STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	C 06/20/2019

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MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/18/2019 through 06/20/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/18/19 through 06/20/19. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 39 current Resident reviews and 5 closed record reviews.	F 000		
F 622 SS=D	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 endangered due to the clinical or behavioral status of the resident;	F 622		7/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/07/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 622	Continued From page 1 (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 must include: (A) The basis for the transfer per paragraph (c)(1)	F 622		

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F 622	Continued From page 2 (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 staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure the required physician documentation was completed and/or that the required transfer documentation was provided to the receiving facility upon hospital transfers for three of 44 residents in the survey sample; Resident #53, #12, and #94.	F 622	1) The facility failed to evidence that the comprehensive care plan goals were sent with resident #12, failed to evidence that the required transfer requirement was provided to the receiving facility for resident #53, and failed to retain a copy of the transfer checklist for resident #94 upon facility initiated transfer. No negative	

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F 622	Continued From page 3 1. The facility staff failed to evidence that the required transfer documentation was provided to the receiving facility for Resident #53's transfer to the hospital on 2/23/19. 2. The facility staff failed to evidence that the comprehensive care plan goals were sent with Resident #12 to the hospital on 04/05/2019. 3. The facility staff failed to evidence what, if any, required transfer documentations was provided to the receiving facility when Resident #94 was transferred to the hospital on 2/18/19. The findings include: 1. The facility staff failed to evidence that the required transfer documentation was provided to the receiving facility for Resident #53's transfer to the hospital on 2/23/19. Resident #53 was admitted to the facility on 7/18/17 with the diagnoses of but not limited to pleural effusion, pulmonary embolism, high blood pressure, chronic kidney disease, heart failure, diabetes, peripheral vascular disease, anxiety disorder, and above knee amputation. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/19/19. The resident was coded as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 2/23/19 that documented, "Resident is 84 year old female, admitted with diagnoses of CHF (congestive heart failure), HLD	F 622	clinical outcome has been identified for Resident #12, #53, or #94. 2) Any resident transferred to the hospital has the potential to be affected if facility staff fail to follow transfer and discharge requirements for any facility and/or resident initiated transfer. Residents transferred in the last 72 hours will be reviewed and variances addressed. 3) Director of Nursing (DON) or designee will educate licensed staff to provide required transfer documentation for facility and/or resident initiated transfers. 4) The DON or designee will review charts of residents transferred to the hospital for evidence that required transfer documentation was provided weekly x 4 weeks, then monthly x 2 months. The DON or designee will report findings to the QAPI committee for further recommendation.	

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F 622	Continued From page 4 (hyperlipidemia) & (and) CAD (coronary artery disease). She is alert and oriented x 3 (alert and oriented to person, place, time), verbally responsive. Currently on ABT (antibiotic therapy) PO (by mouth), Augmentin (1) for UTI (urinary tract infection) & Levaquin (2) tab for PNA (pneumonia). VS (vital signs) 124/80 (blood pressure) 86 (pulse rate) 18 (respirations) 97.9 (temperature) 95% (oxygen saturation) on 2L (two liters) oxygen via NC (nasal cannula). Complained of pleuritic pain radiating to the right flank area at the start of shift, no tenderness or fever noted on assessment, PRN (as needed) Tylenol (3) administered. Approximately 19:30 (7:30 PM) paramedics were seen entering patient's room, she had apparently called 911 and insisted on being taken to the ER (emergency room), unable to reach first emergency contact (name), 2nd emergency contact (name) & MD (medical doctor) notified. Patient transported to (name of hospital) Emergency Room." This note did not document what, if any, required documentation was provided to the hospital upon transfer. Further review of the clinical record revealed a "Nursing Home to Hospital Transfer Form" (E-Interact form) dated 2/23/19 which included information of Resident #53's demographics, code status, emergency contact information, physician contact information, facility contact information, reason for transfer, vital signs, allergies, mental status, usual functional status, devices and treatments, allergies, risk alerts, and impairments. This form did not document that the medication list and comprehensive care plan goals were	F 622		

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F 622	Continued From page 5 provided to the receiving facility for the 2/23/19 hospital transfer. A review of the facility "Transfer Checklist" revealed that a resident's E-Interact form, Face Sheet, Advanced Directives, current medication list, most recent History and Physical, Recent/Relevant Labs [laboratory tests], and Comprehensive Care Plan Goals, among other documents, were to be provided to the hospital. The facility did not retain a copy of this checklist upon completion for Resident #53's 2/23/19 hospital transfer. There was no evidence that any of the required documents were provided to the receiving facility for the 2/23/19 hospital transfer. On 6/20/19 at 2:33 PM, in an interview with RN #3 (Registered Nurse) she stated that the paperwork that is sent to the hospital for residents' includes the care plan, bed hold notice, face sheet, medication list, all the orders. RN #3 stated there was a folder with checklist that is completed and that staff check off on the folder and send it. She stated that a copy of the checklist is not kept. RN #3 stated that the nurse's document in a note what was sent. RN #3 was asked how the facility evidences the information sent to the hospital if the facility does not keep a copy of checklist and does not document a note including the information sent. RN #3 stated that there wouldn't be any if it was not in a note. She stated that EMS (emergency medical services) doesn't wait for a lot of paperwork in an emergency; that most of it is already in the folder. On 6/20/19 at 2:52 PM, in an interview with LPN	F 622		

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F 622	Continued From page 6 #9 (Licensed Practical Nurse) the unit manager, she stated that the facility goes by the checklist for what to send but doesn't keep a copy of the checklist. On 6/20/19 at approximately 4:15 PM, the Administrator (ASM #1 - Administrative Staff Member) and the DON (Director of Nursing, ASM #2) reviewed the clinical record and stated that it did not reflect evidence of what was sent to the hospital upon the 2/23/19 hospital transfer. A review of the facility policy, "Notification of Discharge" did not specify what, if any, required documentation is to be sent with the resident to the hospital. No further information was provided by the end of the survey. (1) Augmentin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a685024.html (2) Levaquin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697040.html (3) Tylenol is used to treat mild to moderate pain. 2. The facility staff failed to evidence that the comprehensive care plan goals were sent with Resident #12 to the hospital on 04/05/2019. Resident #12 was admitted to the facility on 01/16/2017. Her diagnoses included Dementia, Schizoaffective Disorder (1), Epilepsy,	F 622		

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F 622	Continued From page 7 Hypertension (high blood pressure), and Anemia (low level of red blood cells). Resident #12's most recent Minimum Data Set (MDS) assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 03/25/2019. The Brief Interview for Mental Status (BIMS) scored Resident #12 at 15, indicating no impairment. Review of the clinical record revealed that Resident #12 was transferred to the hospital on 04/05/2019. Per a Progress Note dated 04/05/2019 at 10:59a.m., which documented in part the following: "...MD (medical doctor) ordered resident sent to ER (emergency room) via 911 for possible seizure activity with pain in lower abdominal pain associated with menstrual cycle with heavy bleeding. Pt (patient) was taken out at 1105 (11:05a.m.) by Paramedics, Resident sent with discharge paperwork: current med [medication] list, bed hold policy, transfer form, no advanced directives, face sheet." The progress note did not include documentation that resident's comprehensive care plan goals were sent with the resident to the hospital. On 06/20/2019 at 2:45p.m., an interview was conducted with Licensed Practical Nurse (LPN) #9 regarding transfer of residents to the hospital. LPN #9 was asked if comprehensive care plan goals were sent with the resident on transfer to the hospital. LPN #9 stated that they were, and were included on the Transfer Checklist. When asked if the facility retained a copy of the Transfer Checklist as documentation of what is sent with the resident, LPN #9 stated that no copy of the checklist is kept. Administrative Staff Member (ASM) #1, the	F 622		

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F 622	Continued From page 8 Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/20/2019. No further documentation was provided. 1. Schizoaffective disorder is a mental condition that causes both a loss of contact with reality (psychosis) and mood problems (depression or mania). - https://medlineplus.gov/ency/article/000930.htm Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html 3. The facility staff failed to evidence what, if any, required transfer documents was provided to the receiving facility when Resident #94 was transferred to the hospital on 2/18/19. Resident #94 was admitted to the facility on 5/23/16 with the diagnoses of but not limited to unspecified dementia with behavioral disturbance, type 2 diabetes mellitus, end stage renal disease (1), dependence on renal dialysis, and peripheral vascular disease. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 6/2/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 2/18/19, at 9:30 AM, that documented in part, "Res (resident) has temp (temperature) of 101.1 (degrees) at change of shift ...Per NP (Nurse Practitioner) resident to be sent out ...Resident said he is not nauseous but 'does not feel well.' Resident transported to hospital via	F 622		

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F 622	Continued From page 9 stretcher with EMT (Emergency Medical Technician)." A review of the clinical record revealed a physician's note dated 2/18/19, documented in part, " ...Pt (patient) is c/o (complaining of) felling lethargic, malaise w/ (with) feeling hot and tremulous throughout. He said he has chills/fever/night sweats and mumbling ...PCP-NP (Primary Care Physician) immediately notified and gave order for ER (Emergency Room) ..." A review of the "Transfer Checklist" revealed that E-Interact Transfer Form, E-Interact Change in Condition Form, SBAR (Situation, Background, Appearance, and Review and Notify), Face Sheet, Current Medication List, H&P (History and Physical), Advanced Directive, Comprehensive Care Plan Goals, Nursing Home Capabilities List, Bed Hold Policy, (electronic health record) Transfer Order, (electronic health record) Progress Note, and Personal Belongings Sent With Resident is to be documented on this form. However, the facility did not retain a copy of this form for Resident #94's hospital transfer on 2/18/19 and therefore had no evidence that any of the required documentation was sent. On 6/20/19 at 4:07 PM, ASM (administrative staff member) #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings. No further information was provided by the end of the survey. (1) End Stage Renal Disease: is a medical condition in which a person's kidneys cease	F 622		

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F 622	Continued From page 10 functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. This information was obtained from the following website: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		7/23/19

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F 623	Continued From page 11 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance	F 623		

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F 623	Continued From page 12 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure the resident or resident representative, was provided written notification of a hospital transfer for four of 44 sampled residents, (Residents #53, #12, #94, and #43); and failed to provide a copy of the notice of transfer to the ombudsman for one of 44 sampled residents, (Resident #21).	F 623	1) The facility failed to provide written notice to Resident #12, #43, #53 and #94 or the residents Responsible Representatives of facility and/or resident initiated transfers to the hospital, and failed to provide a copy of the notice of transfer to the Ombudsman for resident #21. No negative clinical outcome has been identified for Resident #12, #43, #53 or #94 as a result.	

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F 623	Continued From page 13 1. The facility staff failed to evidence that Resident #53 or the resident representative were provided with written notification of the residents hospital transfer on 2/23/19. 2. The facility staff failed to evidence that the Resident #12 or the responsible party were given written notice for the residents transfer to the hospital on 04/05/2019. 3. The facility staff failed to provide Resident #94's representative with the required written notification of why the resident was sent to the hospital on 2/18/19. 4. The facility staff failed to provide Resident #43's representative with the required written notification of why the resident was sent to the hospital on 4/10/19. 5. The facility staff failed to notify the ombudsman of a facility-initiated transfer on 04/11/19 and 04/16/19 for Resident #21. The findings include: 1. The facility staff failed to evidence that Resident #53 or the resident representative were provided with written notification of the residents hospital transfer on 2/23/19. Resident #53 was admitted to the facility on 7/18/17 with the diagnoses of but not limited to pleural effusion, pulmonary embolism, high blood pressure, chronic kidney disease, heart failure, diabetes, peripheral vascular disease, anxiety disorder, and above knee amputation. The most recent MDS (Minimum Data Set) was a quarterly	F 623	2) Any resident transferred to the hospital has the potential to be affected if facility staff fail to provide written notice of facility and/or resident initiated transfer to a resident, resident representative or the Ombudsman. Medical records of residents transferred to the hospital in the last 72 hours will be reviewed to ensure a Resident or Responsible Representative and the Ombudsman has been notified. Any variance will be addressed. 3) Director of Nursing (DON) or designee will educate licensed nursing staff of the requirement to provide written notice to the resident and/or resident representative. The Director of Nursing (DON) will provide education to Social Services regarding the requirement to provide notification to the Ombudsman of any facility and/or resident initiated transfers. 4) The DON or designee will review charts of residents transferred to the hospital for evidence that the Resident/Responsible Representative and the Ombudsman was provided written notice of facility and/or resident initiated transfer weekly x 4 weeks, then monthly x 2 months. Findings will be reported to the QAPI committee for further recommendation.	

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F 623	Continued From page 14 assessment with an ARD (Assessment Reference Date) of 5/19/19. The resident was coded as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 2/23/19 that documented in part the following, "Complained of pleuritic pain radiating to the right flank area at the start of shift, no tenderness or fever noted on assessment, PRN (as needed) Tylenol (3) administered. Approximately 19:30 (7:30 PM) paramedics were seen entering patient's room, she had apparently called 911 and insisted on being taken to the ER (emergency room), unable to reach first emergency contact (name), 2nd emergency contact (name) & MD (medical doctor) notified. Patient transported to (name of hospital) Emergency Room." This note did not document that a written notification was provided to the resident and/or resident representative. A review of the facility "Transfer Checklist" revealed that, among other documents, a "Transfer & Treatment Form" is included in the hospital transfer packet. The facility did not retain a copy of this checklist upon completion for Resident #53's 2/23/19 hospital transfer. On 6/20/19 at 4:12 PM, an interview was conducted with the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #2). ASM #1 was asked to describe how the resident and the resident's representative are provided written notification of a transfer. ASM # 1 stated, "If we are sending them to the hospital and if the resident is alert we	F 623		

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F 623	Continued From page 15 communicate to them verbally why they are going to the hospital and we complete the transfer packet with all the documentation listed on it. Included in that packet is the transfer note that has the reason for transfer. It is documented in the clinical record (electronic health record) under the progress notes that that they (resident and resident representative) were informed of the transfer. We use the transfer note as the written notification to the resident and resident representative. The Director of Nursing is responsible for ensuring the process is followed." On 6/20/19 at approximately 4:15 PM, ASM #1 and ASM #2, the director of nursing, reviewed the clinical record and stated that it did not reflect evidence of this notification being completed and provided. A review of the facility policy, "Notification of Discharge" documented, "....Discharge notices for emergent discharges will be provided to the patient/representative as soon as practicable....When possible, provide the Discharge notice with the paperwork that accompanies the patient to the hospital. If not possible, issue the notice to a responsible party/representative as soon as practicable following the hospital transfer and document in the medical record...." No further information was provided by the end of the survey. (1) Augmentin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a685024.html	F 623		

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F 623	Continued From page 16 (2) Levaquin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697040.html (3) Tylenol is used to treat mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html 2. The facility staff failed to evidence that the Resident #12 or the responsible party were given written notice for the residents transfer to the hospital on 04/05/2019. Resident #12 was admitted to the facility on 01/16/2017. Her diagnoses included Dementia, Schizoaffective Disorder (1), Epilepsy, Hypertension (high blood pressure), and Anemia (low level of red blood cells). Resident #12's most recent Minimum Data Set (MDS) assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 03/25/2019. The Brief Interview for Mental Status (BIMS) scored Resident #12 at 15, indicating no impairment. Review of the clinical record revealed that Resident #12 was transferred to the hospital on 04/05/2019. Per a Progress Note dated 04/05/2019 at 10:59a.m., which documented in part the following: "...MD (medical doctor) ordered resident sent to ER (emergency room) via 911 for possible seizure activity with pain in lower abdominal pain associated with menstrual cycle with heavy bleeding. Pt (patient) was taken out at 1105 (11:05a.m.) by Paramedics, Resident sent with discharge paperwork: current med [medication] list, bed hold policy, transfer form, no advanced directives, face sheet."	F 623		

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F 623	Continued From page 17 The progress note did not include documentation that a written notification was given to the resident or sent to the RP (responsible party). On 06/20/19 at 4:12 p.m., an interview was conducted with ASM (administrative staff member) # 1, administrator and ASM # 2, the director of nursing. ASM #1 was asked to describe how the resident and the resident's representative are provided written notification of a transfer. ASM # 1 stated, "if we are sending them to the hospital and if the resident is alert we communicate to them verbally why they are going to the hospital and we complete the transfrer packet with all the documentation listed on it. Included in that packet is the transfer note that has the reason for transfer. It is documented in the clinical record (electronic health record) under the progress notes that that they (resident and resident representative) were informed of the transfer. We use the transfer note as the written notification to the resident and resident representative. The director of nursing is responsible for ensuring the process is followed." Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/20/2019. No further documentation was provided. 1. Schizoaffective disorder is a mental condition that causes both a loss of contact with reality (psychosis) and mood problems (depression or mania). - https://medlineplus.gov/ency/article/000930.htm 3. The facility staff failed to provide Resident	F 623		

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F 623	Continued From page 18 #94's representative with the required written notification of why the resident was sent to the hospital on 2/18/19. Resident #94 was admitted to the facility on 5/23/16 with the diagnoses of but not limited to unspecified dementia with behavioral disturbance, type 2 diabetes mellitus, end stage renal disease (1), dependence on renal dialysis, and peripheral vascular disease. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 6/2/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 2/18/19, at 9:30 AM, that documented in part, "Res (resident) has temp (temperature) of 101.1 (degrees) at change of shift ...Per NP (Nurse Practitioner) resident to be sent out ...Resident said he is not nauseous but 'does not feel well.' Resident transported to hospital via stretcher with EMT (Emergency Medical Technician)." A review of the clinical record revealed a physician's note dated 2/18/19, at 9:30 AM, documented in part, " ...Pt (patient) is c/o (complaining of) felling lethargic, malaise w/ (with) feeling hot and tremulous throughout. He said he has chills/fever/night sweats and mumbling ...PCP-NP (Primary Care Physician) immediately notified and gave order for ER (Emergency Room) ..." There was no evidence that the resident representative was provided with the required	F 623		

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F 623	Continued From page 19 written notification of why the resident was sent to the hospital on 2/18/19. On 6/20/19 at 4:12 p.m., an interview was conducted with ASM (administrative staff member) # 1, administrator and ASM # 2, the director of nursing. ASM #1 was asked to describe how the resident and the resident's representative are provided written notification of a transfer. ASM # 1 stated, "If we are sending them to the hospital and if the resident is alert we communicate to them verbally why they are going to the hospital and we complete the transfer packet with all the documentation listed on it. Included in that packet is the transfer note that has the reason for transfer. It is documented in the clinical record (electronic health record) under the progress notes that that they (resident and resident representative) were informed of the transfer. We use the transfer note as the written notification to the resident and resident representative. The director of nursing is responsible for ensuring the process is followed." On 6/20/19 at 4:07 PM, ASM #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings. No further information was provided by the end of the survey (1) End Stage Renal Disease: is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. This information was obtained from the following	F 623		

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F 623	Continued From page 20 website: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html 4. The facility staff failed to provide Resident #43's representative with the required written notification of why the resident was sent to the hospital on 4/10/19. Resident #43 was admitted to the facility on 11/19/18 with the diagnoses of but not limited to unspecified dementia without behavioral disturbance, peripheral vascular disease, type 2 diabetes mellitus, major depressive disorder, and anxiety. The most recent MDS (Minimum Data Set), a 14-day scheduled assessment, with an ARD (Assessment reference date) of 4/29/19, coded the resident as scoring a 12 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 4/10/19, at 3:00 PM, documented in part, "Called Dr. (Doctor) (name of) office to F/U (follow up) with doctor about possible direct admit to (name of) hospital due to fevers, poor appetite, IV (intravenous) fluids, and ABT (antibiotics) due to infection to foot needing amputation ...suggestion to send to (name of) hospital ER (Emergency Room) for admission ...NP (Nurse Practitioner) PCP (Primary Care Physician) made aware and approves orders." Further review of the clinical record revealed a	F 623		

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F 623	Continued From page 21 nurse's note dated 4/10/19, at 3:10 PM, "Called and spoke with daughter/RP (Responsible Party) (name), updated on all information from today's conversations and sending her dad to the hospital ...Daughter is ok with this and approved transfer ...Does not want a bed hold at this time due to cost." There was no evidence that the resident representative was provided with the required written notification of why the resident was sent to the hospital on 4/10/19. On 6/20/19 at 4:12 p.m., an interview was conducted with ASM (administrative staff member) # 1, administrator and ASM # 2, the director of nursing. ASM #1 was asked to describe how the resident and the resident's representative are provided written notification of a transfer. ASM # 1 stated, "if we are sending them to the hospital and if the resident is alert we communicate to them verbally why they are going to the hospital and we complete the transfer packet with all the documentation listed on it. Included in that packet is the transfer note that has the reason for transfer. It is documented in the clinical record (electronic health record) under the progress notes that that they (resident and resident representative) were informed of the transfer. We use the transfer note as the written notification to the resident and resident representative. The director of nursing is responsible for ensuring the process is followed." On 6/20/19 at 4:07 PM, ASM #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings.	F 623		

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F 623	Continued From page 22 No further information was provided by the end of the survey. 5. The facility staff failed to notify the ombudsman of a facility-initiated transfer on 04/11/19, for Resident # 21. Resident # 21 was admitted to the facility on 12/24/18 and a re-admission on 04/18/19 with diagnoses that included but were not limited to: chronic respiratory failure (1), old myocardial infarction (2), and anxiety (3). Resident # 21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/09/19, coded Resident # 21 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The facility's "Progress Notes" for Resident # 21 dated 04/11/2019 documented in part the following, "13:15 (1:15 p.m.) ... New order received to send the resident to (Name of Hospital) ER (emergency room) for further evaluation of ileostomy with constipation with non emergency services. (Name of Transportation Company) called at 13:20 (1:20 p.m.) and awaiting for arrival and call placed to the (Name of Hospital) ER at 13:25 (1:35 p.m.). RP notified and made him aware." On 06/20/2019 at 8:17 a.m., an interview was conducted with OSM (other staff member) # 10, social worker regarding notification to the ombudsman of a resident transfer. OSM # 10 stated, "I send faxes to the ombudsman on a daily basis for planned discharges to assisted living, or home and one time a week I fax a list of	F 623		

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F 623	Continued From page 23 discharges for those that went to the hospital." When asked about residents who are transferred to the hospital, OSM # 10 stated, "When the resident is transferred to the hospital I only notify the ombudsman if the resident is admitted, if they go to the hospital and return the same day I don't notify the ombudsman." OSM # 10 further stated that she was not aware that the ombudsman was required to be notified of all transfers regardless of whether they are admitted or not. On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI, were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 623		
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		7/23/19

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F 625 SS=D	Continued From page 24 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 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 observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to evidence that a written bed hold notice was provided to the resident's representative for a hospital transfer for one of 44 residents in the survey sample; Resident #94. The facility staff failed to provide	F 625	1) The facility failed to provide written notification of bed hold policy upon transfer to the hospital for Resident #94. No negative clinical outcome has been identified for Resident #94. 2) Any resident transferred to the hospital has the potential to be affected if	

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F 625	Continued From page 25 Resident #94's representative written notification of the bed hold policy when the resident was transferred to the hospital on 2/18/19. The findings include: Resident #94 was admitted to the facility on 5/23/16 with the diagnoses of but not limited to unspecified dementia with behavioral disturbance, type 2 diabetes mellitus, end stage renal disease (1), dependence on renal dialysis, and peripheral vascular disease. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 6/2/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note dated 2/18/19, at 9:30 AM, that documented in part, "Res (resident) has temp (temperature) of 101.1 (degrees) at change of shift ...Per NP (Nurse Practitioner) resident to be sent out ...Resident said he is not nauseous but 'does not feel well.' Resident transported to hospital via stretcher with EMT (Emergency Medical Technician)." A review of the clinical record revealed a physician's note dated 2/18/19, at 9:30 AM, documented in part, " ...Pt (patient) is c/o (complaining of) felling lethargic, malaise w/ (with) feeling hot and tremulous throughout. He said he has chills/fever/night sweats and mumbling ...PCP-NP (Primary Care Physician) immediately notified and gave order for ER (Emergency Room) ..."	F 625	facility staff fail to provide written notice of bed hold policy upon transfer to the hospital. Residents transferred to the hospital in the last 72 hours charts will be reviewed to ensure Resident or Responsible Representative were provided written notification of bed hold upon transfer. 3) Director of Nursing (DON) or designee will educate licensed nursing staff of the requirement to provide written notice of bed hold policy upon transfer to the hospital. 4) The DON or designee will conduct an audit for residents transferred to the hospital for evidence that Resident/Responsible Representative were provided written notification of bed hold upon transfer weekly x 4 weeks, then monthly x 2 months. Findings will be reported to the QAPI Committee for further recommendation.	

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F 625	Continued From page 26 A review of the "Transfer Checklist" revealed that E-Interact Transfer Form, E-Interact Change in Condition Form, SBAR (Situation, Background, Appearance, and Review and Notify), Face Sheet, Current Medication List, H&P (History and Physical), Advanced Directive, Comprehensive Care Plan Goals, Nursing Home Capabilities List, Bed Hold Policy, (electronic health record) Transfer Order, (electronic health record) Progress Note, and Personal Belongings Sent With Resident is to be documented on this form. However, the facility did not retain a copy of this form for Resident #94's hospital transfer on 2/18/19 and therefore had no evidence that any of the required documentation was sent. On 6/20/19 at 4:34 PM, an interview with RN (Registered Nurse) #3 was conducted. RN #3 was asked about the process staff follows when a resident goes to the hospital. RN #3 stated, "We send the care plan, bed hold policy, face sheet, doctor's order. There is a list in the transfer folder - a transfer checklist. The packet goes with the resident." RN #3 was asked if the facility cannot evidence the bed hold notification was provided if the information is not documented and a copy of the list is not retained. RN #3 stated, "I guess so." There was no evidence that the resident representative was provided written notification of the bed hold policy when the resident was transferred to the hospital on 2/18/19. A review of the facility's policy "Notice of Bed Hold Policy," documented in part," ...Nursing Services is responsible for ...2.Showing Policy to resident BEFORE the resident goes to the hospital ...3. Forwarding signed form (or witnessed mark) to	F 625		

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F 625	Continued From page 27 Social Services Department ...Social Services/Admissions are responsible for ...Following up to see that nursing has shown form to resident and that resident signed ...2. Notifying responsible party by phone, or in person, documenting conversation on Notice form is notified by phone, having responsible party sign form either in person or by Mail. (Keep a copy of form if sent in the mail) ..." On 6/20/19 at 4:07 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings. No further information was provided by the end of the survey. (1) End Stage Renal Disease: is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. This information was obtained from the following website: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html	F 625		
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:	F 641		7/23/19

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F 641	Continued From page 28 Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 44 residents in the survey sample, Resident # 107. The facility staff failed to accurately code Resident # 107's discharge status to the community on the discharge assessment MDS (minimum data set) with an ARD (assessment reference date) of 04/18/19. Instead, the resident's discharge was coded as 'Acute hospital." The findings include: Resident # 107 was admitted to the facility on 04/04/19 with diagnoses that included but were not limited to muscle weakness, difficulty walking and high blood pressure. Resident # 107's MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 04/18/19, coded Resident # 107 as "03 (three) - Acute hospital" under "section "A2100 Discharge Status." The facility's "Progress Notes" dated 04/18/2019, documented that Resident $ 107 left with her son and was discharged home. On 06/19/19 at 3:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 7, MDS coordinator. LPN #7 was asked if Resident # 107's "Discharge Return Not Anticipated" MDS assessment dated 04/18/2019 was correctly coded. LPN # 7 stated she would check and get back to this surveyor. On 06/19/19 at 4:02 p.m., LPN # 7 stated that	F 641	1) Center staff failed to accurately code Resident #107□s discharge status on the discharge assessment MDS dated 04/18/2019. Resident #107□s, MDS dated 04/18/2019 was modified to reflect discharge status to community. 2) Any resident whose discharge status is not accurately coded in the MDS has the potential to be affected. A review of the current discharged residents will be conducted to ensure accurate coding of the MDS. 3) The interdisciplinary team responsible for coding the MDS will be educated regarding accurate coding of the MDS. 4) MDS coordinators or designee(s) will conduct an audit of 5 completed discharge assessments weekly x 4 weeks, then monthly x 2 months for accurate coding of discharge status. Findings will be reported to the QAPI Committee for further recommendation.	

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F 641	Continued From page 29 after reviewing Resident # 107's progress notes and the discharge plan of care that the MDS was coded incorrectly. On 06/20/19 at 8:08 a.m., ASM (administrative staff member) 3 1, administrator, provided this surveyor with copy of the Resident # 107's corrected discharge MDS assessment dated 04/18/19. Under "section "A2100 Discharge Status" Resident # 107 was coded as "01 (one): Community (private home/apt ...board care, assisted living, group home.)." On 06/19/19 at approximately 5:30 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality assurance and performance improvement), were made aware of the findings. No further information was provided prior to exit.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		7/23/19

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F 656	Continued From page 30 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined that facility staff failed to develop and or implement the comprehensive care plan for three of 44 residents in the survey sample, Residents # 83, # 92, and # 43. 1. The facility staff failed to implement Resident #83's comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed pain medication.	F 656	1) Resident #83□s care plan was reviewed and revised to reflect the use of non-pharmacological interventions prior to administration of as needed pain medication. Residents # 92 and # 43□s care plans were reviewed and revised to reflect the use of side rails. 2) Any resident who resides in the facility has the potential to be affected by this issue. A review of the current residents with as needed pain medication will be conducted to ensure that the Care Plan	

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F 656	Continued From page 31 2. The facility staff failed to develop a comprehensive care plan for the use of side rails for Resident #92. 3. The facility staff failed to develop the comprehensive care plan for the use of bed rails for Resident #43. The findings include: 1. The facility staff failed to implement Resident #83's comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed pain medication. Resident # 83 was admitted to the facility on 12/05/2018 with diagnoses that included but were not limited to rheumatoid arthritis (1), depressive disorder (2), and anemia (3). Resident # 83s most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/28/19, coded Resident # 83 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. On 06/19/19 at 8:41 a.m., an interview was conducted with Resident # 83. When asked if the staff assess her pain before giving her an as needed (prn) pain medication, Resident # 83 stated, "Sometimes they will ask me what my pain level is from one to ten." When asked if the staff try to alleviate her pain using other techniques prior to administering the pain medication Resident # 83 stated, "No." The "Physician's Order Sheet" dated	F 656	includes the use of non-pharmacological interventions prior to administration of as needed pain medication and the use of side rails. 3) The interdisciplinary team responsible for care planning will be educated regarding accurate care planning per the RAI manual. 4) MDS coordinators or designee(s) will conduct an audit of 8 care plans weekly x 4 weeks, then monthly x 2 months. Findings will be reported to the QAPI Committee for further recommendation.	

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F 656	Continued From page 32 "06/19/2019" documented, "Tylenol Tablet 325MG (milligram) (Acetaminophen) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 12/14/2018. Start Date: 12/14/2018." The eMAR (electronic medication administration record) dated "Apr (April) 2019" documented the above physician's order for Tylenol. Review of the eMAR revealed Tylenol 325mg was administered on 04/02/19 at 9:26 p.m., with a pain level of two, 04/08/19 at 9:15 p.m., with a pain level of three, 04/09/19 at 5:49 a.m., with a pain level of two, 04/10/19 at 5:48 a.m., with a pain level of two and at 11:23 p.m., and on 04/21/19 at 8:58 p.m., with a pain level of four. Further review of the eMAR dated "Apr (April) 2019" and the eMAR notes dated 04/02/19 through 04/21/19 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Tylenol. The eMAR (electronic medication administration record) dated "May 2019" documented the above physician's order for Tylenol. Review of the eMAR revealed Tylenol 325mg was administered on 05/19/19 at 6:30 a.m., with a pain level of three and at 6:56 p.m. with a pain level of three. Further review of the eMAR dated "May 2019" and the eMAR notes dated 05/19/19 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Tylenol. The eMAR (electronic medication administration record) dated "June 2019"documented the above physician's order for Tylenol. Review of the eMAR revealed Tylenol 325mg was administered on 06/02/19 at 7:32 a.m., with a pain level of three and on 06/15/19 at 8:27 p.m. with a pain level of	F 656		

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F 656	Continued From page 33 three. Further review of the eMAR dated "June 2019" and the eMAR notes dated 06/02/19 and 06/15/19 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Tylenol. The comprehensive care plan for Resident # 83 dated 01/15/2019 documented, "Focus. (Resident # 83 has potential for pain, has H/O (history of) migraines and has [sic] contractors from arthritis. Date Initiated 12/05/2018. Revision on: 01/15/2019." Under "Interventions/tasks" it documented, "Assess pain level q (every) shift and PRN (as needed) and apply interventions as needed. Date Initiated: 12/05/2018." On 06/20/19 at 10:02 a.m., an interview was conducted with RN (registered nurse) # 2, unit manager. RN #2 was asked to describe the procedure for the administration of prn pain medication. RN # 2 stated, "Ask them if they have pain. Check the record for the resident's prn pain medication based on scale zero to ten, ten being the highest level of pain, and the location of the pain, check the order for which pain medication is prescribe and how much, administer the mediation and document it in the eMAR. Follow up with the resident an hour to determine the effectiveness of the medication." When asked about attempting non-pharmacological interventions, RN # 2 stated, "The non-pharmacological interventions should be attempted prior to administering the medication." When asked where the staff document the non-pharmacological interventions attempted, RN # 2 stated, "It is documented in the eMAR." After review of the eMAR for Resident # 83 dated April, May and June 2019, RN # 2 agreed that for the	F 656		

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F 656	Continued From page 34 above dates and time documented non-pharmacological interventions were not attempted. When asked to describe the purpose of a care plan, RN # 2 stated, "It tells us how to take care of the patient." When asked if the Resident #83's comprehensive care plan was implemented/followed for the use of non-pharmacological interventions RN #2 stated, "No." On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality assurance performance improvement), were made aware of the findings. No further information was provided prior to exit. References: (1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .	F 656		

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F 656	Continued From page 35 2. The facility staff failed to develop a comprehensive care plan for the use of side rails for Resident #92. Resident #92 was admitted to the facility on 5/18/19 with the diagnoses of but not limited to high blood pressure, chronic kidney disease, diabetes, epilepsy, renal dialysis, diabetic retinopathy, diabetic neuropathy, depression, blindness, congestive heart failure, stroke, peripheral vascular disease, end stage renal disease, amputation of right toes. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/25/19. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, hygiene, toileting, dressing, and transfers; and was independent for eating. Observations made of Resident #92 on 6/18/19 at 11:30 AM, 5:15 PM, and on 6/19/19 at 1:44 PM revealed Resident #92 in bed, with half side rails up on both sides. A review of the clinical record revealed that on readmission from the hospital on 5/5/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer	F 656		

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F 656	Continued From page 36 applied). Under that, was "b. If yes: ___1. Half, ___2. Full" (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1 Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #92, this document identified she was to use half-length side rails on both sides of the bed to promote independence with bed mobility. Further review of the clinical record failed to reveal any evidence an assessment for risk of entrapment for the use of side rails with Resident #92 was completed. There was no evidence of risk and benefits for the use of side rails being discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #92. A review of the comprehensive care plan revealed one dated 5/18/19 for "Demonstrates the need for ADL (activities of daily living) assistance." This care plan did not include any interventions for the use of side rails that the resident was observed using. On 6/20/19 at 2:47 PM, an interview was conducted with LPN #9 (Licensed Practical Nurse) the unit manager. She stated that the resident uses her side rails to turn and reposition, that the resident "is blind, has anxiety, and has seizures so side rails are appropriate." When asked if the side rails should be care planned, LPN #9 stated they should be. When asked who can initiate or change a care plan, LPN #9 stated that initially the admitting nurse and supervisor	F 656		

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F 656	Continued From page 37 does, but that any nurse can. A review of the facility policy, "Comprehensive Care Planning Process" documented, "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. An interdisciplinary assessment team shall develop a comprehensive assessment and care plan for each resident based on outcomes of assessments and input from the resident, family and interdisciplinary team members. The team serves as the authority for overseeing resident care services....A comprehensive care plan is developed within seven (7) days of completion of the initial comprehensive assessment (MDS)....Additionally, the care plan is a fluid document and shall be reviewed and updated at any time the resident, family or representative or member of the ID (interdisciplinary) team determines a need for additional interventions or care areas to be addressed...." On 06/20/19 at 4:00 PM, the Administrator, (ASM #1 - administrative staff member), was made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to develop the comprehensive care plan for the use of bed rails for Resident #43. Resident #43 was admitted to the facility on 11/19/18 with the diagnoses of but not limited to unspecified dementia without behavioral	F 656		

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F 656	Continued From page 38	F 656		

disturbance, peripheral vascular disease, type 2 diabetes mellitus, major depressive disorder, acquired absence of right leg above the knee, acquired absence of left leg above the knee, high blood pressure, and anxiety. The most recent MDS (Minimum Data Set), a 14-day scheduled assessment, with an ARD (Assessment reference date) of 4/29/19, coded the resident as scoring a 12 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required limited assistance for eating; extensive assistance for hygiene, dressing, and toileting; total care for bathing and transfers; was always incontinent of bladder and bowel.

On 6/18/19 at 1:45 PM and on 6/19/19 at 2:17 PM, the resident was observed in his room, in his wheel chair next to his bed. His bed was noted to have 2 half-length side rails (one on each side) and the side rails were up at each observation. Although the resident was not seen in bed for any of the observations, the side rails were present, in the up position, and available for potential use by the resident when he is in bed.

A review of the clinical record failed to reveal a comprehensive care plan for the use of bed rails for Resident #43.

On 6/20/19 at 7:33 AM, an interview was conducted with ASM (administrative staff member) #1, the administrator, regarding care planning bed rails. When asked if there are physician's orders for the use of the resident's bed rails, ASM #1 stated, "No, but they are care planned as a nursing intervention. The physician signs off on the care plan." When asked if the

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F 656	Continued From page 39 physician attends the care plan meetings, ASM #1 stated, "No." When asked if the physician reads the care plan, ASM #1 stated, "No." On 6/20/19 at 4:07 PM, ASM #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings. No further information was provided by the end of the survey.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		7/23/19

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F 690	Continued From page 40 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide care and services for a suprapubic catheter to prevent infections for one of 44 residents in the survey sample, Residents # 56. The facility staff failed to prevent Resident # 56's catheter collection bag from resting on the floor. The findings include: Resident # 56 was admitted to the facility on 07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to: retention of urine, hypertension (1), depressive disorder (2), and multiple sclerosis (3). Resident # 56's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/16/19, coded Resident # 56 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 56 was coded as being totally dependent of one staff member for activities of	F 690	1) Facility staff failed to provide care and services for an indwelling catheter to prevent infections by failing to prevent catheter collection bag from resting on the floor for Resident #56. Educational coaching was provided to staff and catheter collection bag was removed from the floor. No negative clinical outcome was identified. 2) Any resident with an indwelling urinary catheter has the potential to be affected if facility staff fail to prevent catheter collection bags from resting on the floor. Residents with indwelling catheters will be observed to ensure collection bags are secured to prevent infections. 3) Center staff will be educated to prevent catheter collection bags from resting on the floor. 4) A random observational audit of residents with indwelling urinary catheters will be conducted daily (M-F) x 5 days, weekly x 3 weeks and monthly x 2 months to verify catheter collection bags are not resting on the floor. Findings will be reported to the QAPI Committee for	

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F 690	Continued From page 41 daily living. Section H "Bladder and Bowel" Resident # 56 was coded as "A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)." On 06/18/19 at 4:21 p.m., an observation of Resident # 56 revealed she was in her room, lying in her bed watching television. Observation of the bed revealed it was low to the ground and the observation of the catheter collection bag revealed it was attached to the side of the bed and resting on the floor. The POS (physician's order sheet) for Resident # 56 dated "June 19, 2019" documented, "Supra pubic catheter 20F (French) with 20cc (cubic centimeters) balloon for neurogenic bladder. Change PRS (as needed) for facility protocol. Order Date: 09/11/17." The comprehensive care plan for Resident # 56 dated 06/08/2015 documented, "Focus: The resident has an Indwelling (Suprapubic) Catheter: Neurogenic bladder. At risk for chronic UTIs (urinary tract infections) date Initiated: 08/19/2016." On 06/19/19 at 11:32 a.m., an interview was conduct with CNA (certified nursing assistant) # 7. When asked to describe the placement of a resident's catheter collection bag, CNA # 7 stated, "The collection bag is put on the side of the bed and low so it drains. It should not be on the floor to avoid infection." On 06/20/19 at 2:25 p.m., an interview was conduct with LPN (licensed practical nurse) # 4. When asked to describe the placement of a resident's catheter collection bag, LPN # 4 stated,	F 690	further recommendations.	

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F 690	Continued From page 42 "The collection bag is put on the side of the bed it should not be on the floor to avoid infection or contamination." The facility's policy "Catheter Care" documented, "PROCEDURE: H4. Collection container is below bladder level but not touching the floor." On 06/19/19 at approximately 5:30 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality assurance and performance improvement), were made aware of the findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness,	F 690		

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F 690	Continued From page 43 trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide care and services for a tracheostomy consistent with professional standards of practice, the comprehensive person-centered care plan for one of 44 residents in the survey sample, Residents # 21. The facility staff failed to wash her hands and change her gloves while providing Resident # 21's tracheostomy care. The findings include: The facility staff failed to wash her hands and change her gloves while providing Resident # 21's tracheostomy care. Resident # 21 was admitted to the facility on	F 695	1) Facility staff failed to provide care and services for a tracheostomy consistent with professional standards of practice and the comprehensive person-centered care plan for Resident #21 by failing to wash hands and change gloves while providing tracheostomy care. Educational coaching was provided to the staff member who completed tracheostomy care. No negative clinical outcome was identified. 2) Any resident requiring tracheostomy care has the potential to be affected if facility staff fail to wash their hands and/or change their gloves while providing tracheostomy care. 3) Licensed staff will be educated regarding professional standards of practice for providing tracheostomy care.	7/23/19

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F 695	Continued From page 44 12/24/18 and a re-admission on 04/18/19 with diagnoses that included but were not limited to: chronic respiratory failure (1), old myocardial infarction (2), and anxiety (3). Resident # 21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/09/19, coded Resident # 21 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Under Section O "Special Treatments, Procedures and Programs" Resident # 21 was coded as "D. Suctioning; E. Tracheostomy care." On 06/19/19 at 10:40 a.m., an observation was conducted of tracheostomy's care to Resident # 21 performed by LPN (licensed practical nurse) # 6. LPN #6 entered resident # 21's room and set up packaged trach (tracheostomy) supplies on a clean barrier. LPN #6 then washed her hands and put on a clean pair of gloves, opened a sterile "Suction Kit". LPN #6 then removed her gloves, opened and put on the sterile gloves from the kit. LPN #6 then opened the package with the sterile suction tubing, connected it to the tubing from the suction machine, and turned on the suction machine with her left sterile gloved hand. LPN #6 then placed both sterile gloved hands on the sterile tubing and placed it the tubing into Resident #21's trach to suction out secretions. Upon completing this task, LPN # 6 turned off the suction machine, disconnected the tubing, and removed the gloves she was wearing. LPN #6 then donned a pair of plastic gloves, opened a sterile "Tracheostomy Care Tray", removed the items and placed them on the clean barrier that included "Powder free Nitrate Gloves." While	F 695	4) The Director of Nursing (DON) or designee will observe tracheostomy care daily (M-F) x 5, weekly x 3 and monthly x 4 for consistency with professional standards of practice. Findings will be reported to the QAPI Committee for further recommendations.	

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F 695	Continued From page 45 wearing the regular plastic gloves LPN # 6 removed the cannula from Resident # 21's trach, placed it in the tray, opened the bottle of saline and peroxide, placed the cannula in the tray and cleaned it using the enclosed brush. While wearing the same gloves LPN # 6 opened another bottle of saline and using a cotton swab cleaned the area around Resident #21's trach opening. LPN #6 then removed a clean strap from the "Tracheostomy Care Tray" and removed the strap on the right side of Resident #21's trach cuff. She then attached the new strap, moved the over-the-bed table while wearing the same gloves, went to the left side of the bed, removed the old strap from the trach cuff and attached the new strap to the left side of the trach cuff. LPN #6 then removed a new cannula, opened the package and placed a new, clean cannula into Resident # 21's trach cuff. The POS (physician's order sheet) for Resident # 21 dated "June 19, 2019" documented, "Trach [tracheostomy] care q (every) shift and PRN (as needed). Order Date: 04/18/19." The comprehensive care plan for Resident # 21 dated 01/18/2019 documented, "Focus: (Resident # 21) is at risk for respiratory problem(s) related to chronic condition DX (diagnosis) of chronic respiratory failure with hypoxia with periods of acute exacerbation. Date Initiated: 01/18/2019." Under "Interventions/Tasks" it documented, "Provide Trach Care as ordered. Date Initiated: 02/08/2019." On 06/19/19 at 1:21 p.m., an interview was conducted with LPN (licensed practical nurse) # 6 regarding the tracheostomy care provided to Resident # 21. When asked to describe the	F 695		

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F 695	Continued From page 46 procedure for using gloves, LPN # 6 stated, "I sanitize or wash my hands between glove use." LPN #6 was then informed of the above observations of not changing gloves, washing her hands between changing gloves and touching items while wearing gloves when providing Resident # 21's trach care. LPN # 6 stated, "I should have only touched the items in the sterilized field. I touched the suction tubing with same gloved hand I turned the suction machine on with." When asked if she washed or sanitized her hands between changing gloves during the trach care for Resident LPN stated, "No." The facility's policy "Tracheostomy Care" documented, "PROCEDURE: A. 2. Wash your hands (keep procedure as aseptic as possible)."." On 06/19/19 at approximately 5:30 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality assurance and performance improvement), were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website:	F 695		

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F 695	Continued From page 47 https://medlineplus.gov/ency/article/000195.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined that facility staff failed to provide pain management for one of 44 residents in the survey sample, Resident # 83. The facility staff failed to implement non-pharmacological interventions prior to the administration of as needed pain medication to Resident #83. The findings include: Resident # 83 was admitted to the facility on 12/05/2018 with diagnoses that included but were not limited to rheumatoid arthritis (1), depressive disorder (2), and anemia (3). Resident # 83s most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/28/19,	F 697	1) Facility staff failed to implement non-pharmacological interventions prior to the administration of as needed pain medication to Resident #83. Educational coaching was provided to the nurse to implement non-pharmacological interventions prior to administration. No negative clinical outcome was identified. 2) Any resident with physician orders for as needed pain medication has the potential to be affected if center staff fail to implement non-pharmacological interventions prior to administering medication. 3) Licensed staff will be educated to implement non-pharmacological interventions prior to the administration of as needed pain medication. 4) The Director of Nursing (DON) or designee will conduct an audit of 10 residents with physician orders for as	7/23/19

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F 697	Continued From page 48 coded Resident # 83 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 83 was coded as requiring extensive assistance of none staff member for all ADLs (activities of daily living). On 06/19/19 at 8:41 a.m., an interview was conducted with Resident # 83. When asked if the staff assess her pain before giving her an as needed pain medication, Resident # 83 stated, "Sometimes they will ask me what my pain level is from one to ten." When asked if the staff try to alleviate her pain with other techniques prior to administering the pain medication Resident # 83 stated, "No." The "Physician's Order Sheet" dated "06/19/2019" documented, "Tylenol Tablet 325MG (milligram) (Acetaminophen) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 12/14/2018. Start Date: 12/14/2018." The eMAR (electronic medication administration record) dated "Apr (April) 2019" documented the above physician's order for Tylenol. Review of the eMAR revealed Tylenol 325mg was administered on 04/02/19 at 9:26 p.m., with a pain level of two, 04/08/19 at 9:15 p.m., with a pain level of three, 04/09/19 at 5:49 a.m., with a pain level of two, 04/10/19 at 5:48 a.m., with a pain level of two and at 11:23 p.m., and on 04/21/19 at 8:58 p.m., with a pain level of four. Further review of the eMAR dated "Apr (April) 2019" and the eMAR notes dated 04/02/19 through 04/21/19 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Tylenol.	F 697	needed pain medication weekly x 4 weeks, then monthly x 2 months for evidence of non-pharmacological intervention prior to pain medication administration.	

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F 697	Continued From page 49 The eMAR (electronic medication administration record) dated "May 2019" documented the above physician's order for Tylenol. Review of the eMAR revealed Tylenol 325mg was administered on 05/19/19 at 6:30 a.m., with a pain level of three and at 6:56 p.m. with a pain level of three. Further review of the eMAR dated "May 2019" and the eMAR notes dated 05/19/19 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Tylenol. The eMAR (electronic medication administration record) dated "June 2019"documented the above physician's order for Tylenol. Review of the eMAR revealed Tylenol 325mg was administered on 06/02/19 at 7:32 a.m., with a pain level of three and on 06/15/19 at 8:27 p.m. with a pain level of three. Further review of the eMAR dated "June 2019" and the eMAR notes dated 06/02/19 and 06/15/19 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Tylenol. The comprehensive care plan for Resident # 83 dated 01/15/2019 documented, "Focus. (Resident # 83 has potential for pain, has H/O (history of) migraines and has [sic] contractors from arthritis. Date Initiated 12/05/2018. Revision on: 01/15/2019." Under "Interventions/tasks" it documented, "Assess pain level q (every) shift and PRN (as needed) and apply interventions as needed. Date Initiated: 12/05/2018." On 06/20/19 at 10:02 a.m., an interview was conducted with RN (registered nurse) # 2, unit manager. RN #2 was asked to describe the procedure for the administration of prn pain	F 697		

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F 697	Continued From page 50	F 697		

medication. RN # 2 stated, "Ask them if they have pain. Check the record for the resident's prn pain medication based on scale zero to ten, ten being the highest level of pain, and the location of the pain, check the order for which pain medication is prescribe and how much, administer the mediation and document it in the eMAR. Follow up with the resident an hour to determine the effectiveness of the medication." When asked about attempting non-pharmacological interventions, RN # 2 stated, "The non-pharmacological interventions should be attempted prior to administering the medication." When asked where the staff document the non-pharmacological interventions attempted, RN # 2 stated, "It is documented in the eMAR." After review of the eMAR for Resident # 83 dated April, May and June 2019, RN # 2 agreed that for the above dates and time documented non-pharmacological interventions were not attempted.

The facility's policy "Pain Management In The Long Term Care Setting" it documented, "3. Document present and past treatments utilized by the resident for the treatment of pain, include: b. alternative treatments such as positioning, heat and cold applications."

On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality assurance and performance improvement), were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A long-term disease. It leads to inflammation

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F 697	Continued From page 51 of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .	F 697		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		7/23/19

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F 700	Continued From page 52 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for twenty four of 44 residents in the survey sample, Residents #56, #21, # 58, #52, #5, #83, #88, #93, #207, #26, #19, #66, #14, #38, #90, #92, #75,# 32, # 53, #94, #43, #105 and #40, as evidenced facility staff failure to assess for the risk of entrapment, review the risks and benefits for the use of siderails and obtain informed consent prior to the use of bed rails. The findings include: 1. The facility staff failed to review risks and benefits and obtain informed consent prior to the use of bed rails for Resident # 56. Resident # 56 was admitted to the facility on 07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to: retention of urine, hypertension (1), depressive disorder (2), and multiple sclerosis (3). Resident # 56's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/16/19, coded Resident # 56 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely	F 700	1) Facility staff failed to assess for the risk of entrapment, review the risks and benefits and obtain informed consent before the use of bed rails for the following residents: #56, #21, #58, #52, #5, #83, #88, #93, #207, #14, #26, #19, #66, #38, #90, #92, #75, #32, #53, #94, #43, #105 and #40. Resident #21, #207 and #92 discharged from facility. Bed rail use was discontinued for resident #52, #66 and #69. Resident #56, #58, #5, #83, #88, #26, #19, #14, #38, #90, #75, #32, #53, #94, #43 and #105 were assessed for entrapment, risks and benefits were reviewed and informed consents were signed for continued use. 2) Any resident with bed rails in use has the potential to be affected if center staff fail to assess the resident for risk of entrapment, obtain a physician order, review risks and benefits and obtain informed consent prior to the use of bed rails. Residents with bed rails in use will be audited to identify a physician order, assessment for entrapment, risks and benefits review and informed consent. Any variances will be addressed. 3) Licensed staff will be educated for the requirement to obtain a physician order, assess the resident for risk of entrapment, review risks and benefits and obtain	

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F 700	Continued From page 53 impaired of cognition for making daily decisions. Resident # 56 was coded as being totally dependent of one staff member for activities of daily living. Review of Resident #56's clinical record failed to evidence documentation that risks and benefits for the use of side rail were reviewed with Resident #56 (or the resident's representative), and failed to reveal documentation of informed consent. The comprehensive care plan for Resident # 56 with a revision on 12/27/2018 documented, "Interventions/Tasks: ½ (half) side rails to assist with bed mobility. Date initiated: 03/16/2015." On 6/20/19 at 11:26 a.m., Resident # 56 was observed in bed. Bilateral quarter rails were observed on the upper portion of the bed and were in the raised position. When asked if the facility staff had discussed the risk and benefits of bed rails, Resident # 56 stated, "No." On 06/20/19 at 7:33 a.m., an interview was conducted with ASM (administrative staff member) #1, administrator regarding bed rails. When asked to provide evidence that the risk and benefits of bed rail use were discussed or provided to the residents or the resident's representatives, ASM # 1 stated, "They are discussed but there is no documentation that it was done." When asked if there are physician's orders for the use of the resident's bed rails, ASM # 1 stated, "No but they are care planned as a nursing intervention." When asked about documentation of routine maintenance of the resident's bed rails, ASM # 1 stated, "It's done on an annual basis". ASM #1 provided	F 700	consent prior to the use of bed rails. 4) The Director of Nursing (DON) or designee will conduct a medical record audit of newly admitted residents using bed rails daily (M-F) x 5, weekly x 3 and monthly x 2 for evidence that an assessment for the risk of entrapment was completed, a physician order and informed consent were obtained prior to the use of bed rails and that risks and benefits were reviewed with the resident or resident representative. Findings will be reported to the QAPI Committee for further recommendation.	

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F 700	Continued From page 54 documentation of a bed inspection of all facility beds in April 2019 that included documentation of bed rail inspection as part of the bed inspection. When asked to provide evidence that a consent was obtained for the use of bed rails for Resident #56, ASM # 1 stated that they did not obtain any consent for the use of bed rails. The facility's policy "Guidelines For Side Rail Use" documented, "Regardless of the reason for use, rails should be managed on a regular basis as you would many [sic] many restraint: [sic] Education resident/family [sic] in potential adverse outcomes." On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality performance improvement nurse), were made aware of the findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.	F 700		

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F 700	Continued From page 55 (3) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. 2. The facility staff failed to review risks and benefits and obtain informed consent prior to the use of bed rails for Resident # 21. Resident # 21 was admitted to the facility on 12/24/18 and a re-admission on 04/18/19 with diagnoses that included but were not limited to: chronic respiratory failure (1), old myocardial infarction (2), and anxiety (3). Resident # 21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/09/19, coded Resident # 21 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 21 was coded as being totally dependent of one staff member for activities of daily living. Review of Resident #21's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #21 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 21	F 700		

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F 700	Continued From page 56 with a revision on 02/12/2019 documented, "Interventions/Tasks: ½ (half) side rails to assist in bed mobility. Date initiated: 05/09/2019." On 6/20/19 at 11:23 a.m., Resident # 21 was observed in bed. Bilateral quarter rails were observed on the upper portion of the bed and were in the raised position. When asked if the facility staff had discussed the risk and benefits of bed rails, Resident #21 stated, "No." On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality performance improvement nurse), were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 700		

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F 700	Continued From page 57 3. The facility staff failed to review risks and benefits and obtain informed consent prior to the use of bed rails for Resident # 58. Resident # 58 was admitted to the facility on 07/14/12 with diagnoses that included but were not limited to: high blood pressure, stroke and high cholesterol. Resident # 58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/19, coded Resident # 58 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 58 was coded as requiring supervision of one staff member for activities of daily living. Review of Resident #58's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #58 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 58 with a revision on 02/27/2018 documented, "Interventions/Tasks: ½ (half) side rails to assist in bed mobility and transfers. Date initiated: 03/07/2017." On 6/20/19 at 11:25 a.m., an observation of resident # 58's room revealed the resident was not present. Observed of the bed revealed bilateral quarter rails were observed on the upper portion of the bed and were in the low position. On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI,	F 700		

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F 700	Continued From page 58 were made aware of the findings. No further information was provided prior to exit. 4. The facility staff failed to review risks and benefits and obtain informed consent prior to the use of bed rails for Resident # 52. Resident # 52 was admitted to the facility on 11/21/17 with diagnoses that included but were not limited to: high blood pressure, low iron and failure to thrive. Resident # 52's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/19/19, coded Resident # 52 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 52 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of Resident #52's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #52 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 52 with a revision on 05/10/2018 documented, "Interventions/Tasks: ½ (half) side rails x (times 1-2 (one to two) as needed for bed mobility/positioning. Date initiated: 12/06/2017." On 6/20/19 at 11:15 a.m., an attempt to observe Resident # 52's room bed was unsuccessful. On 06/20/19 at approximately 2:15 p.m., ASM # 1	F 700		

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F 700	Continued From page 59 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality performance improvement nurse), were made aware of the findings. No further information was provided prior to exit. 5. The facility staff failed to review risks and benefits and obtain informed consent prior to the installation of bed rails for Resident # 5. Resident # 5 was admitted to the facility on 09/03/17 with diagnoses that included but were not limited to: low iron, bipolar disorder (1) and depressive disorder (2). Resident # 5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/14/19, coded Resident # 5 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 5 was coded as requiring limited assistance of one staff member for activities of daily living. Review of Resident #5's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #5 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 5 with a revision on 03/18/2019 documented, "Interventions/Tasks: ½ (half) side rails for assistance with bed mobility and transfers as needed. Date initiated: 09/15/2017." On 6/20/19 at 11:21 a.m., Resident # 5 was observed in bed. Bilateral quarter rails were	F 700		

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F 700	Continued From page 60 observed on the upper portion of the bed and were in the raised position. When asked if the facility staff had discussed the risk and benefits of bed rails, Resident #5 stated, "No." On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality performance improvement nurse), were made aware of the findings. No further information was provided prior to exit. References: (1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. 6. The facility staff failed to review risks and benefits and obtain informed consent prior to the use of bed rails for Resident # 83. Resident # 83 was admitted to the facility on 12/05/2018 with diagnoses that included but were not limited to rheumatoid arthritis (1), depressive disorder (2), and anemia (3). Resident # 83s	F 700		

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F 700	Continued From page 61 most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/28/19, coded Resident # 83 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 83 was coded as requiring extensive assistance of none staff member for all ADLs (activities of daily living). Review of Resident #83's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #83 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 83 with a revision on 03/18/2019 documented, "Interventions/Tasks: ½ (half) side rails x (times) 1-2 (one to two) as needed for bed mobility/positioning. Date initiated: 12/17/2018." On 6/20/19 at 11:28 a.m., Resident # 83 was observed in her room but not in the bed. Bilateral quarter rails were observed on the upper portion of the bed and were in the low position. When asked if the facility staff had discussed the risk and benefits of bed rails, Resident #83 stated, "No." On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI, were made aware of the findings. No further information was provided prior to exit. References: (1) A long-term disease. It leads to inflammation	F 700		

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F 700	Continued From page 62 of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . 7. The facility staff failed to review risks and benefits and obtain informed consent prior to the use of bed rails for Resident # 88. Resident # 88 was admitted to the facility on 05/04/18 with diagnoses that included but were not limited to: difficulty swallowing, low iron and high cholesterol. Resident # 88's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/14/19, coded Resident # 88 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 88 was coded as requiring extensive assistance of one staff member for activities of daily living.	F 700		

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F 700	Continued From page 63 Review of Resident #88's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #88 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 88 with a revision on 02/22/2019 documented, "Interventions/Tasks: ½ (half) side rails to assist with bed mobility and transfers. Date initiated: 05/22/2014." On 6/20/19 at 11:29 a.m., an attempt to observe Resident # 88's room bed was unsuccessful. On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality performance improvement nurse), were made aware of the findings. No further information was provided prior to exit. 8. The facility staff failed to review risks and benefits and obtain informed consent prior to the use of bed rails for Resident # 93. Resident # 93 was admitted to the facility on 06/15/17 with diagnoses that included but were not limited to: heart failure, pain, and hearing loss. Resident # 93's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 06/03/19, coded Resident # 93 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0	F 700		

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F 700	Continued From page 64 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 93 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of Resident #93's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #93 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 93 with a revision on 05/20/2019 documented, "Interventions/Tasks: ½ (half) side rails to assist in bed mobility and transfers. Date initiated: 02/23/2017." On 6/20/19 at 11:23 a.m., Resident # 93 was observed in bed. Bilateral quarter rails were observed on the upper portion of the bed and were in the raised position. When asked if the facility staff had discussed the risk and benefits of bed rails, Resident #93 stated, "No." On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality performance improvement nurse), were made aware of the findings. No further information was provided prior to exit. 9. The facility staff failed to review risks and benefits and obtain informed consent prior to the installation of bed rails for Resident # 207. Resident # 207 was admitted to the facility on 06/08/19 with diagnoses that included but were	F 700		

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F 700	Continued From page 65 not limited to: schizoaffective disorder (1), bipolar (2), and muscle wasting. Resident # 207's most recent MDS (minimum data set) was not due at the time of survey. Resident # 207's nursing admission assessment documented Resident # 207 was oriented to person, place and time. Review of Resident #207's clinical record failed to evidence documentation that risks and benefits for the use of side rails were reviewed with Resident #207 (or the resident's representative) or documentation of informed consent. The comprehensive care plan for Resident # 207 with a revision on 06/11/2019 documented, "Interventions/Tasks: ½ (half) side rails x (times) 1-2 (one to two) as needed for bed mobility/positioning. Date initiated: 06/19/2019." On 6/20/19 at 11:30 a.m., Resident # 207 was observed in bed. Bilateral quarter rails were observed on the upper portion of the bed and were in the raised position. When asked if the facility staff had discussed the risk and benefits of bed rails, Resident #207 stated, "No." On 06/20/19 at approximately 2:15 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality performance improvement nurse), were made aware of the findings. No further information was provided prior to exit. References: (1) A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website:	F 700		

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F 700	Continued From page 66 https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm. (2) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. 10. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the use of bed rails for Resident #14. Resident #14 was admitted to the facility on 12/20/18. Resident #14's diagnoses included but were not limited to alcohol abuse, anxiety disorder and high blood pressure. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/29/19, coded Resident #14 with no cognitive impairment. Section G coded Resident #14 as requiring supervision of one staff member with bed mobility. Review of Resident #14's clinical record revealed a Side Rail Assessment dated 1/22/19, which documented, "Only use upper half rails for independent bed mobility." Review of Resident #14's comprehensive care plan dated 1/1/19 documented, "Half side rails, 1-2 as needed for bed mobility/positioning." Further review of Resident #14's clinical record failed to reveal documented consent, a physician order or documentation that risk and benefits were reviewed with Resident #14 (or the resident's representative).	F 700		

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F 700	Continued From page 67 On 6/19/19 at 11:45 a.m., Resident #14 was observed in bed watching television. Both upper half rails were in the lowest position and not in use. Resident #14 was asked if he used the half rails at any time. Resident #14 stated, "I do not use those things." On 6/20/19 at 7:33 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator) regarding bed rails. ASM #1 was asked to provide evidence that the risk and benefits of bed rail use were discussed or provided to the residents or the resident's representative. ASM #1 stated, They are discussed but there is no documentation that it was done. When asked if there are physician's orders for use of the resident's bed rails ASM #1 stated, "No, but they are care planned as a nursing intervention." When asked about documentation of routine maintenance of the resident's bed rails ASM #1 stated, "It's done on an annual basis" and provided documentation of a bed inspection of all facility beds in April 2019 that included documentation of bed rail inspection as part of the bed inspection. When asked to provide evidence that consent was obtained for the use of bed rails ASM #1 stated that they did not obtain any consent for the use of bed rails. A review of the facility policy, "Guidelines for Side Rail Use," documented, "Side rails may function as an enabler to promote independence with bed mobility and/or transfers when the resident is able to independently use or requires minimal cueing for the device. Regardless of the reason for use, rails should be managed on a regular basis as you would manage any restraint: *Do not use	F 700		

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F 700	Continued From page 68 without evidence of assessment; *Re-evaluate periodically for need and potential hazard; *Education resident/family in potential adverse outcomes; *Monitor resident for potential adverse outcomes; *Document use. All side rails are potential accident hazards - if the resident is attempting to get out of bed (through, over, or around the rails), continued use of the rails must be re-assessed and documentation should indicate that therapeutic benefit from continued use of the rail outweighs the risk of potential injury. When side rails are padded, there should be a specific intervention for the padding and additional interventions to address potential social isolation resulting visual limitation should be addressed. The documentation of the medical record should identify specifically why the rails need to be padded. If the purpose for the use of rails is not for resident independence in bed mobility and/or transfers, the use of the rails may be considered a restraint. Documentation regarding need for and use of side rails should be consistent throughout the clinical record." On 6/20/19 at 4:07 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the findings. No further information was provided by the end of the survey. 11. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the use of bed rails for Resident #19.	F 700		

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F 700	Continued From page 69 Resident #19 was admitted to the facility on 1/24/19. Resident #19's diagnoses included but were not limited to Alzheimer's disease, osteoarthritis and high cholesterol. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/7/19, coded Resident #19 with moderate cognitive impairment. Section G coded Resident #19 as requiring supervision of one staff member with bed mobility. Review of Resident #19's clinical record revealed a Side Rail Assessment dated 5/3/19, which documented, "Only use upper half rails for independent bed mobility secondary to independence with positioning." Review of Resident #19's comprehensive care plan dated 2/5/19 documented, "Half side rails to assist in bed mobility and transfers." Further review of Resident #19's clinical record failed to reveal documented consent, a physician order or documentation that risk and benefits were reviewed with Resident #19 (or the resident's representative). On 6/19/19 at 11:50 a.m., Resident #19 was observed outside of her room sitting in the day room. Bilateral upper rails were noted on Resident #19's bed. Both upper half rails were in the lowest position and not in use. On 6/20/19 at 4:07 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the findings.	F 700		

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F 700	Continued From page 70 No further information was provided by the end of the survey. 12. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the use of bed rails for Resident #26. Resident #26 was admitted to the facility on 6/20/17. Resident #26's diagnoses included but were not limited to diabetes mellitus type 2, high blood pressure and high cholesterol. Resident #26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/15/19, coded Resident #26 with severe cognitive impairment. Section G coded Resident #26 as requiring extensive assistance of one staff member with bed mobility. Review of Resident #26's clinical record revealed a Side Rail Assessment dated 1/9/18, which documented, "Only use upper half rails for independent bed mobility." Review of Resident #26's comprehensive care plan dated 1/9/18 documented, "Half side rails, 1-2 as needed for bed mobility/positioning." Further review of Resident #26's clinical record failed to reveal documented consent, a physician order or documentation that risk and benefits were reviewed with Resident #26 (or the resident's representative). On 6/19/19 at 11:55 a.m., Resident #26 was observed lying in bed with her eyes closed. Bilateral upper rails were noted on Resident #26's bed. Both upper half rails were in the lowest	F 700		

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F 700	Continued From page 71 position and not in use. On 6/20/19 at 4:07 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the findings. No further information was provided by the end of the survey. 13. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the use of bed rails for Resident #38. Resident #38 was admitted to the facility on 3/29/18. Resident #38's diagnoses included but were not limited to Alzheimer's disease, heart failure and anxiety disorder. Resident #38's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/30/19, coded Resident #38 with moderate cognitive impairment. Section G coded Resident #38 as requiring extensive assistance of one staff member with bed mobility. Review of Resident #38's clinical record revealed a Side Rail Assessment dated 1/26/19, which documented, "Only use upper half rails for independent bed mobility." Review of Resident #38's comprehensive care plan dated 4/11/18 documented, "Half side rails, 1-2 as needed for bed mobility/positioning." Further review of Resident #38's clinical record failed to reveal documented consent, a physician	F 700		

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	495038	A. BUILDING _____ B. WING _____	C 06/20/2019

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F 700	Continued From page 72 order or documentation that risk and benefits were reviewed with Resident #38 (or the resident's representative). On 6/19/19 at 12:15 p.m., Resident #38 was observed outside of his room eating lunch in the day room on the Evergreen unit. Bilateral upper rails were noted on Resident #38's bed. Both upper half rails were in the lowest position and not in use. On 6/20/19 at 4:07 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the findings. No further information was provided by the end of the survey. 14. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the use of bed rails for Resident #66. Resident #66 was admitted to the facility on 6/23/17. Resident #66's diagnoses included but were not limited to heart disease, right-sided weakness and high blood pressure. Resident #66's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/22/19, coded Resident #66 with severe cognitive impairment. Section G coded Resident #66 as requiring extensive assistance of two or more staff members with bed mobility. Review of Resident #66's clinical record revealed	F 700		

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F 700	Continued From page 73 a Side Rail Assessment dated 6/19/19, which documented, "Only use upper half rails for independent bed mobility secondary to promote mobility and positioning." Review of Resident #66's comprehensive care plan dated 6/19/19 documented, "Half side rails, 1-2 as needed for bed mobility/positioning." Further review of Resident #66's clinical record failed to reveal documented consent, a physician order or documentation that risk and benefits were reviewed with Resident #66 (or the resident's representative). On 6/19/19 at 12:20 p.m., Resident #66 was observed outside of her room eating lunch in the day room on the Evergreen unit. Bilateral upper rails were noted on Resident #66's bed. Both upper half rails were in the lowest position and not in use. On 6/20/19 at 4:07 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the findings. No further information was provided by the end of the survey. 15. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the use of bed rails for Resident #69. Resident #69 was admitted to the facility on	F 700		

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F 700	Continued From page 74 3/26/13. Resident #69's diagnoses included but were not limited to Alzheimer's disease, osteoarthritis and anxiety disorder. Resident #69's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/22/18, coded Resident #69 with severe cognitive impairment. Section G coded Resident #69 as requiring extensive assistance of two or more staff members with bed mobility. Review of Resident #69's clinical record revealed a Side Rail Assessment dated 6/19/19, which documented, "No side rails indicated at this time. Recommend side rails be removed or tied down to prevent raising." Review of Resident #69's comprehensive care plan dated 3/30/17 documented, "May use half side rails, 1-2 as needed for bed mobility/positioning." Further review of Resident #69's clinical record failed to reveal documented consent, a physician order or documentation that risk and benefits were reviewed with Resident #69 (or the resident's representative). On 6/19/19 at 12:30 p.m., Resident #69 was observed outside of her room eating lunch in the day room on the Evergreen unit. Bilateral upper rails were noted on Resident #69's bed. Both upper half rails were in the lowest position and not in use. On 6/20/19 at 4:07 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff	F 700		

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F 700	Continued From page 75 member) #3 (the regional registered dietitian) were made aware of the findings. No further information was provided by the end of the survey. 16. The facility staff failed to obtain consent, a physician order and review risk and benefits prior to the use of bed rails for Resident #90. Resident #90 was admitted to the facility on 1/9/19. Resident #90's diagnoses included but were not limited to Alzheimer's disease, high blood pressure and depression. Resident #90's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/30/19, coded Resident #90 with severe cognitive impairment. Section G coded Resident #90 as requiring supervision of one staff member with bed mobility. Review of Resident #90's clinical record revealed a Side Rail Assessment dated 1/26/19, which documented, "Only use half upper rails for independent bed mobility." Review of Resident #90's comprehensive care plan dated 1/22/19 documented, "Half side rails, 1-2 as needed for bed mobility/positioning." Further review of Resident #90's clinical record failed to reveal documented consent, a physician order or documentation that risk and benefits were reviewed with Resident #90 (or the resident's representative). On 6/19/19 at 12:37 p.m., Resident #90 was	F 700		

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F 700	Continued From page 76 observed outside of his room eating lunch in the day room on the Evergreen unit. Bilateral upper rails were noted on Resident #90's bed. Both upper half rails were in the lowest position and not in use. On 6/20/19 at 4:07 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the findings. No further information was provided by the end of the survey.No further information was provided by the end of the survey. 17. The facility staff failed to assess Resident #92 for risk of entrapment, review risks and benefits and obtain informed consent prior to the use of bed rails. Resident #92 was admitted to the facility on 5/18/19 with the diagnoses of but not limited to high blood pressure, chronic kidney disease, diabetes, diabetic neuropathy, depression, blindness, peripheral vascular disease, end stage renal disease, and amputation of right toes. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/25/19. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, hygiene, toileting, dressing, and transfers; and was independent for eating. Observations made of Resident #92 on 6/18/19 at 11:30 AM, 5:15 PM, and on 6/19/19 at 1:44 PM	F 700		

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F 700	Continued From page 77 revealed Resident #92 to be in bed, with half side rails up on both sides. A review of the clinical record revealed that on readmission from the hospital on 5/5/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full" (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1 Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #92, this document identified she was to use half-length side rails on both sides of the bed to promote independence with bed mobility. Further review of the clinical record failed to reveal a physician's order for the use of side rails. Further review of the clinical record failed to reveal any evidence of an assessment for risk of entrapment for the use of side rails with Resident #92 was completed. The clinical record failed to evidence documentation that the risk and benefits for the use of side rails were discussed with the resident and family or any evidence of an informed consent for the use of the side rails for	F 700		

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F 700	Continued From page 78 Resident #92. A review of the comprehensive care plan revealed one dated 5/18/19 for "Demonstrates the need for ADL (activities of daily living) assistance." This care plan did not include any interventions for the use of side rails that the resident was observed to be using. On 06/20/19 at 7:33 AM, an interview was conducted with the Administrator, (ASM #1 - administrative staff member), regarding the use of bed rails. When asked to provide evidence that the risk and benefits of bed rail use were discussed or provided to the residents or the resident's representatives ASM # 1 stated, "They are discussed but there is no documentation that it was done." When asked if there are physician's orders for the use of the resident's bed rails ASM # 1 stated, "No but they are care planned as a nursing intervention." When asked about documentation of routine maintenance of the resident's bed rails ASM #1 stated, "It's done on an annual basis" and provided documentation of a bed inspection of all facility beds in April 2019 that included documentation of bed rail inspection as part of the bed inspection. When asked to provide evidence that a consent was obtained for the use of bed rails ASM # 1 stated that they did not obtain any consent for the use of bed rails. On 6/20/19 at approximately 4:00 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the concerns regarding side rails.	F 700		

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F 700	Continued From page 79 No further information was provided by the end of the survey. 18. The facility staff failed to assess Resident #75 for risk of entrapment, review risks and benefits and obtain informed consent prior to the use of bed rails. Resident #75 was admitted to the facility on 5/16/19 with the diagnoses of but not limited to acute cystitis, sacral pressure ulcer, Parkinson's disease, atrial fibrillation, cellulitis, and benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/23/19. The resident was coded as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, toileting, dressing, and transfers; and supervision for eating. On 6/18/19 at 11:30 AM and 5:15 PM, Resident #75 was observed in bed with half side rails up on both sides. On 6/19/19 at 1:44 PM, the resident was not in his room but the side rails were observed in the up position on his bed. A review of the clinical record revealed that upon readmission from the hospital on 5/16/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if	F 700		

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F 700	Continued From page 80 yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full" (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1 Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #75, this document identified she was to use half-length side rails on both sides of the bed to promote independence with bed mobility. Further review of the clinical record revealed a "Safe Transition Meeting" note dated 5/17/19, which documented, "Plan of care has been developed with input from the patient and/or RP (responsible party) / POA (power of attorney)/Interested parties." A review of the comprehensive care plan revealed one dated 5/16/19 for "Demonstrates the need for ADL (activities of daily living) assistance, has UTI (urinary tract infection), OA (osteoarthritis), Rhabdomyolysis, Parkinson's and Diabetes." This care plan included the intervention, dated 5/29/19, for "1/2 (half) side rails x 1-2 (one or two sides) as needed for bed mobility and positioning." As the above intervention was not developed until 5/29/19, it cannot be stated that the resident and family were informed of the use of, risks and benefits of, and consented to, the side rails at the 5/17/19 Safe Transition Meeting. Further review of the clinical record failed to	F 700		

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F 700	Continued From page 81 reveal a physician's order for the use of side rails. Further review of the clinical record failed to reveal any evidence of an assessment for risk of entrapment for the use of side rails with Resident #75 was completed. The clinical record failed to evidence documentation that the risk and benefits for the use of side rails were discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #75. On 6/20/19 at approximately 4:00 PM, ASM (administrative staff member) 1, ASM #3 (the director of risk management and quality assurance & performance improvement), and OSM (other staff member) #3 (the regional registered dietitian) were made aware of the concerns regarding side rails. No further information was provided by the end of the survey. 19. The facility staff failed to assess Resident #32 for risk of entrapment, review risks and benefits and obtain informed consent prior to the use of bed rails. Resident #32 was admitted to the facility on 4/11/19 with the diagnoses of but not limited to pneumonitis, dysphagia, Parkinson's disease, intellectual disabilities, depression, oxygen dependent, tracheostomy, dementia, and high blood pressure. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 4/18/19. The resident was coded as being	F 700		

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F 700	Continued From page 82	F 700		

severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, eating, dressing, and hygiene.

On 6/18/19 at 11:30 AM, 5:15 PM, and 6/19/19 at 9:33 AM revealed the resident to be in bed, in the lowest position, with 1/2 side rails up on both sides. On 6/19/19 at 1:44 PM, the resident was not in bed but the side rails were still observed in the up position.

A review of the clinical record revealed that upon readmission from the hospital on 4/11/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full" (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1 Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #32, this document identified she was to use half-length side rails on both sides of the bed to promote independence with bed mobility.

Further review of the clinical record revealed a "Safe Transition Meeting" note dated 4/12/19,

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F 700	Continued From page 83 which documented, "Plan of care has been developed with input from the patient and/or RP (responsible party) / POA (power of attorney)/Interested parties." A review of the comprehensive care plan revealed one dated 4/11/19 for "Demonstrates the need for ADL (activities of daily living) assistance secondary to weakness, altered balance, decreased safety awareness, comorbidities." This care plan included the intervention, dated 4/28/19, for "1/2 (half) side rails to assist in bed mobility and transfers." As the above intervention was not developed until 4/28/19, it cannot be stated that the resident and family were informed of the use of, risks and benefits of, and consented to, the side rails at the 4/11/19 Safe Transition Meeting. Further review of the clinical record failed to reveal a physician's order for the use of side rails. Further review of the clinical record failed to reveal any evidence of an assessment for risk of entrapment for the use of side rails with Resident #32 was completed. The clinical record failed to evidence documentation that the risk and benefits for the use of side rails were discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #32. No further information was provided by the end of the survey. 20. The facility staff failed to assess Resident #53 for risk of entrapment, review risks and	F 700		

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F 700	Continued From page 84 benefits and obtain informed consent prior to the use of bed rails. Resident #53 was admitted to the facility on 7/18/17 with the diagnoses of but not limited to pleural effusion, chronic kidney disease, heart failure, diabetes, peripheral vascular disease, anxiety disorder, depression, insomnia, cataracts, glaucoma, and above knee amputation. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/19/19. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, toileting, dressing, and transfers; limited assistance for hygiene; and supervision for eating. On 6/18/19 at 11:30 AM, 5:15 PM, on 6/19/19 at 9:33 AM, 11:58 AM, and 1:44 PM, the resident was observed in her room, in her wheel chair next to her bed. Her bed was noted to have 2 half-length side rails (one on each side) and the side rails were up at each observation. Although the resident was not seen in bed for any of the observations, the side rails were present, in the up position, and available for use by the resident when she is in bed. A review of the clinical record revealed that on readmission from the hospital on 5/5/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each	F 700		

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F 700	Continued From page 85	F 700		

line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full" (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1 Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #53, this document identified she was to use half-length side rails on both sides of the bed to promote independence with bed mobility.

Further review of the clinical record revealed a "Care Conference Note" dated 6/4/19, during which the care plan was reviewed. However, it was also documented that the resident and her family did not attend the meeting. Therefore, there was no evidence that the use of side rails was discussed with the resident and family.

Further review of the clinical record failed to reveal a physician's order for the use of side rails.

Further review of the clinical record failed to reveal any evidence of an assessment for risk of entrapment for the use of side rails with Resident #53 was completed. The clinical record failed to evidence documentation that the risk and benefits for the use of side rails were discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #53.

A review of the comprehensive care plan revealed one dated 4/3/19 for "(Resident #53) requires assistance with ADLs (activities of daily

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F 700	Continued From page 86 living) secondary to LLE AKA (left lower extremity above knee amputation), decreased mobility, altered balance, deconditioning, comorbidities." This care plan included the intervention, dated 4/8/19, for "1/2 (half length) side rails to assist in bed mobility and transfers." No further information was provided by the end of the survey. 21. The facility staff failed to assess Resident #94 for risk of entrapment, review risks and benefits and obtain informed consent prior to the use of bed rails. Resident #94 was admitted to the facility on 5/23/16 with the diagnoses of but not limited to unspecified dementia with behavioral disturbance, type 2 diabetes mellitus, major depressive disorder, and peripheral vascular disease. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 6/2/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident required supervision for bathing, transfers, and eating; limited assistance for dressing, hygiene, and toileting; was occasionally incontinent of bladder and always continent of bowel. On 6/18/19 at 4:16 PM and on 6/19/19 at 2:17 PM, the resident was observed in his room, in his wheel chair next to his bed. His bed was noted to	F 700		

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F 700	Continued From page 87	F 700		

have 2 half-length side rails (one on each side) and the side rails were up at each observation. Although the resident was not seen in bed for any of the observations, the side rails were present, in the up position, and available for potential use by the resident when he is in bed.

A review of the clinical record revealed that upon readmission from the hospital on 2/23/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1. Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #94, this document identified he did not require the use half-length side rails on both sides of the bed to promote independence with bed mobility.

Further review of the clinical record failed to reveal a physician's order for the use of side rails.

Further review of the clinical record failed to reveal any evidence of an assessment for the risk of entrapment with the use of side rails for Resident #94. The record failed to evidence any

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F 700	Continued From page 88 of risk and benefits for the use of side rails being discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #94. A review of the comprehensive care plan revealed one dated 12/10/18 for "(Resident #94) demonstrates the need for ADL (activities of daily living) assistance r/t (related to) decreased mobility and impaired altered balance." This care plan included the intervention, dated 12/31/18, for "1/2 (half length) side rails x (times) 1-2 as needed for bed mobility/positioning." Further review of the clinical record revealed a "Care Conference Note," dated 6/18/19, during which the care plan was reviewed. It was documented that the resident attended the meeting. There was no written evidence that risk versus benefits of side rails was discussed and no written consent obtained at this meeting. On 6/20/19 at 1:20 PM, an interview with Resident #94 was conducted. When Resident #94 was asked if the facility discussed risk of entrapment, review risks and benefits, and obtain informed consent prior to the use of bed rails, he stated, "No. No one talked to be about bed rails." On 6/20/19 at 4:07 PM, ASM #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings. No further information was provided by the end of the survey	F 700		

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F 700	Continued From page 89 (1) End Stage Renal Disease: is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. This information was obtained from the following website: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html 22. The facility staff failed to assess Resident #43 for risk of entrapment, review risks and benefits and obtain informed consent prior to the use of bed rails. Resident #43 was admitted to the facility on 11/19/18 with the diagnoses of but not limited to unspecified dementia without behavioral disturbance, peripheral vascular disease, acquired absence of right leg above the knee, acquired absence of left leg above the knee, high blood pressure, and anxiety. The most recent MDS (Minimum Data Set), a 14-day scheduled assessment, with an ARD (Assessment reference date) of 4/29/19, coded the resident as scoring a 12 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required limited assistance for eating; extensive assistance for hygiene, dressing, and toileting; total care for bathing and transfers; was always incontinent of bladder and bowel. On 6/18/19 at 1:45 PM and on 6/19/19 at 2:17	F 700		

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F 700	Continued From page 90 PM, the resident was observed in his room, in his wheel chair next to his bed. His bed was noted to have 2 half-length side rails (one on each side) and the side rails were up at each observation. Although the resident was not seen in bed for any of the observations, the side rails were present, in the up position, and available for potential use by the resident when he is in bed. A review of the clinical record revealed that upon readmission from the hospital on 4/15/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1. Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #43, this document identified he was to use half-length side rails on both sides of the bed to promote independence with bed mobility. Further review of the clinical record failed to reveal a physician's order for the use of side rails. Further review of the clinical record failed to reveal any evidence of an assessment for the risk	F 700		

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F 700	Continued From page 91 of entrapment with the use of side rails for Resident #43. The record failed to evidence any of risk and benefits for the use of side rails being discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #43. A review of the clinical record failed to reveal a comprehensive care plan for the use of bed rails for Resident #43. Further review of the clinical record revealed a "Care Conference Note," dated 5/28/19, during which the care plan was reviewed. However, it was also documented that the resident and his family did not attend the meeting. Therefore, there was no evidence that the use of side rails was discussed with the resident and family. On 6/20/19 at 1:22 pm, an interview with Resident #43 was conducted. When Resident #43 was asked if the facility discussed risk of entrapment, review risks and benefits, and obtain informed consent prior to the use of bed rails, he stated, "No." On 6/20/19 at 4:07 PM, ASM #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings. No further information was provided by the end of the survey 23. The facility staff failed to assess Resident #105 for risk of entrapment, review risks and benefits and obtain informed consent prior to the	F 700		

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F 700	Continued From page 92 use of bed rails. Resident #105 was admitted to the facility on 6/3/19 with the diagnoses of but not limited to type 2 diabetes mellitus, high blood pressure, major depressive disorder, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, displaced intertrochanteric fracture of right femur (1), and anxiety. The most recent MDS (Minimum Data Set), an admission assessment, with an ARD (Assessment reference date) of 6/10/19, coded the resident as scoring an 11 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required extensive assistance for hygiene, dressing, toileting, transfers, and eating; total care for bathing; had an indwelling urinary catheter (2) and was frequently incontinent of bowel. On 6/18/19 at 1:54 PM and on 6/19/19 at 2:20 PM, the resident was the resident was observed in his room, in his wheel chair next to his bed. His bed was noted to have 2 half-length side rails (one on each side) and the side rails were up at each observation. Although the resident was not seen in bed for any of the observations, the side rails were present, in the up position, and available for potential use by the resident when he is in bed. A review of the clinical record revealed that upon admission from the hospital on 6/3/19, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety."	F 700		

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F 700	Continued From page 93 This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1. Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #105, this document identified he was to use half-length side rails on both sides of the bed to promote independence with bed mobility. Further review of the clinical record failed to reveal a physician's order for the use of side rails. Further review of the clinical record failed to reveal any evidence of an assessment for the risk of entrapment with the use of side rails for Resident #105. The record failed to evidence any of risk and benefits for the use of side rails being discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #105. Further review of the clinical record revealed a "Safe Transitions Meeting," dated 6/4/19, during which the care plan was reviewed. It was also documented that the resident and his family attended the meeting. There was no evidence that the use of side rails was discussed with the resident and family.	F 700		

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F 700	Continued From page 94 A review of the comprehensive care plan revealed one dated 6/4/19. "Demonstrates the need for ADL (activities of daily living) assistance d/t (due to) decreased mobility and impaired balance r/t (related to) recent hip fracture." This care plan included the intervention, dated 6/14/19, for "1/2 (half length) side rails x (times) 1-2 as needed for bed mobility." As the above intervention was not developed until 6/14/19, it cannot be stated that the resident and family were informed of the use of, risks and benefits of, and consented to, the side rails at the 6/4/19 Safe Transition Meeting. On 6/20/19 at 1:24 pm, an interview with Resident #105 was conducted. When Resident #105 was asked if the facility discussed risk of entrapment, review risks and benefits, and obtain informed consent prior to the use of bed rails, he stated, "No." On 6/20/19 at 4:07 PM, ASM #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings. No further information was provided by the end of the survey (1) Displaced intertrochanteric fracture of right femur: You had a fracture (break) in the femur in your leg. It is also called the thighbone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0	F 700		

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F 700	Continued From page 95 00166.htm. (2) An indwelling catheter is a tube that drains urine from the bladder to a bag outside of the body. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm 24. The facility staff failed to assess Resident #40 for risk of entrapment, review risks and benefits and obtain informed consent prior to the use of bed rails. Resident #40 was admitted to the facility on 12/12/18 with the diagnoses of but not limited to bipolar disorder, major depressive disorder, high blood pressure, and unspecified cirrhosis of liver (1). The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 5/2/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident required supervision for transfers; limited assistance for hygiene, bathing, dressing, and toileting; independent for eating; was always continent of bladder and bowel. On 6/18/19 at 1:45 PM, 4:53 PM, and on 6/19/19 at 2:17 PM, the resident was not observed in his room. His bed was noted to have 2 half-length side rails (one on each side) and the side rails were up at each observation. Although the resident was not seen in bed for any of the observations, the side rails were present, in the	F 700		

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F 700	Continued From page 96 up position, and available for potential use by the resident when he is in bed. A review of the clinical record revealed that upon admission from the hospital on 12/12/18, a "Nursing Admission/Readmission Assessment & (and) Interim POC (plan of care) - V4 (version four)" form was completed. This form contained a section identified as "Section K. Mobility/Safety." This section contained an area for "Side rails." Next to "Side Rails" was a circle for marking "Yes" or "No." Under that, was "a. if yes: ___1. Left, ___2. Right, ___3. Both." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was "b. If yes: ___1. Half, ___2. Full." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). Under that, was, "c. Are side rails used to promote independence with bed mobility ___1. Yes, ___2. No." (Each line in the above sentence represented a circle on the document, for selecting which answer applied). For Resident #40, this document identified he was to use half-length side rails on both sides of the bed to promote independence with bed mobility. Further review of the clinical record failed to reveal a physician's order for the use of side rails. Further review of the clinical record failed to reveal any evidence of an assessment for the risk of entrapment with the use of side rails for Resident #40. The record failed to evidence any of risk and benefits for the use of side rails being discussed with the resident and family or any evidence of an informed consent for the use of the side rails for Resident #40.	F 700		

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F 700	Continued From page 97	F 700		

A review of the comprehensive care plan revealed one dated 4/3/19 for "(Resident #40) completes all ADLs (activities of daily living) by self but is able to ask for requires assistance at times with ADLs secondary to decreased mobility. Level of assistance needed may vary secondary to fatigue, comorbidities." This care plan included the intervention, dated 1/21/19, for "1/2 (half length) side rails to assist in bed mobility and transfers."

Further review of the clinical record revealed a "Care Conference Note," dated 5/14/19, during which the care plan was reviewed. It was also documented that the resident and his family attended the meeting. There was no evidence that the use of side rails was discussed with the resident and family. There was no written evidence that risk vs benefits of side rails was discussed and no written consent obtained at this meeting.

On 6/20/19 at 1:25 pm, an interview with Resident #40 was attempted. Resident #40 was not in his room.

On 6/20/19 at 4:07 PM, ASM #1, the Administrator and ASM #3, the Director of Risk Management and Quality Assurance & Performance Improvement were made aware of the findings.

No further information was provided by the end of the survey

(1) Cirrhosis: Cirrhosis is scarring of the liver and poor liver function. It is the last stage of chronic

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F 700	Continued From page 98 liver disease. This information was obtained from the following website: https://medlineplus.gov/ency/article/000255.htm	F 700		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to store, and serve food in a sanitary manner. The facility staff failed to remove an eight pound-ten ounce bottle of salsa available for use, sitting on the top shelf of the walk-in refrigerator with an open date of 05/15/19 and a use-by-date of 6/15/19.	F 812	1) The expired bottle of salsa was removed from the walk-in refrigerator. No negative outcome was identified. 2) Any resident has the potential to be affected if facility staff fail to follow facility protocol or food storage guidelines. 3) Dietary staff will be educated regarding facility protocol for food storage. 4) Food storage areas will be audited daily (M-F) x 5 days, weekly x 3 weeks, then monthly x 2 months to verify all food	7/23/19

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F 812	Continued From page 99 The findings include: On 06/18/19 at approximately 11:50 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 4, dietary manager. Observation of the inside of the facility's walk-in refrigerator revealed an eight pound- ten ounce bottle of salsa sitting on the top shelf. The bottle of salsa had two dates written on the outside of the bottle. The dates were open date of 05/15/19 and a use-by-date of 6/15/19. On 06/19/19 at 7:46 a.m., an interview was conducted with OSM # 4, dietary manager. When asked to describe the process of ensuring expired food is not available for use OSM # 4 stated, "We date the item when we receive it, when it was opened and the use by date. We check items on a daily basis and if it is at the use-by date, we discard it. I don't know how we missed that one." The "(Name of Corporation) Food Storage and Retention Guide" provided by OSM # 4 on 06/18/19 at approximately 2:00 p.m. documented, "Salsa. Dry Storage: 12 months. After opening: 1 (one) month. On 06/19/19 at approximately 5:30 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI, (quality assurance and performance improvement) were made aware of the findings. No further information was provided prior to exit.	F 812	items are within the use-by date. Findings will be reported to the QAPI Committee for further recommendation.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/23/19

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F 880	Continued From page 100 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 101 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement infection control practices for two of 44 residents in the survey sample, Residents # 21 and # 56. 1. The facility staff failed to implement infection control practices during Resident # 21's tracheostomy care. 2. The facility staff failed to implement infection	F 880	1) Facility staff failed to implement infection control practices during tracheostomy care for Resident #21 and for the placement of the catheter collection bag for Resident #56. The catheter collection bag was removed from the floor immediately. Staff was provided educational coaching on infection control protocol for tracheostomy care and catheter collection bag placement. 2) Any resident requiring tracheostomy care or the use of a catheter collection	

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F 880	Continued From page 102 control practices for the placement of Resident # 56's catheter collection bag. The findings include: 1. The facility staff failed to implement infection control practices during Resident # 21's tracheostomy care. Resident # 21 was admitted to the facility on 12/24/18 and a re-admission on 04/18/19 with diagnoses that included but were not limited to: chronic respiratory failure (1), old myocardial infarction (2), and anxiety (3). Resident # 21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/09/19, coded Resident # 21 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Under Section O "Special Treatments, Procedures and Programs" Resident # 21 was coded as "D. Suctioning; E. Tracheostomy care." On 06/19/19 at 10:40 a.m., an observation was conducted of tracheostomy's care to Resident # 21 performed by LPN (licensed practical nurse) # 6. LPN #6 entered resident # 21's room and set up packaged trach (tracheostomy) supplies on a clean barrier. LPN #6 then washed her hands and put on a clean pair of gloves, opened a sterile "Suction Kit". LPN #6 then removed her gloves, opened and put on the sterile gloves from the kit. LPN #6 then opened the package with the sterile suction tubing, connected it to the tubing from the suction machine, and turned on the suction machine with her left sterile gloved hand.	F 880	bag has the potential to be affected if facility staff fail to implement infection control practices. 3) The Director of Nursing (DON) or designee will educate center staff on infection control practices regarding glove use and handwashing related to tracheostomy care and catheter collection bag placement. 4) The Director of Nursing (DON) or designee will conduct random observations of residents with catheter collection bags to ensure appropriate placement daily x 5 days (M-F), weekly x 3 weeks and monthly x 2 months. The Director of Nursing (DON) will observe tracheostomy care daily x 5 days (M-F), weekly x 3 weeks and monthly x 2 months to ensure staff follow infection control protocol. Findings will be reported to the QAPI Committee for further recommendation.	

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LPN #6 then placed both sterile gloved hands on the sterile tubing and placed it the tubing into Resident #21's trach to suction out secretions. Upon completing this task, LPN # 6 turned off the suction machine, disconnected the tubing, and removed the gloves she was wearing. LPN #6 then donned a pair of plastic gloves, opened a sterile "Tracheostomy Care Tray", removed the items and placed them on the clean barrier that included "Powder free Nitrate Gloves." While wearing the regular plastic gloves LPN # 6 removed the cannula from Resident # 21's trach, placed it in the tray, opened the bottle of saline and peroxide, placed the cannula in the tray and cleaned it using the enclosed brush. While wearing the same gloves LPN # 6 opened another bottle of saline and using a cotton swab cleaned the area around Resident #21's trach opening. LPN #6 then removed a clean strap from the "Tracheostomy Care Tray" and removed the strap on the right side of Resident #21's trach cuff. She then attached the new strap, moved the over-the-bed table while wearing the same gloves, went to the left side of the bed, removed the old strap from the trach cuff and attached the new strap to the left side of the trach cuff. LPN #6 then removed a new cannula, opened the package and placed a new, clean cannula into Resident # 21's trach cuff.

The POS (physician's order sheet) for Resident # 21 dated "June 19, 2019" documented, "Trach [tracheostomy] care q (every) shift and PRN (as needed). Order Date: 04/18/19."

The comprehensive care plan for Resident # 21 dated 01/18/2019 documented, "Focus: (Resident # 21) is at risk for respiratory problem(s) related to chronic condition DX (diagnosis) of chronic

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F 880	Continued From page 104 respiratory failure with hypoxia with periods of acute exacerbation. Date Initiated: 01/18/2019." Under "Interventions/Tasks" it documented, "Provide Trach Care as ordered. Date Initiated: 02/08/2019." On 06/19/19 at 1:21 p.m., an interview was conducted with LPN (licensed practical nurse) # 6 regarding the tracheostomy care provided to Resident # 21. When asked to describe the procedure for using gloves, LPN # 6 stated, "I sanitize or wash my hands between glove use." LPN #6 was then informed of the above observations of not changing gloves, washing her hands between changing gloves and touching items while wearing gloves when providing Resident # 21's trach care. LPN # 6 stated, "I should have only touched the items in the sterilized field. I touched the suction tubing with same gloved hand I turned the suction machine on with." When asked if she washed or sanitized her hands between changing gloves during the trach care for Resident LPN stated, "No." The facility's policy "Tracheostomy Care" documented, "PROCEDURE: A. 2. Wash your hands (keep procedure as aseptic as possible)."." On 06/19/19 at approximately 5:30 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality assurance and performance improvement), were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your	F 880		

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F 880	Continued From page 105 lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. 2. The facility staff failed to implement infection control practices for the placement of Resident # 56's catheter collection bag. Resident # 56 was admitted to the facility on 07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to: retention of urine, hypertension (1), depressive disorder (2), and multiple sclerosis (3). Resident # 56's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/16/19, coded Resident # 56 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 56 was coded as being totally dependent of one staff member for activities of	F 880		

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F 880	Continued From page 106 daily living. Section H "Bladder and Bowel" Resident # 56 was coded as "A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)." On 06/18/19 at 4:21 p.m., an observation of Resident # 56 revealed she was in her room, lying in her bed watching television. Observation of the bed revealed it was low to the ground and the observation of the catheter collection bag revealed it was attached to the side of the bed and resting on the floor. The POS (physician's order sheet) for Resident # 56 dated "June 19, 2019" documented, "Supra pubic catheter 20F (French) with 20cc (cubic centimeters) balloon for neurogenic bladder. Change PRS (as needed) for facility protocol. Order Date: 09/11/17." The comprehensive care plan for Resident # 56 dated 06/08/2015 documented, "Focus: The resident has an Indwelling (Suprapubic) Catheter: Neurogenic bladder. At risk for chronic UTIs (urinary tract infections) date Initiated: 08/19/2016." On 06/19/19 at 11:32 a.m., an interview was conduct with CNA (certified nursing assistant) # 7. When asked to describe the placement of a resident's catheter collection bag, CNA # 7 stated, "The collection bag is put on the side of the bed and low so it drains. It should not be on the floor to avoid infection." On 06/20/19 at 2:25 p.m., an interview was conduct with LPN (licensed practical nurse) # 4. When asked to describe the placement of a resident's catheter collection bag, LPN # 4 stated,	F 880		

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F 880	Continued From page 107 "The collection bag is put on the side of the bed it should not be on the floor to avoid infection or contamination." The facility's policy "Catheter Care" documented, "PROCEDURE: H4. Collection container is below bladder level but not touching the floor." On 06/19/19 at approximately 5:30 p.m., ASM # 1 (administrative staff member), administrator, and ASM # 3, director of risk management and QAPI (quality assurance and performance improvement), were made aware of the findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness,	F 880		

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F 880	Continued From page 108 trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.	F 880		