Thank you and I will take care of it."

On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing.

The facility policy and procedure titled Catheter

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F 880	Continued From page 78 Care, Urinary revised September 2016 read as follows: Purpose-The purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control: 2.b. Be sure the catheter tubing and drainage bag are kept off the floor. No additional information was provided prior to exit.	F 880		