ManorCare Arlington
550 S. Carlin Springs Road
Arlington, Virginia 22204
703.379.7200
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ManorCare Health Services

March 4, 2019

Nicole Keeney, LTC Supervisor Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Richmond, VA 23233

RE: Manorcare Health Services-Arlington
Provider Number 495102

Dear Ms. Keeney:

Enclosed herein is our revised Plan of Correction (CMS-2567) for the unannounced standard survey and biannual State Licensure inspection that was conducted 2/5/209 through 2/7/2019.

I hope you will accept our plans with favorable considerations.

Yours Sincerely,

Ibrahim Kamara, Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED ARLINGTON, VA 22204

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/5/19 through 02/7/19. The facility's Emergency Preparedness Plan was found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/5/19 through 2/7/19. An extended survey was conducted 2/5/19 through 2/7/19. Seven complaints were investigated. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity Level IV, Isolated, which constituted Substandard Quality of Care. The Life Safety Code survey/report will follow. The census in this 161 certified bed facility was 134 at the time of the survey. The survey sample consisted of 27 current resident reviews and six closed record reviews.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
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	F 550		

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

ADMINISTRATOR 3/4/2019

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

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F 550	Continued From page 1 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. §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 staff observation and staff interview, the facility staff failed for one of 33 residents in the survey sample (Resident #119), to ensure a dignified dining experience during breakfast on 02/5/19. Staff served residents # 105 and # 16 on paper plates on the weekends without a valid reason.	F 550	**F550** It is the practice of the facility to ensure that all residents are accorded the rights to a dignified existence, self-	

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F 550	Continued From page 2 The findings include: Resident #119 was admitted to the facility was originally admitted to the facility on 06/05/13 and readmitted on 11/15/16. Diagnoses included gastroesophageal reflex disease (GERD), peripheral vascular disease, hypertension, hypothyroidism, hyperlipidemia, and dementia without behavioral disturbance. The most recent minimum data set (MDS) dated 01/15/19 assessed Resident #119 as severally cognitive impaired with a score of 04. A dining observation was conducted on the second floor during breakfast on 02/5/19 at approximately 9:00 a.m. During the observation at 9:13 a.m., Resident #119 was observed seated in the the second floor dining room alone. There were no other residents or staff members in the dining room with Resident #119. Resident #119 was observed sitting at the first table sleeping at the table. Resident #119 was not wearing a clothing protector. Resident #119's shirt was observed to have oatmeal spilled on her shirt and some on the edge of the table. Resident #119 meal ticket documented therapeutic diet as "mechanical soft." Resident #119's meal tray was observed to have the following: cereal with milk poured in the cereal container, half-eaten bowl of oatmeal with the spoon inserted in the bowl, a cup of coffee, and orange juice with a straw inserted in the container. Resident #119 continued to sleep and no other residents or staff came into the dining room until prompted by this survey team member to check	F 550	determination, and communication with access to persons and services inside and outside the facility, including all other rights as specified in this section. **I** **Corrective Action** Residents #119 no longer dines alone. Paper plates are no longer used to serve residents, unless there is a natural, electrical, or mechanical cause making serving on non-paper plates impossible.	

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F 550	Continued From page 3 on the resident at 9:18 a.m. At approximately 9:20 a.m., the unit manager (LPN #1) was interviewed regarding Resident #119 being alone in the dining room. LPN #1 stated the majority of the second floor residents eat breakfast in their rooms. LPN #1 continued and stated there are a 3-4 residents who eat breakfast in the second floor dining room. LPN #1 stated one of those residents had an early morning appointment and he was not sure where the other residents were. LPN #1 was interviewed about Resident #119 being left alone in the dining room. LPN #1 stated Resident #119 should not have been left alone. LPN #1 was interviewed about Resident #119 having oatmeal wasted on her clothing and the edge of the table. LPN #1 stated this was not appropriate. LPN #1 continued and stated the certified nursing assistants and nursing staff are expected to assist with meal set-up and service. During the interview with LPN #1, LPN #1 was observed asking a second staff member identified as registered nurse (RN #1) why Resident #119 was left alone in the dining room. RN #1 stated she left Resident #119 to go and get something for another resident. These findings were reviewed with the administrator, director of nursing (DON) and corporate consultant during a meeting on 02/06/19 at 4:45 p.m. 2. Resident # 105 in the survey sample, an 83 year-old male, was admitted to the facility on 2/1/14, and readmitted on 9/28/14 with diagnoses that included anemia, congestive heart failure, hypertension, obstructive uropathy, depression, insomnia, atrial fibrillation, benign prostatic hyperplasia, urinary retention, Merkel Carcinoma (a form of skin cancer), and Guillan Barre	F 550	**II** **Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. The Administrator or designee has completed an audit of meal service for residents to dine with dignity and not serving meals on paper plates. No new issue identified. **III** **Systemic Changes** The administrator or designee would train the nursing staff regarding the avoidance of isolation during meals. The Dietician or designee has completed education on the	

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F 550	Continued From page 4 Syndrome. According to the most recent Quarterly Minimum Data Set, with an Assessment Reference Date of 1/11/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. During a resident interview conducted at 9:45 a.m. on 2/5/19, the subject of food service was discussed. "We get paper plates on weekends sometimes," the resident said. "They don't tell the Administrator," he continued, "I think they are lazy. I used to turn the paper plate upside down on the tray and send it back. Now I just send my tray back if it comes on paper." Asked what he does for food if that happens, the resident said he keeps a supply of snacks, including Cheerios. "I like Cheerios," he said. 3. Resident # 16 in the survey sample, a 67 year-old female, was admitted to the facility on 11/2/18 with diagnosis that included hyperlipidemia, Non-Alzheimer's dementia, and other Symbolic Dysfunctions. According to a Medicare 14-Day Minimum Data Set, with an Assessment Reference Date of 11/14/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. During a resident interview conducted at 10:15 a.m. on 2/5/19, the subject of food service was discussed. "Sometimes on weekends meals are on paper plates because there is not enough staff." During an end of day meeting at 4:45 p.m. on 2/6/19, that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the	F 550	dietary department staff on the facility's practice of not serving meals on paper plates without a compelling reason outside of staff convenience. **IV** **Monitoring** The Administrator or designee would audit compliance of not isolating residents during meals, and of not serving residents on paper plates weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	

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F 550	Continued From page 5 survey team, the use of paper plates for meals on weekends was discussed. The Administrator was specifically asked if paper plates are used on weekends. "Yes," the Administrator replied. "Sometimes if someone calls out and the Kitchen is short of staff. I doesn't happen very often." On 2/7/19 at 8:10 a.m., the Dietary Manager was interviewed regarding the use of paper plates on weekends. Asked if paper plates are used on weekends, the Dietary Manager offered a conflicting response from that of the Administrator. "We do use paper plates, but only if there is a problem with the dishwasher, or if there is a hot water problem," he said. Asked if paper plates would be used on weekends if the Kitchen was short handed, the Dietary Manager said, "No, we call people in."	F 550	V **Date of Compliance 3/23/2019**	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584	\ **F584** It is the practice of the facility to provide a safe, clean, comfortable and homelike environment, including but not	

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F 584	Continued From page 6 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a safe, clean, homelike environment on two of seven living units. A mechanical lift, chair scale, and floor scale were stored in the residents' dining/activity room on the 100 unit. This room also had damage along the wall where the equipment was stored and a cabinet door in disrepair. The floor covering in room 123 was torn and loose across the entrance to the bathroom. The wall near the first bed in this room had widespread vertical scrapes with torn wallpaper.	F 584	limited to receiving treatment and support for daily living safely. **I** **Corrective Action** The residents' dining/activity room on the first floor unit has been cleared of the mechanical lift, chair scale, and floor scale. The damaged wall in the same room has been mended and the cabinet the cabinet door reattached. The torn and loose floor covering in room 123 has been replaced. The scrapes on the wall near the first bed in room 123 have been covered and the wall painted and the wall paper replaced. In room	

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F 584	Continued From page 7 In room 232, the drywall behind the bed was in disrepair and the coaxial cable cover was not mounted to the wall. The findings include: 1. On 2/5/19 at 7:39 a.m., the dining/activity room on the 100 unit was inspected. A mechanical lift and chair scale were stored along the left wall near entrance to the room. A floor scale was positioned on the wall across from the doorway. The left wall where the lift and chair scale were stored had widespread scrapes and gouges in the drywall. A cabinet door under the microwave was hanging loose with the top hinge in disrepair. On 2/5/19 at 8:45 a.m., room 123 was observed with disrepair noted to the wall and floor at the bathroom entrance. The left wall adjacent to the first bed in this room had widespread, vertical scrapes and scratches. The vinyl floor covering in the bathroom was torn and peeling up across the threshold. Strips of white tape had been applied across the floor covering but were loose on the right edge with the floor covering unattached and torn at the corner. On 2/5/19 at 2:23 p.m., the licensed practical nurse (LPN #6) caring for residents on the 100 unit was interviewed about the dining/activity room. LPN #6 stated the room was for residents to use as needed for eating or meeting with their family or visitors. On 2/6/19 at 8:27 a.m., accompanied by the registered nurse unit manager (RN #4), the dining/activity room and room 123 were	F 584	232, the drywall behind the bed has been repaired and coaxial cable cover mounted. II **Identification** All resident rooms and other common living areas have the potential to be affected by the deficient practice. The maintenance director or designee will do a complete walk through of the facility for other possible wall or floor damages and making common areas clutter free. **III** **Systematic Changes**	

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F 584	Continued From page 8 observed. RN #4 stated they planned to change the dining room to a therapy room but this transition was not yet complete. RN #4 stated the room was available for resident use if desired. RN #4 stated they had other storage areas for lifts and scales. RN #4 was not aware of the torn floor covering and wall damage in room 123. RN #4 stated any needed repairs were supposed to be reported to maintenance with use of their computerized work order system. On 2/6/19 at 9:30 a.m., the facility's maintenance director was interviewed about the needed repairs on the 100 unit. The maintenance director stated no work orders had been entered regarding the disrepair in the dining/activity room and room 123. The maintenance director stated any needed repairs were supposed to be entered into their computerized work order system. These findings were reviewed with the administrator and director of nursing during a meeting on 2/6/19 at 5:00 p.m. 2. On 02/05/19 at 8:30 a.m., during the initial tour the drywall in room 232-A was observed in disrepair. The wall behind the bed had a section of torn drywall, the protective vinyl wall sheet was not mounted on the wall, instead it was laying on the floor under the two wheels at the head of the resident's bed, and the co-axial cable cover was not mounted to the wall. On 02/05/19 at 8:45 a.m., the unit manager (LPN #1) was interviewed regarding the condition of the drywall, protective vinyl sheet and co-axial cable cover in room 232-A. LPN #1 stated he was not aware of the maintenance needs in room 232-A. LPN #1 stated the staff are supposed to use an electronic system to record work requests for the	F 584	The Administrator or designee will educate the maintenance director on completion of room rounds and facility inspection and to address identified issues in order to keep the facility at homelike environment. **IV** **Monitoring** The Administrator or designee will audit resident's rooms, common areas, and entire facility with the maintenance director weekly for four weeks and monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	

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F 584	Continued From page 9 maintenance department. LPN #1 further stated sometimes staff will use the electronic system and/or they will notify the maintenance staff verbally if they see them on the unit. On 02/06/19 at 9:53 a.m., accompanied with the maintenance department manager (other staff, OS #4) the above referenced areas were observed in room 232-A. OS #4 stated he had been working at the facility for two months and was working on trying to get things repaired. OS #4 stated he had not been notified of the the maintenance needs in room 232-A. OS #4 stated he did not have a work order request for room 232-A. OS #4 stated the staff does not use the electronic work order system as they should and often he finds out about maintenance needs when someone verbally tells him on the unit. These findings were reviewed with the administrator, director of nursing (DON), and corporate consultant during a meeting on 02/06/19 at 4:45 p.m.	F 584	**V** **Date of Compliance 3/23/2019**	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment was completed for one of 33 residents in the survey sample, Resident #21. Resident #21's MDS assessment did not	F 641	**F 641- Accuracy of Assessments**	

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F 641	Continued From page 10 accurately reflect the resident's status regarding dental health. Findings include: Resident #21 was originally admitted to the facility on 02/28/11, with the most current readmission on 11/18/18. Diagnoses for Resident #21 included, but were not limited to: anemia, high blood pressure, PVD (peripheral vascular disease), renal failure dependent upon hemodialysis, DM (diabetes mellitus), depression, and bilateral AKA (above the knee amputations.) The most current full MDS (minimum data set) was an annual assessment dated 11/14/18, which assessed the resident as 99 cognitively, indicating the resident was unable to complete the interview; the resident was assessed with short term memory impairment with modified independence in daily decision making skills. The resident was assessed as requiring extensive assistance for most all ADL's (activities of daily living) including dressing, toileting, personal hygiene, and total dependence for bathing with one person assist. This MDS also assessed the resident in Section L. Oral/Dental Status L0200L. Dental, as having no dental issues, no pain/discomfort, no fragments, no issues with bleeding or inflamed gums, and no obvious or likely cavities/broken natural teeth. The resident was assessed as having none of the above, indicating no dental/oral cavity concerns. The resident triggered in the CAAS (care area assessment summary) on this MDS for, but not limited to: cognition ADL function and dental.	F 641	**1.** **Correction** Resident #21 had no adverse effects. MDS assessment now appropriately reflects resident's dental condition. **II** **Identification** All residents have the potential to be affected by this deficient practice. a.The facility will conduct an audit of all Long Term Care residents annual MDS for accurate assessment and coding b.Immediate corrective actions will be taken. **III** **System change** Initiate a process that all LTC residents will have a dental assessment completed with the annual pain assessment.	

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F 641	Continued From page 11 On 02/05/19 at 1:45 PM, Resident #21 was observed in her room with a lunch tray in front of her. The resident stated that she was tired from dialysis. The resident was observed with missing and decayed teeth in the upper and lower mouth. The resident's CCP (comprehensive care plan) was reviewed and documented, "...ADL self care deficit...assist with daily hygiene...oral care...dental or oral cavity health problem risk r/t (related to) teeth in poor condition (date initiated 05/19/18)...effective pain management...ability to eat and drink per baseline...administer medications as ordered...assist with oral hygiene as needed...refer to dentist/hygienist for evaluation/recommendations re: teeth pulled, repair of carious teeth (date initiated: 08/07/18)...report changes in oral cavity, chewing ability, S&S(signs and symptoms) of oral pain, etc..." On 02/06/19 at 10:38 AM, Resident #21 was interviewed and stated that her teeth are not hurting now, but did point to the tooth/area that was hurting. The resident opened her mouth and pointed to the upper right, front area. The resident had several teeth missing, with multiple broken off teeth in the top of her mouth. The teeth present had visible decay and several, including the tooth that the resident was pointing to, were decayed and flush with the resident's gum line. On 02/06/19 at 11:24 AM, RN (registered nurse) #5, also known as the MDS coordinator, was interviewed regarding the accuracy of Resident #21's most current MDS full assessment and informed of the above observations of Resident #21. RN #5 was asked who completed the	F 641	c. Facility will conduct education on the new process to all MDS nurses. **IV** **Monitoring** In order to ensure ongoing compliance, the facility will conduct random audits of annual assessments weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V.** **Date of Compliance** **3/23/2019**	

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	495102	A. BUILDING _____ B. WING _____	C 02/07/2019

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F 641	Continued From page 12 assessment. The RN stated, "I did." RN #5 further stated that she would get information from the nursing notes, dietitian, and the patient; but if the patient tells us we would have to report it to the physician. RN #5 stated that her assessment is based on the diet the resident is on and what the dietitian said and if the resident has had any weight loss or any chewing/swallowing issues, and base it on the notes we have during the 7 day look back; if the nurses don't document that there are any issues, we don't document on the MDS. RN #5 was made aware that information about the resident's teeth being decayed and missing should be carried over on each MDS to accurately assess the individual, unless the dental health changes or no longer applies. RN #5 stated that they mainly go off of paper/documented notes to gather resident information. RN #5 agreed that the resident's poor dental health condition should have been, and should be, on the MDS. The DON (director of nursing) and the administrator were made aware in a meeting with the survey team on 02/06/19 at approximately 4:50 PM No further information and/or documentation was presented prior to the exit conference on 02/07/19 at 11:30 AM.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656	**F 656- Development of Comprehensive Care Plans** It is the practice of this facility to develop a comprehensive	

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F 656	Continued From page 13 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 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:	F 656	person-centered care plan for each resident **I** **Correction** Resident #117 had no adverse effects. The care plan for resident #117 has been corrected to reflect the resident's smoking status. **II** **Identification** All residents have the potential to be affected.	

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F 656	Continued From page 14 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to develop a comprehensive care plan for two of 32 residents, Resident #117 and Resident #50. 1. Resident #117 did not have a comprehensive care plan to address smoking. 2. Resident #50 did not have a care plan for the use of oxygen. Findings were: 1. Resident #117 was admitted to the facility on 11/12/2018 with the following diagnoses, but not limited to: Paraplegia, acute kidney failure, hypertension, chronic obstructive pulmonary disease, and neuromuscular dysfunction of the bladder (requiring indwelling catheterization). A significant change MDS (minimum data set) with an ARD (assessment reference date) of 1/14/2019, assessed Resident #117 as cognitively intact, with a summary score of "15". Section J: Health Conditions, J1300 "Tobacco Use" was checked "No." In the course of the survey process a list of "residents who smoke" was requested from the administrative staff. Resident #117 was identified on the list as a "smoker." The clinical record was reviewed on 02/05/2019 at approximately 2:00 p.m. A smoking assessment was not observed on the electronic record. The care plan was reviewed. There were no interventions on the care plan regarding smoking.	F 656	a.The facility will conduct a 100 % audit of all smoking residents to assure they have a care plan in place. b. Immediate corrective actions will be taken. c. Care plans will be reviewed by the MDS staff during the MDS completion process, updates will be made as needed. **III** **System changes** Facility will conduct mandatory education to the nursing and MDS staff. **IV** **Monitoring** . In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality	

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F 656	Continued From page 15 On 02/05/2019 at approximately 3:30 p.m., Resident #117 was interviewed. She was asked if she was a smoker. She stated, "Yes, but I don't smoke everyday, or every smoke break...I usually just go down once a day...I went for so long without smoking because I was so sick, but I've started again... I am going out today at 4:00 [p.m.]." Resident #117 was asked where she kept her cigarettes. She stated, "They are downstairs with my lighter." During the interview, Resident #117 was asked if she could move her legs or had any feeling in them. She stated, "No, they said I have a clot on my spine that is causing it [paralysis]...I don't know if my legs will get better or not." At 4:00 p.m., two surveyors went to the smoking area to observe the residents. Resident #117 was smoking. She was not wearing an apron. She was sitting with her back to the door and her smoking could not be visualized from inside. A copy of the facility policy was requested at 4:10 p.m. The corporate nurse and the DON (director of nursing) stated that the smoking guidelines were located in the resident admission packet. The "Patient Information Handbook" was reviewed. Page 3 contained the following information regarding smoking: "SMOKING We believe in providing a healthy environment for you. Our center is designated as 'smoke-free.' Smoking is not permitted on the campus or may be permitted in designated area only. Smoking materials, including lighters, matches, cigarettes, and cigars, must be stored at the nurse's station." The DON was again asked if there was a facility policy regarding smoking. She stated, "We are	F 656	Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. I Resident # 50 had no adverse effects. #50 now has a care plan for the use of oxygen. II All residents have the potential to be affected. a. facility will conduct an audit for all residents on Oxygen to assure a care plan is in place. b. Immediate corrective actions will be taken c. Care plans will be reviewed by the MDS staff during the MDS completion process; updates will be made as needed.	

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F 656	Continued From page 16 looking for it...what we have are called 'guidelines', not a policy." The "SMOKING GUIDELINES" included the following information: "PURPOSE: To determine if a patient is an Independent Smoker or an At Risk Smoker before the patient exercises the privilege to smoke while residing within the center and to establish guidelines for all patients that desire to smoke, as well as non-smokers" "GUIDELINES: -The IDT (inter-disciplinary team) completes completes a comprehensive patient care plan that reflects the: -smoking evaluation outcome -smoking supervision that is necessary -type of protective smoking equipment that is needed, e.g., smoking apron or vest -education on the Smoking Guidelines and options for smoking cessation activities offered and/or provided to the patient or family members..." On 02/05/2019 at 5:11 p.m., the survey team met with the administrator, the DON (director of nursing). During the meeting they were informed that Resident #117 was not care planned for smoking. The facility staff presented an updated care plan for Resident #117 on 02/05/2019 at 8:23 p.m. The new care plan contained the following: "History of smoking in community smoking related to: Personal preference...Interventions: Complete smoking evaluation per facility guidelines...develop an agreed upon smoking	F 656	III The Facility will provide education to the nursing and MDS staff IV In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **Date of Compliance 3/23/2019**	

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F 656	Continued From page 17	F 656		

plan; do not leave unattended while smoking; resident will use smoking apron r/t (related to) paraplegia of lower extremities..."

No further information was obtained prior to the exit conference on 02/07/2019.

2. Resident #50 was admitted to the facility on 01/05/2017 with the following diagnoses, but not limited to: End stage renal disease with hemodialysis, depressive disorder, hypertension and COPD (chronic obstructive pulmonary disease).

An annual MDS (minimum data set) with an ARD (assessment reference date) of 12/11/2018, assessed Resident #50 as cognitively intact with a cognitive summary score of "15".

On 02/05/2019 at approximately 7:55 a.m., Resident #50 was observed sitting in a chair at his bedside. He was wearing a nasal cannula with oxygen running at two liters. Resident #50 was asked about the use of oxygen. He stated, "I just use it at night...I don't use it when I go out of the room or to dialysis, it helps me when I sleep."

At approximately 10:15 a.m., the clinical record was reviewed. There were no interventions on the care plan for the use of oxygen.

On 02/06/2019 at approximately 8:00 a.m., LPN (licensed practical nurse) #2, a unit supervisor was interviewed about the use of oxygen. She was asked if oxygen should be on a care plan if used by a resident. She stated, "Yes." She was asked specifically about Resident #50's care plan. She reviewed the care plan and stated, "You're right, it isn't on there."

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F 656	Continued From page 18 At approximately 8:30 a.m. LPN #2 came to the conference room and stated, "I contacted the physician and I have updated that and I will update the care plan." Further review of the clinical record showed that Resident #50 was care planned for oxygen prior to a hospitalization in May 2018. The oxygen was removed from the care plan at the time of the hospitalization and marked as "Resolved." At approximately 9:50 a.m., RN (registered nurse) #2, the MDS nurse came to the conference room. She was asked about the care plan for oxygen. She stated, "Yes, it looks like when he went into the hospital the care plan area for oxygen was noted as resolved...when he came back it looks like we didn't put it back on the care plan." No further information was obtained prior to the exit conference on 02/07/2019.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	**F 657- Care Plan Timing and Revision** It is the practice of this facility to review and revise the comprehensive care plan for the prevention of falls **1. Correction** Resident #34 now has a revised care plan to minimize or reduce falls.	

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F 657	Continued From page 19 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan (CCP) for the prevention of falls for two of 33 residents in the survey sample, Resident #129 and Resident #34. 1. The facility staff failed to ensure a comprehensive care plan was reviewed, revised and implemented for interventions and supervision for the prevention of falls, for Resident #129. 2. Resident #34's care plan was not reviewed and revised to included increased interventions/safety measures for her continued wandering, falls, and falls with injury. Findings include: 1. Resident #129 was admitted to the facility on 12/19/18. Diagnoses for this resident included, but were not limited to: history of cerebral infarction (stroke), high blood pressure,	F 657	**II** **Identification** All residents with wandering, falls and falls with injury have the potential to be affected. a. The facility will conduct an audit to identify residents who had a fall in the last 30 days or have a potential to wander to ensure that they have care plans that have been reviewed and revised as needed b. Immediate corrective actions will be taken. **III** **System Change**	

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F 657	Continued From page 20 hemiplegia and hemiparesis affecting left non dominant side, major depression, partial right nephrostomy, renal cancer and hypothyroidism. The most recent full assessment for Resident #129 was a 14 day admission MDS (minimum data set) dated 12/26/18. This MDS documented the resident was assessed as a "14", indicating the resident was cognitively intact for daily decision making skills. Resident #129 required extensive assistance for most all ADL's (activities of daily living) including bed mobility, transfers, locomotion on and off unit, toilet use, and personal hygiene. The resident was also assessed as "not steady, only able to stabilize with staff assistance" for moving from seated to standing position, walking (with assist device if needed), moving on and off toilet, and surface to surface transfer (transfer between bed and chair or wheelchair), and documented as having impairment in upper and lower extremity on one side of body. This MDS assessed the resident as having one fall since admission, without injury. The resident triggered in the CAAS (care area assessment summary) of this MDS for, but not limited to: ADL function, urinary incontinence, and falls. During a complaint investigation, the complainant alleged that the resident had a fall on 12/22/18 and that the nurse who reported the fall, alleged that the resident had not called for assistance to go to the bathroom. It was further alleged that on 01/01/19 the resident had a fall while attempting to go to the bathroom without assistance and it was reported that the resident rang her call bell, but no one answered, the resident fell and struck her head on the corner of the bed, was sent out	F 657	Initiate a new process to ensure all residents with falls and the potential to wander have an appropriate care plan. a. Care plans will be reviewed by the MDS staff during the MDS completion process; updates will be made as needed. b. MDS staff will be provided education on the new process. **IV** **Monitoring** In order to ensure ongoing compliance, the facility will conduct random audits of 4	

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F 657	Continued From page 21 for treatment and received five staples in the back of the head. Resident #129's clinical records were reviewed and revealed the following: An admission assessment of Resident #129 dated 12/19/18 documented, "...oriented to time, person, and situation...Falls: New/readmission...at risk for falls due to CVA (stroke), minimize risk for falls, encourage to transfer and change positions slowly, have commonly used articles within easy reach, reinforce need to call for assistance...Ambulation: partial/moderate assistance...Bed Mobility: partial/moderate assistance...Toileting: partial/moderate assistance...Transfer: partial/moderate assistance...ADL self care deficit...weakness related to CVA...Will receive assistance necessary to meet...needs...Assist...as needed..." The resident's physician's orders were reviewed and documented, "...Falls, visual impairment, left sided weakness..." A PT (Physical Therapy) evaluation dated 12/20/18 documented, "...CVA...resulting in left hemiplegia/weakness...left side weakness, left side neglect, poor dynamic standing balance, poor posture stability...impulsivity, poor safety awareness and high risk for falls...Precautions:...Fall...has patient fallen in last year: No...does patient feel unsteady: Yes...does patient worry about falling: Yes..." An OT (Occupational Therapy) evaluation dated 12/20/18 documented, "...long term goals: Patient will safely perform toileting tasks...with	F 657	residents weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. I Resident # 129 had no adverse effects. Resident #129 now has a revised care plan to reduce or minimize falls. II. All residents with falls have the potential to be affected. a. The facility will conduct an audit to identify residents who had a fall in the last 30 days to	

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F 657	Continued From page 22 CGA (contact guard assist) with reduced risk for falls...Toileting: Max A (assist)...pt is alert and oriented X 3 able to follow 1 command direction...due to documented physical impairments and associated functional impairments...at risk for falls..." Nursing notes were reviewed and documented that the resident had a fall on 12/22/18 at approximately 12:10 AM with no injuries. The resident was found lying on the floor next to her bed, when asked how did you get on the floor, patient stated that, "when I put the wipes on the trash can I slid from bed." A nursing note dated 12/29/18 at 8:32 AM documented, "...S/P (status post) fall no injury noted..." A nursing note dated 12/29/18 at 8:44 PM documented, "Resident is on S/P fall Day 2, neuro checks continue..." A nursing note dated 01/01/19 at 9:35 PM documented, "...writer found resident sitting on floor in her room ...alert and oriented but after assessment writer observed blood on the back of residents head and observered (sic) small gatch [sic] to her head...MD (medical doctor) notified and gave order to send to ER (emergency room)...RP (responsible party) notified..." On 01/02/19 at 12:25 AM, a CT report documented, " ...injury or trauma ...Fall; fall with posterior head lac ...continued evolution of large right MCA territory infarct with resolution of midline shift; no acute findings." A nursing note dated 01/02/19 at 3:50 AM,	F 657	ensure interventions are reviewed and implanted as needed. B. Immediate corrective actions will be taken. III Initiate a new process to ensure all residents with falls have interventions reviewed, initiated and updated as needed. a. Care plans will be reviewed by the MDS staff during the MDS completion process; updates will be made as needed. b. nursing and MDS staff will be provided education on the new process. IV In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents, weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality	

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F 657	Continued From page 23 documented, "...returned from [initials of hospital]...5 staples observed to the lower back of her head...bruise to left lateral thigh tender to touch...", and at 10:45 PM, " ...S/P fall day 2 ...no changes in mental status ...neuro checks in progress ...reminded resident to use call light ...assisted to rest room as needed..." The resident's CCP (comprehensive care plan) date initiated: 12/19/18 documented, "...self-care deficit.....assist with daily hygiene...transfer with one...weakness related to CVA...assist as necessary...unsteady gait...bed in low position...encourage to transfer and change positions slowly...provide assist to transfer and ambulate as needed...reinforce need to call for assistance..." The CCP documented, "date initiated 12/21/18...attain and maintain ability to transfer self with supervision...provide one person guidance and physical assist..." The CCP documented, "date initiated 12/24/18...Reinforce w/c safety...provide assist to transfer and ambulate as needed...bed in low position...assist with bed mobility...provide assistance with toileting...adjust toileting times to meet patient needs...remind and assist as needed with toileting at routine times...provide incontinence care as needed...assist to bathe/shower as needed..." The facility failed to implement existing interventions for the prevention of falls and failed to implement any new interventions after the fall on 12/28/18 and the fall on 01/01/19. On 02/06/19 at approximately 4:50 PM, the DON	F 657	Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	

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F 657	Continued From page 24 (director of nursing) and the administrator were made aware of concerns regarding this resident and the lack of interventions after the resident had another fall and then fell sustaining an injury. The administrator stated that the resident was non compliant. The administrator and DON were asked for any information and/or documentation and was additionally asked for any investigations for this resident's falls. An investigation dated 12/22/18 and timed 12:10 AM, documented that the resident was found lying on the floor. A statement from the LPN (licensed practical nurse) documented, "...around 12:10 pt [patient] was calling, upon arrival pt noted to be lying on the floor next to bed...pt was dry, call light was within reach...bed in low position..." A CNA (certified nursing assistant) statement documented, "...was in room [number] when nurse called for help...then saw pt on floor..." An investigation dated 12/28/18 and timed 6:30 PM documented, "...writer called by CNA to (room number) found resident on floor...supine...nurse asked resident [what happened] and resident stated she was trying to pick up something off the floor..." A statement from the CNA documented, "..I went to answer (room number - room of Resident # 129) and found her lying on floor...called nurse...no injuries..." An investigation dated 01/01/19 and timed 10:21 PM documented, "...resident found sitting on floor in her room...blood observed to back of head from small cut...no visible signs of distress noted...writer asked resident what happened...resident alert and oriented stated she fell trying to go to bathroom...blood on back of	F 657	V **Date of compliance 3/23/2019**	

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F 657	Continued From page 25	F 657		

head...apply pressure...new order to send to ER...resident stated she pressed call bell and couldn't wait she stated it was very embarrassing to have incontinence on self...resident transferred..."

The CCP was not reviewed or revised after the fall on 01/01/19.

The DON, administrator and corporate nurse were made aware of serious concerns with this resident falling and sustaining an injury that required outside treatment and interventions and that the resident's CCP existing interventions were not implemented and no new interventions were developed to prevent falls with injury. The facility staff were made aware that the resident was documented as continent with poor safety awareness and that the resident had significant physical deficits, which made the resident a known, high fall risk.

No further information and/or documentation was presented prior to the exit conference on 02/07/19 at approximately 11:30 AM, to evidence the facility staff implemented existing or developed new interventions to prevent falls (with injury) for this resident who was assessed as high risk for falls and was known to have an increased fall risk due to physical and mental impairments related to a stroke.

This is a complaint deficiency.
2. Resident #34 was admitted to the facility on 05/15/2018. Her diagnoses included but were not limited to: Type II Diabetes Mellitus, Parkinson's disease, dementia with behavioral disturbance, Major depressive disorder, and hypertension.

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F 657	Continued From page 26 Her admission MDS (minimum data set) with an ARD (assessment reference date) of 05/22/2018 coded Resident #34 as having impairment with both long and short term memory, and severely impaired for daily decision making skills. . The clinical record was reviewed on 02/05/2018 at approximately 6:30 p.m. Review of the progress note section indicated that Resident #34 had a history of wandering, falls and falls with injury. The clinical record included documentation of approximately 17 falls, 2 elopements, two fractures and two lacerations requiring sutures/staples since admission to the facility. The most recent fall was 02/01/2019. The care plan was reviewed at approximately 7:00 p.m. and contained the following focus area: "Exit seeking/elopement risk multiple attempts to leave facility related to: cognitive impairment, new admission/change of environment." Interventions (revised 08/21/2018) listed included: "Accompany to meals and scheduled activities; ALERT BRACELET; Calmly redirect; Engage in activities/tasks to keep occupied." An additional focus area for: "At risk for falls due to history of fall, recent fall, non steady gait, not using safe judgement D/T dementia disease process" was observed on the care plan. Interventions included: "Administer Calcium and Vitamin D per protocol; Administer medication per physician orders; All interventions reviewed and continue with plan of care; Bed in low position; Encourage resident to sit in front of nursing station; have commonly used articles within easy reach; Reinforce w/c (wheelchair) safety as needed such as locking brakes; visual monitoring as resident allows; FALL RISK (FYI);	F 657		

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F 657	Continued From page 27 Reinforce need to call for assistance." The care plan was not updated to include increased interventions/supervision to prevent further falls with injury. On 02/06/2019 at approximately 3:20 p.m., was interviewed regarding staff interventions to supervise Resident #34. The DON was asked if she felt the interventions on the care plan were sufficient to supervise and prevent Resident #34 from falling. She stated, "We have an opportunity to increase her supervision...the care plan could be better." No further information was obtained prior to the exit conference on 02/07/2019.	F 657		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed, for one of 33 residents in the survey, to ensure a nurse was knowledgeable of the resident's resuscitation status. A nurse caring for Resident #101 stated the resident's resuscitation status was a "DNR" (do not resuscitate) when the resident was actually a full code, requiring resuscitation in case of cardiac arrest.	F 659	**F 659** **Qualified Persons** **I** **Correction** Resident #101 is now a full code. All documentation has been changed to reflect full code status.	

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F 659	Continued From page 28 The findings include: Resident #101 was admitted to the facility on 1/9/19 with diagnoses that included cerebral infarction, tachycardia, congestive heart failure, high blood pressure, deep vein thrombosis, anxiety, depression and atrial fibrillation. The minimum data set (MDS) dated 1/16/19 assessed Resident #101 with short and long-term memory problems and severely impaired cognitive skills. The first page of Resident #101's clinical record stored on the unit documented a Durable Do Not Resuscitate Order (DDNR) dated and signed by the physician on 1/12/19. The record documented a physician's progress note dated 1/12/19 stating, "DNR signed." The resident nor the authorized representative had signed the DDNR order. Resident #101's plan of care (revised 1/11/19) listed the resident's resuscitation status as "full code." On 2/6/19 at 8:05 a.m., the licensed practical nurse (LPN #7) caring for Resident #101 was interviewed about the resident's current resuscitation status. LPN #7 stated, "She [Resident #101] is a DNR." When asked how she knew the code status of residents, LPN #7 went to the chart area and stated residents with a DNR order had a red sheet in the front of their chart. Resident #101's chart was reviewed at this time with no red sheet positioned at the front of the chart but the DDNR form was on file. The registered nurse unit manager (RN #4) came up at this time and stated Resident #101 was a "full code" because the family had not signed all the	F 659	**II** **Identification** All residents have the potential to be affected. a. The facility provided immediate re-education to the nurse on the DNR process. **III** **System changes** Facility will conduct re-education to all nursing staff on the DNR process.	

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F 659	Continued From page 29 required paperwork for the do not resuscitate order. On 2/6/19 at 8:07 a.m., RN #4 was interviewed further about Resident #101's resuscitation status. RN #4 stated for those with a DNR order, a red sheet was placed in the front of the chart and nurses were supposed to look for the red sheet to know the resuscitation status of residents. On 2/6/19 at 1:50 p.m., RN #4 stated she thought LPN #7 saw the DDNR form in the front of the record and thought the resident was a DNR. These findings were reviewed with the administrator and director of nursing during a meeting on 2/6/19 at 5:00 p.m.	F 659	**IV** **Monitoring** In order to ensure ongoing compliance, the facility will conduct random quizzing of 4 nursing staff weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of compliance** **3/23/2019**	
F 677 SS=D	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, clinical record review, and staff interview, the facility staff failed to ensure two of 33 residents (Resident #119 and Resident #45) were provided with care and services to carry out activities of daily living (ADL's). 1. The facility staff failed to provide Resident #119 with feeding assistance during a breakfast meal service. 2. The facility staff failed to provide Resident #45 with nail care.	F 677		

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F 677	Continued From page 30 The findings include: 1. Resident #119 was admitted to the facility was originally admitted to the facility on 06/05/13 and readmitted on 11/15/16. Diagnoses included gastroesophageal reflex disease (GERD), peripheral vascular disease, hypertension, hypothyroidism, hyperlipidemia, and dementia without behavioral disturbance. The most recent minimum data set (MDS) dated 01/15/19 assessed Resident #119 as severally cognitive impaired with a score of 04. A dining observation was conducted on the second floor during breakfast on 02/5/19 at approximately 9:00 a.m. During the observation at 9:13 a.m., Resident #119 was observed seated in the the second floor dining room alone. There were no other residents or staff members in the dining room with Resident #119. Resident #119 was observed sitting at the first table sleeping at the table. Resident #119 was not wearing a clothing protector. Resident #119's shirt was observed with oatmeal spilled on her shirt, and some on the edge of the table. Resident #119 meal ticket documented a therapeutic diet as "mechanical soft." Resident #119's meal tray was observed with the following: cereal with milk poured in the cereal container, half-eaten bowl of oatmeal with the spoon inserted in the bowl, a cup of coffee, and orange juice with a straw inserted in the container. Resident #119 continued to sleep and no other residents or staff came into the dining room until prompted by this surveyor to check on the	F 677		

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F 677	Continued From page 31 resident at 9:18 a.m. On 02/05/19 at approximately 9:20 a.m., the unit manager (LPN #1) was interviewed regarding Resident #119 being alone in the dining room. LPN #1 stated the majority of the second floor residents eat breakfast in their rooms. LPN #1 stated there are a 3 to 4 residents who eat breakfast in the second floor dining room. LPN #1 stated one of those residents had an early morning appointment and he was not sure where the other residents were this morning. LPN #1 was asked about Resident #119 being left alone in the dining room. LPN #1 stated Resident #119 should not have been left alone. LPN #1 was asked about Resident #119 having oatmeal on her clothing and the edge of the table. LPN #1 stated this was not appropriate. LPN #1 stated the certified nursing assistants and nursing staff are expected to assist with meal set-up and service and someone should remain in the dining room while residents are eating meals. During the interview with LPN #1, LPN #1 was observed asking a second staff member identified as registered nurse (RN #1) why Resident #119 was left alone in the dining room. RN #1 stated she left Resident #119 to go and get something for another resident. On 2/5/19 at approximately 11:00 a.m., Resident #119's clinical record was reviewed. A review of Resident #119's physician orders documented the following: "Diet - Regular diet - Mechanical Soft texture. Order Date: 11/22/2016. Start Date 11/22/2016." The most recent minimum data set (MDS) dated 01/15/19 under Section G, functional status assessed Resident #119 for eating as requiring supervision, with one person	F 677	**F 677- ADL Care Provided for Dependent Residents** **I Correction** Resident #119 had no adverse effects; resident is now an assisted feeder. Resident #119	

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F 677	Continued From page 32 physical assist. A review of Resident #119's care plans documented the following: "Focus - ADL Self care deficit decline in mobility, cognition. Date Initiated: 06/06/13, Revision: 08/10/18. Goal - Will receive assistance necessary to meet ADL needs. Interventions: Assist with daily hygiene, grooming, dressing, oral care and eating as needed." "Focus - At risk for chewing/swallowing problems r/t (related to) edentulous. Date Initiated 05/16/2014 Revision: 08/10/18. Goal: To be able to chew/swallow with no difficulties. Interventions: Report changes in oral cavity, chewing ability, S&S (signs and symptoms) oral pain, etc." On 02/06/19 at approximately 9:30 a.m., the certified nursing assistant (CNA #1) who routinely assists Resident #119 was interviewed regarding Resident #119 needing assistance with meals. CNA #1 stated Resident #119 needs assistance and cueing during meals. CNA #1 stated Resident #119 eats more when someone assists her at meals. On 02/06/19, at approximately 9:45 a.m., RN #3 who routinely provides care for Resident #119 was interviewed regarding Resident #119 needing assistance with meals. RN #3 stated Resident #119 eats about 50-75% with assistance and encouragement from staff during all meals. RN #3 stated Resident #119 requires assistance and cueing at all meals. These findings were reviewed with the	F 677	now has a care plan as an assisted feeder. **II Identification** All residents have the potential to be affected. a. The facility will conduct an audit of all residents during meal time to ensure residents who require assistance with feeding are provided with feeding assistance. Care plans of residents identified requiring assistance with feeding would have their care plan reflecting their feeding status.	

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F 677	Continued From page 33 administrator, director of nursing (DON) and corporate consultant during a meeting on 02/06/19 at 4:45 p.m. 2. Resident #45 was admitted to the facility on 04/05/2018 with the following diagnoses, but not limited to: Cerebral infarction, Flaccid hemiplegia effecting the left (non-dominate side), hypertension, and dysphagia. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/04/2018, assessed Resident #45 as cognitively intact with a cognitive summary score of "14". On 02/05/2019 at approximately 8:20 a.m., Resident #45 was observed lying in bed, watching television. She was interviewed regarding life at the facility. Resident #45 stated that she had been there almost a year due to a stroke. She stated that she was unable to use her left side. The fingernails on her right hand were observed. They were long, soiled with brown debris, and yellow in color. She was asked if she was letting her nails grow. She stated, "No, I would like to get them cut, they are too long." She was asked if the nails on her left hand were the same length. She stated, "Yes." She used her right hand to pull her left hand from under the covers, turn it over and pry it open to show the nails on her left hand. The nails on her left hand were also long. The fingers on her left hand were contracted, pressing the long nails against the palm of her hand. Resident #45 was asked if the nails were cutting into her hand. She stated, "Not yet." She was asked if she was a diabetic. She stated, "No, not that I know of." She was asked who normally cut her nails for her. She stated, "It's been a long time since they've been cut, I don't really remember who cut them last time or	F 677	**System changes** Facility will provide education to the nursing and dietary staff. **IV Monitoring** In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and	

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F 677	Continued From page 34 when." On 02/06/2019, LPN # 1, a unit manager was interviewed regarding nail care at the facility. He stated, "Unless the patient is a diabetic, anyone, the nurses or the CNAs [certified nursing assistants] can cut them, if they are diabetic we get podiatry." He was asked how often nails were cut. He stated, "As needed." He was asked specifically about Resident #45's nails. He stated, "She is not a diabetic, anyone could do them." LPN #1 and this surveyor went to Resident #45's room to look at her nails. The nails on both hands had been trimmed and were filed. Resident #45 was asked when her nails were cut. She laughed and stated, "Somebody must have heard us talking about them yesterday...they came in here last night and worked on them...they cut them back and filed them...they feel so much better...I was afraid to scratch an itch for fear of drawing blood." After leaving the room LPN #1 was asked who looked at the nails of residents to determine if they needed to be cut. He stated, "The CNA should look every time a bath is given and provide the care then." A copy of the facility policy regarding nail care was requested from the DON (director of nursing). The policy contained the following: "Purpose: To provide for personal hygiene needs and prevent infection." The policy also contained information regarding the equipment needed to perform nail care and the procedure but did not address the frequency. No further information was obtained prior to the exit conference on 02/07/2019.	F 677	Assurance Committee will determine the need for further audits and/or action plans. I Resident #45 had no adverse effects. Residents nails were cleaned and trimmed. II All residents have the potential to be affected. a. The facility will conduct an audit of all residents to assure nails are cleaned and trimmed. b. Immediate corrective actions will be taken. III Facility will provide education to the nursing staff. IV In order to ensure ongoing compliance, the facility will conduct weekly checks on 5 residents weekly for four weeks and once a month for two months. Data collected will be	

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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 medication pass and pour observation, staff interview, resident interview and clinical record review, the facility staff failed to administer medications per physician order. Resident #117's Symbicort inhaler was not administered per physician orders. Findings were: Resident #117 was admitted to the facility on 11/12/2018 with the following diagnoses, but not limited to: Paraplegia, acute kidney failure, hypertension, chronic obstructive pulmonary disease, and neuromuscular dysfunction of the bladder (requiring indwelling catheterization). A significant change MDS (minimum data set) with an ARD (assessment reference date) of 1/14/2019, assessed Resident #117 as cognitively intact, with a summary score of "15". On 02/05/2019 at approximately 8:15 a.m., a medication pass and pour observation was conducted with LPN (Licensed practical nurse) #3 on the third floor. LPN #3 prepared morning	F 684	forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of compliance 3/23/2019** **F 684- Quality of Care** **1.** **Correction** Resident #117 had no adverse effects. LPN #3 has been educated on the appropriate dispensing of symbicort inhaler. **II** **Identification** All residents have the potential to be affected.	

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F 684	Continued From page 36 medications for Resident #117, which included but were not limited to: Spiriva 18 mcg inhaler (2 puffs), Symbicort 160-4.5 mcg (2 puffs), and other oral medications to be taken in tablet form. LPN #3 took the medication to Resident #117's room. Resident #117 was sitting up in bed watching television. Her bedside table was across her over the bed. LPN #3 placed all the medications on the bedside table. Resident #117 picked up the Symbicort inhaler and put it back down stating, "I don't want to start with that one." She then took her oral medications and then used her Spiriva inhaler. She handed the Spiriva inhaler and the Symbicort inhaler back to LPN #3. He stated, "Did you use this one (holding up the Symbicort)?" Resident #117 nodded her head and stated, "Yes, I think so." LPN #3 returned to the medication cart and put the inhalers away. LPN #3 was asked if he was through with Resident #117's medication administration. He stated, "Yes." LPN #3 was informed that Resident #117 had not used her Symbicort inhaler. He removed the inhaler from the cart looked at it and returned to Resident #117's room. He stated, "You didn't use your Symbicort inhaler...I know that because the numbers on the inhaler count down when you use it, they have not changed." Resident #117 stated, "You're right, I picked it up first and then I set it to the side." Resident #117 used her inhaler without difficulty. No further information was obtained prior to the exit conference on 02/07/2019.	F 684	a. The facility will provide immediate re-education to the nurse on medication administration of inhalers. **III** **System changes** Facility will provide education to nursing staff on medication administration of inhalers. **IV** **Monitoring** In order to ensure ongoing compliance, the facility will conduct random medication pass audits for use of inhalers 2 nurses weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 37 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, facility staff failed to ensure two of four residents identified as "smokers" were assessed to determine if they were safe to smoke either independently or were at risk. The residents, one of whom was paraplegic, were observed outside without protective aprons and without direct supervision by facility staff. This was identified as Immediate Jeopardy (IJ) in the area of Quality of Care on 02/05/2019 at 5:01 p.m., with resulting SQC (substandard quality of care). The immediacy was abated on 02/05/2019 at 8:23 p.m. After removal of the immediate jeopardy on 02/07/2019 at 9:30 a.m., the Scope and Severity was lowered to Level III, Isolated. The facility staff also failed to implement interventions and supervision for the prevention of elopement, multiple falls, and falls resulting injury (Harm) for two of 32 residents, and failed to immediately respond and implement safety interventions in response to an emergency door alarm on one of seven units, the 100 unit. 1. Resident #117, a paraplegic, was not assessed to determine her ability to smoke safely and independently. Resident #117 was observed	F 689	action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of compliance 3/23/2019** **F689** **Free of accident hazards/Supervision/Devices** It is the practice of the facility to ensure that (1) residents environment remains as free of accident hazards as is possible, and (2) that each resident receives adequate supervision and assistance devices to prevent accidents.	

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F 689	Continued From page 38 outside smoking cigarettes without a protective apron and without direct staff supervision. This resulted in the identification of Immediate Jeopardy. 2. The facility staff failed to provide adequate supervision to prevent elopement from the facility, multiple falls and falls with injury (harm) for Resident #34. Resident #34 was found in the parking lot on 05/26/2018 requiring evaluation at a local hospital, she had multiple documented falls at the facility including three incidents of harm: a fall with resulting acute proximal humeral shaft fracture on 08/11/2018; a fall on 08/18/2018 with resulting laceration above her right eyebrow requiring 13 sutures; and an acute fracture of the proximal phalanx (ring finger) that was identified on 12/02/2018. 3. The facility staff failed to implement interventions and supervision for the prevention of falls for Resident #129, which resulted in harm. Resident #129 had a fall and was sent to the hospital for evaluation, receiving five staples to the back of the head for a laceration. 4. The facility staff failed to accurately assess Resident #60's ability to smoke independently or safely without direct supervision. 5. Facility staff failed to immediately respond and implement safety interventions in response to an emergency door alarm on the 100 unit. The alarm sounded for almost 30 minutes without any response or interventions from staff members present on the unit. A charge nurse interviewed was not knowledgeable about the alarm or what actions were required in response to the alarm.	F 689	**I** **Corrections** Resident #117 now wears a protective apron and has direct supervision during smoking. The identified immediate jeopardy was corrected and abated upon identification during the survey. Resident #34 has not eloped since 5/26/2018 as she now wears a wander guard. Resident #34 now has a revised care plan for falls to minimize falls with injury. Resident #129 no longer resides in the facility. Resident #60 now has a smoking assessment completed and care plan developed and implemented regarding smoking, and is now being	

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F 689	Continued From page 39 Findings were: 1. Resident #117 was admitted to the facility on 11/12/2018 with the following diagnoses, but not limited to: Paraplegia, acute kidney failure, hypertension, chronic obstructive pulmonary disease, and neuromuscular dysfunction of the bladder (requiring indwelling catheterization). A significant change MDS (minimum data set) with an ARD (assessment reference date) of 1/14/2019, assessed Resident #117 as cognitively intact, with a summary score of "15". Section J: Health Conditions, J1300 "Tobacco Use" was checked "No." In the course of the survey process a list of "residents who smoke" was requested from the administrative staff. Resident #117 was identified on the list as a "smoker." The clinical record was reviewed on 02/05/2019 at approximately 2:00 p.m. A smoking assessment was not observed on the electronic record. The care plan was reviewed. There were no interventions on the care plan regarding smoking. On 02/05/2019 at approximately 3:30 p.m., Resident #117 was interviewed. She was asked if she was a smoker. She stated, "Yes, but I don't smoke everyday, or every smoke break...I usually just go down once a day...I went for so long without smoking because I was so sick, but I've started again... I am going out today at 4:00 [p.m.]." Resident #117 was asked where she kept her cigarettes. She stated, "They are downstairs with my lighter." During the interview, Resident #117 was asked if she could move her	F 689	directly supervised during smoking. The LPN and RN nurses identified during the survey as not being knowledgeable about the alarm or what actions required in response to the alarm have been educated on the alarm and what is required to be done in response to an alarm sound.	

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F 689	Continued From page 40 legs or had any feeling in them. She stated, "No, they said I have a clot on my spine that is causing it [paralysis]...I don't know if my legs will get better or not." At 4:00 p.m., two surveyors went to the smoking area to observe the residents. The area was located at the end of the facility outside the dining room. OS (Other Staff) #2 was standing in the dining room at the door to the smoking area. She entered a code and allowed the surveyors to walk outside. The smoking area was a covered cement patio with a locked privacy fence in front of it. The dining room door was the only entrance back inside the building and had a narrow, long window above the door knob. The window in the door was the only indoor point of visualization to the smoking area. Three residents were observed smoking. One resident was wearing an apron. OS #2 came outside and offered the other two residents an apron. Both residents declined. OS #2 went back inside the building. Resident #117 was not wearing an apron. She was sitting with her back to the door and her smoking could not be visualized from inside. The residents were talking and Resident #117 stated, "My husband brought me some cigarettes, I need to bring them downstairs to the desk, I forgot them in my room." When the observation was complete, OS #2 opened the door for the surveyors to come back into the facility. She was asked what her role was. She stated, "I'm here for the smoking time, but I'm not going out there...I don't smoke." A sign was observed beside the door with posted smoking times and the following sentence: "Smoking aprons must be worn at all times..."	F 689	**II** **Identification** Residents, staff, and visitors have the potential to be affected by these deficient practices. **III** **System changes** The facility has completed an audit of all residents present in the facility up to 2/7/2018 for	

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F 689	Continued From page 41 A copy of the facility policy was requested at 4:10 p.m. The corporate nurse and the DON (director of nursing) stated that the smoking guidelines were located in the resident admission packet. The "Patient Information Handbook" was reviewed. Page 3 contained the following information regarding smoking: "SMOKING We believe in providing a healthy environment for you. Our center is designated as 'smoke-free.' Smoking is not permitted on the campus or may be permitted in designated area only. Smoking materials, including lighters, matches, cigarettes, and cigars, must be stored at the nurse's station." The DON was again asked if there was a facility policy regarding smoking. She stated, "We are looking for it...what we have are called 'guidelines', not a policy." The "SMOKING GUIDELINES" included the following information: "PURPOSE: To determine if a patient is an Independent Smoker or an At Risk Smoker before the patient exercises the privilege to smoke while residing within the center and to establish guidelines for all patients that desire to smoke, as well as non-smokers." "GUIDELINES: - Evaluate patients that smoke utilizing the Smoking Evaluation tool either: (a) upon admission; (b) when a previous non-smoking patient takes up smoking; (c) if unsafe smoking practices are observed in a current smoker; or, (d) when a patient that smokes has a significant change in medical condition. -The Smoking Evaluation is generated from the	F 689	smoking. No new smoker was identified above those it currently has on the smoking list. The facility continues to complete smoking assessments for all residents admitted since the survey and will continue with such plans going forward. All new smokers will be added to the smoking list, following the completion of care plans for smoking, and would be directly supervised, if needing supervision. The facility has completed education of its staff regarding the facility's smoking policy on 2/7/2019. The facility will continue training its staff on fire doors alarm and response actions needed. The facility will complete an education on the revision of	

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F 689	Continued From page 42 assessment tab in [name of computer system]. -Provide education of the Smoking Guidelines to the patient, family members or responsible party and visitors that may supervise patients during smoking. Education is provided when: (a) a new patient is identified as a smoker; (b) a previous non-smoker patient takes up smoking; (c) if unsafe smoking habits are observed in a current smoker; or, (d) a patient that smokes has a significant change in medical condition. The education is documented and saved in the patient's electronic health record utilizing the Patient Education Progress Note or per state requirements.... -Upon completion of the evaluation, the Interdisciplinary team [IDT], including the attending physician, will make a decision whether the patient is an Independent or an At Risk Smoker. -If the patient is determined to be an Independent Smoker, the patient may smoke without assistance at center designated times. Independent Smokers must still follow smoking guidelines including, but not limited to, keeping smoking accessories in control of the center staff when not in use and smoking only in designated areas at designated times. -If the patient is determined to be an At Risk Smoker, the patient is required to wear a protective smoking vest or apron if needed and is supervised while smoking. -The IDT completes completes a comprehensive patient care plan that reflects the: -smoking evaluation outcome -smoking supervision that is necessary -type of protective smoking equipment that is needed, e.g., smoking apron or vest - education on the Smoking Guidelines and options for smoking cessation activities offered and/or provided to the patient or family members...	F 689	care plans related to fall following every fall. **V** **Monitoring** The administrator or designee will complete random audits for compliance regarding smoking assessments and care plan completion, fire alarm response, and fall care plan revision weekly for 4 weeks and randomly thereafter for 2 months. Data collected will be	

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F 689	Continued From page 43 -Direct personal supervision is provided to At Risk Smokers while smoking. Center administration provides supervision and direction to center staff responsible for providing direct supervision. Other patients cannot, under any circumstances, provide supervision for At Risk Smokers... -Any non-compliance with the smoking guidelines is addressed with the patient and family members as the non-compliant activities occur. Additional education is provided as needed and the plan of care is updated to reflect the patient's current needs..." The survey team met to discuss the smoking observations, the lack of smoking assessment, care plan, and supervision for Resident #117, a paraplegic. The team determined that guidelines for Immediate Jeopardy were met. The team supervisor and the State agency were contacted for validation. The office concurred and Immediate Jeopardy was implemented at 5:01 p.m., with subsequent Substandard Quality of Care. On 02/05/2019 at 5:11 p.m., the survey team met with the administrator and the DON (director of nursing). The team leader informed them that the survey team with concurrence from the main office had implemented Immediate Jeopardy at 5:01 p.m., and SQC due to the facility's failure to assess Resident #117, a smoker with paraplegia for safe smoking. They were told that Resident #117 was observed outside smoking without a protective apron, without direct supervision, without a care plan or assessment for smoking, and that her MDS did not identify her as a smoker. The administrator was informed that a plan of removal for immediacy would need to be developed and presented to the survey team for	F 689	forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **3/23/19**	

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F 689	Continued From page 44 approval before the immediacy would be abated. The facility staff presented the following five point plan of correction that was accepted by the survey team on 02/05/2019 at 8:23 p.m.: "This serves as Manor Care Health Services Arlington [sic] response to the Immediate Jeopardy Notification that the center received on February 5, 2019. The facility Quality Assessment and Performance Improvement [QAPI] Committee met on February 5, 2019 to resolve the alleged failure to assess a smoking patient for smoking needs. 1. Resident [initials of Resident #117] was observed smoking without direct supervision. Further investigation also showed that the same resident does not have a smoking assessment on record, there was no care plan completion, and there was no MDS assessment completed. The resident, [initials of Resident #117], has been educated regarding the facility smoking policy. 2. The facility has completed a smoking assessment on [initials of Resident #117] today, 2/5/19. The patient's care plan has been completed to reflect her smoking status. Furthermore, a significant change in status MDS for [initials of Resident #117] has been initiated. The staff responsible for smoking supervision have been educated on direct supervision and use of apron during smoking. 3. The facility would [sic] continue to educate the entire staff on Manor Care's smoking policy. Education has begun today, 2/5/2019, and anticipated to be completed by end of day, 2/7/19.	F 689		

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F 689	Continued From page 45 4. The facility has completed an audit of all residents presently in the facility for smoking. No new smoker was identified above those it currently has on the smoking list. The facility will complete a smoking assessment for all new residents admitted in the facility going forward. 5. This plan of correction has been forwarded to an ad hoc QAPI committee for adoption or further recommendation." Also presented was a "Staff Development Program Attendance Record" with five staff listed who had received training on "DIRECT SUPERVISION FOR SMOKERS". The education attached was: "1. IF ANY RESIDENT IS NOT ON THE CURRENT SMOKERS LIST AND THEY COME OUT TO SMOKE. [sic] YOU MUST STOP THEM AND NOTIFY NURSING FOR RESIDENT TO HAVE SMOKING ASSESSMENT COMPLETED TO DETERMINE THEIR SAFETY. THE SUPERVISOR OF SMOKERS WILL CHECK THE CURRENT LIST TO ENSURE ONLY THOSE RESIDENTS LISTED ARE SMOKING. 2. WHILE OBSERVING THE SMOKERS YOU WILL NEED TO MAINTAIN VISUAL CONTACT AND ENSURE RESIDENTS ARE FACING YOU. 3. WHEN INDICATED ENSURE THE RESIDENT HAS SMOKING APRON ON. 4. NURSING/DESIGNEE WILL UPDATE THE SMOKERS LIST FOR NEW ADMISSIONS AND CHANGES OF CONDITIONS AS NEEDED." Resident #117's smoking evaluation was	F 689		

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presented and reviewed. Resident #117 was assessed by the facility as an "At Risk Smoker, Requires family, friend or staff for physical support or supervision to smoke...Patient able to smoke with apron, and educated on times and need for smoking materials to be secure during non-smoking hours."

On 02/07/2019, during the morning, the survey team conducted random interviews throughout the facility to ascertain that staff had received the training outlined on the plan of removal. All interviewees had been trained and were knowledgeable regarding the facility's smoking policy. The facility checklist indicated that all staff had received training as of 9:30 a.m. on 02/07/2019.

No further information was obtained prior to the exit conference on 02/07/2019.

2. Resident #34 was admitted to the facility on 05/15/2018. Her diagnoses included but were not limited to: Type II Diabetes Mellitus, Parkinson's disease, dementia with behavioral disturbance, major depressive disorder, and hypertension.

Her admission MDS (minimum data set) with an ARD (assessment reference date) of 05/22/2018 coded Resident #34 as having impairment with both long and short term memory, and severely impaired for daily decision making skills. Resident #34 was also coded as needing limited assistance of one for walking in her room and in the corridor. Under the area "Balance During Transitions and Walking (G0300) she was coded as "Not steady, only able to stabilize with staff assistance" in the areas of "Moving from seated to standing position; Walking; turning around;

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F 689	Continued From page 47 moving on and off toilet; and surface-to-surface transfer." The quarterly MDS with an ARD of 11/22/2018 also coded Resident #34 as impaired with both long and short term memory, and severely impaired for daily decision making skills. She was coded as needing limited assistance of one for walking in her room and in the corridor. Under the area "Balance During Transitions and Walking" she was coded as "Not steady, only able to stabilize with staff assistance" in the areas of "Moving from seated to standing position; Moving on and off toilet; and surface-to-surface transfer"; and coded as "Not steady, but able to stabilize without staff assistance" in the areas of "Walking and turning around." Resident #34's room was located at the end of the the unit on the second floor. Her room was not visible from the nurses station. On 02/05/2019 at approximately 9:15 a.m., Resident #34 was observed in her room eating breakfast. She was sitting in a chair beside her bed. Food was on the floor around her, she got up and down out of the chair and walked to a different chair in her room and then returned to the chair where her breakfast tray was located multiple times. When an interview was attempted Resident #34 spoke no English. No staff was in the vicinity to assist her. On 02/05/2019 from approximate 2:30 p.m. until 2:35 p.m., Resident #34 was observed walking around her room. She was wearing only a wander guard and a sock on her left foot. She walked back and forth from a chair in her room to her bed. She was observed to lay down in the bed,	F 689		

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cover up and then immediately get back up. Her clothes and brief were in a pile on the floor. This surveyor walked around the third floor looking for someone to assist Resident #34; a CNA (certified nursing assistant) was located at the far end of the floor and was asked if she was working with Resident #34. She stated, "No, I am on the other end. What does she need." When the situation was described the CNA went to the room to assist Resident #34.

The clinical record was reviewed on 02/05/2018 at approximately 6:30 p.m. Review of the progress note section indicated that Resident #34 had a history of wandering, falls and falls with injury. The clinical record included documentation of approximately 17 falls, 2 elopements, two fractures and two lacerations requiring sutures/staples since admission to the facility.

Documentation in the progress notes included the following:

"05/15/2018 23:47 (11:23 p.m.) Patient present(s) with diagnosis of weakness, post status fall, deep dark bruises on her body, bruises and bumps on the forehead, red scabs to both knees, confusion, mental status change, she speaks and understands very little English...

05/16/2018 4:20 [a.m.] ....she is monitored frequently as she gets up unassisted and gait is unsteady...

05/17/2018 08:51 [a.m.] Resident found lying on the floor at 11:55 p.m....no signs of discomfort...

05/29/2018 07:34 [a.m.] Patient is alert, stable and very confused, refuses to stay on the bed or

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F 689	Continued From page 49 chair, trying to get up but she does not have good gait or good balance, staff have [sic] baby siting [sic] most of the night... 05/17/2018 16:56 [4:56 p.m.] POST FALL NURSES ASSESSMENT; Resident was very combative and refused to stay sitting on her W/C [wheelchair]. Resident was put in bed to rest and few minutes later, she got up and began to walk down the hall-way to 2-west unnoticed by staff. She accidentally fell in room [number] @1:30 p.m. today...no new skin impairment... 05/23/2018 00:07 [12:07 a.m.] Patient found on the floor on her right side by 3 E [east] [not Resident #34's floor] nurses station during shift change. Staff reported she has been wandering around most of the shift...[no injury] 05/26/2018 11:45 [a.m.] Front desk paged writer and stated come down stair [sic] to see resident for Spanish Interpreter, came to front desk and saw resident with fire department, ambulance, stated they found her in Manor Care back of the parking lot...MD gave order to transfer resident to ER for evaluation... 05/26/2018 16:54 [4:54 p.m.] Resident is alert and oriented...Resident up walking independently...writer saw resident around 11:15 a.m. sitting in Longue [sic]with no distress noted...At 11:45 [a.m.] supervisor call writer stated come in front desk [sic], noted resident with fire department, ambulance, they stated they found her in back of Manor Care parking lot...send to ER... 05/26/2018 20:01 [8:01 p.m.] Patient skin reveals bruises to the lower left back, left temple and right	F 689		

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F 689	Continued From page 50 arm possible from the reported fall on 5/23/18. She returned from ER for evaluation to rule out dehydration...[physician name] notified for wander guard for safety. 06/11/2018 17:00 [5:00 p.m.] Patient fell out of the facility on her way in for readmission. She was discharged home early at 10:00 AM with her daughter...writer was told that she [Resident #34] refused to stay at [name of facility] and returned to Manor Care...She fell at door entrance and got a cut on the back of her head...911... 06/11/2018 22:59 [10:59 p.m.] Patient was readmitted from [hospital]...patient has stitches in her head related to fall: wounds noted on the head. One has 4 staples and the other has 1 staple... 06/21/2018 13:08 [1:08 p.m.] Resident is confused, while transferring from bed to w/c lost her balance and sat on floor... 08/11/2018 08:18 [a.m.] Resident was alert with intermittent confusion. Neurocheck was in progress....send resident to emergency department to evaluate for acute proximal humeral fracture via 911...order due to X-ray result shown [sic] fracture on the proximal hum oral shaft...[NOTE: No documentation in clinical record regarding aforementioned x-ray or fall] 08/11/2018 11:32 [a.m.] During AM care this writer was called to resident room by CNA [certified nursing assistant] stating resident right elbow appears swollen. On assessment skin warm to touch, no redness noted in skin, resident alert and verbal, s/s [signs and symptoms] of grimacing noted while touching right	F 689		

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F 689	Continued From page 51 elbow...limited ROM [range of motion] on right extremity... 08/11/2018 12:44 [p.m.]...on call MD notified...new order given to do x-ray of shoulder 2 views... 08/11/2018 13:10 [1:10 p.m.] ...spoke to RP [responsible party] that she [Resident #34] has an accident and fell from her bed. Neurochecks initiated. 08/11/2018 16:39 [4:39 p.m.] Resident fell in front of her room while ambulating to her room to use the bathroom around 2:00 p.m....no apparent injury, redness noted in left side of the head, passive ROM in left upper extremity and both lower extremities within normal limits...right upper extremity has limited ROM... 08/11/2018 18:00 [6:00 p.m.] Mobile tech in X-ray done results pending. 08/11/2018 08:30 [a.m.] [Name] emergency was called to ascertain patient condition and her nurse...indicated that her doctor might discharge her back today. 08/12/2018 16:36 [4:36 p.m.] Resident arrived back from [name] er at 3:45 p.m....noted on her left upper side of the face slightly swollen with redness, right upper shoulder noted swollen, with bruising, and the right lower arm in a cast wrap with ace wrap and in sling...left fifth finger noted with old open area but dry measuring 0.5 cm X 0.5 cm, left knees noted with open area measuring 2.0 cm X 1.0 cm, below left knee noted with scabbed measuring 1.0 cm X 1.0 cm...	F 689		

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F 689	Continued From page 52 08/12/2018 19:58 [7:58 p.m.] ...came back with diagnosis of closed fx [fracture] of right proximal humerus...During skin assessment old healing scar with scabbed [sic] noted to the back of the head, right upper shoulder at the back noted with open area measuring 1.0 cm X 1.0 cm, mid back noted with open area measuring 2.0 cm X 0.3 cm and also another tiny open area to mid back measuring 0.3 cm X 0.3 cm and at the right outer back noted with old healed scar.....resident pulling on her cast and sling... 08/18/2018 10:40 [a.m.] Writer calle [sic] at this time to attention stating resident fell in lunch room on west side and sustained a laceration to upper right eyebrow measured 4 cm X 2 cm with large amount thick red blood from site. Ice pack applies to site...resident transferred to [hospital name] at 10.5 am {sic], report given to ER nurse. 08/18/2018 15:36 [3:36 p.m.] Resident back from the hospital...13 sutures noted intact to facial laceration...Resident in bed at this time but trying to get out of the bed... 08/21/2018 08:23 [a.m.] Patient was found sitting [on] the floor at 7:30 a.m., neurological check done and no change notice [sic] 08/21/2018 16:56 [4:56 p.m.] Loud Portuguese language heard coming from the room and this writer went to check, patient was observed lying on her right side, the right arm on the pillow. No apparent injury noted, skin assessment done, resident noted with right eye lid dark purple color, and stitches in place in right forehead close to right eye, large dark purple discoloration noted in right thigh all those from previous falls...resident was transferred with tow assist to bed, bed was in	F 689		

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F 689	Continued From page 53 low position. 08/28/2018 01:54 [a.m.] ...very combative with staff going from room to room unsteady on her feet, requires one on one monitoring to prevent falls... 09/05/2018 19:50 [7:50 p.m.] ...called writer to room and resident was observed on the floor at 6:20 p.m. lying on her right side beside the entrance door. Based on observation, resident was consuming her dinner meal when she decided to got [sic] up and walk from his [sic] Mw/c and she accidentally fell to the floor at 6:30 p.m. today. Resident assessed head to toe...no new skin impairment...ROM performed...no limitations noticed except little limitation observed on her right fractured humerus from post fall recently... 09/21/2018 15:41 [3:41 p.m.] Resident was observed sitting in wheelchair at the nursing station with other residents at 2:25 p.m. This writer went to assist the aide to transfer another patient from the chair to bed, when she came out of the room this patient was observed sitting on the floor...no apparent injury observed... 09/23/2018 22:35 [10:35 p.m.]...oob to w/c sitting in front of nurses station and as soon as staff goes to attend to other resident, resident will get up from her w/c and ambulate to other resident room and nurse redirected back to her w/c... 10/06/2018 15:26 [3:26 p.m.] Resident was observed at 1:55 PM sitting on the floor in front of her room, bedside table behind her...no apparent injury...resident was last seen lying in her bed resting around 1:40 p.m...	F 689		

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F 689	Continued From page 54 11/17/2018 17:35 [5:35 p.m.] ...at 4:10 p.m. sitting in her w/c in front of nurses station, per assign [sic] cna resident wants to stand up, her w/c was locked but the w/c moved a little bit and resident slide [sic] to the floor. Assign [sic] cna said she hold resident on one side and she try to hold resident on the other side but resident slide and sit on floor and resident head, a little bit touch on the wall...no apparent injury...do neurochecks for 24 hours..if any change in mental status send resident to ER... 11/28/2018 00:07 [12:07 a.m.] Resident is alert and very confused wander into physical therapy room and lock self up in there the room several attempt patient before patient open room, skin audit done assessment done no acute distress noted... 12/02/2018 16:50 [4:50 p.m.] ...resident ambulating in her room when nurse making round at the start of shift at 3:05 PM and no distress noted...staff from activity dept came and wheeled resident to activity upstairs in w/c before 3:30 p.m. Daughter visited and nurse told daughter that resident went upstairs with activity...daughter went upstairs and came down with resident and daughter brought to nurse [sic] attention of resident left 4th finger reddening and swollen. When nurse asked resident what happened resident stated "I hit it somewhere 2 days ago and it pain a little"...left 4th finger assessed noted swollen and reddening 4th palm noted bruising...daughter requesting x-ray... 12/03/2018 18:26 [6:26 p.m.] ...x-ray results positive for acute fracture of the proximal phalanx of the ring finger...to schedule appointment with	F 689		

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F 689	Continued From page 55 ortho... 12/08/2018 09:57 [a.m.]...resident walking in the hallway all naked. Aide working with this resident was in the shower room given [sic] shower to resident in room [number]. Writer took resident in the room, provided ADL care and dress resident... 12/08/2018 16:28 [4:28 p.m.] Writer was called to attention by another staff stating resident is sitting on the floor at west unit station...resident in upright position on floor. Head to toe assessment done, no s/s pain noted... 02/01/2019 15:32 [3:32 p.m.] Resident was observed sitting on the floor in room [number] [NOTE: not Resident #34's room], no apparent injury noted... The care plan was reviewed at approximately 7:00 p.m. and contained the following focus area: "Exit seeking/elopement risk multiple attempts to leave facility related to: cognitive impairment, new admission/change of environment." Interventions listed included: "Accompany to meals and scheduled activities; ALERT BRACELET; Calmly redirect; Engage in activities/tasks to keep occupied.." An additional focus area for: "At risk for falls due to history of fall, recent fall, non steady gait, not using safe judgement D/T dementia disease process" was observed on the care plan. Interventions included: "Administer Calcium and Vitamin D per protocol; Administer medication per physician orders; All intervention reviewed and continue with plan of care; Bed in low position; Encourage resident to sit in front of nursing station; have commonly used articles within easy	F 689		

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F 689	Continued From page 56 reach; Reinforce w/c safety as needed such as locking brakes; visual monitoring as resident allows; FALL RISK (FYI); Reinforce need to call for assistance." On 02/06/2019 at approximately 7:50 a.m., the DON (director of nursing) was asked for any investigations/incident reports that had been completed on Resident #34 since her admission to the facility in May 2018. The DON was also asked if the facility used bed or chair alarms. She stated, "No." She was asked what the facility did to call attention to residents getting up unassisted who may fall. She stated, "We make frequent rounds and care plan them for falls." At approximately 8:00 a.m., RN (registered nurse) #1, the unit manager, RN #6 and LPN (licensed practical nurse) #3 were interviewed regarding Resident #34's wandering, falls, and falls with injury. All three were asked what was done by the facility staff to prevent her falls and injuries. RN #6 stated, "On nights we bring her with us." LPN #3 and RN #1 were asked what was done during day shift. LPN #3 stated, "We have a care plan that we follow." Concerns were voiced to RN #1 and LPN #3 that while the survey team had been in the building, staff had not been readily available on that end of the hallway. Observations of staff being at the far end of the floor when needed was voiced. Concern over the "visualization" of Resident #34 were also discussed. Resident #34's room was not visible from the nursing station. LPN #3 and RN #1 were asked how often Resident #34 was observed. RN #1 stated, "Yes, I see what you are saying...I am new here, I will see what we can do." At approximately 1:45 p.m., Resident #34 was	F 689		

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sitting in her room. Her daughter was at her bedside. The daughter was interviewed regarding Resident #34's care at the facility. The topic of Resident #34's falls were discussed. The daughter stated, "They talked to me just now about moving her to a room where they can see her better...my mother needs to be in a private room or she messes with other peoples things...the problem isn't her room, the problem is the staff is never down here where she is...they don't watch her...I always have to look for them when she needs something...the only time she is watched is when I am here...she can't go home with me because my home has steps, and she is less safe there."

At approximately 3:20 p.m., after multiple requests, the DON presented incident reports for Resident #34 and they were reviewed. The DON was interviewed regarding staff interventions to supervise Resident #34. The first elopement of Resident #34 on 05/23/2018 when she was found lying in front of the nurse's station on a different floor was discussed. The DON stated, "That's when we implemented the wander guard." The DON was informed that the wander guard was not implemented until Resident #34 was found in the back of the facility parking lot on 05/26/2018. She was asked if the wander guard should have been implemented when the resident was found on another floor of the facility after falling.. She stated, "Yes, I would think so." Resident #34's fall with fracture, fall with laceration requiring sutures, and the fracture of her finger were discussed. The DON was asked if she felt the interventions on the care plan were sufficient to supervise and prevent Resident #34 from falling. She stated, "We have an opportunity to increase her supervision...the care plan could be better...we

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F 689	Continued From page 58 could be giving her more supervision." There was no incident report for 11/28/2018 when Resident #34 locked herself in the physical therapy department. The DON was asked if the incident had been investigated. She did not answer. The DON was asked how Resident #34 had become locked in the physical therapy department on the second floor. She stated, "Someone must have left the door open or unlocked and she went in there." The DON was asked if the door to the therapy department was suppose to be closed and locked when not in use. She stated, "Yes." She was asked if she knew anything about the incident prior to our discussion. She shook her head side to side indicating, "No." On 02/06/2019 at approximately 3:40 p.m., the DON was notified that the incidents with Resident #34 were identified as harm by the survey team. No further information was obtained prior to the exit conference on 02/07/2019. 3. Resident #129 was admitted to the facility on 12/19/18. Diagnoses for this resident included, but were not limited to: history of cerebral infarction (stroke), high blood pressure, hemiplegia and hemiparesis affecting left non dominant side, major depression, partial right nephrostomy, renal cancer and hypothyroidism. The most recent full assessment for this resident was a 14 day admission, MDS (minimum data set) dated 12/26/18. This MDS documented the resident was assessed as a "14", indicating the resident was cognitively intact for daily decision making skills. The resident required extensive assistance for most all ADL's (activities of daily	F 689		

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F 689	Continued From page 59 living) including bed mobility, transfers, locomotion on and off unit, toilet use, and personal hygiene. The resident was also assessed as "not steady, only able to stabilize with staff assistance" for moving from seated to standing position, walking (with assist device if needed), moving on and off toilet, and surface to surface transfer (transfer between bed and chair or wheelchair) and documented as having impairment in upper and lower extremity on one side of body. This MDS assessed the resident as having one fall since admission without injury. Resident #129's clinical records were reviewed and revealed the following: An admission assessment of Resident #129 dated 12/19/18 documented, "...adequate hearing...clear speech...makes self understood...able to communicate needs...oriented to time, person, and situation...non-smoker...Falls: New/readmission...at risk for falls due to CVA [stroke], minimize risk for falls, encourage to transfer and change positions slowly, have commonly used articles within easy reach, refer to the therapy plan of treatment in the medical record for more detail, reinforce need to call for assistance...Ambulation: partial/moderate assistance...Bed Mobility: partial/moderate assistance...Toileting: partial/moderate assistance...Transfer: partial/moderate assistance...ADL self care deficit...weakness related to CVA...Will receive assistance necessary to meet ADL needs...Assist...as needed..."	F 689		

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F 689	Continued From page 60 The resident's physician's orders were reviewed and documented, "...Falls, visual impairment, left sided weakness..." A PT (Physical Therapy) evaluation dated 12/20/18 documented, "...61 year old female...CVA...resulting in left hemiplegia/weakness...Patient presented with left side weakness, left side neglect, poor dynamic standing balance, poor posture stability and control impulsivity, poor safety awareness and high risk for falls...Precautions:...Fall...has patient fallen in last year: No...does patient feel unsteady: Yes...does patient worry about falling: Yes...LLE [left lower extremity] impaired..." An OT [Occupational Therapy] evaluation dated 12/20/18 documented, "...short term goals:....will transfer supine to sit with SBA [stand by assist] in order to prepare for transfers...will transfer to/from wheelchair with SBA w/o [without] LOB [loss of balance]...will increase standing balance...long term goals: Patient will safely perform toileting tasks...with CGA [contact guard assist] with reduced risk for falls...decrease in functional mobility, decrease in strength, decreased orientation, postural alignment, falls/fall risk, functional limitation with ambulation reduced static balance...LUE [left upper extremity] impaired...due to stroke... Toileting: Max A [assist]...pt is alert and oriented X 3 able to follow 1 command direction...due to documented physical impairments and associated functional impairments...at risk for falls..." The clinical record further documented the following: 12/19/18 Admission note: "...alert and oriented X	F 689		

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F 689	Continued From page 61 3...DX [diagnosis] of CVA [stroke] left sided hemiplegia/weakness...can make all needs known...can communicate to staff...continent of bowel and bladder..." A nursing note on 12/22/18 at 3:45 AM, that the resident had a fall on 12/22/18 at approximately 12:10 AM, "...found lying on the floor next to her bed, when asked how did you get on the floor, patient stated that, 'when I put the wipes on the trash can I slid from bed'..." A physician's progress note dated 12/26/18 documented, "...left arm paralysis-can not move it at all, sensation intact, left leg weakness...left hemiparesis with spasticity and left inattention..." There was no mention of the resident's fall. A nursing note on 12/29/18 at 8:32 AM, "...S/P fall no injury noted..." A physician's progress note "LATE ENTRY" dated 12/31/18 at 7:37 PM (CREATED ON: 01/01/19 7:38 PM) documented, "...left hip pain, schedule tylenol...left hip XR ordered..." A physician's order dated 12/31/18 at 4:35 PM " ...tylenol 650 mg PO Q 12 hours for L hip pain ...Xray left hip 2 views ..." A Mobile X radiology report dated 01/01/19 and timed 5:14 PM documented that the resident had no acute fracture or dislocation ..." A nursing note dated 01/01/19 at 21:35 PM (created at 9:38 PM) documented, "...writer found resident sitting on floor in her room ...alert and oriented but after assessment writer observed blood on the back of residents head and	F 689		

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F 689	Continued From page 62 observered (sic) small gatch [sic] to her head...MD [medical doctor] notified and gave order to send to ER [emergency room]...RP [responsible party] notified..." A nursing note dated 01/01/19 at 21:35 PM (created at 10:07 PM) documented, "...writer continued to perform NERO [sic] checks and clean area of resident applying pressure to wound." A nursing note on 01/02/19 at 3:50 AM documented, "...returned from [initials of hospital]...5 staples observed to the lower back of her head...bruise to left lateral thigh tender to touch..." A nursing note on 01/02/18 at 22:45 (10:45) PM "...S/P fall day 2 ...no changes in mental status ...neuro checks in progress ...reminded resident to use call light ...assisted to rest room as needed ...." The resident's CCP (comprehensive care plan) date initiated: 12/19/18 documented, "...self-care deficit...assist to bathe/shower as needed...assist with daily hygiene...transfer with one...weakness related to CVA...assist as necessary...unsteady gait...attain and maintain ability to transfer self with supervision...provide one person guidance and physical assist...date initiated: (12/24/18 incontinence...provide assistance with toileting...remind and assist as needed with toileting at routine times such as upon rising...before/after meals...)...bed in low position...encourage to transfer and change positions slowly...provide assist to transfer and ambulate as needed...reinforce need to call for assistance...(Date initiated: 12/24/18 Reinforce	F 689		

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F 689	Continued From page 63 w/c safety...assist with bed mobility...) The CCP did not implement any new interventions and/or changes after the fall on 12/28/18 or the fall on 01/01/19. The DON (director of nursing) and the administrator were made aware in a meeting with the survey team on 02/06/19 at approximately 4:50 PM. The DON was asked for any investigation regarding this resident's falls. An investigation dated 12/22/18 and timed 12:10 AM documented that the resident was found lying on the floor. A statement from the LPN (licensed practical nurse) documented, "...around 12:10 pt [patient] was calling, upon arrival pt noted to be lying on the floor next to bed...pt was dry, call light was within reach...bed in low position..." A CNA (certified nursing assistant) statement documented, "...was in room [number] when nurse called for help...then saw pt on floor..." An investigation dated 12/28/18 and timed 6:30 PM documented, "...writer called by CNA to [room number] found resident on floor...supine...nurse asked resident and resident stated she was trying to pick up something off the floor and slid..." A statement from the CNA documented, "..I went to answer room [room of Resident # 129] and found her lying on floor...called nurse...no injuries...' An investigation dated 01/01/19 and timed 10:21 PM documented, "...resident found sitting on floor in her room...blood observed to back of head from small cut...no visible signs of distress	F 689		

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F 689	Continued From page 64 noted...writer asked resident what happened...resident alert and oriented stated she fell trying to go to bathroom...blood on back of head...apply pressure...new order to send to ER...resident stated she pressed call bell and couldn't wait she stated it was very embarrassing to have incontinence on self...resident transferred..." The DON, administrator and corporate nurse were made aware of serious concerns with this resident falling and sustaining an injury that required outside treatment and interventions. No further information and/or documentation was presented prior to the exit conference to evidence that the facility staff assisted the resident with toileting needs or implemented effective interventions for the prevention of falls on 02/07/19 at approximately 11:30 AM This is a complaint deficiency. 4. Resident # 60 was admitted to the facility 9/15/15 with diagnoses to include: heredity and idiopathic neuropathy, diabetes, anemia, alcohol abuse, and high blood pressure. The most recent MDS (minimum data set) was a quarterly review dated 12/4/18. Resident # 60 was assessed as cognitively intact with a total summary score of 15 out of 15. The admission MDS dated 9/22/15 documented the resident was not a tobacco user. On the annual assessment dated 7/2/16 the resident was then assessed as using tobacco products. The clinical record was reviewed 2/6/19 beginning at 8:00 a.m.	F 689		

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F 689	Continued From page 65 Resident # 60 was assessed as a smoker. The smoking assessment was dated 6/2/16 (9 months after admission). The smoking assessment included: "Directions: Complete the Smoking Evaluation for patients that smoke; upon admission, upon commencement of smoking, when unsafe smoking practices are noted and when a significant change in condition is determined. Utilize the most recent MDS responses, patient observation and interview to assist with the completion of the tool." This smoking assessment documented the resident as an "at risk" smoker requiring staff, family or friend for physical support or supervision to smoke. Under "Additional Information" was documented "Patient has been seen smoking outside the lobby without staff knowledge. No evaluation of his prior smoking techniques /skills has been done." A smoking assessment dated 6/28/17 did not include any documentation whether the resident was an "Independent Smoker" or an "At Risk" smoker. The care plan was then reviewed, and Resident # 60 was care planned as a smoker who was non-compliant with the smoking guidelines. The care plan did not address whether the resident was an at risk smoker or independent, or if he required supervision. Resident # 60 had been observed by two surveyors on 2/5/19 smoking unsupervised in the established smoking area, without an apron. On 2/6/19 at 2:20 p.m. Resident # 60 was interviewed. He stated "Yes, they put a smoking apron on me but I don't need one. I can smoke	F 689		

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F 689	Continued From page 66 unassisted; they just did that 'cause y'all are here to make them look good." Resident was observed sitting in his room in his wheelchair. On 2/6/19 at 2:45 p.m. during an interview with the DON (director of nursing) and the corporate consultant, they were asked if an updated assessment had been done since 6/28/17. The corporate consultant stated "No; when we looked at those yesterday as a result of the immediate jeopardy (name of resident # 60) had one done and has not had a significant change in condition which would trigger another assessment being done..." The corporate consultant was then advised the assessment done 6/28/17 was not complete; it did not identify Resident # 60 as an "at risk" smoker or an "independent" smoker. The consultant then stated "You know, I will be honest; I did not look that far down the form...you're right; he should have another assessment done since that one did not identify his status." The DON was also asked why the resident was assessed as an "at risk" smoker previously on the form dated 6/2/16. She stated "I assume because he is noncompliant with the smoking rules." It was then discussed that being noncompliant was different from the physical ability to smoke. The consultant then interjected "We will go do another assessment now to determine his status." On 2/6/19 at 3:30 p.m. the activities director, identified as "OS (other staff) # 7 was interviewed about the assessment done 6/28/17. She stated the reason the assessment had been done was for an update in education provided to smokers. She further stated "I just totally missed checking the boxes for the determination of whether to code him as safe or needing supervision."	F 689		

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F 689	Continued From page 67 The above findings were discussed during an end of the day meeting 2/6/19 beginning at 4:45 p.m. with the DON, administrator, and corporate consultant. No further information was provided prior to the exit conference 2/7/19. 5. On 2/5/19 at 7:45 a.m., a constant ringing alarm was heard on the 100 unit. The alarm could be heard throughout the unit. The alarm sounded constantly for the next 30 minutes without any response from staff members. At least three staff members were observed during this time going in and out of resident rooms. Three additional staff members were observed at the nursing desk during this time. No staff members responded to, investigated or deactivated the alarm from 2/5/19 at 7:45 a.m. until 2/5/19 at 8:14 a.m. when licensed practical nurse (LPN) #5 was interviewed about the alarm. On 2/5/19 at 8:14 a.m., LPN #5 working on the unit was interviewed about the ringing alarm. LPN #5 stated the alarm was for an "emergency." When asked what type of emergency, LPN #5 stated again, "Emergency." When asked for the third time about the reason for the sounding alarm, LPN #5 stated, "A building emergency." LPN #5 had no response when asked what actions were needed when this alarm sounded. At this time, the registered nurse, unit manager (RN #4), entered the interview and stated the alarm was from the fire exit door and it was activated when someone held the door open too long. RN #4 went to the fire exit door and entered a code in the panel beside the door that deactivated the alarm. RN #4 stated a staff person probably went out the door and held it	F 689		

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F 689	Continued From page 68 open too long. There were no other observed actions taken by the staff in response to the alarm. On 2/6/18 at 8:10 a.m., accompanied by RN #4, the fire door alarming on 2/5/19 was observed. The door was in a small lobby area with an unlocked door leading to unit one and an elevator leading to the second and third floors of the facility. The fire door opened to the outside parking lot area. When the handle was pushed, the door remained locked with a repeating "beeping" alarm sound. When the door handle was held/pushed against for 15 seconds, the door opened and a constant alarm sounded. The alarm sounded until RN #4 entered a code in the panel. RN #4 was interviewed at this time about the expected staff response to the fire door alarm. RN #4 stated the door was locked and a code had to be entered to open the door. RN #4 stated when the door alarm was heard, staff members were supposed to go and deactivate the alarm. When RN #4 was asked why staff members on 2/5/19 took no action in response to the alarm, RN #4 stated the code to the door changed recently and staff members were not aware of the new code. RN #4 stated LPN #5 was the "charge nurse" on the 11:00 p.m. to 7:00 a.m. shift. On 2/6/19 at 9:30 a.m., the maintenance director was interviewed about the fire door alarm heard on unit one on 2/5/19. The maintenance director stated the door was an exit for use in case of an emergency. The maintenance director stated the door was locked but could be opened with use of a code. The maintenance director stated this code was changed monthly and was	F 689		

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F 689	Continued From page 69 communicated to staff member during morning meetings. On 2/6/19 at 2:42 p.m., the maintenance director tested the fire door and stated it was working properly. The maintenance director stated if the door alarm activated, the door had been opened without a prior code entered or held open for an extended time. The maintenance director stated he did not have a policy about staff actions in response to the fire door alarm. On 2/6/19 at 2:45 p.m., LPN #6 working on the 100 unit was interviewed about what actions to take if the fire door alarm was activated. LPN #6 stated she was supposed to check that residents were not outside and account for residents. On 2/6/19 at 3:20 p.m., the administrator was interviewed about expected staff response to the fire door alarms. The administrator stated the fire door was tested as part of the life safety code. The administrator stated nursing staff should have checked for residents and investigated why the alarm was sounding. The administrator stated he had no specific policy about alarms but had a missing person protocol. On 2/6/19 at 3:55 p.m., the administrator stated, "When the door alarm goes off, it activates the missing person protocol." The administrator presented a copy of the facility's missing person protocol. This policy titled "Missing Residents" (dated 5/2017) documented, "The Missing Resident Response Plan is intended to provide guidelines for resident accountability, searching for missing residents and communicating with outside agencies. This plan supplements the most current clinical services information regarding missing residents." This protocol included steps	F 689		

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F 689	Continued From page 70 to determine if a resident was missing and stated to conduct a "...page and/or headcount as determined by the situation to locate a missing resident..." These findings were reviewed with the administrator and director of nursing during a meeting on 2/6/19 at 5:00 p.m.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of 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, clinical record review and facility document review, the facility staff failed to ensure oxygen administration was properly administered for one of 33 residents (Resident #19) and failed to obtain an oxygen order for one of 33 residents (Resident # 50). 1. The facility staff failed to administer oxygen appropriately via trach for Resident #19. 2. Resident #50 did not have a physician's order for the use of oxygen. Findings include: 1. Resident #19 was originally admitted to the	F 695	**F695** It is the practice of this facility to ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning are provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences.	

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F 695	Continued From page 71 facility on 08/05/10. The most current readmission was on 12/13/17. Diagnoses for Resident #19 included, but were not limited to: anoxic brain injury/damage resulting in a persistent vegetative state, gastronomy tube, aphasia, anemia, high blood pressure, tracheostomy with continuous oxygen use, and intermittent asthma. The most current full MDS (minimum data set) assessment dated 08/10/18 documented the resident as being in a persistent vegetative state. The resident was totally dependent upon at least one staff person for all ADL's (activities of daily living). The resident was assessed on this MDS as requiring and receiving oxygen therapy, suctioning, and tracheostomy care. On 02/05/19 at 8:04 AM, Resident #19 was observed laying in bed supine, covered, with eyes open. The resident had a trach, covered by trach collar and trach mask delivering oxygen (O2). The O2 mask covering the trach had a dial with numbers ranging from 35% to 55%, with the resident's dial set at 40%. The oxygen was being delivered via portable O2 concentrator. The O2 concentrator was humidified, with O2 set at 5 liters/min, which was the maximum delivery for this machine. A wall oxygen delivery system was observed, with tubing attached, but was not connected or in use. The resident was observed several times throughout the day, with the same O2 therapy being administered as described above. Resident #19's physician's orders were reviewed and documented, "...Oxygen 40% continuous via trach q [every] shift...[order date: 12/13/17]..."	F 695	**I** **Corrective Action** Resident #19 now receives proper oxygen administration and resident #50 now has an active physician order for oxygen use. The medication administration record has now been corrected to reflect the oxygen order changes. The patient also has a care plan to reflect oxygen use. **II** **Identification** All residents residing in the facility who are oxygen	

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F 695	Continued From page 72 Resident #19's CCP (comprehensive care plan) documented, "...assess respiratory changes...labs as ordered...administer oxygen as per physician's order..." On 02/06/19 at 11:05 AM, the resident was observed again. The resident was receiving O2 via trach collar/mask attached to a humidified, O2 concentrator. The resident's collar/mask dial was turned to 40 %, but the O2 concentrator was set to 3 L/min. On 02/06/19 at 11:15 AM, the UM (unit manager), also known as RN (registered nurse) #5 was interviewed regarding Resident #19's oxygen delivery system. The UM was asked how she or other nurses knew what percentage of oxygen the resident was supposed to get. The UM stated that the resident is supposed to get 40 % oxygen. The UM was asked to look at the O2 delivery for the resident. The resident was laying in bed supine with a trach collar/mask with O2 (as described above). The dial was pointed to 40% and had a mark above it that documented for the range of 35% to 55% the oxygen liters should be set to 6 Liters. The UM pointed to the dial and stated that the resident gets 40%. The UM was asked about the dial that indicated the oxygen should be set to 6 liters. The UM stated that she thought that was correct. The UM was then asked why the resident's oxygen concentrator was set to 3.5 liters. The UM stated that she was not sure, but would ask the floor nurse. The UM called for LPN #8 and asked about the resident's oxygen. LPN #8 stated the concentrator was not working properly and she was planning on switching out the concentrator and stated, "I'll do that now." LPN #8 was asked what was wrong	F 695	dependent and have tracheostomy have the potential to be affected by this alleged deficient practice. **III** **Systematic Changes** The DON or designee will educate the nursing staff on the administration of oxygen to patients needing it, including those with tracheostomies, and to ensure physician orders are obtained for	

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F 695	Continued From page 73 with the concentrator that it wasn't working correctly. LPN #8 stated that when you start the machine, you can put it on 5 liters, but it goes down by itself and must have stopped at 3.5 liters. LPN #8 was asked how long that had been happening or had been in this condition. LPN #8 stated, "Probably a couple of days." LPN #8 stated that the oxygen concentrator is supposed to go to 6 liters per minute, but when you turn it on it goes down by itself. The UM stated that the O2 concentrator did not go up to 6, it only went up to 5, as indicated on the flow meter gauge and LPN #8 stated that she would get one. The UM stated to the LPN, you need one that goes higher. LPN #8 left the room and returned with another O2 concentrator that was similar, and only had a max of 5 on the flow meter gauge. LPN #8 was asked why the resident was not receiving the O2 from the wall unit that delivered O2 up to 16 LPM (liters per minute). LPN #8 stated that it was broken. LPN #8 stated that the wall mount O2 delivery system needed a humidifier. LPN #8 then stated that the wall mount works and turned the O2 wall unit on, and then stated that we don't have the humidifier bottles for it. LPN #8 was asked how long the resident had been connected to the O2 concentrator and how long had there not been a supply of humidifier bottles for the wall mount. LPN #8 stated that, it has probably been like that a couple of days and that she had been reported the lack of supplies. LPN #8 stated, "We are short of supply and [name of central supply person] will get some supply. A policy on oxygen administration was requested from the DON (director of nursing) on 02/06/19 at approximately 1:30 PM. A policy was presented, titled, "Oxygen	F 695	**IV** **Monitoring** The DON or designee will audit five patients for available oxygen orders and proper oxygen administration once a week, including residents with tracheostomy, for two weeks and weekly for four weeks. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **3/23/2019**	

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F 695	Continued From page 74 Administration", which documented, "...Purpose: To describe method of delivering oxygen in order to improve tissue oxygenation, reduce risk of hypoxia...portable oxygen cylinder, oxygen concentrator or wall unit oxygen source...regulator and flow meter...prefilled sterile humidifier bottle if oxygen is above 4 liters...physician's order...for oxygen wall unit, connect adapter, check for leaks...if oxygen flow rate is 4 liters per minute or less, humidification is NOT required...Use prefilled humidifier bottle...only use a simple mask with a 5 liter concentrator, all other masks require a higher concentration of oxygen...administration thorough trach collar...place collar over stoma and secure...set flow rate...high flow oxygen: follow manufacturer's instructions when using high flow oxygen delivery devices...record in progress notes...type of delivery, device used and flow rate of oxygen..." On 02/06/19 at 4:50 PM, the administrator and DON were made aware of the above information in a meeting with the survey team. The DON was asked for and additional information regarding oxygen administration for resident's with a trach. On 02/07/19 at approximately 8:30 AM, the DON was again asked for any type of reference or procedure manual that a nurse may use to ensure safe and prescribed oxygen is being administered for a resident with a trach. The DON stated that all nurses are educated and instructed when they are hired, but stated that the facility does not have a reference guide or procedure manual to provide instruction for nurses to use as a quick reference to ensure correct and consistent oxygen administration facility wide.	F 695		

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F 695	Continued From page 75 No further information and/or documentation was presented prior to the exit conference on 02/07/19 at 11:30 AM. 2. Resident #50 was admitted to the facility on 01/05/2017 with the following diagnoses, but not limited to: End stage renal disease with hemodialysis, depressive disorder, hypertension and COPD [chronic obstructive pulmonary disease]. An annual MDS (minimum data set) with an ARD (assessment reference date) of 12/11/2018, assessed Resident #50 as cognitively intact with a cognitive summary score of "15". On 02/05/2019 at approximately 7:55 a.m., Resident #50 was observed sitting in a chair at his bedside. He was wearing a nasal cannula with oxygen running at two liters. Resident #50 was asked about the use of oxygen. He stated, "I just use it at night...I don't use it when I go out of the room or to dialysis, it helps me when I sleep." At approximately 10:00 a.m., the clinical record was reviewed. There was no order for the use of oxygen on the current physician order sheet. Nor were there any interventions on the care plan for the use of oxygen. On 02/06/2019 at approximately 8:00 a.m., LPN (licensed practical nurse) #2, a unit supervisor was interviewed about the use of oxygen. She was asked if a physician order was needed. She stated, "Yes, we need an order." She was asked if there was a physician order for Resident #50 to use oxygen. She looked a the physician orders and stated, "I don't see an order...He [Resident #50] just likes to use it...it is his preference, he	F 695		

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F 695	Continued From page 76	F 695		

doesn't use it out of the room, it is PRN {as needed]. LPN #2 was asked if that meant he didn't need a physician order. She stated, "No, he should have an order." LPN #2 was asked if there were entries on the TAR (treatment administration sheet) regarding changing the oxygen tubing, water bottle, etc. She looked and said, "No, but they do that on Tuesday nights." LPN #2 and this surveyor went to Resident #50's room. The water bottle was empty and not dated, the oxygen tubing and nebulizer equipment were in plastic bags and dated 02/05/2019. LPN #2 stated, "They changed the tubing last night, but not the water bottle...I will get a new water bottle and contact the physician."

At approximately 8:30 a.m. LPN #2 came to the conference room and stated, "I contacted the physician. We have an order now for the oxygen. I have updated that and I will update the care plan."

Further review of the clinical record showed that Resident #50 had a physician order and was care planned for oxygen prior to a hospitalization in May 2018. The order was not rewritten upon his return and was removed from the care plan.

At approximately 9:50 a.m., RN (registered nurse) #2, the MDS nurse came to the conference room. She was asked about the care plan and the orders for oxygen. She stated, "Yes, it looks like when he went into the hospital the care plan area for oxygen was noted as resolved...when he came back it looks like we didn't have an order and didn't put it back on the care plan."

The facility policy for oxygen therapy was requested and received. The policy, "Oxygen

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F 695	Continued From page 77 Administration" contained the following: "PROCEDURE: Verify Physician's Order...SUGGESTED DOCUMENTATION: Record in Progress Note date and time oxygen was initiated, condition necessitating oxygen use, respiratory status related to oxygen use, type of delivery, device use and flow rate of oxygen and any reassessments or other related interventions. Record oxygen administration on Treatment Administration Record. Record oxygen concentrator maintenance and oxygen device used per cent procedure." No further information was obtained prior to the exit conference on 02/07/2019.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732	**F732** It is the practice of the facility to ensure that the posting of nursing staff data be done daily and visible readily accessible to residents and visitors. **I** **Corrective Action**	

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F 732	Continued From page 78 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post daily nurse staffing in a visible area in the facility. Findings include: On 2/5/19 at 3:45 p.m. a tour of the facility nursing stations was conducted. There were no nurse staffing postings observed at the nurses' stations. On 2/5/19 at 4:00 p.m. the DON (director of nursing) was asked about the daily staff posting. She stated "No; there's no posting for the staffing...there's a clipboard at the nurses' station as far as who is on duty..." A few minutes later the DON returned to the conference room and told this surveyor "I'm going to take care of that right now." The administrator, DON, and corporate	F 732	Nursing staff data has now been posted at all nurses' stations. **II** **Identification** All nurses' stations were reviewed and issue identified were corrected. **III** **Systemic Changes** Director of Nursing and/or designee will in-service licensed nursing staff on the requirements of posting Nursing Staff Information daily at the start of each shift. **IV** **Monitoring**	

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F 732	Continued From page 79 consultant were informed of the above findings during an end of day meeting 2/6/19 beginning at 4:45 p.m. No further information was provided prior to the exit conference 2/7/19.	F 732	The Administrator or his designee will randomly audit for nursing staffing data to be posted at nurses' station. Random audits will be conducted weekly for 4 weeks and randomly thereafter for 2 months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **3/23/19**	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications were	F 761	**F 761** **Label/Storage Drugs and Biologicals**	

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F 761	Continued From page 80 not available for use on one of five medication carts inspected. A vial of Lantus insulin, opened for more than 28 days, was available for use on a third floor medication cart. The findings include: On 2/5/19 at 3:45 p.m., accompanied by licensed practical nurse (LPN) #9, a medication cart on the third floor unit was inspected. A vial of Lantus insulin marked as opened on 12/14/18 was stored and available for use on this cart. LPN #9 was interviewed at this time about the insulin that had been opened for 52 days. LPN #9 stated he thought the insulin was to be discarded 28 days after opening. LPN #5 stated the insulin was for a current resident in the facility. The manufacturer's label on the vial of Lantus insulin was printed with instructions to discard after 28 days from initial use. On 2/6/19 at 11:00 a.m., the corporate nursing consultant was interviewed about a facility or company policy related to insulin storage. The nursing consultant stated they did not have a policy about storage or discarding of insulin. These findings were reviewed with the administrator and director of nursing during a meeting on 2/6/19 at 5:00 p.m.	F 761	**I.** **Correction** No residents were effected. The facility has audited all insulin to ensure proper storage and dating. Al insulin over 28 days has been discarded. **II** **Identification** All residents on insulin have the potential to be affect a. The nurse was provided immediate education. b. The facility will conduct a 10% audit on all insulins to assure they have a date and discard any open insulin without a date or that is expired.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791	**III** **System changes**	

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F 791	Continued From page 81 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 791	Facility will provide re-education on the nursing staff **IV** **Monitoring** In order to ensure ongoing compliance, the facility will conduct random audits of 4 insulin vials weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **3/23/19**	

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F 791	Continued From page 82 Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure routine and emergency dental services for one of 33 residents in the survey sample, Resident #21. The facility did not provide routine and/or emergency dental services to Resident #21. Resident #21 had poor dental health and had not been seen by a dentist. The resident began having dental pain and was prescribed an antibiotic without being seen by a dentist and/or a physician; no followup care was provided. Findings include: Resident #21 was admitted to the facility originally on 02/28/11, with the most current readmission on 11/18/18. Diagnoses for Resident #21 included, but were not limited to: anemia, high blood pressure, PVD (peripheral vascular disease), renal failure dependent upon hemodialysis, DM (diabetes mellitus), depression, and bilateral AKA (above the knee amputations.) The most current full MDS (minimum data set) was an annual assessment dated 11/14/18, which assessed the resident as 99 cognitively, indicating the resident was unable to complete the interview; the resident was assessed with short term memory impairment with modified independence in daily decision making skills. The resident was assessed as requiring extensive assistance for most all ADL's (activities of daily living) including dressing, toileting, personal hygiene, and total dependence for bathing with one person assist. The resident was assessed as having "highly impaired" vision.	F 791	**F 791** **Routine/Emergency Dental Services in NF** **I** **Correction** Resident #21 had no adverse effects, dental appointment made. **II** **Identification** All residents have the potential to be affected. a.The facility will conduct an oral exam on all residents to identify any dental issues b.Immediate corrective actions will be taken. **III** **System changes** Initiate a process in which during quarterly and annual assessments MDS will do an	

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MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED ARLINGTON, VA 22204

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F 791	Continued From page 83 This MDS also assessed the resident in Section L. Oral/Dental Status L0200L. Dental: as having no dental issues, no pain/discomfort, no fragments, no issues with bleeding or inflamed gums, and no obvious or likely cavities/broken natural teeth. The resident was assessed as having none of the above, indicating no dental/oral cavity concerns. On 02/05/19 at 8:22 AM, Resident #21 was not in her room. A nurse stated the resident was at dialysis and would be gone until 11:00 or 11:30 AM. On 02/05/19 at 1:45 PM, Resident #21 was observed in her room, with a lunch tray in front of her. The resident stated that she was tired from dialysis. The resident had poor dental health, with missing and decayed teeth in the upper and lower mouth. Resident #21's clinical records were reviewed. The resident's physician's orders did not include any orders for routine or emergency dental care services or treatment. A physician's order was written on 01/21/19 for: "Amoxicillin 500 mg (milligrams) TID (three times a day) X (times) 10 days for tooth pain...indications for use: tooth pain..." The resident's nursing notes were revealed a nursing note dated 1/21/2019 and timed 7:40 AM which documented, "...C/O [complained of] pain of her upper tooth and swollen. PRN [as needed] Tylenol was given around 6 am. [name of doctor] notified and N.O. [new order] of Amoxicillin 500 mg tab PO TID for 10 days. First dose was given	F 791	oral exam with the pain assessment. Facility will provide education to MDS Nurses **IV** **Monitoring** In order to ensure ongoing compliance, the facility will conduct random audits of 4 residents weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **3/23/19**	

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F 791	Continued From page 84 from Emergency Kit..." A nursing noted dated 01/21/2019 and timed 12:18 PM documented, "...Patient continues on Amox 500mg PO for tooth abscess, there is no adverse reaction noted." A nursing note dated 1/23/2019 and timed 2:48 PM documented, "...Patient continues on Amox 500mg PO for tooth infection, there is no adverse reaction noted, no sweeling [sic]noted on cheeks, eating without difficulty..." A nursing note dated 01/24/2019 and timed 07:17 documented, "...Continues on Amoxicillin tab 500 mg for tooth pain, afebrile..." The resident finished the medication on 01/31/19. The resident's CCP (comprehensive care plan) was reviewed and documented, "...ADL self care deficit...assist with daily hygiene...oral care...dental or oral cavity health problem risk r/t teeth in poor condition (date initiated 05/19/18)...effective pain management...ability to eat and drink per baseline...administer medications as ordered...assist with oral hygiene as needed...refer to dentist/hygienist for evaluation/recommendations re: teeth pulled, repair of carious teeth (date initiated: 08/07/18)...report changes in oral cavity, chewing ability, S&S of oral pain, etc... On 02/06/19 at 10:38 AM, Resident #21 was interviewed and stated that her teeth were not hurting now, but did point to the tooth/area that was hurting. The resident opened her mouth and pointed to the upper right, front area. The resident had several teeth missing, with multiple	F 791		

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F 791	Continued From page 85 broken off teeth in the top of her mouth; the teeth present had visible decay and several, including the tooth that the resident was pointing to, were decayed and flush with the resident's gum line. She was asked if she had been to the dentist and the resident stated, yes. No documentation was found in the residents clinical record or electronic record that the resident had seen a dentist at all. The resident's physician's progress notes were reviewed. The physician's progress notes did not document any information regarding the resident's teeth, nor any information about being seen and/or prescribed an antibiotic for her teeth. On 02/06/19 at 8:35 AM, the UM (unit manager) was interviewed regarding Resident #21's teeth. The UM stated that the resident had seen a dentist. The UM was asked where the documentation was for that. The UM stated it should be in the nursing notes. The UM began to look. The UM again stated that the resident had been seen by a dentist, but did not want her teeth pulled. The UM was asked to present any information regarding this. No information and/or documentation was presented by the UM regarding the above. On 02/06/19 at approximately 9:30 AM, the administrator was asked for any policies on dental care for residents. A policy presented, titled "Oral Hygiene and Denture Care" documented, only how to brush and care for teeth and dentures. The policy did not address dental issues or concerns, either	F 791		

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F 791	Continued From page 86 routinely or emergent. A policy presented, titled "Denture Guidelines" documented, "dental care and dentures are the responsibility of the patient...contracted dental providers will provide emergency dental services to facility patients..." This policy documented about dentures and did not specifically address dental issues and concerns with a resident's own/natural teeth. The administrator stated that this policy is for both, dentures and natural teeth. On 02/06/19 at approximately 4:20 PM, the SW (social worker) was interviewed and asked about Resident # 21. The SW stated, "I don't know anything about her teeth." The SW was made aware of the above information regarding the resident' teeth and antibiotic use due to poor dental health. The SW stated that if she or the other SW had been notified they would have made the resident an appointment. The SW stated that they have a dentist that comes to the facility; that she (the resident) doesn't have to go out to see a dentist. The SW stated that nursing will keep social services up to date regarding the resident's teeth and dental concerns. The SW stated that the nurse's will call SW or the nurses may speak to the dentist while here to see someone that may not have been on the list. The SW stated that they get notes monthly from the dentist and the dentist comes in once a month. The SW was asked to look for notes or anything regarding Resident #21. The SW looked in the computer and stated that the resident was not on the list now and had not been on the list since she (SW) started working at the facility January of 2018. The SW stated that she inputs the	F 791		

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F 791	Continued From page 87 information and that the dentist will send notes for residents seen once a month and she had not received any information at all on this resident. The SW stated that she had not received any notification for this resident's teeth. The SW stated, "I'm going to add her to the list now." The SW was asked if the UM informed her (the SW) via phone or in person regarding concerns with Resident #21's teeth. The SW stated, "She (the UM) called and asked about the dental list and if this resident has been on the list, but did not ask me to put the resident on the list and did not inform me that the resident was on antibiotic for dental issues." The SW stated, "I genuinely had no idea." The SW stated that they (SW) are not clinical and rely on the nurses to provide information regarding residents. On 02/07/19 at 9:57 AM, the administrator, DON, and corporate nurse were asked for any additional information or documentation regarding this resident, and were made aware of the concerns with Resident #21's poor dental health, and concerns that the resident was prescribed an antibiotic for this without being seen by the physician or the physician writing a progress note. The administrator stated that the physician came in yesterday (02/06/19) and wrote a note regarding Resident #21, but he did not see her initially regarding the teeth, but did prescribe the antibiotics for the resident. No further information/documentation was presented prior to the exit conference on 02/07/19 at 11:30 AM.	F 791		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

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F 804	Continued From page 88 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and in the coarse of a complaint investigation, the facility failed to ensure appetizing food temperatures. The staff served food on the third floor unit that was less than appetizing in temperature. The findings include: Resident #50 was admitted to the facility on 01/05/2017 with the following diagnoses, but not limited to: End stage renal disease with hemodialysis, depressive disorder, hypertension and COPD (chronic obstructive pulmonary disease). An annual MDS (minimum data set) with an ARD (assessment reference date) of 12/11/2018, assessed Resident #50 as cognitively intact with a cognitive summary score of "15". Resident #50 interviewed on 2/5/19 at 7:55 AM, regarding food. Resident #50 stated that breakfast will not arrive until about 10:00 a.m; "We are at the end of the line, the room next to me is last and I am next to last." Asked if food was hot when he got it, stated, "No." On 2/6/19 at 8:50 AM, a test tray was performed	F 804	**F804** It is the practice of the facility to provide each resident with food and drink that is palatable, attractive, and at a safe and appetizing temperature. **I** **Corrective Action** Resident #50's meal preferences regarding temperature of his meals were addressed by Food Service Director. Food is now being served to all residents at the proper temperature.	

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F 804	Continued From page 89 for the third floor main unit as follows: At 8:50 AM, holding temperatures for confetti eggs (eggs in a casserole dish) were 174 degrees, scrambled eggs were 168 degrees, puree eggs and sausage were 180 degrees. At 9:03 AM, staff started plating food and loading the meal cart. At 9:15 AM, the last tray was put on meal cart. The temperature of the confetti eggs on the tray was 150 degrees. Holding temperature of confetti eggs on the steam table at this time was 179 degrees. At 9:17 AM, the meal cart arrived on the unit (13 meal trays were on cart, including test tray). At 9:20 AM, a certified nursing assistant (CNA) began to pass trays and setting up residents to eat. Another CNA began helping the first CNA with only 4 trays remaining to be passed to residents. At 9:40 AM, the last meal tray was served. At this time the dietary manager and this surveyor pulled the test tray and took a temperature of the food. The confetti eggs had a temperature of 116.4 degrees. This surveyor along with the dietary manager tasted the confetti eggs. The dietary manager was asked his opinion of how the eggs tasted and temperature. The dietary manager verbalized that the eggs seemed cool and could be hotter, this surveyor agreed. On 02/06/19 at 4:50 PM, during an end of day meeting, the director of nursing and administrator was made aware of the above findings.	F 804	II **Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **III** **Systematic Changes** The Food Service Director and/or designee will in-service dietary staff about resident's food temperature preference and insure food look appetizing and are palatable. The Director of Nursing and/or designee will in-service certified nursing assistants about passing trays timely. **IV** **Monitoring**	

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F 804	Continued From page 90 No other information was presented prior to exit conference on 2/7/19. This is a complaint deficiency.	F 804	The Administrator and/or designee will randomly audit residents regarding meals being at proper temps and palatable.	
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, the facility staff failed to ensure no more than 14 hours elapsed between the evening meal and breakfast, and failed to offer a nourishing bedtime snack on one of seven units, three main. Findings were:	F 809	Audits will be done weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **3/23/19** **F809** It is the practice of the facility that each resident receives a nourishing snack when meals	

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F 809	Continued From page 91 Resident #50 was admitted to the facility on 01/05/2017 with the following diagnoses, but not limited to: End stage renal disease with hemodialysis, depressive disorder, hypertension and COPD [chronic obstructive pulmonary disease]. An annual MDS (minimum data set) with an ARD (assessment reference date) of 12/11/2018, assessed Resident #50 as cognitively intact with a cognitive summary score of "15". During initial tour of the facility on 02/05/2019 at approximately 7:55 a.m., Resident #50 was observed sitting in his room. He was interviewed regarding life at the facility. During the interview, Resident #50 was asked if he was waiting on breakfast. He stated, "It will be two hours before I see my breakfast." He was asked to explain. He stated, "The room next to me is the last to be served, I'm next to last...I'll get my breakfast around 10:00 [a.m.], lunch will be around 2:30 [p.m.], and supper will be around 6:30 [p.m.]. This surveyor commented that there wasn't much time between lunch and supper. Resident #50 stated, "No, it's not, but it's a long time between supper and breakfast." Resident #50 was asked if he was offered a bedtime snack. He stated, "No, they don't offer us anything." He was asked if he knew whether or not a snack was available if he asked for it. He stated, "I don't know." At approximately 10:00 a.m., Resident #50 was observed eating his breakfast. He was asked when he had gotten his tray. He stated, "Just before you walked in." Resident #50 was asked if he ate all of his meals in his room. He stated, "Yes." Resident #50 was asked if his food was	F 809	between dinner and breakfast are longer than 14 hours. **I** **Corrective Action** Resident #50 will be offered a nourishing snack at night. **II** **Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **III** **Systematic Changes** The Dietitian will in-service the Food Service Director on what	

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F 809	Continued From page 92 hot. He stuck his finger into his cup of "hot" tea and stated, "What's that tell you?" The "Dining Meal Times and Locations" schedule that had been provided to the survey team was reviewed. The schedule listed the following times for meals on 3 main: "Breakfast: 8:35 [a.m.], Lunch: 1:10 [p.m.], Dinner: 6:35 [p.m.]. At approximately 2:30 p.m., Resident #50 was observed eating his lunch. He was asked when his tray had been served. He stated, "About 15 minutes ago...this is how it always is." A staff member on the floor was asked what time the trays had arrived to the unit. She stated, "I'm not sure...but I know that the kitchen always has someone sign a paper when they get up here." On 02/06/2018, at approximately 8:30 a.m., the logs for the last two weeks, documenting the time of tray deliveries to the units, were requested from the dietary manager. The logs contained the following information: 1/23: Dinner Meal: 6:25 p.m. 1/24: Breakfast Meal: Not logged (the unit served prior to 3 main was delivered at 9:20 a.m.) 1/24: Dinner Meal: 6:41 p.m. 1/25: Breakfast Meal: 8:53 a.m. 1/25: Dinner Meal: 6:40 p.m. 1/26: No Log 1/27: Breakfast Meal: 9:06 a.m. 1/27: Dinner Meal: 6:40 p.m. 1/28: Breakfast Meal: 9:11 a.m. 1/28: Dinner Meal: 6:02 p.m.	F 809	constitutes a nourishing snack for the various diets within the facility. The Food Service Director and/or designee will in-service dietary staff to insure nourishing snacks are sent to the nursing stations when required. The Food Service Director will in-service dietary staff about insuring that meals are ready per time frames established by the facility. **IV** **Monitoring** The Administrator and/or designee will randomly audit to insure nourishing snacks are being sent to the nurses' station when needed.	

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F 809	Continued From page 93 1/29: No Log 1/30: Breakfast Meal: 8:59 a.m. 1/30: Dinner Meal: 6:36 p.m. 1/31: Breakfast Meal: 8:50 a.m. 1/31: Dinner Meal: 6:48 p.m. 2/01: Breakfast Meal: 9:05 a.m. 2/01: Dinner Meal: 6:11 p.m. 2/02: Breakfast Meal: 9:07 a.m. 2/02: Dinner Meal: 5:35 p.m. 2/03: Breakfast Meal: 9:35 a.m. 2/03: Dinner Meal: 6:22 p.m. 2/04: Breakfast Meal: 9:30 a.m. 2/04: Dinner Meal: 6:34 p.m. 2/05: Breakfast Meal: 9:41 a.m. 2/05: Dinner Meal: 6:27 p.m. 2/06: Breakfast Meal: 9:20 a.m. On ten different days there were greater than 14 hours between the evening meal and breakfast. The dietary manager was interviewed on 02/06/2019 at approximately 10:25 a.m. regarding meal times. He was asked why the logs were done. He stated, "To show what time we get the carts to the floors." The span of greater than 14 hours between dinner and breakfast on the 3 main unit were discussed. He stated, "I see that." He was asked if snacks were available to residents on the units. He stated, "We send up snacks in the evening." He pointed to a chart on the wall and stated, "That is what we send to each unit." Listed on the chart were the following:	F 809	The Administrator and/or designee will randomly audit meal trays to insure they are being sent within established timeframes weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	

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F 809	Continued From page 94 "Animal Crackers: 2 packages" "Crackers: 2 packages" "Graham Crackers: 2 packages" "Oreo Cookies: 2 packages" "PB [peanut butter] Crackers: 2 packages" "SF [sugar free] Cookies: 2 packages' "Chocolate Pudding: 2 cups" "Vanilla Pudding: 2 cups" "Apple: 2 each" "Orange: 2 each" The dietary manager was asked what on the list he would consider to be a nourishing snack. He stated, "Probably just the fresh fruit." He was asked what on the list could be served to a resident who was ordered a high protein renal diet (the physician prescribed diet for Resident #50). The dietary manager stated, "Hmmm...probably just the crackers." Concerns were voiced to the dietary manager regarding the time span between the dinner meal and breakfast on 3 main, as well as the lack of nourishing snacks. He verbalized his understanding. No further information was obtained prior to the exit conference on 02/07/2019.	F 809	**V** **Date of Compliance** **3/23/19**	
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	**F812** It is the practice of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety.	

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MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD REVISED ARLINGTON, VA 22204

(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 812	Continued From page 95 (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, staff interview, and review of facility policies, the facility failed to store food in a sanitary manner in the main kitchen. The findings include: The initial tour of the kitchen was conducted on 02/05/19 at 7:45 a.m. A dietary aide, identified as OS#9 accompanied this surveyor during the tour. In the walk-in refrigerator was an opened pack of hot dogs laying on a flat pan. The package was not sealed or marked with an open date. OS#9 stated, "I am not sure when these were opened. I was off yesterday." A stand alone refrigerator labeled "Cooks Box II" was observed. A metal container that contained spicy green peppers was loosely covered with plastic wrap, dated 1/29. A small plastic baggie contained chopped onion without a date and a partially cut whole onion was laying on top of this baggie without any covering or date. OS#9 went to OS#8 (the morning cook) and asked her when these items had been opened. OS#8 gave OS #9 dates. OS#9 wrote those dates on the opened, undated containers and placed them back into the refrigerator.	F 812	**I** **Corrective Action** All food items identified in the kitchen tour by surveyors were immediately discarded. **II** **Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **III** **Systematic Changes** The Food Service Director and/or designee will in-service	

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F 812	Continued From page 96 A second stand alone refrigerator labeled "Cooks Box I" contained 14 individual bowls of cottage cheese that were not dated. A small container of chicken base was opened, without a proper lid. A metal container of tuna salad covered with plastic wrap was not dated. A personal lunch bag was stored in this refrigerator, along with a plastic bag of fried rice and a small styrofoam container of chinese food and several containers of different sauces. OS#9 stated, "I don't know who this belongs to. It must be someone's lunch." On 02/05/19 at approximately 4:00 p.m. the DM brought requested facility policies to this surveyor. The policy, "Labeling Food and Date Marking" included: "Types of Labels That Can Be Used" 1. Plain adhesive labels can be used but information needs to be hand printed on the label. 2. Some items can be labeled by marking directly on the package, plastic wrap, disposable lid or foil covering the item. 3. An indelible pen will help prevent writing from running and fading. A wax pen writes on wet or frozen items. 4. Labeling guns with labels that have the appropriate information may be used..." The DM was interviewed on 02/06/19 at 9:45 a.m.. The DM stated, "We have a policy for outside food brought into residents, but not food brought in by employees. My expectation is there should be no employee food in the kitchen. They have a refrigerator in their break room. All opened foods in the kitchen should be sealed properly and dated with the date of opening." The Administrator and DON (director of nursing) were informed of the above during a meeting with survey team on 02/06/19 at approximately 5:00	F 812	dietary staff on storing, preparing, distributing and serving food in accordance with professional standards for food safety. **IV** **Monitoring** The Administrator and/or designee will randomly audit kitchen to insure compliance with maintaining professional food safety standards. Random audits will be done weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and	

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F 812	Continued From page 97 p.m. No further information was received by the survey team prior to the exit conference on 02/07/19.	F 812	Assurance Committee will determine the need for further audits and/or action plans.	
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 the identification of Immediate Jeopardy and Substandard Quality of Care, as well as observations and staff interviews, the facility Administrator failed to exercise due diligence in the day-to-day operation of the facility. The Administrator failed to ensure a paraplegic smoker was assessed for safe smoking, failed to ensure the resident was care planned for smoking, and failed to ensure the resident was supervised during smoking. In addition, door alarms in the building were sounding without a response from the staff. The Administrator failed to ensure there was a specific policy in place that provided staff with direction as to how to respond to door alarms. The findings were: 1. During the survey, a female paraplegic resident was identified as a smoker. Thorough review of the resident's clinical record revealed she had not been assessed for safe smoking. She was not identified on her most recent Minimum Data Set as using tobacco, and she	F 835	**V** **Date of Compliance** **3/23/19** **F835** It is the practice of the facility to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. **I** **Corrective Action**	

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F 835	Continued From page 98 had not been care planned for smoking. The resident was observed in a smoking area located outside the main Dining Room without a protective smoking apron, and smoking without direct supervision of a staff member. This resulted in the identification of Immediate Jeopardy and Substandard Quality of Care. During a review of the facility's QAA (Quality Assessment and Assurance)/QAPI (Quality Assurance and Performance Improvement) program, the Administrator was interviewed regarding resident smoking and supervision of smokers. Asked about supervision of smoker, the Administrator said, "...I had no idea that the staff who were supervising them (smokers) were not out there with the smokers." Asked if he ever made random rounds to make sure staff were following the facility protocols for smoking, and if he ever observed the smoking area on those rounds, the Administrator said, "No. I will be honest, I have not been out there to that area. I do go out on the floors to see if residents are receiving care, but not out to the smoking area. I assumed it (supervision) was being done per the discussion and training." 2. At 7:45 a.m. on 2/5/19, a constant ringing alarm was heard on the 100 Unit. The alarm, which could be heard throughout the unit, rang continually for 30 minutes without any response from the unit staff. At 8:14 a.m. on 2/5/19, LPN # 5 (Licensed Practical Nurse), who was later identified as the Unit Charge Nurse, was asked two times why the alarm was sounding. Each time LPN # 5 stated, "Emergency." Asked a third time, LPN # 5 said, "A building emergency." Asked what actions needed to be taken, LPN # 5 had no response.	F 835	Issues identified by surveyor were immediately addressed by the facility. The facility smoking practice identified by the surveyors has now been corrected. The facility will educate its staff on its fire door alarm response practices. **II** **Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **III** **Systematic Changes** The Regional Director of Operations or designee will in-service Administrator on the day to day operations of the	

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F 835	Continued From page 99 At 8:15 a.m., RN # 4 (Registered Nurse) joined the surveyor and LPN # 5 and said the alarm was for a fire exit door, and that the alarm was activated when someone held the door open too long. RN # 4 went to the fire exit door and entered a code on a panel next to the door deactivating the alarm. At 8:10 a.m. on 2/6/19, RN # 4 was interviewed again about the door alarm. Asked why staff members on the 100 Unit took no action in response to the alarm that sounded the previous morning. RN # 4 said the code to the door had recently been changed and the staff members were not aware of the new code. At 3:20 p.m. on 2/6/19, the Administrator was interviewed regarding expectations for staff response to door alarms. The Administrator said staff should have "...checked for residents and investigated why the alarm was sounding." Asked if there was a policy giving staff direction as to how to respond to door alarms, the Administrator said he had no specific policy about alarms, only a missing person protocol. "When to alarm door alarm goes off, it activates the missing person protocol," the Administrator said. The Administrator provided a copy of the "Missing Residents" protocol which noted in part, "The Missing Resident Response Plan is intended to provide guidelines for resident accountability, searching for missing residents, and communicating with outside agencies."	F 835	facility to include risk management. **IV** **Monitoring** The Regional Director of Operations and/or his designee will randomly audit for compliance of risk management. Random audits will be done weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		

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F 867	Continued From page 100 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop and implement an appropriate plan of action for an identified quality deficiency regarding smoking. The facility QAA (Quality Assessment and Assurance)/QAPI (Quality Assurance and Performance Improvement) committee failed to develop and implement an appropriate plan of action for an identified deficiency with residents' smoking; the facility failed to ensure that an action plan was in place to ensure safe smoking for residents. Findings included: The administrator was interviewed 2/07/19 at 9:14 a.m. He was asked if the QAA committee had identified any problems with the smokers who should have direct supervision. He stated "When I came here we put together the smoking times, had meetings with families, residents and activities. Then met with the people who be providing supervision; the expectation was they were to stay out in the smoking area with the residents. On weekends the staff are smokers and they do stay out there with them. One staff member stated they had asthma, and could they stand inside the door with door open to supervise the smokers? We stated yes, that could be done. But I had no idea the staff providing supervision	F 867	**V** **Date of Compliance** **3/23/19** **F867** It is the practice of the facility to develop and implement an appropriate action for an identified quality deficiency, including smoking. **I** **Corrective Action** An ad-hoc QAPI meeting was held on 2/6/2017 following the identification of residents smoking without supervision. An appropriate plan of action	

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F 867	Continued From page 101 were not out there with the smokers. Had I been aware that the staff who were supervising them were not out there, that certainly would have been an intervention QAA would have looked at and made recommendations on." The administrator was asked if he made random rounds to ensure staff were following protocols, specifically if the smoking area was ever observed? The administrator stated "No; I will be honest...I have not been out there to that area. I do go out on the floors to see if residents are receiving care, but not out to the smoking are. I assumed it was being done per the discussion and training."	F 867	regarding supervision of smokers has been developed and implemented to ensure there is supervision at all times during smoking. **II** **Identification**	
F 880 SS=F	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. §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;	F 880	All the residents residing in the facility, staff, and visitors have the potential to be affected by this alleged deficient practice. **III** **Systematic Changes** The Administrator or Designee will re-educate the QAPI committee members on the identification of deficient practices related to smoking and to develop a plan of action for the correction of the deficient practice related to the supervision of smokers. **IV**	

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F 880	Continued From page 102 §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 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.	F 880	**Monitoring** The Administrator or Designee will complete a weekly audit of smokers for completion of assessment, plan of care, and proper supervision for four weeks and monthly for two months for compliance of this requirement. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **3/23/2019** **F 880**	

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F 880	Continued From page 103 §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 staff interview and facility document review, the facility staff failed to ensure policies and procedures were developed and implemented for an effective water management program for the prevention of legionella and other opportunistic pathogens in the facility's water system. Findings included: On 02/05/19 at 7:30 AM, the survey team entered the facility. Upon entry, the water fountain located on the first floor, in front of the main elevators, had a hand written sign laying on top of the fountain, that read: "Out of Order-Do Not Use." On 02/05/19 at approximately 3:00 PM, the DON (director of nursing) was asked any information on the water management program. The DON stated that is the maintenance department's area. The DON later presented and binder and stated that this binder contained information regarding the water management program, but the maintenance director would have to speak to the water management program. The water management binder was reviewed and did not contain any type of facility risk assessment for the identification where legionella or other waterborne pathogens could grow and spread in the facility water system, did not include any type of control measures (physical,	F 880	It is the practice of this facility to complete policies and procedures are developed and implemented for an effective water management program for the prevention of legionella and other opportunistic pathogens in the facility's water system. I A water management program binder with policies and procedures has been completed and maintained at the facility. Initial testing of water for legionella has been completed with no pathogens identified.	

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F 880	Continued From page 104 temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens), and did not specify testing protocols and acceptable ranges for control measures, did not document results of testing and corrective actions taken when control limits are not maintained. The binder did not have policies/procedures or protocols on how the facility would manage the requirements of a water management program for prevention of legionella or other waterborne pathogens. On 02/05/19 at approximately 3:45 PM, the administrator presented a facility document, "...March 1, 2018...Water Management Program Implementation...is implementing a water management program ...a hard copy of the WMPP [water management program protocol] template document, including section tabs, attachments, and program documentation requirements. The program will need to be customized for each facility, primarily to describe the building water system...after you customize the plan for your facility, please insert the text into the workbook...designed to be used a program binder to keep required documents that may be requested during survey or during a disease investigation, should one occur...each facility will create a water management team..." On 02/06/18 at approximately 9:45 AM, the maintenance director was interviewed regarding information pertaining to the water management program binder for the prevention of legionella. The maintenance director stated, "I don't know nothing about that." The maintenance director stated that he was new and had only been at this facility for two months.	F 880	**II** **Identification** All the residents, staff, and visitors have the potential to be affected by this deficient practice. **III** **Systematic Changes** The Administrator or designee will educate the maintenance director on the water management program, including periodic testing. **IV** **Monitoring**	

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F 880	Continued From page 105 The maintenance director was asked to present any additional information and/or documentation regarding a water management program. The maintenance director was also asked at this time about the water fountain on the first floor, that was posted as non operational. The maintenance director stated that he did not have any work orders in the system regarding the water fountain and that he did not know what was wrong with it. The maintenance director was asked to provide any information regarding the water fountain, as well. On 02/05/19 at approximately 5:30 PM, the DON and administrator were made aware of the above information and were asked for assistance in obtaining any additional information regarding the water management program. The DON and administrator were asked what was wrong with the water fountain. The administrator stated, "It's been broke for years" and further stated that it had been broken for at least a couple of years, that he (the administrator) remembered it being broken before he ever worked here. On 02/07/18 at 7:30 AM, upon entry into the facility, the water fountain that had been non functional (with signage) was removed from the wall and was removed from the area. At approximately 9:30 AM, the administrator, DON and corporate nurse were again informed of concerns regarding the water management program. The administrator stated that he had it. The administrator was asked to present any information. At approximately 9:40 AM the administrator stated that he had requested information be	F 880	The Administrator or Designee will do a weekly audit of the water program binder for the periodic completion of control measures checks and corrective actions documentation for out of range results weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V **Date of compliance is 3/23/2019**	

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F 880	Continued From page 106 faxed to the facility from an outside lab that did testing for legionella on 05/24/18. The information was presented and reviewed. No further information and/or documentation was presented prior to the exit conference on 02/07/19 at 11:30 AM, to evidence that an effective water management program was developed and implemented.	F 880		