STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 08/29/2019

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ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/27/19 through 8/29/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/27/19 through 8/29/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Nine complaints were investigated during the survey. The census in this 138 certified bed facility was 112 at the time of the survey. The survey sample consisted of 57 current resident reviews and 9 closed records reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		10/7/19

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

Electronically Signed | 09/20/2019

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility document review the facility staff failed to ensure 1 of 66 residents in the survey sample (Resident #78) had footwear and clothing other than the facility's hospital gowns to wear. The findings included: Resident #78 was originally admitted to the facility 3/5/19 and readmitted 7/19/19 after an acute care hospital stay. The current diagnoses include anemia, and a seizure disorder.	F 550	F 550 1. Resident #78 was affected by the oversight. Clothing was obtained for her on 8-27-19 by CNA #3 from the laundry. Her name was placed in her clothes which were then placed in her closet. Social Services attempted to contact the family on 8-29-19 to bring her more clothes and shoes. 2. Any resident may be affected especially residents with limited outside	

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F 550	Continued From page 2 The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/26/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #78's cognitive abilities for daily decision making was moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, extensive assistance of one person with dressing, eating, toileting, personal and hygiene and total care with bathing. Resident #78 was observed in bed on 8/27/19, at approximately 2:00 p.m., dressed in a blue and white hospital gown with the ties untied and exposing her upper chest area. She was also wearing light pink booties. There were no top bed linens either. The resident stated she had not been out of bed and she didn't know why she was still wearing a gown and she would prefer to dress in street clothing and wear shoes instead of slippers. Observation of the resident's closet revealed three cardigans and the dresser drawer contained only odd socks and incontinence briefs. On 8/27/19 at approximately 4:00 p.m., an interview was conducted with certified nursing assistant (CNA) #3 who was providing care to Resident #78 before dinner. She stated she would go to the laundry and bring the residents clothing to her room for she was aware a washer was out of service and it was likely the reason there was no clothing in the resident's closet or drawers. Again on 8/28/19 at approximately 11:15 a.m.,	F 550	support. 3. Social Services, Nursing staff, and Activities staff will check all resident rooms including Resident #78's rooom for clothing and shoe needs. Social Services will notify family/guardian of need for clothing and shoes. CNA□s will be instructed to dress residents who desire to be dressed in street clothes with shoes daily including Resident #78. Documentation will be completed for residents who do not wish to be dressed in street clothes. If resident does not have clothing including Resident #78, the CNA will go to the laundry to secure any clothing there. If resident has no clothing in the laundry, including Resident #78, the CNA will report the lack of clothing to the Charge Nurse and to Social Services using Hey! Social Services form. Social Services will contact family/guardian to provide clothing. Any unlabeled clothing noted in laundry will be kept for 30 days. At the end of the 30 days the clothes will be taken to the Dining Room where residents, staff and family can take any clothes needed. CNA□s will label the clothing obtained, Any clothing remaining will be donated to charity. 4. Charge Nurses will have a daily check list that will include the monitoring of resident clothing. This check list will be turned in daily to Director of Nursing, Assistant Director of Nursing, or Unit Manager who will check daily for 2 weeks, then 3 times per week for 2 weeks, then weekly ongoing. Appropriate staff will be in-serviced on procedure by Staff Development Coordinator, Director of	

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F 550	Continued From page 3 Resident #78 was observed dressed in a hospital gown and pink booties; an interview was conducted with CNA #1 who stated when Resident #78 was admitted to the facility she was wearing a hospital gown and no personal belongings came with her. She stated the staff got clothing from the clothes closet to dress the resident in on a daily basis but there was no longer a clothes closet therefore she wore only hospital gowns. CNA #1 further stated they reported this concern to the charge nurses multiple times yet the resident remained without clothing except the sweaters in the closets which were obtained from the clothing closet but were not worn by the resident. On 8/28/19 at approximately 3:30 p.m., an interview was conducted with the laundry supervisor who stated he had obtained some donated clothes from the laundry for Resident #78 and her name was labeled inside the items so they would be returned to her after they are laundered. The laundry supervisor stated most likely the previous items the staff obtained from the clothing closet when it existed had not be labeled with her name therefore; they were not returned to her after they were laundered for they didn't know they were her items. An observation was made of Resident #78's closet on 8/29/19 at approximately 11:45 a.m. and revealed approximately 4 outfits labeled with her name. The resident was seated bedside her bed dressed in street appropriate attire but she was still wearing only socks no shoes. An interview was conducted with the Social Worker on 8/29/19 at approximately 2:30 p.m., the Social Worker stated no one had told him that	F 550	Nursing, or designee on or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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F 550	Continued From page 4 Resident #78 didn't have her own clothing and footwear. He further stated the resident's authorized representative was not very active in her care but he would reach out and make attempts to obtain Resident #78 needed clothing and shoes. On 8/29/19 at approximately 6:00 p.m., the above findings were shared with the Administrator and Director of Nursing. The Administrator stated staff was working on resolving Resident #78's clothing and footwear concerns.	F 550		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident	F 553		10/7/19

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F 553	Continued From page 5 of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to invite 2 (Resident #37 and 64) of 66 residents in the survey sample, to attend their person centered care plan meeting. The findings included: 1. The facility staff failed to invite Resident #37 to participate in her person centered care plan meeting. Resident #37 was originally admitted to the facility on 02/27/19. Diagnosis for Resident #37 included but not limited to, Cerebral Palsy. The current Minimum Data Set (MDS), a 30-day PPS assessment with an Assessment Reference Date (ARD) of 06/14/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. During the initial tour of the facility on 08/26/19 at approximately 3:04 p.m., an interview was conducted with Resident #37 who stated when asked about care plan meetings, "No one has ever given me a care plan letter or invited me to attend a care plan meeting."	F 553	F-553 1. Residents #37 and #64 were affected by this oversight. As this occurred in the past there was no opportunity for immediate corrective action. 2. All residents have the potential to be affected. 3. Social Services will mail a care plan invitation to the RP based on the monthly calendar provided by MDS nurses. Said letter will be sent with a return receipt requested for verification of delivery. Social Services will also provide a letter of invitation to the resident in the facility. Resident will sign a letter of receipt. If resident is not able to sign it swill be signed by 2 witnesses who may or may not be facility staff. Social Services will maintain a file of return receipts and letters of receipt as well as documenting that letter was received. If resident's primary language is not English and there is no family available to assist in translation , the language line will be utilized. If a resident is unable to make decisions and there is no family can be contacted Social Services will refer	

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F 553	Continued From page 6 An interview was conducted with Social Worker (SW) #2 on 08/28/19 at approximately 4:00 p.m., who stated, "I am unable to provide evidence that Resident #37 was invited to attend her care plan meetings." She said a care plan meeting was held for Resident #37 on March 18, 2019 and another care plan meeting should have been in June 2019. The SW stated, "(Resident #37) has only had one care plan meeting since her admission and there should have been two care plan meetings held." When asked should Resident #37 attend her person-centered care plan meeting, she replied, "Absolutely." On 08/28/19 at approximately 4:52 p.m., an interview was held with MDS Coordinator #1. She said Resident #98 should have had a care plan meeting scheduled for 14 days after admission. An interview was conducted with the Administrator on 08/29/19 at approximately 3:30 p.m. She said all residents are to be invited to attend their care plan meeting. The surveyor asked, "What is the purpose of inviting a resident to attend their person-centered care plan meeting?" She stated, "So the resident can have say over their own care and make changes to toward their own goals." The Administrator was informed of the finding during a briefing on 08/29/19 at approximately 7:15 p.m. The facility did not present any further information about the findings. 2. For Resident #64, facility staff failed to provide evidence that the resident and/or family member was invited to attend the quarterly care plan	F 553	resident to a guardianship program. Nursing staff will assist Social Services in getting residents to the care plan meeting. 4. Social Services will retain return receipts and signed letters of receipt and present to the Administrator weekly for 12 weeks. Administrator, DON, or designee will in-service Social services and MDS on procedure to be completed by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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meetings and the facility staff failed to provide evidence that the quarterly care plan meetings were actually taking place.

Resident #64 was admitted to the facility on 12/20/11 and readmitted on 4/16/19 with diagnoses that included but were not limited to cardiovascular disease, high blood pressure, adult failure to thrive, and Alzheimer's disease. Resident #64's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/23/19. Resident #64 was coded as being severely impaired in cognitive function scoring 00 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #64's clinical record failed to evidence notes from the social worker regarding quarterly care plan meetings. Further review of the clinical record revealed that Resident #64 had been her own responsible party.

On 8/27/19 at 2:12 p.m., an interview was attempted with Resident #64's emergency contact, her sister. The phone number was disconnected.

On 8/28/19 at 8:51 a.m., an interview was attempted with Resident #64. Resident #64 stated that she didn't speak English. Resident #64's breakfast was then delivered to her. A language pamphlet with a translator hotline was located on the back wall behind the bed.

Review of Resident #64's care plan dated 4/17/19 documented that Resident #64 spoke Chinese and/or Vietnamese. The following intervention was documented: "language interpreter hotline."

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On 8/28/19 at approximately 9:30 a.m., this writer called the translator on the telephone to conduct a second interview attempt in language (Vietnamese). This writer asked the translator if she was being invited to care plan meetings, where staff make her aware of the care that she is receiving. The translator stated that the resident was having a hard time understanding what was being asked. Resident #64 could however understand some questions regarding activities and food.

On 8/28/19 at 9:49 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When if she had a different number on file for Resident #64's emergency contact, LPN #2 stated, "Her sister passed away I believe." LPN #2 also stated that social services had been working to get another emergency contact for Resident #64.

On 8/28/19 at 10:00 a.m., an interview was conducted with OSM (other staff member) #1, the social worker. When asked how often care plan meetings were held, OSM #1 stated quarterly. When asked who was responsible for inviting the resident and/or family, OSM #1 stated that he was responsible. OSM #1 stated that if the resident cannot attend he will send a letter to the family to RSVP. When asked who attended the care plan meetings for Resident #64, OSM #1 stated that her sister would attend by phone conference. When asked if Resident #64 would ever attend, OSM #1 stated that Resident #64 had severe dementia and that she could not understand what was going on in the meetings. When asked if her language made it hard for the resident to understand her care plan meetings,

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OSM #1 stated that they have used the translator phone in the past and the resident still could not understand. OSM #1 stated that recently he has had a hard time getting in touch with the sister. When asked if the sister had passed away, OSM #1 stated, "I have heard that." When asked where did he hear that from, OSM #1 stated that the sister's caregiver had called to say she had passed away in response to the facility sending mail to her address. When asked when the sister had passed away, OSM #1 stated sometime in July of 2019. OSM #1 was asked to provide evidence that the resident and/or sister was invited to the care plan meetings since last survey (5/4/18).

On 8/29/19 at 9:35 a.m., further interview was conducted with OSM #1. OSM #1 could only provide a care plan invitation to Resident #64 on 7/23/19. OSM #1 could only provide a quarterly dietary note dated 7/23/19. OSM #1 could not provide any additional evidence that care plan meetings were actually taking place. OSM #1 stated that he could not find any documentation since 5/4/2018.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator, was made aware of the above concerns. A policy could not be provided regarding the above concerns.

Facility policy titled, "How to Care Plan," documents in part, the following: "Meeting; Best Practices 7 days following ARD (assessment reference date). Off of Quarterly Calendar Provided by MDS. SS (social services) to send letter to family, resident, and make a note. Disciplines needed in the meeting: SS, MDS,

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F 553	Continued From page 10 DON (Director of Nursing) (or designee, Activities, Dietary. Care plans need to be reviewed and updated as needed every Quarterly and Annual (and as needed)."	F 553		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		10/7/19

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F 582	Continued From page 11 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices were issued in accordance with applicable Federal regulations to 2 of 3 residents (Resident #7 and #93) in the survey sample. The findings included: 1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #7 who was discharged from skilled services with Medicare days remaining. Resident #7 was admitted to the nursing facility on 05/17/19. Diagnosis for Resident #7 included but not limited to Dementia without behavior disturbances. Resident #7's Minimum Data Set (MDS), a quarterly assessment with an Assessment	F 582	F-582 1. Resident #7 and #93 were issued ABN notices. 2. All residents have the potential to be affected. 3. Social Workers will be in-services on or before October 6th, 2019 by Business office Manager regarding the Federal Requirements to issue ABN notices to residents informing them that Medicare may not pay, and they may be responsible 4. BOM will or designee will audit ABN notices daily X 1-week, weekly x4, and monthly x4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. October 7, 2019.	

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Reference Date (ARD) of 05/24/19 coded Resident #7 with short and long-term memory problems and with severe cognitive impairment - never/rarely made decisions.

During review of the Beneficiary Notification Checklists provided by the facility it was noted that Resident #7 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123) issued to Resident #7 on 02/08/19, however no copies of the SNF ABN (CMS-10055) were provided.

Resident #7 started a Medicare Part A stay on 01/23/19 and the last covered day of this stay was 02/11/19. Resident #7 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #7 had only used 20 days of her Medicare Part A services.

An interview was conducted with Social Worker (SW) #1 on 08/28/19 at approximately 8:57 a.m. He (SW) stated, "I was not able to find an ABN for Resident #7." He stated, "I do not know what an ABN is or the purpose for the ABN."

The Administrator was informed of the finding on 08/29/19 at approximately 3:30 p.m. The facility did not present any further information about the findings.

2. Resident #93 was admitted to the nursing facility on 04/08/19. Diagnoses for Resident #93

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included but not limited to Muscle Wasting. Resident #93's Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 07/29/19 coded Resident #93 a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident with moderate cognitive impairment.

During review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #93 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123) on 05/11/19, however no copies of the SNF ABN (CMS-10055) were provided.

Resident #93 started a Medicare Part A stay on 04/08/19, and the last covered day of this stay was 05/13/19. Resident #93 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and a NOMNC (CMS-10123). Resident #93 only used 37 days of his Medicare Part A services.

An interview was conducted with Social Worker (SW) #1 on 08/28/19 at approximately 8:57 a.m. He (SW) stated, "I was not able to find a ABN for Resident #93." He stated, "I do not know what an ABN is or the purpose for the ABN."

The Administrator was informed of the finding on 08/29/19 at approximately 3:30 p.m. The facility did not present any further information about the findings.

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F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		10/7/19

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F 584	Continued From page 15 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, complaint investigation and staff interviews the facility staff failed to ensure the environment was safe, clean and comfortable for potentially all residents in the facility and specifically for 3 of 66 residents in the survey sample, Residents #14, #40, #109). The findings included: 1. During a complaint investigation indicating the facility was without linens it was determined that one of two facility washing machines became inoperable. A review of a facility email dated June 24, 2019 indicated that a request for the purchase of a washer was instituted on June 24, 2019 at 7:48 A.M. by the Administrator. The washer was not installed until 8/30/19. During an interview with the Housekeeping Director on August 28, 2019 at 2:15 P.M. he stated, "The washer had been out for about two months. When asked what "out" meant he stated "The washer was not operating properly and was not in operating condition." When asked how he was keeping up with the linen and resident clothing, the Housekeeping Director stated, we were behind about a week to two weeks in keeping resident clothing and facility linen clean." When asked when was the washer to be replaced, the Housekeeping Director stated, "The washer was scheduled to be installed on August 29, 2019." On August 29, 2019 at 8:30 A.M. the new washer was observed being installed by an outside	F 584	F-584 1. A New washing machine installed on 8/29/19. The displaced ceiling tiles within the corridor of the 300 hall was replaced on 8/29/19, The dead bug in hallway light fixture on Homer hall was cleaned on 8/30/19. Plaster chipping off wall in room #225 was removed and replaced with FRP on 9/19/18. Jagged edges to entry doorway of room #234 was repaired on 8/29/19. Chipping on a wooden shoe railing between rooms 217 and 219 will be repaired on 9/19/19. Shower room column chipped tile was replaced on 9/19/19. Bracket on shower room wall in Homer hall was removed on 8/29/19. Resident #14 had left arm of wheelchair was replaced on 8/29/19. Resident #109 had footboard of bed replaced on 8/29/19 by the Maintenance Director or designee. Housekeeping cleaned the dry tube feeding from Resident #40s floors, T.V table and side rails on 8/29/19. 2. All residents have the potential to be affected. 3. All staff will be in-serviced on use of Reqqer system for maintenance repair requests. Maint. Director or designee, using the “maintenance rounds audit” form, will perform a random audit including; torn wheelchair arm, loose foot boards, clean light fixtures, chipped plaster in rooms or shoe railings and floor tiles, jagged doorway edges, exposed brackets, displaced or stained ceiling tiles.	

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F 584	Continued From page 16 vendor. A review of the Service Work Order dated 8/28/19 indicated the washer was purchased on 8/28/19. The Laundry room was observed to have bags of soiled clothing and facility linen stored in a pile measuring around seven feet wide, ten feet long and six feet high. During an interview on 8/30/19 at 3:30 P.M. with the Administrator she stated, the washer was out of service for about two months. The washer was installed on 8/29/19. A facility Maintenance Service policy indicated: "Maintenance service shall be provided to all areas of the building, grounds and equipment. 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. Maintaining the building in compliance with current federal. state and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. d. Maintaining the heat/cooling system, plumbing fixtures, wiring,etc. in good working order." During an environment observation held on 8/27/2019, the observations concluded that the facility failed to provide services to maintain a safe and sanitary environment. On 8/27/2019 beginning at 10:50 a.m., an inspection of the resident rooms, corridors, and shower room was conducted with the Director of Maintenance yielding the following observations	F 584	Audits will be daily x 3 weeks, weekly x4, biweekly x 4, and monthly x4 All housekeeping staff will be in-serviced on proper cleaning of resident's room. Using Housekeeping's "Quality Assurance Inspection" audit form, A sample of 6 resident rooms will be audited by ED or designee daily X 3 weeks, weekly X 4, biweekly X4 and monthly X4 for room cleanliness. 4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. October 7,2019	

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and responses:

At 10:50 a.m., the surveyor observed displaced ceiling tile within corridor of the 300 resident hallway. When asked about the displaced tile the Director of Maintenance responded. "The tiles are in the process of being remodeled..i don't have an ETA ..they are in process."

At 11:01 a.m., the surveyor observed a dead bug in a hallway light fixture. When asked about the dead bug, the Director of Maintenance responded, "I will get that out quickly."

At 11:04 a.m., the surveyor observed plaster chipping off a wall within resident bedroom #225. When asked about the chipped plaster, the Director of Maintenance responded, "We will scrape it down and paint over it. We can get it done this week."

At 11:07 a.m. the surveyor observed damaged, jagged edges on the entry door of resident room #234. When asked about associating potential hazards, the Director of Maintenance responded, "We will put some wood glue there. Injuries like cuts, scrapes and scratches would result. We make CAN's aware to inform us of structure issues."

At 11:13 a.m., the surveyor observed chipping on a wooden shoe railing between resident rooms 217 and 219 of the Fine Hall corridor. When asked about potential hazards, the Director of Maintenance responded, "That is a potential hazard. We need to replace that today." The surveyor also pointed out water stained ceiling tiles throughout the Fine Hall corridor near the nurse's station. The Director of Maintenance

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resident hallway responded, "We would normally replace those...but the rippling is caused by condensation. We will change tiles out this week...it will be addressed."

At 1:45 p.m., the surveyor observed within the shower room located on Fine Hall, chipped tile on a column wall, exposed, dead roaches and gnats within a light fixture and an exposed, rusted bracket on the wall. The Director of Maintenance responded, "Someone could get hurt from that."

The observations referenced above were shared with the Facility Administrator. The facility maintenance policy was requested from the Administrator and Director of Maintenance however none was provided.

3. For Resident #14, facility staff failed to ensure her wheelchair was free from disrepair.

Resident #14 was admitted to the facility on 12/2/16 and readmitted on 1/16/17 with diagnoses that included but were not limited to Alzheimer's disease, dementia without behavioral disturbance, and high blood pressure. Resident #14's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/31/19. Resident #14 was coded as being severely impaired scoring 06 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 8/27/19 at 11:14 a.m., 1:35 p.m., and 3:41 p.m., and on 8/28/19 at 9:02 a.m., and 4:19 p.m., observations were made of Resident #14. Her wheelchair arm rest to the left arm was torn up exposing yellowing padding. On 8/27/19 at 1:35 p.m. an interview was conducted with Resident #14. When asked if the torn up rest had bothered

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her, she stated, "It is what it is." Resident #14 could not say how long her wheelchair rest was in that condition.

On 8/28/19 at 5:26 p.m., an interview was conducted with OSM (other staff member) #3, the Director of Maintenance. When asked how he is made aware of a wheelchair that needs repair, OSM #3 stated that any staff member can fill out a work order and the work order would alert him to repair a wheelchair or anything else on the unit. When asked if he would expect staff to report a ripped up wheelchair arm, OSM #3 stated that he would expect nursing staff to report that. When asked if he had a work order for Resident #14's wheelchair, OSM #3 checked his work orders and stated that he did not. When told OSM #3 about the above observations, OSM #3 stated that her wheelchair arm was probably like that for awhile if the whole arm was ripped up exposing the yellow padding.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator, was made aware of the above concerns. A policy could not be provided regarding the above concerns.

4. The facility staff failed to provide a comfortable homelike environment for Resident #40's room from 8/27/19 to 8/28/19.

The findings include:

Resident #40 was originally admitted to the facility on 11/09/18 with a readmission date of 06/28/18. Diagnoses for Resident #40 included but not limited to Sepsis and Anemia.

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The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 04/25/19 coded the resident on the Brief Interview for Mental Status as not able to complete the interview. Resident coded as having Short term and Long term memory problems. Indicating a severe impairment for daily decision-making. Resident #40 was coded total dependence, two person physical assistance staff with personal hygiene.

On 8/27/19 at 11:06 AM a small to moderate amount of dry tube feeding was observed on the left side rail as well as on the floor and TV table.

On 08/27/19 at approximately 1:05 PM, the Resident's side rail had a small to moderate amount of dry tube feeding on it. There was a small to moderate amount of dry tube feeding on the floor and TV stand.

On 08/28/19 at approximately, 11:43 AM, the Resident's side rail had a small to moderate amount of dry tube feeding on it. The resident's floor had a small to moderate amount of dry tube feeding observed.

On 08/28/19 at approximately 12:53 PM. a room observation was made. The TV table was now cleaned. The side rails on the left still had a small to moderate amount of tube feeding as well as on the floor.

On 08/29/19 at approximately 10:25 AM an interview was conducted with (Certified Nursing Assistant) CNA #6. She was asked what would she do if she saw dried up tube feeding on the side rails and the floor in a resident's room? She stated "I would clean it up."

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On 08/28/19 at approximately, 11:55 AM (Licensed Practical Nurse) LPN #8 was asked who was responsible for making sure a resident's side rails were cleaned off if enteral (tube) feeding was spilled on the side rails, floor or TV stand. She stated, "Housekeeping should do the cleaning."

On 08/29/19 at approximately 7:13 PM a pre-exit interview was conducted with the Administrator. The above findings were discussed. No comments were made.

5. The facility staff failed ensure Resident #109's footboard was in good working condition, safe and secure. Resident #109 was admitted to the facility on 05/23/18. Diagnosis for Resident #109 included but not limited to Cognitive communication deficit.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 08/14/19 coded the resident with a 07 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe impairment. In addition, the MDS coded Resident #109 with extensive assistance of one with bed mobility, bathing, limited assistance of one with transfer, dressing, hygiene and bed mobility with Activities of Daily Living (ADL).

During the initial tour of the facility on 08/27/19 at approximately 3:31 p.m., Resident #109's footboard was loose and leaning forward toward to his bed. The surveyor asked Resident #109, "How long has your footboard bed been leaning forward, he replied, "I don't know but it's been like that this for a long time now."

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On 08/28/19 at approximately 9:30 a.m., the footboard remained loose and leaning forward toward to his bed. On the same day at approximately 3:25 p.m., the footboard remained unchanged. On the same day at approximately 3:35 p.m., an interview was conducted with the Maintenance Director. The Maintenance Director said the bolts attached to the footboard is very loose which at any time the footboard could fall off into the resident's bed. He said the footboard is probably over 15 years old. He said "The staff should be checking the resident furniture to include the footboards when they are doing around for furniture that needs repair." He said "The staff should have put in a work order ticket through our ReQQer program system." He said with this type of system the staff will put in a work ticket; it will automatically come through to my work phone and my computer desktop. On the same day at approximately 4:10 p.m., the Maintenance Director approached this surveyor with another footboard in his hand. He said this is a good footboard; it nice and sturdy. At approximately 4:28 p.m., the Maintenance Director stated, "I have removed the old footboard from Resident #109's bed and have replaced it with another one. The footboard is now safe and secure."

An interview was conducted with the Administrator on 08/29/19 6:36 p.m. The Administrator said the nursing staff should be checking the resident's furniture/equipment on a daily basis to make sure they are in good working condition and good repair. She said the nursing staff should put in a work ticket, which goes straight into our ReQQer program. The information will go straight to the maintenance departments desktop and the work phone.

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F 584	Continued From page 23 The Administrator was informed of the finding on 08/29/19 at approximately 3:30 p.m. The facility did not present any further information about the findings. The facility's policy titled Bedrooms (Revised May 2017). Policy statement: All residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. Policy Interpretation and Implementation include but not limited to: 4 (a). Each resident is provide with functioning furnishings appropriate to his or her needs. Definitions: -ReQQer is a centralized system that tracks and prioritizes all maintenance tasks (reqqer.com).	F 584		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622		10/7/19

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	495241	A. BUILDING _____ B. WING _____	C 08/29/2019

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(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)

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F 622	Continued From page 25 (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, facility document review, and clinical record review, it was determined that facility staff failed to provide the required documentation upon transfer to the hospital for five of 66 residents in the survey sample, Residents #15, #78, #102, #37 and #71. The findings included:	F 622	F-622 1. As the oversight that affected residents #15, #78, #102, #37 and #71 occurred in the past. Nurses were in-serviced on 8-28-19 to immediately include the care plan goals when sending a resident to the hospital.	

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F 622	Continued From page 26 1. Resident #15 was admitted to the facility on 6/14/18 and readmitted on 6/28/19 with diagnoses that included but were not limited to dementia, HIV (Human Immunodeficiency virus), and weakness. Resident #15's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/31/19. Resident #15 was coded as being severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that he went out to the hospital on 6/27/19. The following in part, was documented: "At 9:25 p.m. resident was in bed throwing up x 2 (two times) and continued to state that he did not feel good. vital signs were obtained blood pressure 101 over 56 pulse 103 respiration 18 temperature 99.4 and O2 (oxygen) stats (saturation) 96% clients appearance was pale sweating . Staff/writer called 911 and sent to (Name of Emergency room)." Further review of the clinical record revealed that Resident #15 arrived back to the facility on 6/28/19 with diagnoses of a UTI (urinary tract infection). There was no evidence that the required documentation, i.e. contact information of the practitioner responsible for the care of the resident, Resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate nor the comprehensive care plan goals were sent with the resident upon transfer to the hospital.	F 622	2. Any resident requiring transfer to the hospital has the potential to be affected. 3. Alphabetical accordion files will be placed at each nurses station. Copies of the care plan goals will be placed in the accordion files for each resident. Nurses will remove the care plan goals and send to the hospital when a resident is transferred. Nurses will document in the medical record what was sent with the resident on transfer. Unit Managers will be responsible for replacing care plan goals as they are used. 4. All Discharged resident records will be reviewed daily Monday-Friday for documentation that the care plan goals were sent to the hospital ongoing. If a resident was transferred to the hospital the DON, ADON, Unit Manager, or designee will go the hall the resident was transferred from and verify that the care plan goals had been removed. Licensed Nurses will be in-serviced by SDC, DON, or designee on transfer process in accordance with the policy and the documentation required by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October7, 2019	

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On 8/28/19 at 4:30 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked what documents were sent with residents at the time of a transfer to the hospital, LPN #2 stated that the face sheet, pertinent labs, and the medication list were sent with the resident upon transfer to the hospital. When asked if the care plan or care plan goals were sent with the resident upon transfer, LPN #2 stated that they have never done that. LPN #2 stated she didn't know that was a requirement. LPN #2 stated that advanced directives and physician and responsible party contact information would be located on the face sheet. When asked how to know that the face sheet was sent with the resident upon transfer to the hospital, LPN #2 stated that a note should be documented saying that all paperwork was sent.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator was made aware of the above concerns. No further information was presented prior to exit.

2. The facility staff failed to convey Resident #78's comprehensive care plan goals upon transfer to the acute care hospital on 7/11/19.

Resident #78 was originally admitted to the facility 3/5/19 and readmitted 7/19/19 after an acute care hospital stay. The current diagnoses include anemia, and a seizure disorder.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/26/19 coded the resident as completing the Brief Interview for Mental Status

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(BIMS) and scoring 10 out of a possible 15. This indicated Resident #78's cognitive abilities for daily decision making was moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, extensive assistance of one person with dressing, eating, toileting, personal and hygiene and total care with bathing.

Review of the clinical record revealed no nurse's note dated 7/11/19, which stated Resident #78 was transferred to the local acute care hospital's emergency room.

An interview was conducted with the Assistant Director of Nursing (ADON) on 8/29/19, at approximately 3:15 p.m. The ADON stated a nurse's note should have been written including why the resident was being sent to the emergency room, all information sent with the resident and to the hospital staff. The ADON further stated, likely the transferring nurse sent the Hospital Transfer Form, a face sheet and the Physician's Order summary but, "Not the care plan for we were not aware of the requirement."

On 8/29/19, at approximately 6:00 p.m., the above findings were shared with the Administrator, and the Director of Nursing. No further information was provided by the facility staff.

3. Resident #102 was initially admitted to the facility on 03/20/2014. Resident #102 was discharged to the hospital on 08/04/2019 and readmitted to the facility on 08/06/2019. Diagnoses included but were not limited to, Seizure Disorder and Chronic Obstructive

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Pulmonary Disease.

Resident #102's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/13/2019 coded Resident #102 with a BIMS (Brief Interview for Mental Status) score of 02 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #102 as requiring supervision with set up help only with eating, extensive assistance of 1 with bed mobility, dressing, toilet use and personal hygiene and total dependence of 1 with transfer and bathing.

On 08/28/2019 at 3:30 p.m., an interview was conducted with the Director of Nursing (DON) and she was asked for evidence that Resident #102's care plan goals were sent with the resident upon discharge to the hospital on 08/04/2019. The DON stated, "I wasn't aware that the care plan goals were to be sent to the hospital when the residents are discharged. Nursing has not been sending the care plan goals to the hospital when the residents are discharged." The DON stated that the nursing staff would start sending the care plan goals with the residents when they are discharged to the hospital.

On 08/28/2019 at 3:45 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1 and she was asked, "What documents do you send out with a resident when they are discharged to the hospital?" LPN #1 stated, "I send their face sheet, medication list and then I will call their report." LPN #1 was asked, "Do you send the residents care plan goals when they are discharged to the hospital?" LPN #1 stated, "No."

The Administrator was informed of the finding at

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the pre-exit meeting on 08/29/2019 at approximately 7:15 p.m. The facility did not present any further information about the finding.
4. The facility staff failed to ensure that Resident #37's Plan of Care Summary to include her care plan goals was sent upon transfer/discharge to the hospital on 04/28/19 and 08/06/19. Resident #37 was originally admitted to the facility on 02/27/19. Diagnosis for Resident #37 included but not limited to Cerebral Palsy.

The current Minimum Data Set (MDS), a 30-day PPS assessment with an Assessment Reference Date (ARD) of 06/14/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

According to the facility's documentation on 04/28/19, Resident #37 complained of pain to her abdomen incision but refused alternative medication for pain. The open area to abdomen observed with brown mucous like drainage. Resident #37 was transferred to the local hospital Emergency Room (ER) via EMR transport.

An interview was conducted with License Practical Nurse (LPN) #1 on 08/28/19 at approximately 3:45 p.m. The surveyor asked, "What paperwork is sent with the resident when they are being sent out to the hospital." The nurse replied, "I will send the resident's face sheet, medication list, and bed hold policy. The surveyor asked, "Should the items sent to the hospital be documented in the resident clinical record to include the bed hold policy being sent upon discharge" she replied, "Yes."

An interview was conducted with the

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Administrator on 08/29/19 at approximately 3:30 p.m. She said the care plan should be sent with the resident when being discharged to the hospital. The surveyor asked, "What is the purpose of sending the resident care plan." The Administrator stated, "It gives the receiving provider, knowledge on how to care for the resident and to maintain their care plan goals that has been set by the sending facility." The Administrator said there is no documentation to show evidence the bed hold policy was sent with Resident #37 when discharged to the hospital on 04/28/19 and 08/06/19.

The Administrator was informed of the finding during a briefing on 08/29/19 at approximately 7:15 p.m. The facility did not present any further information about the findings.

5. The facility staff failed to ensure that Resident #71's Plan of Care Summary to include his care plan goals was sent upon transfer/discharge to the hospital on 07/10/19.

Resident #71 was admitted to the facility on 09/14/18 and readmitted to the facility on 07/16/19. Diagnoses for Resident #71 included but not limited to Sepsis and Multiple Sclerosis.

The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 07/10/19. Staff assessment of mental status coded the resident as having short term memory problems with severely impaired cognition. In section "G" (Physical functioning) the resident was coded as requiring total dependence of one person physical assistance with personal hygiene, locomotion off the unit, eating, locomotion on the unit, dressing, bathing, bed mobility, transfers, and toileting.

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The Discharge MDS assessments was dated for 07/10/19 - discharge return anticipated.

On 08/29/19 at approximately 1:55 PM an interview was conducted with the ADON (Assisting Director of Nursing) concerning nurses notes on hospital transfers. There were no notes written and transfer notices sent with resident according to the ADON facility's documentation.

On 08/29/19 received the facility policy titled Transfer Form. It included the following: Policy Statement: This facility provides a completed and accurate Transfer Form to a resident transferred or discharged or from our facility. Policy Interpretation and Implementation: 1. Should it become necessary to transfer a resident from the facility, a Transfer Form will be executed and forwarded with the resident. 2. The transfer form will be completed by nursing services and will include:

a. Current medical findings;
b. Diagnosis;
c. Medications at time of discharge.
d. Rehabilitative potential;
e. Nursing/dietary information;
f. ADL functions;
g. Ambulation status;
h. Summary of the course of treatment followed;
i. The basis for the transfer or discharge.
j. Contact information of the practitioner responsible for the care of the resident.
k. Resident representative information including contact information.
l. Advanced Directive information.
m. All special instructions or precautions for ongoing care, as appropriate.
n. Comprehensive care plan goals; and.

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F 622	Continued From page 33 o. All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. On 08/29/19 at approximately 7:10 PM an interview was conducted with (Licensed Practical Nurse) LPN #11. She was asked what documents are sent with residents when they are transferred to the hospital. She stated, "I send the MAR (Medication Administration Record), TAR (Treatment Administration Record), the H&P (History and Physical), the E-Interact, the Order Summary and the Face sheet." On 08/29/19 at approximately 7:13 PM a pre-exit interview was conducted with the Administrator concerning the above issues. No further information was provided by facility staff.	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to 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	F 625		10/7/19

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F 625	Continued From page 34 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 staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written bed hold notification upon transfer to the hospital for five of 66 residents in the survey sample, Residents #15, #78, #102, #37, & #71. The findings included: 1. Resident #15 was admitted to the facility on 6/14/18 and readmitted on 6/28/19 with diagnoses that included but were not limited to dementia, HIV (Human Immunodeficiency virus), and weakness. Resident #15's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/31/19. Resident #15 was coded as being severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that he went out to the hospital on 6/27/19. Further review of the clinical record revealed that Resident #15 arrived back to the facility on	F 625	F-625 1. As the oversight that affected residents #15, #78, #102, #37 and #71 occurred in the past. Nurses were in-serviced on 8-28-19 to immediately include the bed hold policy when sending a resident to the hospital 2. Any resident requiring transfer to the hospital has the potential to be affected. 3. Alphabetical accordion files will be placed at each nurses station. Copies of the bed hold policy will be placed in the accordion files for each resident. Nurses will remove the bed hold policy and send to the hospital when a resident is transferred. Nurses will document in the medical record what was sent with the resident on transfer. Unit Managers will be responsible for replacing bed hold policy as they are used. 4. All Discharged resident records will be reviewed daily Monday-Friday for documentation that the bed hold policy was sent to the hospital ongoing. If a	

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F 625	Continued From page 35 6/28/19 with diagnoses of a UTI (urinary tract infection). There was no evidence that written bed hold notification was sent with Resident #15 upon transfer to the hospital. On 8/28/19 at 4:30 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked what documents were sent with residents at the time of a transfer to the hospital, LPN #2 stated that the face sheet; pertinent labs, and the medication list were sent with the resident upon transfer to the hospital. When asked if the bed hold notice was sent with the resident, LPN #2 stated that bed hold was something that was addressed with the admissions department when first admitted. LPN #2 stated that nurses did not send the bed hold with the other paperwork. On 8/29/19 at 9:09 a.m., an interview was conducted with OSM (other staff member) #4, the Director of Admissions. When asked if she sends written bed hold notification with residents at the time of a transfer to the hospital, OSM #4 stated that she presented the bed hold policy when a resident is admitted. OSM #4 stated that she believed nursing sent written bed hold notification upon transfer to the hospital. On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator was made aware of the above concerns. No further information was presented prior to exit. 2. For Resident #78, the facility staff failed to provide written information to the resident or	F 625	resident was transferred to the hospital the DON, ADON, Unit Manager, or designee will go the hall the resident was transferred from and verify that the bed hold policy had been removed. Licensed Nurses will be in-serviced by SDC, DON, or designee on transfer process in accordance with the policy and the documentation required by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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resident representative which specifies the duration of the bed-hold policy upon transfer to the local acute care hospital on 7/11/19.

Resident #78 was originally admitted to the facility 3/5/19 and readmitted 7/19/19 after an acute care hospital stay. The current diagnoses include anemia, and a seizure disorder.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/26/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #78's cognitive abilities for daily decision making was moderately impaired.

Review of the clinical record revealed no nurse's note dated 7/11/19 that a bed hold notice was provided to the resident or resident representative.

An interview was conducted with the Assistant Director of Nursing (ADON) on 8/29/19, at approximately 3:15 p.m. The ADON stated a nurse's note should have been written including why the resident was being sent to the emergency room, all information sent with the resident and to the hospital staff. The ADON further stated, likely the transferring nurse sent the Hospital Transfer Form, a face sheet and the Physician's Order summary but, not the written bed-hold notice.

On 8/29/19, at approximately 6:00 p.m., the above findings were shared with the Administrator, and the Director of Nursing. An opportunity was given for the facility to provide additional information but they did not.

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3. Resident #102 was initially admitted to the facility on 03/20/2014. Resident #102 was discharged to the hospital on 08/04/2019 and readmitted to the facility on 08/06/2019. Diagnosis included but were not limited to, Seizure Disorder and Chronic Obstructive Pulmonary Disease.

Resident #102's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/13/2019 coded Resident #102 with a BIMS (Brief Interview for Mental Status) score of 02 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #102 as requiring supervision with set up help only with eating, extensive assistance of 1 with bed mobility, dressing, toilet use and personal hygiene and total dependence of 1 with transfer and bathing.

On 08/28/2019 at 3:30 p.m., an interview was conducted with the Director of Nursing (DON) and she was asked for evidence that a written bed hold notice was sent with the resident upon discharge to the hospital on 08/04/2019. The DON stated, "I wasn't aware that a written bed hold notice was to be sent to the hospital when the resident was discharged. Nursing has not been sending the bed hold notice to the hospital when the residents are discharged." The DON stated that the nursing staff would start sending the bed hold notice with the residents when they are discharged to the hospital.

On 08/28/2019 at 3:45 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1 and she was asked, "What documents do you send out with a resident when they are discharged to the hospital?" LPN #1 stated, "I

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send their face sheet, medication list and then I will call their report." LPN #1 was asked, "Do you send the bed hold notice when the resident is discharged to the hospital?" LPN #1 stated, "No."

The Administrator was informed of the finding at the pre-exit meeting on 08/29/2019 at approximately 7:15 p.m. The facility did not present any further information about the finding.
4. The facility staff failed to ensure that Resident #37 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 04/28/19 and 08/06/19. Resident #37 was originally admitted to the facility on 02/27/19. Diagnosis for Resident #37 included but not limited to Cerebral Palsy.

The current Minimum Data Set (MDS), a 30-day PPS assessment with an Assessment Reference Date (ARD) of 06/14/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

The Discharge MDS assessments dated 04/28/19 - discharge return anticipated, resident readmitted on 05/17/19.
The Discharge MDS assessments dated 08/06/19 - discharge return anticipated, resident readmitted on 08/20/19.

According to the facility's documentation on 04/28/19, Resident #37 complained of pain to abdomen incision; refused alternative medication for pain. The open area to her abdomen observed with brown mucous like drainage. Resident #37 was transferred to the local hospital Emergency Room (ER) via EMR transport.

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According to the facility's documentation on 08/06/19, Resident #37 left for local ER for evaluation. She was transported by Fast Track EMS at approximately 1:30 p.m. Report called to ER charge nurse.

Review of Resident #37's clinical record for 04/28/19 and 08/06/19 did not reveal evidence that the bed hold policy was sent upon discharge to the local ER or shortly after.

An interview was conducted with License Practical Nurse (LPN) #1 on 08/28/19 at approximately 3:45 p.m. The surveyor asked, "What paperwork is sent with the resident when they are being sent out to the hospital." The nurse replied, "I will send the resident's face sheet, medication list, and the bed hold policy. The surveyor asked, 'Should the resident's clinical record include the bed hold policy was sent upon discharge to the facility" she replied, "Yes, if it is not documented, then you have know way of knowing it was actually sent.

The Administrator was informed of the finding during a briefing on 08/29/19 at approximately 7:15 p.m. The facility did not present any further information about the findings.

5. The facility staff failed to ensure that Resident #71 was provided a written copy of the facility's bed hold and reserve bed payment policy upon transfer/discharge to the hospital on 07/10/19.

Resident #71 was admitted to the facility on 09/14/18 and readmitted to the facility on 07/16/19. Diagnoses for Resident #71 included but not limited to Alzheimer's disease and Anxiety Disorder.

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F 625	Continued From page 40 The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 07/23/19. Staff assessment of mental status coded the resident as having short term and long term memory problems. The Discharge MDS assessments was dated for 07/10/19 - discharge return anticipated; re-admitted to the facility on 07/16/19. On 08/29/19 at approximately, 1:55 PM an interview was conducted with the ADON (Assisting Director of Nursing) concerning bed hold notifications. She stated there were no bed hold notices on the above resident. On 08/29/19 at approximately, 7:13 PM an exit interview was conducted with the Administrator concerning the failure to issue a bed hold notice. No further information was provided by the facility staff. Facility policy: Titled- Notice of Bed Hold Policy. Stated the following: In the event a resident is transferred to a hospital or for a therapeutic leave, MEDICARE does not pay the center to hold a resident's bed. If a Medicare beneficiary is not Medicaid eligible, the resident's bed will be held if the resident requests the bed to be held and agrees to pay the Center the daily private pay rate for the days the bed is on hold.	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	F 641		10/7/19

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F 641	Continued From page 41 resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure an accurate MDS (Minimum Data Set) assessment was completed for one of 66 residents in the survey sample, Resident #220. The findings included: Resident #220 was admitted to the facility on 9/19/18 and readmitted on 10/19/18 with diagnoses that included but were not limited to chronic respiratory failure, pneumonia, stroke, tracheostomy status, quadriplegia (paralysis all four limbs), and gastrostomy status (feeding tube). Resident #220's most recent comprehensive MDS assessment was an admission assessment with an ARD (assessment reference date) of 9/26/18. Resident #220 was coded as being severely impaired in cognitive function on the Staff Interview for Mental Status exam. Review of Resident #220's clinical record revealed that she had gone into cardiac arrest on 10/26/18 in between the 11 PM-7 AM and 7 AM-3 PM shift. The following was documented by the unit manager: "Charge nurse on 11-7 walked to resident charts, stated resident is a full code and that she was unresponsive this writer instructed nurse to start CPR (cardiopulmonary resuscitation) this writer @645 (a.m.) called code blue to room @645 this writer called 911 and updated with resident condition. @650 this writer meet EMT at door with resident info @652 fire dept. arrived @738 resident left facility with CPR	F 641	F-641 1. As this oversight affected discharged Resident #220 no corrective action could be taken. 2. All residents have the potential to be affected. 3. 100% audit will be completed on all active residents to ensure that all MDS assessments are correct for type. Audit to be done on 10 residents per day until completed. When new MDS assessment is completed the MDS nurse who did not complete the assessment will verify the correct assessment per the RAI manual was done. A log of MDS assessments completed will be maintained and verification will be noted on log. This log will be reviewed by DON or designee daily times 2 weeks then 3 times a week for 2 weeks then weekly for 8 weeks. 4. A log of MDS assessments completed will be maintained and verification will be noted on log. This log will be reviewed by DON or designee daily times 2 weeks then 3 times a week for 2 weeks then weekly for 8 weeks. SDC, DON, or designee will in-service MDS nurses on process by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been	

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F 641	Continued From page 42 still being performed and breathing to (Name of hospital). R/P (responsible party) was called several times with no answer next of was called @747 spoke with (Name of Resident's daughter) with updated (sic) stated she will contact (Name of RP (responsible party)) to return call back." The emergency room records dated 10/26/19 documented the following: "0800 pt (patient) arrived via EMS (emergency medical services)...trached with ETT (endotracheal tube), pt bagged by EMS...Pt Hx (history) of pneumonia, CVA (stroke), nonverbal with trach and G (gastrostomy) tube. Per EMS report patient found at 0650 a.m. with occluded trach, aprox (approximately) 50-60 mins (minutes) downtime...pulse felt and lost in field...in room for airway management...Sputum bright red and took over bagging...8:39 a.m. Time of Death per (Name of Emergency Room MD (medical doctor))." Review of Resident #220's MDS (minimum data set) assessments revealed that a "Death in Facility" MDS was completed on 10/26/19. This MDS was inaccurate as Resident #220 had been transferred to the hospital and had expired in the emergency room. On 8/29/19 at 4:05 p.m., an interview conducted with OSM (other staff member) #5, the MDS nurse. When asked if a "Death in Facility" MDS should be completed for a resident who had coded but was still breathing when going out of the building; OSM #5 stated that she was not sure and would have to look at the RAI (Resident Assessment Instrument) manual (the reference for MDS coding).	F 641	attained for 60 days. 5. October 7, 2019	

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F 641	Continued From page 43 On 8/29/19 at 4:30 p.m., further interview was conducted with OSM #5. OSM #5 stated that if the resident was not pronounced dead at the facility then a "Discharge/Returned Anticipated" assessment should have been completed, not a "Death in Facility" MDS assessment. OSM #5 stated that she was not the MDS nurse at this time. On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the above concerns. A policy could not be provided regarding the above concerns. The RAI 3.0 MDS manual documents in part, the following: "Death in Facility Assessment- Must be completed when the resident dies in the facility or when on LOA. · Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days). · Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days). · Consists of demographic and administrative items. · May not be combined with any type of assessment."	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		10/7/19

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F 655	Continued From page 44 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details	F 655		

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F 655	Continued From page 45 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility stafff failed to develop a baseline care plan for 2 of 66 residents in the survey sample, Resident #418 and #419. The findings included: 1. The facility staff failed to develop a baseline care plan within forty-eight (48) hours of Resident #418's admission. Resident #418 was admitted to the facility on 8/26/19 with diagnoses to include but not limited to, end stage renal disease requiring hemodialysis and liver failure. At the time of the survey the Admission MDS (Minimum Data Set) required by day 14 had not been completed as the resident was still in the look back period. On 8/28/19 at 5:30 p.m., the clinical record failed to evidence that the baseline care plan was developed. The Holmes Hall unit manager was interviewed. She stated the baseline care plan is initiated upon admission by the admission nurse. She stated the baseline care plan has to be signed by a registered nurse. When asked if Resident #418's baseline care plan has been initiated or completed, she reviewed the electronic record and stated, "No." She then began to initiate the baseline care plan. On 8/29/19 at 1:15 p.m., an interview was conducted with the Director on Nursing (DON). The DON was asked if Resident #418's baseline care plan was developed and signed by the	F 655	F-655 1. Residents #418 and #419 were affected by this oversight. The baseline care plan for both residents was started on admission and completed within 48 hours. As the 48 hour time period had passed there was no corrective action to be taken for them not being presented within 48 hours. 2. Any new admission has the potential to be affected. 3. The nurse who admits the resident is responsible for initiating the base line care plan. The new admission electronic record will be reviewed in the next 2 clinical meetings for completion and accuracy. It will be the responsibility of the Unit Manager, ADON, DON or designee to present the base line care plan to the resident and/or family/guardian in 48 hours. A copy of the signed base line care plan will be maintained in the resident's medical record. 4. DON, ADON, Unit Manager, or designee will audit new admit medical records after 48 hours to ensure that the base line care plan has been signed by the resident or the family. SDC, DON, or designee will in-service appropriate staff on process by or before 10-6-19 and annually. New hire will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will	

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F 655	Continued From page 46 resident. The DON reviewed the electronic medical record and stated that it had not been signed by the resident. She stated the nurse opens the baseline care plan the day the resident is admitted and it is signed during the meeting, she further stated that the facility had been doing the baseline care plans within 72 hours of admission. She stated she did not know they had to be developed within 48 hours of admission. She stated, "Sorry, we screwed up, I'm going to delegate someone to see that it get's done within 48 hours." 2. The facility staff failed to develop a baseline care plan within forty-eight (48) hours of Resident #419's admission. Resident #419 was admitted to the facility on 8/26/19 with diagnoses to include but not limited to, stroke effecting the right dominant side. At the time of the survey the Admission MDS (Minimum Data Set) required by day 14 had not been completed as the resident was still in the look back period. On 8/28/19 at 5:30 p.m., the clinical record failed to evidence that the baseline care plan was developed. On 8/29/19 at 1:15 p.m., an interview was conducted with the Director on Nursing (DON). The DON was asked if Resident #419's baseline care plan had been developed. The DON reviewed the electronic medical record and stated, "Nope, it's not there." When asked if it should have been completed, she stated, "Of course." She stated the nurse opens the baseline care plan the day the resident is admitted and it is signed during the meeting, she further stated that	F 655	be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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the facility had been doing the baseline care plans within 72 hours of admission. She stated she did not know they had to be developed within 48 hours of admission. She stated, "Sorry, we screwed up, I'm going to delegate someone to see that it get's done within 48 hours."

The above findings was shared with the Administrator during the pre-exit meeting conducted on 8/29/19.

The facility's policy titled Care Plans-Baseline with a revised date of December 2016 read, in part: Policy Statement- A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.

Policy Interpretation and Implementation
1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.
3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.
4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to:
a. The initial goals of the resident;
b. A summary of the resident's medications and dietary restrictions;
c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and
d. Any updated information based on the details of the comprehensive care plan, as necessary.

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F 656	Continued From page 48	F 656		
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 (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	F 656		10/7/19

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F 656	Continued From page 49 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 staff interview, facility document review and clinical record review, it was determined that facility staff failed to develop the comprehensive care plan for 2 of 66 residents in the survey sample, Residents #67 and 98. The findings included: 1. For Resident #67, facility staff failed to develop an ADL (activities of daily living) care plan that was a triggered area on his CAA (care area assessment) worksheet from his annual MDS (Minimum Data Set) assessment with an ARD (assessment reference date) of 2/28/19. Resident #67 was admitted to the facility on 4/23/18 with diagnoses that included but were not limited to high blood pressure, difficulty walking, chronic kidney disease, and altered mental status. Resident #67's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/23/19. Resident #67 was coded as being severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #67 was coded as requiring extensive assistance from one person with bed mobility, locomotion on and off the unit, dressing, toileting, personal hygiene and bathing; and extensive assistance from two persons with transfers.	F 656	F-656 1. Resident #67 was affected by this oversight. His ADL care plan was completed 8-29-19. Resident #98 was affected by this oversight. Her anti-coagulation care plan were completed 8-29-19. Resident #98 has no diagnosis for Psychosis and Major Depression and has never received a psychotropic medication. 2. All residents have the potential to be affected. 3. MDS nurses will review the CAA's on the 19th day. Any staff member who has not completed the care plan for his/her triggered CAA will be notified that there is only 2 more days to complete the care plan. On the 20th day the MDS Nurses will review the care plan to ensure that it is comprehensive. Any missing part will be addressed by the department responsible for completion. MDS will review care plans in care plan meeting to ensure that all areas of concern are included on the care plan. 4. 100 % of care plans will be audited to ensure completion and accuracy. Audit will be done on 10 residents per day until completed. A log of residents who need a care plan completed based on the CAA's will be maintained by the MDS nurses.	

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F 656	Continued From page 50 Review of Resident #67's annual MDS assessment with an ARD of 2/28/19 revealed in Section V (Care Area Assessment (CAA) Summary), "ADL Functional/Rehabilitation Potential" was a care area triggered. An "X" was also marked under section: "Care Planning Decision," indicating that ADL's would be care planned. The following was also documented: "(Name of Resident #67) had impaired cognitive function or impaired thought processes r/t (related to) alteration in mental status." The CAA worksheet signed and dated 3/12/19 documented the following for ADLS: "1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for bed mobility was needed as indicated by: Bed mobility: self-performance 1 - Supervision." Review of Resident #67's comprehensive care plan dated 3/22/19 with the latest revision on 6/21/19, failed to indicate a care plan for ADL's and more specifically reflecting bed mobility. On 8/29/19 at 8:59 a.m., an interview was conducted with OSM (other staff member) #5, an MDS nurse. When asked if ADL's should be on the comprehensive care plan if this was an area triggered on the CAA and a decision was made to care plan ADL's, OSM #5 stated that ADL's should be a part of the comprehensive care plan if a decision was made to care plan the area. OSM #5 stated that she uses the RAI (Resident Assessment Instrument) manual as a guide when completing the MDS. OSM #5 stated that she had started in June of 2019 and the previous MDS nurse was no longer an employee at the facility.	F 656	This log will be reviewed daily for 2 weeks, then 3 times a week for 2 weeks, then weekly times 8 weeks by the Administrator, DON or designee. SDC, DON, or designee will in-service the MDS nurses on process by or before 1-06-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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When asked the purpose of the care plan, OSM #5 stated that the purpose of the care plan was to serve as a guide to determine a resident's needs. When asked if it was important that the care plan be accurate, OSM #5 stated that it was.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator was made aware of the above concern. No further information was presented prior to exit.

The following is taken from Section V of the MDS-Version 3.0:
"Section V: Care Area Assessment: V0200. CAAs and Care Planning
1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed Care Plan column must be completed within 7 days of completing the RAI [MDS and CAA(s)]. Check column B if the triggered care area is addressed in the care plan."
2. The facility staff failed to develop a comprehensive person-centered care plan for Resident #98 to include the following: Atrial Fibrillation with the use of anticoagulation, Psychosis and Major depressive disorder with the use of antipsychotic medication use.

Resident #98 was admitted to the facility on 05/17/19. Diagnoses for Resident #98 included but are not limited to Morbid (severe) obesity. Resident #98's Minimum Data Set (MDS-an assessment protocol) a quarterly with an Assessment Reference Date of 08/05/19 coded

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the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #98 extensive assistance of one with transfer, dressing, hygiene, bathing, bed mobility and toilet use for Activities of Daily Living (ADL) care. The MDS was also coded for the use of indwelling Foley catheter and frequently incontinent of bowel.

Review of Resident #98's care plan created on 05/18/19 with a revision date of 05/27/19 included the following focus problems/areas:
-Code Status
-Falls
-Nutrition and Pain

On 08/29/19 at approximately 11:18 a.m., an interview was conducted with MDS Coordinator #1. She reviewed Resident #98's care plan then stated "This is definitely not a comprehensive care plan for (Resident #98)." She said a comprehensive care plan should be developed within 14 days after being admitted to the facility. On the same day at approximately 5:23 p.m., MDS Coordinator #2 present a newly developed care plan with a revision date of 08/29/18. The new comprehensive care plan included the following focus problems:

-Full Code Status.
-Allergic to Aspirin and Benadryl.
-At risk for bleeding/bruising associated with use of anticoagulant.
-Potential/actual impairment to skin integrity r/t decrease in mobility, CVA and pain.
-At risk for respiratory distress associated with obesity, CVA, obstructive sleep apnea, COPD and Heart Failure,

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F 656	Continued From page 53 -At risk for hypo/hyperglycemia d/t Diabetes Mellitus. -Has ADL self-care performance deficit r/t limited mobility, stroke and pain. -Will be free of complications associated with indwelling catheter d/t urine retention. -At risk for weight loss/gain. -At risk for falls. -Potential for pain. An interview was conducted with the Director of Nursing (DON) on 08/29/19 at approximately 11:19 a.m. The DON stated "A comprehensive care plan should have been completed by day 14 after admission for (Resident #98)." The Administrator was informed of the finding during a briefing on 08/29/19 at approximately 7:15 p.m. The facility did not present any further information about the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		10/7/19

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F 657	Continued From page 54 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to review and revise the care plan for two of 66 residents in the survey sample, Resident #15, and 37. 1a. For Resident #15, facility staff failed to revise his care plan after he was admitted back to the facility on 6/29/19 with a diagnosis of a urinary tract infection requiring antibiotic therapy. 1b. For Resident #15, facility staff failed to revise his care plan after a fall on 1/20/19. The findings included: 1a. Resident #15 was admitted to the facility on 6/14/18 and readmitted on 6/28/19 with diagnoses that included but were not limited to dementia, HIV (Human Immunodeficiency virus), and weakness. Resident #15's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/31/19. Resident #15 was coded as being severely impaired in cognitive function	F 657	F-657 1. Resident #15 was affected by this oversight. His UTI had already resolved and he was no longer receiving antibiotics; therefore, no corrective action was taken. Resident #37 was affected by this oversight. Her care plan was updated on 8-29-19 for use of an anticoagulant and for use of an anti-psychotic. 2. All residents have the potential to be affected. 3. Licensed Nurses will update/revise care plans as new orders are received, incidents occur and or a clinical change manifests. All new orders, incident reports, the 24 hour report and the care plan will be reviewed in clinical meeting to ensure completion and accuracy of care plan update/revision. 4. 100 % of care plans will be audited to ensure completion and accuracy. Audit will be done on 10 residents per day until completed. A log will be maintained by the DON of the new orders, incident reports,	

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F 657	Continued From page 55 scoring 02 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that he went out to the hospital on 6/27/19. The following in part, was documented: "At 9:25 p.m. resident was in bed throwing up x 2 (two times) and continued to state that he did not feel good. vital signs were obtained blood pressure 101 over 56 pulse 103 respiration 18 temperature 99.4 and O2 (oxygen) stats (saturation) 96% clients appearance was pale sweating . Staff/writer called 911 and sent to (Name of Emergency room)." Further review of the clinical record revealed that Resident #15 arrived back to the facility on 6/28/19 with a diagnosis of a UTI (urinary tract infection) and an order for antibiotics. Review of Resident #15's physician orders revealed the following order: "Keflex (1) (Antibiotic) 500 mg (milligrams) for uti for 7 days." Review of Resident #15's comprehensive care plan dated 3/26/19 with revisions failed to evidence that his care plan was revised to reflect his urinary tract infection at that time. A resolved care plan could not be found for his UTI. On 8/29/19 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked the purpose of the care plan, LPN #4 stated that the purpose of the care plan was to serve as a guide for providing care. LPN #4 stated that the care plan alerted staff on what care areas to focus on. When asked if a resident was started on antibiotic therapy for an infection if she would expect the care plan to reflect that	F 657	and 24 hour reports verifying that the care plan was reviewed and found to have been updated/revised. This log will be maintained daily for a period of 3 months and reviewed by the Administrator or designee. SDC, DON, or designee will in-service Licensed Nurses on process by or before 1-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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information, LPN #4 stated that she would.

On 8/29/19 at 11:00 a.m., an interview was conducted with LPN #6. When asked when the care plan was revised, LPN #6 stated that the care plan was revised with any new change such as antibiotic therapy, any decline in status, falls etc. LPN #6 stated that floor nurses can revise the care plan.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.

(1) This information was obtained from The National Institutes of Health https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=37ec3f8b-51d1-4d74-a4ee-9240c734b1a6.

1b. Resident #15 was admitted to the facility on 6/14/18 and readmitted on 6/28/19 with diagnoses that included but were not limited to dementia, HIV (Human Immunodeficiency virus), and weakness. Resident #15's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/31/19. Resident #15 was coded as being severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #15's clinical record revealed that he had fallen on 1/20/19. The following nursing note was documented: "At 1645 (4:45 p.m.) this resident was found on the floor in his

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room. Asked him what happened he could not tell me in detail, except that he fell. Passive ROM (range of motion) performed and vital signs taken. Neuro checks initiated, which were all wnl (within normal limits). Staff assisted to the bed and he was educated on to ask for help and to utilize call bell. He appeared to understand..."

Review of Resident #15's comprehensive care plan dated failed to evidence that the care plan was reviewed or revised after his all on 1/20/19.

On 8/28/19 at 4:21 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked process when a resident has a fall, LPN #2 stated that nurses will assess the resident; perform ROM (range of motion) with all extremities and if the resident is not hurting, nurses will try to assist them off the floor to safety. LPN #2 stated that nurses would alert the medical doctor and responsible party and complete an incident report. LPN #2 stated that nurses should be updating the care plan with a new intervention to prevent falls. LPN #2 stated that floor nurses can revise the care plan. When asked the process if all fall interventions were exhausted; nurse stated that a note would be documented that the care plan was reviewed and no new interventions were needed.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.

2. The facility staff failed to revise Resident #37's comprehensive person-centered care plan to include the use of the antipsychotic medication (Seroquel) and an anticoagulation medication

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(Coumadin). Resident #37 was originally admitted to the facility on 02/27/19. Diagnosis for Resident #37 included but not limited to Schizophrenia.

The current Minimum Data Set (MDS), a 30-day PPS assessment with an Assessment Reference Date (ARD) of 06/14/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #37 total dependence of two with transfer, total dependence of one with toilet use, personal hygiene and bathing and extensive assistance of one with dressing with Activities of Daily Living (ADL).

The physician Order Sheet (POS) for August 2019 included the following orders:
-08/20/19-start Seroquel 25 mg daily at bedtime.
-08/20/19-start Coumadin 2.5 mg daily with 3 mg tablet daily to equal 5.5 mg for Deep Vein Thrombosis (DVT).

Resident #37's comprehensive person-centered care plan did not include the use of an antipsychotic or anticoagulation usage.

An interview was conducted with the MDS Coordinator on 08/29/19 at approximately 11:10 a.m. MDS Coordinator reviewed Resident #37's care and stated, "Most definitely, the use of an antipsychotic and anticoagulation use of medications should be care planned.

On 08/29/19 at approximately 3:33 p.m., the following care plans was provided to the surveyor with a revision date of 08/29/19 which included but not limited to:

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ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 59 Use of an anticoagulation care plan include but not limited to: -Focus: At risk for abnormal bleeding, bruising or hemorrhage due to anticoagulation use related to history of acute embolism and thrombus. -Goal: will be free from complication associated with abnormal bleeding through next review date of 11/29/19. -Interventions/tasks: monitor for and report to nurse any of the following signs and symptoms of bleeding: bleeding gums, nose bleeds, unusual bruising, tarry/black stools, pink or discolored urine and administer anticoagulation are currently prescribed by the physician. Use of a psychotropic care plan include but not limited to: -Focus: Psychotropic medication use related to Psychosis, Depression and Bipolar. -Goal: resident will not result in adverse effected through next review date of 11/29/19. -Interventions/tasks: administer medication as ordered; assess for continued need for psychoactive medications through facility Gradual Dose Reduction (GDR) process. -Pharmacy to review medication and make recommendations. -Utilized psychiatric services as needed and per MD order. The Administrator was informed of the finding during a briefing on 08/29/19 at approximately 7:15 p.m. The facility did not present any further information about the findings. Definitions: -Seroquel tablets and extended-release tablets	F 657		

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F 657	Continued From page 60 are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) (https://medlineplus.gov/ency/article/007365.htm). -Coumadin is used prevent blood clots from forming or growing larger in your blood and blood vessels (https://medlineplus.gov/ency/article/007365.htm).	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide ADL (activities of daily living) care to dependent residents for five of 66 residents in the survey sample; Residents #67, #15, #218, #31 and #102. The findings included: 1. For Resident #67, facility staff failed to provide fingernail care. Resident #67 was admitted to the facility on 4/23/18 with diagnoses that included but were not	F 677	F-677 1. Residents #67 and #15 were affected by the oversight. Both residents were given nail care on 8-29-19. Resident #218 was affected by the oversight but is no longer in the facility. No corrective action could be taken. Resident #31 was affected by the oversight. His hand was cleaned immediately. Resident #102 was affected by the oversight. The CNA's on her unit were in-serviced on giving her shower as scheduled and to document any refusals on 8-29-19. 2. All residents have the potential to be affected.	10/7/19

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F 677	Continued From page 61 limited to high blood pressure, difficulty walking, chronic kidney disease, and altered mental status. Resident #67's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/23/19. Resident #67 was coded as being severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #67 was coded as requiring extensive assistance from one person with bed mobility, locomotion on and off the unit, dressing, toileting, personal hygiene and bathing; and extensive assistance from two persons with transfers. On 8/28/19 at 10:59 a.m., and 12:08 p.m., an observation was made of Resident #67. His fingernails to both hands were about 2-3 centimeters (cm) in length. Resident #67 had dark debris under his right thumbnail. There was no evidence in Resident #67's clinical record of a history of refusing nail care. Resident #67 did not have an ADL (activities of daily living) care plan. On 8/28/19 at 4:21 p.m., an interview was conducted with CNA (certified nursing assistant) #4. When asked who was responsible for providing nail care, CNA #4 stated the nursing aides were responsible for cutting nails, unless a resident is diabetic and then the nurses were responsible. CNA #4 stated that nails were cut on shower days (two times a week). CNA #4 stated that if resident refuses nail care, they will document a customized note in the POC (point of care) charting. CNA #4 stated that will alert the nurses if a resident refuses nail care. When	F 677	3. A new shower schedule will be developed along with a new shower sheet to verify that care was completed or refused. This will be turned into the Charge Nurse who will verify that the shower was given. Both sheets will be given to the Unit Manager who will randomly verify that ADL care was provided as scheduled. These sheets will be maintained by the Unit Manager for 1 month. 4. DON, ADON, or designee will review shower sheets and Licensed Nurses check off list daily for 2 weeks, 3 times a week for 2 weeks, then weekly ongoing. SDC, DON, or designee will in-service the CNA's and the Licensed Nurses on process by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October6, 2019	

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asked if Resident #67 ever refused nail care, CNA #4 stated, "I am pretty sure, no." CNA #4 could not recall the last time Resident #67's nails were cut.

On 8/28/19 at 4:28 p.m. an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked who was responsible for providing nail care, LPN #2 stated that the nurses will cut nails if a resident is diabetic and the CNAs will cut nails on assigned shower days if needed if the residents are not diabetic. LPN #2 stated that nails are cleaned as needed; when staff see that nails are dirty.

On 8/28/19 at 4:50 p.m. LPN #2 followed surveyor to Resident #67's room. LPN #2 confirmed that Resident #67's nails were long and needed to be cut.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator was made aware of the above concerns. No further information was presented prior to exit.

2. For Resident #15, the facility staff failed to provide fingernail care.

Resident #15 was admitted to the facility on 6/14/18 and readmitted on 6/28/19 with diagnoses that included but were not limited to dementia, HIV (Human Immunodeficiency virus), and weakness. Resident #15's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/31/19. Resident #15 was coded as being severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (Brief

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Interview for Mental Status) exam.

On 8/28/19 at 9:35 a.m., and at 1:00 p.m., observations were made of Resident #15. His fingernails to both hands were long and jagged and approximately 2-3 cms (centimeters) long. He had black debris under each fingernail.

There was no evidence in Resident #15's clinical record of a history of refusing nail care.

Resident #15's ADL (activities of daily living) care plan dated 3/30/19, did not address fingernail care or grooming.

On 8/28/19 at 4:21 p.m., an interview was conducted with CNA (certified nursing assistant) #4. When asked who was responsible for providing nail care, CNA #4 stated the nursing aides were responsible for cutting nails, unless a resident is diabetic and then the nurses were responsible. CNA #4 stated that nails were cut on shower days (two times a week). CNA #4 stated that if resident refuses nail care, they will document a customized note in the POC (point of care) charting. CNA #4 stated that will alert the nurses if a resident refuses nail care.

On 8/28/19 at 4:28 p.m. an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked who was responsible for providing nail care, LPN #2 stated that the nurses will cut nails if a resident is diabetic and the CNAs will cut nails on assigned shower days if needed if the residents are not diabetic. LPN #2 stated that nails are cleaned as needed;when staff see that nails are dirty.

On 8/28/19 at 4:30 p.m., Resident #15 was

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observed up in his wheelchair at nurses station. His fingernails were in the same condition; long and jagged with black debris underneath each nail. CNA #4 was at the nurses station at this time. CNA #4 was asked to look at Resident #15's nails. CNA #4 confirmed this writer's observations. CNA #4 stated that she usually stays on top of her residents to make sure nails are clean and short. CNA #4 stated that she didn't notice Resident #15's nails.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.

Facility policy titled, "Care of Fingernails and Toenails," documents in part, the following: "Nail care includes daily cleaning and regularly trimming."

3. The facility staff failed to ensure Resident #218 was provided personal hygiene.

Resident #218 was originally admitted to the facility 08/16/18 and discharged from the facility on 12/15/18. The current diagnoses included; Anemia and Hypertension. Being the resident was no longer in the facility a closed record review was conducted.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 08/23/18, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.

In section "G" (Physical functioning) the resident was coded as requiring the assistance of one

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person with personal hygiene, bathing and locomotion off the unit. Eating and locomotion requiring set-up help only. Extensive assistance of two people with bed mobility, transfers, and toileting.

According to the documentation summary from the ADL record Resident #218 was not provided personal hygiene on the following dates: 12/01/18 (3-11 shift) 12/04/18 (7-3 shift) 12/13/18 (11-7 shift).

On 08/29/19 at approximately 6:30 PM, Licensed Practical Nurse #11 was asked to view the ADL documentation and to commented on the document not being signed off. She stated, "If it's not signed off, it wasn't done."

On 08/29/19 at approximately, 7:30 PM, the above findings were shared with the Administrator. No comments were made.

4. The facility staff failed to ensure Resident #31's hands were clean and free of odor.

Resident #31 was admitted to the facility on 12/19/2019. Diagnosis included but were not limited to, Central Cord Syndrome at C4 Level of Cervical Spinal Cord, sequela, and Hypertension. Resident #31's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 06/12/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 00 indicating severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #31 as requiring extensive assistance of 1 with dressing and eating, extensive assistance of 2 with bed mobility and total dependence of 2 with

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transfer, toilet use, personal hygiene and bathing.

On 08/28/2019 at 10:55 a.m., Resident #31 was observed lying in bed. Resident was noted to have dried, yellowish discolored skin in the palms of his hands.

On 08/28/2019 at 12:05 p.m., Resident #31 was observed lying in bed and noted to have dried, yellowish discolored skin in the palms of his hands.

On 08/29/2019 at 11:00 a.m., observed dried, yellowish skin in the palms of Resident #31's hands. A foul, sour odor was detected coming from his hands.

On 08/29/2019 at 11:10 a.m., RN #1 was asked to accompany the surveyor at Resident #31's bedside and to view Resident #31's hands. RN #1 was asked, "What do you see in Resident #31's hands?" RN #1 stated, "Crust." RN #1 was asked, "Do you smell a foul, sour odor coming from his hands?" RN #1 stated, "Yes. I will get someone to clean his hands."

On 08/29/2019 at 1:15 p.m., the Director of Nursing was informed of the observations.

The Administrator was informed of the finding at the pre-exit meeting on 08/29/2019 at approximately 7:15 p.m. The facility did not present any further information about the finding.

5. The facility staff failed to ensure Resident #102 received showers/baths per schedule as care planned.

Resident #102 was initially admitted to the facility

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on 03/20/2014. Resident #102's most recent discharge to the hospital was on 08/04/2019 and readmitted to the facility on 08/06/2019. Diagnoses included but were not limited to, Seizure Disorder, Chronic Obstructive Pulmonary Disease and Dementia.

Resident #102's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/13/2019 coded Resident #102 with a BIMS (Brief Interview for Mental Status) score of 02 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #102 as requiring supervision with set up help only with eating, extensive assistance of 1 with bed mobility, dressing, toilet use and personal hygiene and total dependence of 1 with transfer and bathing.

On 08/29/2019 review of Resident #102's comprehensive care plan revealed the following: "Staff to assist (Resident Name) with shower/bath per schedule to include shampoo, bathing, and nail care."

On 08/29/2019 at approximately 5:00 p.m., the surveyor requested CNA (Certified Nursing Assistant) ADL (Activities of Daily Living) logs documenting showers/baths for July and August 2019. CNA ADL logs were received. Review of the July 2019 log revealed no documentation for the period of July 13, 2019 through July 31, 2019. (Resident #102 was in the hospital for the period of July 15, 2019 through July 19, 2019.) The surveyor reviewed CNA ADL log for August 2019 and unable to evidence that Resident #102 received a shower or bath. Nursing staff documented that Resident #102 was provided twenty (20) bed baths out of 27 days on the Day

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shift; seven (7) bed baths out of 27 days on the Evening shift; and five (5) bed baths out of 28 days on the Night shift.

On 08/29/2019 at approximately 5:45 p.m., the surveyor reviewed the CNA ADL documentation logs with the DON (Director of Nursing) and she was asked, "Why are all the spaces blank on the July 2019 ADL log?' The DON stated, "I don't know. I know we have changed over to a new system." The DON was asked, "Can you provide any evidence that Resident #102 received a shower or tub bath during that time in July?" The DON stated, "No." The surveyor reviewed August 2019 ADL log with the DON. The DON was asked, "Should Resident #102 receive showers or tub baths?" The DON stated, "She should be receiving a shower." The DON was asked, "According to the ADL log is Resident #102 getting showers?" The DON stated, "No." The DON was asked, "Is there any documentation stating that Resident #102 refused showers?" The DON stated, "No." The DON stated, "Everyone is down for a shower 3 times a week. The staff just aren't giving them." The DON was asked, "What are your expectations of the nursing staff giving residents showers?" The DON stated, "I expect the aides to give the showers as ordered." The DON stated, "I will inservice the staff on how to approach the residents to encourage them to take a shower and also educate them on the process of giving showers."

The surveyor asked LPN #7 on 08/29/2019 at approximately 6:00 p.m., "What are Resident #102's shower days?" LPN #7 stated, "(Resident Name) is ordered to receive showers on Monday and Thursdays on the 11-7 shift."

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F 677	Continued From page 69 The Administrator was informed of the finding at the pre-exit meeting on 08/29/2019 at approximately 7:15 p.m. The facility did not present any further information about the finding. Complaint deficiency.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure appropriate care and services were provided to 1 of 66 residents in the survey sample, Resident #86. The facility staff failed to assess the resident's self inflicted wound to the left buttock on a weekly basis and failed to apply dressing changes as ordered. The findings included: Resident #86 was admitted to the facility on 8/21/06 and re-admitted on 9/30/15 with diagnoses to include but not limited to, paraplegia (paralysis of the lower portion of the body and of both legs). The current MDS (Minimum Data Set) was an annual with an assessment reference	F 684	F-684 1. Resident #86 was affected by the oversight. Wound Care Nurse performed a Weekly Skin Assessment and a weekly Wound Alteration Assessment on 8-29-19. 2. All residents with skin concerns have the potential to be affected. 3. Wound Care Nurse and other Licensed Nurses will complete all documentation timely and accurately. Wound Care Nurse will complete a Wound Alteration report weekly and a Weekly Skin Assessment. 4. An audit of 100% of medical records for residents with skin concerns will be completed for missing documentation and	10/7/19

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F 684	Continued From page 70 date of 7/24/19. The MDS coded the resident as a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the resident's cognition was intact. The comprehensive person-center care plan, revised on 7/24/19, evidenced the resident had an alteration in skin integrity related to a self inflicted excoriation to the left buttock. The goals listed were that the resident will have improved skin integrity as evidenced by area healed, will have signs of healing and or resolution of non-pressure skin issue, wound will be free of infection, and skin will remain intact and free of non-pressure skin issues. The goals were listed as to assess for pain/comfort level every shift and as needed/prior to dressing change, discuss non-compliance and educate, and heels off loaded when in bed. The clinical record evidenced the resident had a self inflicted excoriation that was identified on 8/7/18 as an abrasion to the left buttock. On 9/15/18 the wound was then identified on the Weekly Skin Alteration Report as a self inflicted wound to the left buttock that was not measurable at that time with pink tissue and bloody. The wound was assessed on a weekly basis from 9/1/18 through 5/14/19. The clinical record evidenced there were no weekly assessments of the wound from 5/14/19 through 7/1/19, and 8/5/19 through 8/29/19. The 5/14/19 Weekly Skin alteration Report documented the self inflicted left buttock excoriation measured 7.5 cm (centimeters) in length, 6.5 cm in width and 0.1 cm in depth, with full thickness skin loss. The note read, "Resident continues to self-inflict by scratching area to L buttocks and reopen area despite covering. Decline noted this week d/t	F 684	for accuracy both assessments and TAR's. DON, ADON, Unit Manager or designee will accompany Wound Care Nurse on random residents to observe wound care and documentation daily times 2 weeks 3 times per week for 2 weeks then weekly for 8 weeks. DON, ADON, Unit Manager or designee will randomly check dressings and documentation on 10% of residents requiring wound care and compare to TAR's for accuracy and completion. Licensed Nurses including the Wound Care Nurse will be in-serviced by the SDC, DON, or designee on timely and accurate documentation and care by or before and annually. New hires will be in-serviced in orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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resident refusals of daily dressing changes. Resident is non-compliant with daily dressing changes despite being educated. MD/RP (Medical Doctor/Responsible Party) updated."

On 5/29/19 a culture of the left buttock wound was obtained. On 5/31/19 the lab reported the wound was positive for the following micro-organisms: heavy growth of pseudomonas aeruginosa and heavy growth of proteus mirabilis. The resident was treated per the physician orders with IV antibiotics therapy of ceftazidime 6/4/19 through 6/9/19 and Tobramycin 6/9/19 through 6/14/19.

The wound nurse was interviewed on 8/29/19 at 11:25 a.m., and asked about the missing Weekly Skin Alteration Reports from 5/14/19 through 7/1/19. She stated she was behind on her documentation and was able to provide a Non-Pressure Wound Report dated 7/1/19 through 8/5/19. On this report was a line list of eight residents wound measurements to include Resident #86. When asked where were the Weekly Skin Alteration Reports from 5/14/19 through 7/1/19 for Resident #86 she was not able to produce them, stating they did not get done, she stated she is often pulled from her duties as the wound nurse to work the medication cart due to staffing issues. She stated, "I am required to see him (Resident #86) at least once a week, I look at every wound." When asked if the wound should have been assessed weekly, she stated, "Correct." The documentation on the Non-Pressure Wound Report evidenced that on 8/5/19 the wound measured 6.0 cm x 7.0 cm, there was no description of the wound bed. The wound nurse did not provide weekly wound assessments from 8/5/19 through 8/29/19. The

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F 684	Continued From page 72 current wound treatment was to cleanse the wound with wound cleanser, apply calcium alginate with silver to the wound bed, skin prep surrounding intact skin and cover with foam dressing daily, start date 7/25/19. The blank entries for the administration of the dressings for July and August 2019 was shared with the wound nurse. She stated the resident often refuses to have the dressing change, as noted on the treatment administration records (TAR) and coded as a 2-refused. She stated for the blank entries, "If it wasn't documented than it was not done, period." Blank entries on the July and August 2019 TAR's were as follows: July 8, 9, 31, and August 11and 18. A wound change observation was declined by the resident on 8/29/19 at approximately 2:00 p.m., however the resident did allow this inspector to see the dressing. The left buttock dressing was dated as last changed on 8/27/19. Documentation on the TAR evidenced the nurse initialed that the dressing change to the left buttock was done on 8/28/19. An interview with this nurse (Licensed Practical Nurse #1) on 8/29/19 was conducted, she stated she did not do the treatment on 8/28/19 but documented that it was administered prior to the resident refusing, and forgot to go back and code it correctly. The above findings was shared with the Administrator during the pre-exit meeting conducted on 8/29/19. No further information was provided by the facility staff.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/7/19

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F 695	Continued From page 73 § 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, facility document review and clinical record review, it was determined that facility staff failed to follow orders and the comprehensive care plan for oxygen administration for one of 66 residents in the survey sample, Resident #114. The findings included: Resident #114 was admitted to the facility on 7/25/15 and readmitted on 8/1/19 with diagnoses that included but were not limited to heart failure, chronic respiratory failure type two diabetes, and bipolar disorder. Resident #114's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/15/19. Resident #114 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #114 was coded in section O, "Special Treatments and Programs," as receiving respiratory therapy. Review of Resident #114's POS (physician order summary) dated August 2019, revealed the following oxygen orders: "Oxygen @ 3 L (liters) via N/C (nasal cannula) every 8 hours as needed for sob (shortness of breath)."	F 695	F-695 1. Resident #114 was affected by this oversight. Her O2 flow rate was adjusted immediately. 2. Any resident with orders for O2 have the potential to be affected. 3. Licensed Nurses will check O2 flow rate with each med pass and document on the MAR ongoing. 4. 100% of residents with O2 orders will be audited for accuracy of O2 flow rate. Unit Manager, ADON, DON or designee will check 10% of MARs on each hall daily for 2 weeks then 3 times a week for 2 weeks then weekly for 8 weeks. SDC, DON, or designee will in-service Licensed Nurses on process by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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Resident #114's care plan dated 1/8/19 documented in part, the following: "(Name of Resident #114) has potential for Alteration in Gas exchange r/t (related to) asthma, heart disease, chronic respiratory failure...Administer oxygen per physician order."

On 8/27/19 at 12:20 p.m., an observation was made of Resident #114's oxygen concentrator. The flow meter was set in-between the 2 and 2.5 line (top of ball at the 2.5 liter mark) and the oxygen was in use via nasal cannula.

On 8/28/19 at 11:14 a.m., an observation was made of Resident #114's oxygen concentrator. The flow meter was set in-between the 2 and 2.5 line and the oxygen was in use via nasal cannula.

On 8/28/19 at 4:30 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked how to properly read and set an oxygen flow meter; LPN #2 stated that the top of the flow meter ball should be set on the line (liters of 02 ordered). LPN #2 stated, "So if an order was for 3 liters, the top of the ball should hit the 3 line." When asked if oxygen orders should be followed, LPN #2 stated "Yes, it should be followed. Oxygen is a medication." LPN #2 followed this writer to Resident #114's room. LPN #2 stated that Resident #114 was receiving 2.5 liters. LPN #2 stated, "It should be at 2 liters right?" LPN #2 stated that she better go check the order. LPN #2 checked Resident #114's order and stated that her order was for 3 liters. LPN #2 stated that she will adjust Resident #114's oxygen.

On 8/29/19 at approximately 5:30 p.m., ASM

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F 695	Continued From page 75 (administrative staff member) #1, the Administrator was made aware of the above concerns. No further information was presented prior to exit. A policy on reading oxygen flow rate could not be provided. The following was obtained from The American Federation of Medical Research 2019: "Respiratory therapists and nurses were more likely than physicians of any level of training to interpret the flowmeter correctly. Only respiratory therapists universally "read the ball" in the middle, as recommended by the flow meter manufacturer for accurate flow interpretation. The most common error in interpretation by physicians and nurses was to "read the ball" at the bottom."	F 695		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that facility staff failed to provide medically related social services following the loss of a loved one for one of 66 residents in the survey sample, Resident #64. The findings included: Resident #64 was admitted to the facility on 12/20/11 and readmitted on 4/16/19 with diagnoses that included but were not limited to cardiovascular disease, high blood pressure, adult failure to thrive, and Alzheimer's disease.	F 745	F-745 1. Resident #64 was affected by this oversight. Resident #64 has not presented any symptoms of depression or anxiety. Facility will refer to psych services as necessary. 2. Any resident who develops S/S of depression for any reason has the potential to be affected. 3. Social Services will offer emotional support to residents when S/S of depression are noted. Licensed Nurses or	10/7/19

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F 745	Continued From page 76 Resident #64's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/23/19. Resident #64 was coded as being severely impaired in cognitive function scoring 00 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. On 8/27/19 at 2:12 p.m., an interview was attempted with Resident #64's emergency contact, her sister. The phone number was disconnected. On 8/28/19 at 9:49 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked if she had a different number on file for Resident #64's emergency contact, LPN #2 stated, "Her sister passed away I believe." LPN #2 also stated that social services had been working to get another emergency contact for Resident #64. Review of Resident #64's clinical record failed to evidence any documentation regarding her recent loss of her sister. There was no evidence of any monitoring for depression or behaviors related to her loss. There was no evidence that emotional support was provided to Resident #64. There was no evidence of a recent loss on Resident #64's comprehensive care plan dated 4/17/19. On 8/28/19 at 10:00 a.m., an interview was conducted with OSM (other staff member) #1, the social worker. OSM #1 stated that recently he has had a hard time getting in touch with Resident #64's sister. When asked if the sister had passed away, OSM #1 stated, "I have heard that." When	F 745	any other staff member noting an emotional change in the resident will notify Social Services by completing a Hey! Social Services form. Social Services will assess that resident and develop a care plan to ensure that all staff are aware of the resident□s needs. 4. Social Services will bring Hey! Social Service forms to the clinical meeting daily to ensure that care plan has been updated ongoing. The 24 hour report and new orders will be reviewed in clinical meeting daily to ensure that no Hey! Social Service forms need to be completed ongoing. SDC, DON or designee will in-service appropriate staff on the process by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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asked where he heard that from, OSM #1 stated that the sister's caregiver had called to say she had passed away in response to the facility sending mail to her address. When asked when the sister had passed away, OSM #1 stated sometime in July of 2019. When asked if he had documented this information in the clinical record, OSM #1 stated that he did not. OSM #1 stated that he has not seen any other family member in to see Resident #64. OSM #1 stated that he had no other family contact information for Resident #64. When asked if Resident #64 was aware of her sister's passing, OSM #1 stated that he had told her. When asked if he had documented this conversation as well as her response in the clinical record, OSM #1 stated that he did not. When asked how Resident #64 had responded to this news, OSM #1 stated that she seemed okay but wasn't sure how much she comprehended due to her dementia. When asked if there was also a language barrier due to her first language being Vietnamese, OSM #1 stated that he had used the language hotline. When asked if any type of monitoring is usually put into place after a resident suffers a loss of a loved one, OSM #1 stated that he did monitor Resident #64 for depression but that he did not document this monitoring in her clinical record. When asked if emotional support should also be provided, OSM #1 stated that emotional support is also provided after a resident suffers a loss. OSM #1 stated that he did not document that he had provided emotional support to Resident #64 after her loss.

On 8/28/19 at 4:40 p.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked again about the recent passing of Resident #64's sister, LPN #2 stated that she had heard that information

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from social services but could not recall when the sister had passed. When asked if she would expect to see a progress note reflecting that information and any type of monitoring of the resident's mood, LPN #2 stated that the social worker would usually watch for depression. LPN #2 stated that she would expect to see monitoring documented by the social worker. When asked if nursing would monitor a resident after a loss, LPN #2 stated that they would monitor and only document if there was a change in the resident's mood or behavior. When asked if the care plan would be revised to reflect a recent loss and to monitor for mood/behaviors, LPN #2 stated, "Something like that would not be on the care plan." When asked how staff would know to monitor for depression or an increase in behaviors, LPN #2 stated that it would be passed on in a verbal report. When asked if Resident #64 was aware that her sister had passed, LPN #2 stated that she was not sure.

On 8/29/19 at 10:00 a.m., further interview was conducted with OSM #1. When asked if the care plan would be revised to reflect Resident #64's loss, OSM #1 stated that he would probably expect to see a care plan reflecting a loss and to monitor for behaviors or mood. OSM #1 stated that he did not revise the care plan. When asked how staff are made aware of a loss and to monitor for an increase in moods or behaviors, OSM #1 stated that he told the unit manager (LPN #2) that she can revise the care plan if needed.

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator, was made aware of the above concerns. A policy could not be provided

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F 745	Continued From page 79 regarding the above concerns. The social worker job description was requested by administration on several occasions on 8/28/19 and 8/29/19 but was not provided.	F 745		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		10/7/19

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F 755	Continued From page 80 This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, record review and staff interviews it was determined that the facility staff failed to ensure medications for the treatment of scabies was available from the pharmacy for 10 of 66 residents in the survey sample, Residents #43, #75, #82, #219, #56, #224, #66, #115, #92, and #22 The findings included: The facility staff failed to obtain medications to treat residents during a "Scabies" outbreak. Two residents were initially identified as having "Scabies" on 11/8/18 and admitted to the hospital. On 11/8/18 the Director of Nursing received a call from the hospital informing the confirmation of "Norwegian Scabies." The facility identified ten active residents on two different living units and three active staff between 11/6/18 through 11/15/18. The first order was placed to the pharmacy on 11/7/18 which included 20 tubes of permethrin cream and 480 tablets of Ivermectin 3 mg each. The local Health Department recommended Ivermectin po (by mouth-tablet) weekly, times 4 weeks, and topical permethrin cream qod (every other day) x 1 week, then twice weekly until healed. The medication start dates for each Resident was as follows: Resident #43-11/6/18-cream and tablet, Resident #75 -11/8/18-cream and tablets,	F 755	F-755 1. Residents #43, #75, #82, #219, #56, #224, #66, #115, #92, and #22 were affected by this oversight. All of the resident's did receive the medication as ordered. and there was no negative outcome. 2. All residents have the potential to be affected. 3. At this time we have a different pharmacy. If a new medication is ordered and the pharmacy informs the facility that they do not have it in stock for any reason, the facility will direct the pharmacy to order the medication from the back up pharmacy. 4. DON or Administrator will meet with pharmacy rep to present process going forward. New orders will be reviewed in clinical meeting ongoing and DON or designee will ensure that new medication has been obtained timely. SDC, DON, or designee will in-service Licensed Nurses on process by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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Resident #82- 11/8/18-cream and tablets,
Resident #219-11/8/18-cream and tablets,
Resident #56 -11/12/18-cream and tablets,
Resident #224-11/6/18-cream and tablets,
Resident #66-11/15/18-cream and tablets,
Resident #115-11/15/18-cream and tablets,
Resident #92-11/14/18-cream and tablets,
Resident #22-11/9/18-cream and tablets.

A facility Performance Improvement Action Plan dated 11/7/18 Indicated: "Ensure affected residents and staff are treated and placed on contact isolation throughout period of treatment."

A Note from the Medical Director dated November 13, 2018 Indicated: "Continue with isolating all patients to one part of the building to lessen spread. Keep trying to get the "Ivermectin" (medication to treat scabies) as the crusted scabies are very difficult to eliminate."

A follow-up note dated November 13, 2018 from the Assistant Director of Nursing (ADON) indicated: "This is an update on scabies on scabies treatment in facility. Ivermectin in (sic) on back order per pharmacy. Writer called pharmacy 11/9/18 and was informed that medication was on back order until 11/12/18, residents did receive initial dose per order, dosages calculated as prescribed. Pharmacy 11/12/18 informed writer stating medication would come from back up stock that day, facility still has not received medication, called again this morning, was informed that medication had not been obtain from back stock and they would need to investigate, continuing with creams and showers, currently have 7 resident (sic) with rashes in the building. All appear to be resolving. 1 room on Holmes Hall, remaining are contained to back of

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F 755	Continued From page 82 Fine Hall, need advice on how to proceed until Ivermectin obtained." During an interview on 8/29/19 at 11:11 A.M. with the ADON, she stated, "The initial break out involved two residents. They received their initial dose of medication. The initial order was placed on 11/7/18. A second order was made on 11/14/18. The medication did not arrive until 11/15/18." A review of the facility's medication purchase order/invoice indicated: date order 11/7/18 please send stat delivery. A second request dated 11/14/18 indicated: please send ASAP. A shipment order statement indicated: "11/15/18 1:18 PM delivered. Shipment Orders : House Stock Ivermectin 3 mg tablet quantity 480-date filled 11/14/18. A second Shipment Order indicated: Permethrin 5 % cream, quantity 3600-date filled 11/14/18. A request for a facility Pharmacy Policy was made to the ADON and the Administrator, no pharmacy policy was made available prior to exit. The facility staff failed to ensure medications were available to residents through pharmaceutical services.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		10/7/19

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F 758	Continued From page 83 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 84 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to ensure one resident (Resident #110) in the survey sample of 66 residents was provided with a gradual dose reduction (GDR) of the psychotropic medication Seroquel. The finding included: Resident #110 was initially admitted to the facility on 10/21/16 and readmitted to the facility on 1/9/19. Diagnoses for this resident included Bipolar disorder, delusional disorder, major depression, dementia without behavioral disturbance, psychosis not due to a substance or known physiological condition and anxiety. A 8/19/19 Significant Change Minimum Data Set (MDS) assessed this resident in the area of Cognitive Patterns (Brief Interview for Mental Status) BIMS as a (15). In the area of Mood this resident was assessed as having little interest in activities. In the area of behaviors this resident assessed as not having any behaviors. In the area of Medications this resident was assessed as receiving Antipsychotic and Antianxiety medications. A revised care plan dated 8/21/19 indicated Resident #110 uses psychotropic medication due to unspecified psychosis/Bipolar disorder. Interventions- Monitor for side effects and adverse reactions of psychoactive medications: A physician's order dated 8/6/19 included:	F 758	F-758 1. Resident #110 was affected. This resident does not meet the criteria for a GDR due to her age and her diagnosis. Pharmacy, MD, and psych services have reviewed resident's medication and determined that no changes are needed at this time. 2. Any resident receiving a psychotropic medication who meets the age and diagnosis criteria for a GDR has the potential to be affected. 3. DON, SDC, or designee will inform the pharmacist and the MD of the regulations regarding a GDR and the need for documentation to support not recommending/completing a GDR. 4. 100% audit of residents receiving psychotropic medications will be done to include date of last GDR. DON, ADON, or designee will audit medical records daily for 2 weeks 3 times a week for 2 weeks then weekly for 8 weeks. The DON will review the pharmacy recommendations monthly and report to the MD ongoing for recommendations and completion of GDR's. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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F 758	Continued From page 85 Seroquel tablet 100 MG (milligrams) give 1 tablet by mouth one time a day for Unspecified Psychosis/Bipolar disorder. related to unspecified psychosis not due to a substance or known physiological. The order indicated a start date of 05/23/18 at 100 mg one tablet one time a day. A review of the pharmacy review dated 5/24/19 indicated no recommendations for a (GDR). A pharmacy Gradual Dose Reduction Tracking Report dated March 31, 2019 included: Resident #110 - medication-Seroquel-Therapeutic Class-Antipsychotic-Diagnosis-Bipolar Disorder-Therapy Start- 11/4/2016-last GDR Attempt (Blank)- Next GDR Eval- (Blank). During an interview on 8/30/19 at 9:30 A.M. with the Director of Nursing (DON) she stated, there was no (GDR) attempted or recommended for the use of Seroquel for Resident #110. A Gradual Dose Reduction policy was requested from the DON. As of exit, the facility did not provide a policy for Gradual Dose Reduction of psychoactive medications.	F 758		
F 812 SS=E	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.	F 812		10/7/19

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F 812	Continued From page 86 (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 observations, and staff interview it was determined that the facility staff failed to store and prepare food under sanitary conditions. The findings included: During the kitchen inspection conducted on 8/28/19 at 11:45 A.M. the facility staff was observed to take clean steam table tray tops from the bottom of the steam table. The bottom shelf of the steam table was observed to have copious amounts of debris and dried food particles. The tray tops were observed to be stored face down with the tops outer surface contacting the debris and dried food particles. The back kitchen wall extending from the three compartment sink to the free standing refrigerator in the kitchen was observed to have dirt, debris, and black-green substance not easily removed, on the floor and on the wall. The soiled utility room utilized to store soiled aprons and towels was observed to be dirty and having a black-green substance on the floor. The floor was observed to have an open drain with trash, debris and a black gooey substance in it.	F 812	F-812 1. Tray tops removed and sanitized on 8/29/19. Bottom of steam table cleaned and recovered on 8/29/19. Back kitchen wall and floor cleaned on 8/29/19 Soiled utility room cleaned on 8/29/19, drain cover replaced and drain suctioned on 8/29/19. Hole behind dish machine repaired on 9/19/19. Loose floor tiles and baseboards replaced on 9/19/19 Lights replaced in overhead secure area on 8/29/19 Wall behind ice dispenser cleaned and repaired on 8/29/19 2. All residents have the potential to be affected. 3. Using the “Culinary sanitation audit” Dietary Manager or designee will audit kitchen daily x 3 weeks, weekly x 4 weeks, biweekly x4, and monthly x4. Audits will consist of both cleaning and maintenance related items. 4. The results of the audits will be presented to the QAPI committee for review and input for 3 months or until resolved. 5. October 9, 2019	

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F 812	Continued From page 87 The drain was noted to have a pungent order emitting from it. A hole was noted behind the dish wash machine. Floor tiles and loose baseboards was observed around the the base of the kitchen area. A wooden board was observed under the three compartment sink where a hose bib was leading to the outside. Two lights in the overhead service area were noted to be out. An accumulation of dust, dirt, food residue or other debris was observed on the wall behind the ice dispenser. The wall appeared to have water damage and a black-green substance. During an interview with the Dietary Manager on 8/29/19 at 12:45 P.M. he stated, he had only been assigned the kitchen for about two months. A request was made for policy and procedure regarding storing and preparing food under sanitary conditions. The policy and procedure was not provided prior to exit.	F 812	F-842	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		10/7/19

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§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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F 842	Continued From page 89 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure a complete and accurate clinical record for five of 66 residents in the survey sample, Resident #114, #418, #86, #87 and #31. The findings included: 1. For Resident #114, the facility staff failed to document treatments that were performed. Resident #114 was admitted to the facility on 7/25/15 and readmitted on 8/1/19 with diagnoses that included but were not limited to heart failure, chronic respiratory failure, type two diabetes, and bipolar disorder. Resident #114's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/15/19. Resident #114 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 842	F-842 1. Residents #114 and #86 were affected by this oversight. Nursing staff was in-serviced on 8-28-19 on proper documentation of care provided including TAR documentation. Resident #418 was affected by the oversight. A dialysis order was written immediately. Resident #87 was not affected as this resident was not hospice at this time. Hospice services were D/C'd 2-1-19. No corrective action was required. Resident #31 was affected, Resident #31 was referred to therapy on 8 -29-19 to determine continued need for splint. 2. All residents have the potential to be affected. 3. Licensed Nurses will document care given daily including the TAR. Licensed Nurses will obtain orders for dialysis on admission/re-admission or as needed. Licensed Nurses will be responsible for	

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F 842	Continued From page 90 Review of Resident #114's clinical record revealed that she had obtained a DTI (deep tissue injury) (1) on 5/30/19. The following was documented: "DTI noted to L (left) heel purplish, red and intact. Dx: type II DM (diabetes mellitus) w/ (with) diabetic neuropathy... morbid obesity due to excess calories, HTN (high blood pressure), edema, hypothyroidism. Diet: Controlled carb (carbohydrates)/NAS (No added salt) mechanical soft diet... Resident is on an air mattress. MD (medical doctor)/RP (responsible party) updated." Review of Resident #114's physician order sheet revealed the following active order: "L heel DTI: Skin prep (liquid barrier dressing) (2) q (every) shift for DTI." Review of Resident #114's August 2019 TAR (treatment administration record) revealed several blanks (holes) on the following dates: 8/23/19, 8/24/19, 8/25/19, and 8/26/19 all 7 AM-3 PM shift. On 8/28/19 at 4:20 p.m., an interview was conducted with Resident #114. When asked if staff put a treatment on her left heel every shift, Resident #114 stated that they did. When clarified if staff put the treatment on three times a day, Resident #114 again stated that they did. On 8/28/19 at 4:31 p.m., interview was conducted with LPN (Licensed Practical Nurse) #2, the unit manager. When asked what blanks (no initials) meant on TAR, LPN #2 stated that it meant treatment was not completed or the nurse forgot to document. When asked if care given should be documented, LPN #2 stated that it should.	F 842	notifying the Business Office when hospice services are D/C'd. Licensed Nurses will be responsible for ensuring that all residents with splints or braces has an order that includes when the splint/brace should be worn. Residents with splints/braces will be referred to therapy. 4. DON, ADON, Unit Managers or designee will audit TARs daily for 2 weeks then 3 times per week for 2 weeks then weekly for 8 weeks for missing documentation. Charts of 100% of the residents receiving dialysis will be audited for dialysis orders. New orders, 24 hour reports, new admissions and re-admissions will be audited daily in clinical meeting ongoing to ensure that dialysis orders have been written and to note when hospice services have been D/C'd and verify that the BOM is aware of the payer source change. This will be ongoing. Therapy will screen all residents with contractures to determine need for splints. Therapy will provide DON with list of residents as they are screened. SDC, DON, or designee will in-service Licensed Nurses, Therapy and other appropriate staff on all process by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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F 842	Continued From page 91 On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the Administrator was made aware of the above concerns. No further information was presented prior to exit. (1) Deep Tissue Injury- "A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise, and they may herald the subsequent development of a Stage III-IV pressure ulcer, even with optimal treatment." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2/. (2) This information was obtained from https://www.edgepark.com/ostomy/skin-prep-and-adhesive-removers/skin-prep-wipes/smith-and-nephew-skin-prep-protective-barrier-wipes/p/54420400. 2. The clinical record for Resident #418 was incomplete; there was no order for the resident's dialysis treatments. Resident #418 was admitted on 8/26/19 with diagnoses to include but not limited to, end stage renal disease requiring hemodialysis and liver failure. At the time of the survey the Admission MDS (Minimum Data Set) required by day 14 had not been completed as the resident was still in the look back period. On 8/27/19 the resident was noted to not be in the facility, per the nurses notes timed at 12:08 p.m., the resident was at the dialysis center. A	F 842		

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review of the physician orders did not evidence an order for dialysis.

On 8/29/19 at 9:45 a.m., the resident was noted to not be in the facility. The nurses notes for 8/29/19 entered at 2:06 p.m., documented the resident was at dialysis. The resident returned at 4:00 p.m.

08/29/19 at 5:24 p.m., the Director of Nursing (DON) was interviewed, the missing physician order for Resident #418's dialysis was shared. She reviewed the electronic record and stated the resident did not have an order for dialysis. At 6:05 p.m., a copy of a physician order was provided to this inspector and the DON stated, "She does have one now." The physician order for dialysis was dated 8/29/19 and read, "Pt is to receive hemodialysis every Tuesday, Thursday and Saturday at (name and address of dialysis center) chair time 11 a.m." This order was obtained after it was brought to the attention of the DON earlier.

The above findings was shared with the Administrator during the pre-exit meeting conducted on 8/29/19.

3. The treatment administration record (TAR) for Resident # 86 had incomplete documentation entries for July and August 2019.

Resident #86 was admitted to the facility on 8/21/06 and re-admitted on 9/30/15 with diagnoses to include but not limited to, paraplegia (paralysis of the lower portion of the body and of both legs). The current MDS (Minimum Data Set) an annual with an assessment reference date of 7/24/19 coded the resident as scoring a 15 out of

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a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the resident's cognition was intact.

The clinical record evidenced the resident had a self inflicted excoriation that was identified on 8/7/18 as an abrasion to the left buttock. On 9/15/18 the wound was then identified on the Weekly Skin Alteration Report as a self inflicted wound to the left buttock. The 5/14/19 Weekly Skin alteration Report documented the self inflicted left buttock excoriation measured 7.5 cm (centimeters) in length, 6.5 cm in width and 0.1 cm in depth, with full thickness skin loss. The note read, "Resident continues to self-inflict by scratching area to L buttocks and reopen area despite covering. Decline noted this week d/t resident refusals of daily dressing changes. Resident is non-compliant with daily dressing changes despite being educated. MD/RP updated."

The current wound treatment was to cleanse the wound with wound cleanser, apply calcium alginate with silver to the wound bed, skin prep surrounding intact skin and cover with foam dressing daily, start date 7/25/19.

A review of the TAR (treatment administration record) for June and August 2019 was reviewed. There were no nurse initials to evidence/record the administration of the treatments on the following dates: July 8, 9, 31, and August 11th, and 18th. In addition, there were multiple entries on the TAR that were coded a "2" (chart code 2 = refused).

The wound nurse was interviewed on 8/29/19 at 11:25 a.m., the multiple blank entries for the

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administration of the dressings for July and August 2019 was shared with the wound nurse. She stated the resident often refuses to have the dressing change, as noted on the treatment administration records (TAR) and coded as a 2-refused. She stated for the blank entries, "If it wasn't documented than it was not done, period." Blank entries on the TAR were as follows: July 8, 9, 31, and August 11th, and 18th. There was no accompanying documentation in the nurses notes for those dates on why the treatment was not done.

A wound change observation was declined by the resident on 8/29/19 at approximately 2:00 p.m., however the resident did allow this inspector to see the dressing. The left buttock dressing was dated as last changed on 8/27/19. Documentation on the TAR evidenced the nurse initialed that the dressing change to the left buttock was done on 8/28/19. An interview with this nurse (licensed practical nurse #1) on 8/29/19 was conducted, she stated she did not do the treatment on 8/28/19 but documented that it was administered prior to the resident refusing, and forgot to go back and code it correctly.

The above findings was shared with the Administrator during the pre-exit meeting conducted on 8/29/19.

4. For Resident #87, the facility staff failed to have a current order for Hospice Care.

Resident #87 was admitted to the facility on 08/08/2018. Diagnosis included but were not limited to, Dementia and Heart Disease. Resident #87's Minimum Data Set (MDS an assessment protocol) with an Assessment

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Reference Date of 07/25/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 00 indicating severely impaired cognitive skills for daily decision making.

On 08/28/2019 review of Resident #87's MDS, Section "O" - Special Treatments and Programs, revealed that the resident was coded as receiving Hospice Care as a resident. The Physician Order Summary for August 2019 was reviewed and did not evidence that Resident #87 had an order for Hospice Care.

On 08/28/2019 at approximately 3:00 p.m., an interview was conducted with the Director of Nursing (DON) and she was asked, "Is Resident #87 on Hospice?" The DON stated, "Yes." The DON was asked, "Does Resident #87 have an order for Hospice Care?" The Director of Nursing stated, "Yes." The Surveyor made the DON aware that the Physician Order Summary was reviewed and the inability to locate evidence of a current order for Hospice Care. The DON stated, "I will check and get back to you."

On 08/28/2019 at 4:15 p.m., the Don stated, "On July 7 and 8 of this year the facility switched the medical records over to PCC (Point Click Care) and (resident name) order for Hospice Care did not carry over." The DON was asked, "Does Resident #87 have a current order for Hospice Care?" The DON stated, "No, but I will go ahead and write an order for Hospice."

On 08/29/2019 at approximately 7:15 p.m., the Administrator was informed of the finding at the pre-exit meeting. The facility did not present any further information about the finding.

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Definitions:
Point Click Care - Point Click Care is a EHR (Electronic Health Record) Software https://pointclickcare.com

5. The facility staff failed to ensure Resident #31 had a complete order for the brace to left hand, failed to include order to apply brace to left hand with parameters indicating when to be worn.

Resident #31 was admitted to the facility on 12/19/2019. Diagnoses included but were not limited to, Central Cord Syndrome at C4 Level of Cervical Spinal Cord, sequela, and Hypertension. Resident #31's Quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 06/12/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 00 indicating severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #31 as requiring extensive assistance of 1 with dressing and eating, extensive assistance of 2 with bed mobility and total dependence of 2 with transfer, toilet use, personal hygiene and bathing.

On 08/27/2019 at approximately 2:00 p.m., Resident #31 was observed without a hand brace on his left hand.

On 08/28/2019 review of Resident #31's Physician Order Summary for August 2019, revealed an order with an order date of 02/06/2019, "Remove brace to left hand to provide skin care and monitor skin integrity every shift for monitoring." Review of Physician Order Summary did not reveal an order to apply hand brace to left hand.

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On 08/28/2019 review of Resident #31's comprehensive care plan did not address hand brace on left hand.

On 08/28/2019 at 10:55 a.m., Resident #31 was observed lying in bed, no hand brace on left hand.

On 08/28/2019 at 12:05 p.m., Resident #31 was observed lying in bed, no hand brace on left hand.

On 08/29/2019 at 11:10 a.m., Resident #31 was observed lying in bed, no hand brace was on the left hand. An interview was conducted with Registered Nurse (RN) #1 and she was asked, "Does Resident #31 wear a brace on his left hand?" RN #1 stated, "I think it was D/C'd (Discontinued)."

On 08/29/2019 a copy of Resident #31's Treatment Administration Record (TAR) was requested and received. Review of TAR revealed the following treatment: "Remove brace to left hand to provide skin care and monitor skin integrity every shift for monitoring." Review of the TAR for the period of August 1 through August 28, 2019 revealed checkmarks and the initials of Licensed Nurses in 80 of 84 boxes. Review of the chart code on the TAR revealed that the checkmarks indicated that the treatment was administered indicating that the brace was removed from the left hand for skin care and monitoring. The Surveyor did not observe Resident #31 wearing the hand brace during the survey.

On 08/29/2019 at 1:15 p.m., the above was

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F 842	Continued From page 98 reviewed with the Director of Nursing (DON) and an interview was conducted. The DON was asked to review the Physician Order Summary for August 2019 and she was asked, "Does Resident #31 have an order for staff to apply a brace to his left hand?" The DON stated, "No." The DON stated, "I will check with therapy and clarify the order and will include when to don and doff the brace." The TAR was reviewed with the DON and she was asked, "Why are the boxes checked and initialed that the brace was removed from the hand if the staff didn't have an order to apply the brace?" The DON stated, "They probably just went down and clicked on the boxes." The DON was asked, "Should the Nurses document on the TAR that they removed the hand brace if they did not remove it?" The DON stated, "No, they should not document doing something that they did not do." The DON was asked, "What are your expectations of the nurses when they note an incomplete order?" The DON stated, "The nurses should have clarified the order and referred to therapy." On 08/29/2019 at approximately 7:15 p.m., the Administrator was informed of the findings at the pre-exit meeting. The facility staff did not present any further information about the finding.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/7/19

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F 880	Continued From page 99 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 100 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility documentation and clinical record review, it was determined that facility staff failed to implement effective infection control practices for 4 of 66 residents in the survey sample. For Resident #31, the facility staff failed to prevent the indwelling catheter drainage bag from touching the floor. The facility staff failed to follow infection control practices as evidenced by not performing hand hygiene before and after medication administration for three residents in the medication administration observation, Resident #114, #24, and #113. The findings included: 1. Resident #31 was admitted to the facility on 12/19/2019. Diagnosis included but were not limited to, Central Cord Syndrome at C4 Level of	F 880	F-880 1. Resident #31 was affected by oversight. Resident #31 was care planned for Foley touching the floor on 8-28-19 as resident has had multiple falls and requires the low bed for safety. Residents #114, #24, and #113 were affected by the oversight. Nurse was in-serviced on hand hygiene when passing meds on 8-27-19. 2. Al residents have the potential to be affected. 3. Licensed Nurses will wash or sanitize their hands before and after each resident contact with meds. If nurse has to wear gloves for the procedure, then he/she will wash his/her hands before donning gloves and after removing gloves. Licensed Nurses and CNA's will keep Foley catheters from touching floor. SDC, DON,	

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F 880	Continued From page 101 Cervical Spinal Cord, sequela, and Neuromuscular Dysfunction of Bladder, Unspecified. Resident #31's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 06/12/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 00 indicating severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #31 as requiring extensive assistance of 1 with dressing and eating, extensive assistance of 2 with bed mobility and total dependence of 2 with transfer, toilet use, personal hygiene and bathing. On 08/27/2019 at 11:51 a.m., Resident #31 was observed lying in bed and the bed was in the lowest position. The residents indwelling Foley catheter (a catheter inserted into the bladder to drain urine) drainage bag was hanging from the frame of the bed and resting on the floor. On 08/27/2019 at 1:36 p.m., Resident #31 was observed lying in bed and the bed was in the lowest position. The resident's indwelling Foley catheter drainage bag was hanging from the frame of the bed and resting on the floor. On 08/28/2019 at 5:00 p.m., Resident #31 was observed lying in bed and the bed was in the lowest position. The resident's indwelling catheter drainage bag was hanging from the frame of the bed and resting on the floor. The surveyor asked Licensed Practical Nurse (LPN) #10 to accompany her at the residents bedside. LPN #10 was asked, "Should the Foley drainage bag be touching the floor?" LPN #10 stated, "No, it needs to be below the resident but should not be touching the floor." LPN #10 was asked, "Why shouldn't the drainage bag be on the floor?" LPN	F 880	or designee will in-service Licensed Nurses on hand washing process during med pass by or before 10-6-19 and annually. Licensed Nurses and CNA's will be in-serviced by SDC, DON, or designee on Foley procedure by or before 10-6-19 and annually. New hires will be in-serviced during orientation and annually. 4. Random med pass observations will be completed by DON, ADON, SDC, or designee to observe hand hygiene daily for 2 weeks then 3 times a week for 2 weeks then weekly times 8 weeks. All residents with Foley catheters will be observed daily for 2 weeks then 3 times a week for 2 weeks then weekly times 8 weeks to ensure Foley's are not touching the floor. Failure to comply will result in progressive disciplinary action up to and including termination. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	

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#10 stated, "Because of infection control issues." The LPN stated that she would hang the bag to prevent it from touching the floor.

A copy of the Infection Control Policy was requested but was not received.

The Administrator was informed of the finding at the pre-exit meeting on 08/29/2019 at approximately 7:15 p.m. The facility did not present any further information about the finding.

2. Facility staff failed to follow effective infection control practices as evidenced by not washing hands before and after medication administration for three residents in the medication administration observation; Resident #114, #24 and #113.

Resident #114 was admitted to the facility on 7/25/15 and readmitted on 8/1/19 with diagnoses that included but were not limited to heart failure, chronic respiratory failure type two diabetes, and bipolar disorder. Resident #114's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/15/19. Resident #114 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #24 was admitted to the facility on 1/13/17 with diagnoses that included but were not limited to high blood pressure, type two diabetes, and neuropathy. Resident #24's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/4/19. Resident #24 was coded as being intact in cognitive function scoring 15 out of

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possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #113's was admitted to the facility on 8/8/19 with diagnoses that included but were not limited to fracture of the left leg, heart failure, type two diabetes and neuropathy. Resident #113's most recent MDS assessment was an admission assessment with an ARD (assessment reference date) of 8/15/19. Resident #113 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 8/27/19 at 12:37 p.m., a medication administration observation was conducted with LPN (Licensed Practical Nurse) #3. At approximately 12:50 p.m., LPN #3 prepared the following medications for Resident #114: Colace, gabapentin capsule and valproic acid. LPN #3 did not wash or sanitize her hands prior to preparing these medications. At approximately 12:55 p.m., LPN #3 administered these medications to Resident #114. LPN #3 did not wash or sanitize her hands after the administering these medications.

On 8/27/19 at 12:57 p.m., LPN #3 prepared a Gabapentin Capsule for Resident #24. LPN #3 was not observed to wash or sanitize her hands prior to preparing this medication. At approximately 12:58 p.m., LPN #3 administered the gabapentin capsule to Resident #24. LPN #3 was not observed to wash or sanitize her hands after administration.

On 8/27/19 at 1:04 p.m., LPN #3 prepared an ensure liquid supplement for Resident #114. LPN #3 walked into Resident #114's room and handed

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her the supplement. LPN #3 did not wash or sanitize her hands prior to leaving the room.

On 8/27/19 at approximately 1:06 p.m., LPN #3 prepared the following medications for Resident #113: Gabapentin Capsule and Lyrica. LPN #3 did not wash or sanitize her hands prior to preparing these medications. At approximately 1:10 p.m., LPN #3 administered these medications to Resident #113. LPN #3 was not observed to wash or sanitize her hands after administration.

On 8/29/19 at 11:21 a.m., an interview was conducted with LPN #3. When asked how to maintain infection control practices when administering medications, LPN #3 stated that she should wash or sanitize her hands before and after patient contact or in between resident rooms. LPN #3 stated, "I know. I am aware. I just totally forgot because people (residents) were talking to me but I know what I am supposed to do."

On 8/29/19 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.

Facility policy titled, "Hand Washing/Hand Hygiene,"documents in part, the following: "Use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...b. Before and after direct contact with residents; c. Before preparing or handling medications..."

No further information was presented prior to exit.

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F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview,and in the course of a complaint investigation, the facility staff failed to maintain equipment to include an ice dispenser in the kitchen and a washing machine in safe operating conditions. The findings included: During the Kitchen Inspection on 8/28/19 at 11:45 A.M. the ice dispenser located in the kitchen was observed to be in poor repair. The ice dispenser was noted not able to dispense ice. During an interview on 8/28/19 at 12:45 P.M. with the Dietary Manager, he was asked how long the ice dispenser had been inoperable. The Dietary Manager stated, the ice dispenser had not operated properly for several weeks. During a complaint investigation indicating the facility was without linens it was determined that one of two facility washing machines had been inoperable. A review of a facility email dated June 24, 2019 indicated that a request for the purchase of a washer was instituted on June 24, 2019 at 7:48 A.M. by the Administrator. During an interview with the Housekeeping Director on August 28, 2019 at 2:15 P.M. he stated, "The washer had been out for about two months. When asked what "out" meant he stated, "The washer was not operating properly and was	F 908	F-908 1. Washing machine was replaced on 8/29/19. Ice machine was approved to be ordered on 9/18/19 2. All residents have the potential to be affected. 3. Washing machine and ice machine will be assessed for proper functioning daily for 3 weeks, weekly x4 weeks, and monthly x4. 4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7, 2019	10/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 908	Continued From page 106	F 908		

not in operating condition." When asked how he was keeping up with the linen and resident clothing, the Housekeeping Director stated, we were behind about a week to two weeks in keeping resident clothing and facility linen clean." When asked when was the washer to be replaced, the Housekeeping Director stated, "The washer was scheduled to be installed on August 29, 2019."

On August 29, 2019 at 8:30 A.M. the new washer was observed being installed by an outside vendor. A review of the Service Work Order dated 8/28/19 indicated the washer was purchased on 8/28/19. The laundry room was observed to have bags of soiled clothing and facility linen stored in a pile measuring approximately seven feet wide, ten feet long and six feet high.

During an interview on 8/30/19 at 3:30 P.M. with the Administrator she stated, the washer was out of service for about two months. The washer was installed on 8/29/19.

A facility Maintenance Service policy indicated: "Maintenance service shall be provided to all areas of the building, grounds and equipment.

1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

2. Functions of maintenance personnel include, but are not limited to:
a. Maintaining the building in compliance with current federal. state and local laws, regulations, and guidelines.
b. Maintaining the building in good repair and free

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F 908	Continued From page 107 from hazards. d. Maintaining the heat/cooling system, plumbing fixtures, wiring,etc. in good working order." Complaint deficiency.	F 908		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview it was determined that the facility staff failed to maintain an effective pest control system. The findings included: During the kitchen inspection on 8/28/19 at 11:45 A.M. house flies were observed in the kitchen area. Drain flies were observed in the mop room and dishwasher room. Fruit flies were observed in the conference room. Mice dropping's were observed in the kitchen area under the three compartment sink and in the dry storage room area. During an interview on 8/29/19 at 12:50 P.M. with the Dietary Manager, he stated, the drain flies have been a concern and there is a new pest control company that is servicing the facility. The pest control company came monthly and as needed. A review of the Pest Management policy indicated: "Mission-We shall first seek to understand the unique needs of each customer,	F 925	F-925 1. Kitchen mop room, dishwasher room, conference room, kitchen dry storage room areas were all deep cleaned and treated by a professional pest control company on 9/17/19 2. All residents have the potential to be affected 3. Using the “Culinary Sanitation Audit” form, ED or designee will audit the kitchen mop room, dishwasher room, conference room, and kitchen dry storage room for fruit flies, house flies, and mice droppings daily for 4 weeks, weekly x 4 weeks, and monthly x 4. 4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been attained for 60 days. 5. October 7,2019.	10/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 925	Continued From page 108 formulate effective solutions, and implement the actions in a timely professional manner." The facility staff failed to maintain and effective pest control program. Complaint deficiency.	F 925		