STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495235		C 06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		
	An unannounced Emergency Preparedness survey was conducted 06/05/19 through 06/20/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.			
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that	E 004		8/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/18/2019

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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E 004	Continued From page 1 must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to review and revise the emergency plan annually. The findings included: On 6/6/19 during review of the facility emergency preparedness program, the facility staff failed to provide verification that the program had been reviewed annually. On 6/6/19 during an interview with the Administrator when asked for verification of the annual review, the Administrator stated, "that's a good question." On 6/6/19, at the end of the day Employee H, the Regional Clinical Director stated, "I have nothing further to provide."	E 004	The annual review of the facility Emergency Preparedness Plan (EPP) will be completed. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- Emergency Preparedness specific to the required annual review of the EPP. The annual review of the facility EPP has been added to the facility's TELS Preventative Maintenance (PM) calendar, and will continue to be monitored in accordance with the standard. Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in	E 007		8/4/19

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E 007	Continued From page 2 an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to address in their emergency plan the patient/client population, including persons at-risk, and the type of services the facility has the ability to provide in an emergency. The findings included: On 6/6/19 during review of the facility emergency preparedness program, the facility staff failed to address persons at-risk and the services the facility staff can provide in an emergency event. On 6/6/19 during an interview with the Administrator when asked for this information she stated, "I don't have it." On 6/6/19 at the end of the day, Employee H, the Regional Clinical Director stated, "I have nothing further to provide."	E 007	The facility EPP will be updated to include documentation of the persons at-risk and the services the facility staff can provide in an emergency event. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73(a)(3)- EP Program Patient Population specific to the facility EPP including documentation of the persons at-risk and the services the facility can provide in an emergency event, and will continue to monitor in accordance with the standard. Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least	E 009		8/4/19

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E 009	Continued From page 3 annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to include a process for cooperation and collaboration with local, regional, State and Federal emergency preparedness officials to maintain an integrated response during a disaster or emergency situation. The findings included: On 6/6/19 during review of the facility emergency	E 009	The facility EPP will be updated with verification of collaboration or contact with local, regional, State and Federal emergency preparedness officials in emergency planning efforts. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of	

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E 009	Continued From page 4 preparedness program, the facility staff was unable to provide verification of their collaboration or contact with local, regional, State and Federal emergency preparedness officials in emergency planning efforts. On 6/6/19 during an interview with the Administrator when asked for this information she provided a photo of herself with several uniformed individuals. When advised this could have been a presentation she attended, the Administrator stated, "Oh, that's true, I see that." The Administrator was not able to show any verification of local, regional, State and Federal emergency preparedness officials in the development or planning of emergency planning for the facility. On 6/6/19 at the end of the day, Employee H, the Regional Clinical Director stated, "we have nothing further to provide."	E 009	Clinical Services on the importance of 42 CFR 483.73- Local, State, Tribal Collaboration Process specific to the facility EPP including verification of collaboration or contact with local, regional, State and Federal emergency preparedness officials, and will continue to monitor in accordance with the standard. Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must	E 013		8/4/19

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E 013	Continued From page 5 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to review the emergency preparedness policies and procedures annually. The findings included: On 6/6/19 during review of the facility emergency preparedness program, the facility staff provided	E 013	The facility emergency utility policy will be reviewed and updated in the facility EPP. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42	

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E 013	Continued From page 6 an emergency utility policy, which had a review date of 11/30/14. There was no indication that this policy had been reviewed since 2014. On 6/6/19 during an interview with the Administrator when asked for verification of the annual review, the Administrator stated, "I don't have that." On 6/6/19, at the end of the day when Employee H, the Regional Clinical Director was asked again she stated, "I have nothing further to provide."	E 013	CFR 483.73- Development of EP Policies and Procedures specific to reviewing the facility EPP emergency utility policy annually, and will continue to monitor in accordance with the standard. Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to review and revise the communication plan annually. The findings included: On 6/6/19 during review of the facility emergency preparedness program, the facility staff failed to provide verification that the communication policy and procedure had been reviewed annually. On 6/6/19 during an interview with the Administrator when asked for verification of the annual review, the Administrator stated, "I do not have it."	E 029	The facility EPP will be updated with verification that the communication policy has been reviewed. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- Development of Communication Plan specific to reviewing the facility EPP communication policy annually, and will continue to monitor in accordance with the standard.	8/4/19

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E 029	Continued From page 7	E 029	Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the	E 036		8/4/19

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E 036	Continued From page 8 emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to review and revise the training and testing program annually. The findings included: On 6/6/19 during review of the facility emergency preparedness program, the facility staff failed to provide verification that the program had been reviewed annually. On 6/6/19 during an interview with the Administrator when asked for verification of the annual review, the Administrator stated, "I don't have it." On 6/6/19, at the end of the day Employee H, the Regional Clinical Director stated, "we have nothing further to provide."	E 036	The facility will document the annual review of the EPP training and testing program. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- EP Training and Testing specific to reviewing the facility EPP training and testing program annually, and will continue to monitor in accordance with the standard. Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness	E 037		8/4/19

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E 037	Continued From page 9 policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the	E 037		

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procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent

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with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must

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E 037	Continued From page 12 demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to provide initial and annual employee training of the emergency plan. The findings included: On 6/6/19 during review of the facility emergency preparedness program, the facility staff failed to provide verification that the staff had been trained on the facility emergency plan. On 6/6/19 during an interview with the Administrator when asked for verification of the annual review, the Administrator stated, "we review it monthly during our town hall meetings." Sign-in sheets were reviewed and indicated the meetings lasted 30 minutes and a multitude of topics were reviewed in this 30 minute meeting. On 6/6/19, Employee E and LPN A were interviewed and were unaware of the emergency preparedness book and program. On 6/6/19, Employee H, the regional clinical consultant provided a listing of employees who had completed Relias, computer based "Workplace Emergencies and Natural Disasters: An Overview" training. There was no evidence that facility staff had been trained on the facility specific emergency	E 037	The facility EPP will be updated with verification that staff have been trained on the facility emergency plan. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- EP Training and Testing specific to providing staff with initial and annual training on the emergency plan. The Executive Director/ designee will educate staff on the facility emergency plan. Emergency plan training will be added to the facility's training calendar, and will continue to be monitored in accordance with the standard. Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	

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E 037	Continued From page 13	E 037		
	preparedness program.			
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2)	E 039		8/4/19
	(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:			
	*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]			
	(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.			
	(ii) Conduct an additional exercise that may include, but is not limited to the following:			
	(A) A second full-scale exercise that is community-based or individual, facility-based.			
	(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			
	(iii) Analyze the [facility's] response to and			

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E 039	Continued From page 14 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to conduct an exercise analysis, response review and revise the emergency plan based on the analysis. The findings included: On 6/6/19 during review of the facility emergency preparedness program, the facility staff failed to have any analysis and response review of the exercise conducted in September 2018. On 6/6/19 during an interview with the Administrator when asked for the analysis and response review of the incident, the Administrator	E 039	The facility EPP will include documentation of exercise analysis and review, in the form of an After Action Report (AAR), to include areas of improvement. There is only one required EPP, therefore no additional reviews were needed. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- EP Testing Requirements specific to documenting exercise analysis and review, in the form of an AAR, and will continue to monitor in accordance with the	

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E 039	Continued From page 15 stated, "we held a meeting." When asked for minutes or sign in sheet of the meeting, the Administrator stated, "I don't have anything."	E 039	standard. Any findings will be reported to the monthly QAPI Committee for further review. Date of Compliance- 8/4/19	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/05/19 through 06/20/19. Substandard Quality of Care was identified and an extended survey was conducted 06/14/19 through 06/20/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Fourteen complaints were investigated during the survey. Immediate Jeopardy was identified in the area of Abuse, Neglect, and Exploitation at a Scope and Severity Level four, widespread. After abatement, it was lowered to a Level three pattern. The census in this 130 certified bed facility was 118 at the time of the survey. The survey sample consisted of 76 resident reviews.	F 000		
F 550 SS=E	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.	F 550		8/4/19

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F 550	Continued From page 16 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §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 observation, staff interview, and clinical record review, the facility staff failed to maintain dignity for 3 residents (Resident #102, Resident #121, Resident #4) and failed to promote resident	F 550	1. Resident #176 is discharged, CNA-A who was caring for Resident # 102 during the survey observation will be re-educated on resident dignity RN-C is no longer	

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F 550	Continued From page 17 rights for 2 residents (Residents #176, and #30) in a sample size of 76 residents The findings included: 1. For Resident #102, the facility staff left her in bed with her breasts exposed and the privacy and room door open on 06/06/2019. Also, a facility staff member left Resident #102 exposed from the waist down while leaving the room to obtain wipes for pericare on 06/13/2019. Resident #102, a 90-year old female, was admitted to the facility on 09/02/2004. Diagnoses included but not limited to Alzheimer's disease, depression, and generalized muscle weakness. Resident #102's most recent Minimum Data Set with an Assessment Reference Date of 05/05/2019 was coded as a significant change in status assessment. The Brief Interview for Mental Status was coded as 9 out of possible 15 indicative of moderate cognitive impairment. Functional status for bed mobility and dressing were coded as requiring extensive assistance from staff. On 06/06/19 at 08:42 AM, this surveyor stood at the room door which was open and observed Resident #102 lying flat in her bed on her left side, facing the window. Resident #102 did not have bed covers on. She was wearing a hospital gown that covered her back. At the time of the observation, Resident #102 reached for her trapeze bar and turned herself in the bed to a right side lying position, facing the room door/hall. The hospital gown was wide open in the front and ties remained tied around her waist. Resident #102's breasts were fully exposed, her brief was	F 550	employed by the facility. LPN-D who was caring for Resident #121 will be re-educated on resident dignity, RN-C is no longer employed by the facility. Resident #121 has been reviewed for appropriate clothing and shoes/socks on 7/16/19. CNA-A who was observed assisting Resident #4 with her meal during survey has been re-educated on dignity during meals. Resident #30 has been informed that he can bring his dog to the dining room and to activities that include food. 2. All residents have the potential to be effected. Resident Council meeting was held on July 11, 2019 to review dignity and resident rights for any further concerns. 3. All RN's,LPN's and CNA's will be re-educated on dignity and their responsibility for ensuring that residents are cared for in a dignified manner by DON/designee and external clinical consultant. This education will include discussion on exposure, appropriate clothing, maintaining a clean home-like environment, dignity during meal service, and honoring resident choice. In addition, the facility policy on service animals has been reviewed and is consistent with federal ADA guidelines. The leadership and IDT have been in-service on the policy by Executive Director. Resident Council meetings will be held 2x / month x 6 months to obtain resident input of service provision and care.	

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F 550	Continued From page 18 fully exposed, the privacy curtain was open, and the room door was open. Resident #102 did not respond when her name was called and did not attempt to cover herself. This surveyor went to alert staff and returned to room with certified nursing assistant A (CNA A). Before entering the room, this surveyor stated to CNA A that Resident #102 needed assistance. CNA A entered the room and this surveyor stood at the room entrance. CNA A looked at Resident #102 and stated, "She moves around and does her own thing." CNA A did not cover her up and did not pull the privacy curtain. CNA A left the room and when asked if she observed anything that concerned her, she stated that there were supposed to be 6 aides and 3 nurses working but there were only 4 aides working currently, 2 called out. CNA A also stated that 7 people needed assistance eating and that she was assigned "the whole hall." CNA A then walked down the hall, retrieved linen, re-entered Resident #102's room, and closed the door to render care. On 06/13/2019 at approximately 10:15 AM, an interview with the unit manager, Licensed Practical Nurse C (LPN C) was conducted. When notified of observations on 06/06/2019 of Resident #102, LPN C stated CNA A should have made sure [Resident #102]'s "privacy was adhered to; she should've covered her up, pulled the curtain, and got her dressed again." When asked why this was important, LPN C stated it was a privacy and dignity issue. On 06/13/2019 at approximately at 11:00, this surveyor and the wound care nurse, Registered Nurse C (RN C), went to Resident #102 in her room for a skin check. The room door was left ajar and prior to skin assessment, RN C pulled	F 550	Concerns identified during the meetings will be logged in the facility grievance log, investigated, and follow up provided to individual residents and/or to the resident group. 4. Rounds will be conducted 5 days a week x 3 months by assigned leadership team members to observe for resident dignity and if ADL care has been provided appropriately and timely; if variances are identified they will be corrected and/or reported to the Unit Managers for follow-up. Meal observations [resident rooms / dining room / other common area] will be observed 3x per week x 3 months Unit Manager / designee to ensure that residents are being assisted with their meal in a dignified manner. Observed variances will be immediately addressed and staff will be re-educated. Findings from the daily observations will be submitted to the DON / ADON for tracking / trending and additional actions. Findings from the weekly observations and actions taken will be reported to the monthly QAPI Committee for additional oversight and recommendation. The Social Worker / designee will conduct at least 5 resident interviews per week x 3 months with alert and oriented residents to determine if they are being treated in a dignified manner. Findings from the weekly interviews will be shared with the appropriate department head / manager	

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F 550	Continued From page 19 privacy curtain and uncovered Resident #102. Resident #102 was wearing a green sweatshirt, a brief, and no pants so her legs were exposed. Resident #102 stated, "It's cold." RN C did not cover Resident #102's legs after she completed the skin assessment of bilateral lower extremities. RN C assisted Resident #102 to position on the right side and removed Resident #102's brief, noting it was wet. RN C left Resident #102 lying on her right side, exposed and uncovered from the waist down and walked about the room and looked for wipes. Not finding any, RN C left the room for approximately 2 minutes and returned with a washcloth. RN C rendered pericare, completed the skin assessment and left the room with this surveyor. When asked about leaving Resident #102 exposed, RN C stated she shouldn't have left her uncovered. She went on to say she thought the linen cart would be just outside the room door but it wasn't so she needed to go down the hall to get another washcloth. On 06/20/2019 at the conclusion of the survey, the administrator had no further documentation or information to offer. 2. For Resident #121, the facility staff failed to maintain his dignity and cover him as he was ambulating the hall barefoot in a hospital gown with his brief exposed on 06/06/2019. Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to dementia. Resident #121's most recent Minimum Data Set	F 550	for follow up and grievances will be documented in the grievance log along with the facility's response to the resident. Findings from the weekly interviews will be submitted to the Assistant Executive Director weekly for tracking / trending and a summary report will be submitted to the monthly QAPI Committee. A summary of resident concerns and action taken by the facility as identified during the Resident Council meetings will be submitted to the monthly QAPI Committee for additional oversight or recommendation. 5. 8-4-2019	

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F 550	Continued From page 20 with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Functional status for locomotion on unit was coded as not occurring. Functional status for eating was coded as requiring supervision from staff (one-person physical assist for support). Behaviors for psychosis or wandering were coded as not exhibited. On 06/06/19 at 08:26 AM, this surveyor observed Resident #121 in another resident's room (a female resident identified in the sample as Resident #37). Resident #121 was seated on the side of her bed eating her breakfast that was on her tray table. Resident #37 was not in her room (room "A") and her roommate was asleep in her bed by the window. This surveyor alerted Licensed Practical Nurse D [LPN D] at the nurse's station, and LPN D went to room "A" and redirected Resident #121 back to his room (room "B"). Resident #121 was barefoot and wearing a hospital gown that was open in the back exposing his bare back, legs, and a loosely-fitted brief. LPN D did not attempt to cover Resident #121 as she re-directed him to his room. When they reached the doorway of room "B", LPN D instructed Resident #121 to go sit down and then LPN D walked back toward the nurse's station. At 08:30 AM, Resident #121 entered his room and sat down in a chair in front of his tray table. The breakfast plates/tray on top of the table were empty. There were bits of food on the floor under the table, the chair, and under and around the feet of Resident #121. Resident #121 then stood up, walked out into the hall, and asked this surveyor for pancakes. This surveyor alerted nearby staff and the wound nurse, RN C, stated	F 550		

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she would find out how to order more pancakes for Resident #121. Neither nurse addressed Resident #121's open gown, loose brief, bare feet, or the food on the floor in his room.

On 06/06/19 at 09:07 AM, this surveyor observed Resident #121 standing outside room "C". Resident #121 had a hospital gown on, open in the back, exposing his back, legs, and loosely-fitted brief. Employee K, a housekeeper, also saw Resident #121 and told him to go back to his room and pointed in the direction of which hall to walk down to get to his room. There were no nurses seen at the nurse's station by room "C" or down either hall. The housekeeper and this surveyor observed Resident #121 walking into and out of room "D". The housekeeper stated that room "D" used to be Resident #121's room. Resident #121 continued to walk down the hall and entered room "E", walked to the food tray and picked up an unwrapped straw. At that time, certified nursing assistant B [CNA B] entered room "E", saw Resident #121, redirected him, and walked alongside Resident #121 headed toward his room.

On 06/06/2019 at approximately 9:15 AM, LPN D was asked about Resident #121 and she stated "Sometimes he gets confused where his room is, we redirect him."

On 06/13/2019 at approximately 10:15 AM, an interview with the unit manager, LPN C, was conducted. When notified of observations on 06/06/2019, LPN C stated all staff should make sure his dignity remains intact, covering him up, ensuring safety, making sure he had skid-proof socks on, making sure his room is tidy, and also check on him if he's still hungry, get him

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something to eat. When asked how long this behavior had been occurring, LPN C stated that staff said [Resident #121] "does this from time to time" and went on to say "but there's no documentation about it." When asked about expectations for documenting behaviors, LPN C stated she expects to see documentation "any and all behaviors each shift and follow-up so the IDT [interdisciplinary team] can make adjustments and meet their needs." She stated she would also expect to see it on the care plan as it happens.

On 06/20/2019 at the conclusion of the survey, the administrator had no further documentation or information to offer.

3. For Resident #4, a facility staff member stood by her bed while feeding her breakfast on 06/06/2019 thus failing to maintain her dignity.

Resident #4, a 77-year old female, was admitted to the facility on 06/20/2013. Diagnoses included but not limited to schizophrenia, dementia, depression, and dysphagia.

Resident #4's most recent Minimum Data Set with an Assessment Reference Date of 02/16/2019 was coded as a quarterly review. Resident #4 did not have a Brief Interview for Mental Status coded but cognitive skills for daily-decision-making was coded as severely impaired. Eating was coded as total dependence on staff.

On 06/06/19 at 08:32 AM, Resident #4 was in her bed with the head of the bed elevated and

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F 550	Continued From page 23 certified nurse assistant A (CNA A) was observed standing next to Resident #4 feeding her breakfast. On 06/06/19 at 02:13 PM, the observation was shared with the DON and she stated the staff should be sitting when feeding residents. A copy of the policy for assisting residents with meals was requested. By the end of the survey, the facility did not provide a policy. On 06/20/2019 at the conclusion of the survey, the administrator had no further documentation or information to offer. 4. For Resident #176 the facility staff failed honor Resident's choice to go to Emergency Room. Resident #176 a 61 year old woman admitted to the facility on 5/4/18 with diagnoses of but not limited to Atrial Fibrillation, Major Depressive Disorder, and Gastro-Intestinal Hemorrhage. The Resident's most recent (Minimum Data Set) MDS with an Assessment Reference Date of 6/28/18 coded as a Quarterly Assessment coded Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. Resident #176 was also listed as her own (Responsible Party) RP. An entry into the progress notes on 7/4/18 states that the resident requested to be sent out to the Emergency Room due to complaints of Nausea Vomiting and Diarrhea, and having just completed antibiotics for Clostridium Difficile [an inflammation of the colon caused by bacteria].	F 550		

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An excerpt from the progress notes dated 7/4/2018 at 3:22 AM read, "she wanted to get anxiety med but wasn't due for it. She [sic] received pain and n/v [nausea/vomiting] med an hour before. she [sic] had large bm loose and sm amt of vomitus, she asked if she could go to the hospital since nurse could not give axiety [sic] med, and was informed that was not an emergency. "

Resident then called the rescue squad from her cell phone and according to EMS Report dated 7/4/19 the EMS squad was dispatched to the facility and was met at the door by a nurse who stated that she didn't call EMS and it must be a "false alarm." The report goes on to further state "the resident stated she called 911 because the facility staff refuse to take care of her or send her to the hospital, she stated they won't even take my blood pressure."

The EMS report stated that as she was being prepared for transport they noticed a large amount of dark loose stools soaking the bed and the resident. They further state that Resident #176 stated she had been that way for a while that the staff refused to clean her up.

An excerpt from the EMS report stated "While leaving [facility name redacted] some remarks are exchanged between the patient and a nurse that seemed inappropriate and as if grief were being cast on the patient for calling 911."

On 6/11/19 at 10:00 AM in an interview with the DON she stated "If a resident is her own RP and requests to seek emergency medical attention we should get a set of vitals and notify MD of Resident desire to be transferred to ER and then

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F 550	Continued From page 25 call 911. A resident should never have to call the EMS by themselves. During the end of day meeting on 6/20/19 the Administrator was made aware of the issue and no further information was provided. 5. For Resident #30 the facility staff failed to ensure Resident's Right to keep his service dog with him in the dining room during meal service or any activities involving food. Resident #30, a 35 year old man admitted to the facility on 5/11/18 with diagnoses of but not limited to Spina Bifida, Major Depressive Disorder, and Paraplegia. Resident #30's most recent (Minimum Data Set) MDS coded as a Quarterly Assessment, with an (Assessment Reference Date) ARD of 3/14/19 codes Resident #30 as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. The MDS also codes the Resident as using wheelchair for transport and is a total assist for transfers. Resident is unable to stand or bear weight. On 6/5/19 at 2:00 PM during initial tour Resident #30 was observed sitting in his wheelchair in his room with a small dog in his lap. The Resident indicated that the dog was his service dog. Resident stated that the facility staff would not allow the service dog into the dining room. The Resident further elaborated that this also included any activities that included food. The Resident stated he would like to go to Bingo and the Ice Cream Socials, or other activities but was not	F 550		

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F 550	Continued From page 26 allowed to bring his service dog and he stated he could not leave his dog alone in the room because of the "Contract" he signed with the Administrator. On 6/6/19 during clinical record review it was noted that Resident #30's care plan did not address his having a service dog. His care plan however does read: "Encourage resident to attend group activities. Celebrations Parties, Coffee Hour, Cookouts, Bingo" On 6/7/19 at 10:45 AM in an interview with Administrator she was asked if the Dog was allowed in the dining room she stated that she was not. When asked if the Dog was trained she stated that the dog was "well behaved." When asked does the dog cause a disruption in the dining room by barking or begging for food or running around the dining room, she stated that the dog stays in Resident #30's lap. When asked if the dog was being appropriately cared for walked, fed, required shots and medical care and kept clean she stated that she had no problems with the care of the dog. When asked why the dog was not allowed in the dining room she stated "Well we took a vote in Resident Council." Administrator produced a contract and copies of the Dog's Service dog certification as well as the dog's medical record. On 6/7/19 at 11:30 AM, an interview was conducted with Employee N (Activities Director) when asked if she was a part of the	F 550		

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F 550	Continued From page 27 Interdisciplinary Team who wrote care plans, and she indicated that she was. When asked if she knew that Resident #30 had a service dog she indicated that she was aware. When asked if she had input on his care plan dated 2/15/19 she stated that she had. When asked if she was aware the care plan suggested inviting Resident #30 to group activities such as Celebrations and Parties, Coffee Hour, Cookouts and Bingo. Employee N admitted she was aware of those entries in the care plan. When asked how the Resident can attend the activities if he could not bring his service dog she replied "I bring him ice cream and coffee and any food we have at the events since he cannot bring the dog in the dining room." When asked if she was aware that the activities were not just about food but also about socialization, she indicated she was aware but the Administrator would not let the dog in the dining room. During the end of day meeting the Administrator was made aware of the findings and no further information was provided.	F 550		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident	F 551		8/4/19

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must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.
(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.
(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of

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F 551	Continued From page 29 competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure Residents were afforded their right to designate a representative, for 3 Residents (Resident's #38, #66, and #76) in a survey sample of 76 residents. The findings include: 1. For Resident #38 the facility staff issued ABN Part B notice to Resident who is not her own Responsible Party. Resident #38, a 68 year old woman admitted to the facility on 11/30/15 with diagnoses of but not limited to Cognitive Communication Deficit. Schizoaffective Disorder, Anxiety Disorder, Unspecified Psychosis not due to a substance or known physiological condition, and Major Depressive Disorder. On 6/7/19 upon review of clinical records it was found that in the nurse's notes for Resident #38, the Social Worker (Employee L) wrote the	F 551	1. Resident #38 husband was notified on 7/9/19 of ABN; Resident #66 on 7/15/19 a copy of the ABN was mailed Certified to Catholic Charites. Resident #76□s RP was notified regarding the smoking policy and procedure, refusal of care and treatments, and status of wounds, and Advanced Beneficiary Notice. 2. All residents have the potential to be impacted. A review of current residents will be completed to ensure that the resident□s representative is clearly identified in the medical record. 3. DON, and or Designee will educate the Social Worker and licensed nursing staff to check the medical record for identification of the resident□s representative and to notify appropriately. The Social Worker or designee will review the resident□s medical record at least quarterly during the care plan process to ensure that the resident representative□s	

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F 551	Continued From page 30 following: 4/5/19 4:43 PM -Social Service Progress Note Social Services Visit- The resident was issued a Part B ABN [Advance Beneficiary Notice] for her therapy services. The resident fully understood the document. On 6/10/19 at 3:15 PM an interview was conducted with Social Workers (Employees K and L) they were asked if Resident #38 was her own (Responsible Party) RP. Employee K stated that the Resident was not her own RP and Employee L stated that he was not sure. They looked in the EMR (electronic medical record) and found that Resident #38's spouse was her RP. When asked if Resident #38 is able to sign her own ABN notices the Employee K stated that when a Resident is not his or her own RP all legal and financial documents must be signed by the RP. On 6/20/19 during the end of day conference the Administrator was made aware and no further information was provided. 2. For Resident #66 the facility staff issued ABN Part B notice to Resident who is not his own Responsible Party. Resident # 66, a 73 year old man admitted to the facility on 12/21/18 with diagnoses of but not limited to Peripheral vascular disease, hypertension, muscle weakness, Chronic Kidney Disease. Resident most recent (Minimum Data	F 551	name and contact information is accurate and documented in the medical record. The Social worker will be re-educated on completing and notifying resident / representative when a resident is no longer receiving Medicare Part A services by Clinical Quality Specialist. 4. The Unit Managers / designee will audit 5 resident records per week x 3 months, of residents who required notification to the resident / resident representative for a change in condition or who were no longer eligible for Medicare Part A services. If variances are found the appropriate resident representative will be notified and the responsible staff member will be re-educated. The results will be reported to the Quality Assurance Performance Committee by the DCS for further compliance 5. 8-4-2019	

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F 551	Continued From page 31 Set) MDS a quarterly with an ARD (Assessment Reference Date) of 4/25/19, coded resident as having a (Brief Interview of Mental Status) score of 10 indicating moderate cognitive impairment. On 6/7/19 during clinical record review it was noted that Employee L made the following entries into Residents chart: 4/19/19 2:36 PM "Social Services Visit - The resident was issued a PART B ABN [Advance Beneficiary Notice] for therapy services ending on 4/23. The resident understood the document." 4/23/19 2:59 PM "Social Services Visit - Social Services and the Business Office Manager issued the Notice of Medicare Non-coverage and SNFABN to the resident. The resident fully understood both documents." On 6/7/19 at 3:15 PM an interview was conducted with Social Workers (Employees K & L) they were asked if Resident #66 was his own RP. Employee K stated that Resident #66 was not his own RP. They looked in the EMR (electronic medical record) and found Resident # 66 was represented by a legal guardian with a local charity organization. When asked if Resident #66 is able to sign his own ABN notices the Employee K stated that when a Resident is not his or her own RP all legal and financial documents must be signed by the RP. On 6/20/19 during the end of day meeting the Administrator was made aware of the issues and no further information was provided	F 551		

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	3. For Resident #76 the facility staff issued ABN notices and Smoking Policy Documents to Resident who is not his on RP. Resident #76 a 68 year old man admitted to the facility on 4/9/19 with diagnoses of but not limited to Paranoid Schizophrenia, Parkinson's disease, Schizophrenia and Unspecified, Mood Disorder. On 6/7/19 during clinical record review it was noted that Resident # 76 was not his own Responsible Party. Resident #76's Responsible Party is his sister. Entry into nursing progress notes dated 6/5/19 at 5:45 PM gives dimensions of wounds and the treatment orders then states " Resident is own Responsible Party and aware of treatments." On 6/11/19 interview was conducted with Unit Manager who stated "I spoke with his sister yesterday she is his medical Power of Attorney as well as Financial." On 6/20/19 during the end of day conference the Administrator was made aware and no further information was provided.			
F 558 SS=G	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		8/4/19

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F 558	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record interview, facility documentation review, and in the course of investigating a complaint, the facility staff failed make reasonable accommodations of needs for 3 (resident #25, 37, and 30) of 76 sampled residents. This resulted in harm for Resident #25. The Findings included: 1. The facility staff failed to provide an appropriately sized bed for Resident #25 who was 7 feet tall and weighed 466 pounds, resulting in psychological harm. Resident #25 was a 45 year old who was admitted to the facility in 10/4/17. His diagnoses included Bipolar Disorder, Right Shoulder Pain, Insomnia, Major Depressive Disorder, Anxiety, Generalized Muscle Weakness, Pain in Left Knee, Abnormal Posture, Difficulty Walking, Lack of Coordination, and Osteoarthritis of the Right Hand. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/11/19 was reviewed. Resident #25 was coded as requiring the extensive physical assistance of 2 or more persons for transfers, personal hygiene, and toileting. On 6/05/19 at 2:34 P.M., during a facility tour, Resident #25's door was observed to be open. From the hallway, the resident was observed with his legs (from the knee down) and feet hanging	F 558	1. For Resident #25 the bed was adjusted during survey. New bed given to resident on 07/03/19. For Resident #37 linen was supplied to the unit and resident was bathed and gotten out of bed. For Resident #30 he was informed by the Executive Director during Survey that his service dog would be permitted to go into the dinning area with his service dogs and attend activities that involved food with his dog. 2. All residents have to potential to be affected. An audit of all current residents to ensure they are on the correct size of bed. Follow-up based on Findings. An inventory of linen was performed and follow up based on finding. The dog is allowed in dining area. 3. All RN□s, LPN□s, CNA□s and Activity Staff will be educated by the DON or designee on accommodation of resident□s needs, i.e.: beds that fit, linen that fit bed, and service animals. A Resident Council meeting will be held to review residents□ rights regarding dignity, privacy, reasonable accommodation of need, self-determination, and will include a review of the facility policy on service animals and the facility process for expressing concerns and grievances. Resident Council meetings will be held 2x month x 6 months. Concerns identified during the meetings will be logged in the facility grievance log, investigated, and	

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F 558	Continued From page 34 over the foot of his bed. Upon entering the room, the resident was interviewed. Resident #25 complained of not being able to move in the bed. He stated that he cut his foot on the footboard because he couldn't stretch his leg out. He said because of the injury, the staff had removed the footboard and placed against the wall. He pointed to the footboard, which was on the floor, placed against the wall opposite the foot of his bed. An observation was made of the second toe of his right foot, which had a laceration on it. Resident #25 stated that his bed was too short, and that it had caused him to feel humiliated, anxious and frustrated. He stated that he transferred rooms in February, and that he had an appropriately long bed in his former room. He stated that the facility did not transfer the bed with him. He further stated that he was frustrated due to his inability to move around and shift his weight in the bed. He stated that the facility had refused to set up transportation and help him obtain outside psychiatric services, as was his preference. On 6/5/19 an observation was conducted of Resident #25's former room and bed. The extended length bariatric bed was in the room. On 6/6/19 at 9:15 A.M., an interview was conducted with the Regional Clinical Director (Employee H) in the hallway outside of Resident #25's room. His door was open. When asked to describe what she noticed about Resident #25, she stated, "He's hanging off, it could cause pressure sores. You can develop a pressure ulcer very quickly. You should change position every two hours." Upon entering the room, Resident #25 was asked by the surveyor to describe how	F 558	follow up provided to individual residents and/or to the resident group. 4. Rounds will be conducted 5 days / week x3 months by assigned leadership team members to observe for resident reasonable accommodation of needs. Findings from the daily observations will be submitted to the DON / ADON for tracking / trending and additional actions. Findings from the weekly observations and actions taken will be reported to the monthly QAPI Committee for additional oversight and recommendation. The Social Worker / designee will conduct 5 interviews per week x 3 months with alert and oriented residents to determine if they are being treated in a dignified manner. Findings from the weekly interviews will be shared with the appropriate department head / manager for follow up and grievances will be documented in the grievance log along with the facility□s response to the resident. Findings from the weekly interviews will be submitted to the Assistant Executive Director weekly for tracking / trending and a summary report will be submitted to the monthly QAPI Committee. A summary of resident concerns and action taken by the facility as identified during the Resident Council meetings will be submitted to the monthly QAPI Committee for additional oversight or recommendation.	

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F 558	Continued From page 35 the bed affected him. He stated, "It restricts my movement. I have to stay in one position. I can't move from side to side. I feel cramped. My neck gets stiff on the right side. I feel anxiety and depression. I want to see an outside psychiatrist, and I want a longer bed." On 6/6/19 at 6:00 P.M. an interview was conducted with the facility Administrator. She stated, "I found out how to extend the bed. We did it and added a mattress extender. We have fitted sheets." When asked why the bed hadn't been adjusted since February, the Administrator did not respond. A follow-up observation was conducted of Resident #25 in his bed. His legs and feet were on the mattress and he appeared to be comfortable. His bed had been adjusted, and he stated that he was more comfortable and satisfied with it. On 6/6/19 a review was conducted of facility documentation, revealing the manufacturers' instructions. The Bar 750 Bariatric bed width could be extended from 39 inches to 48 inches. The length could be extended from 88 inches to 96 inches. The weight limitation was 750 pounds. On 6/5/19 a review was conducted of Resident #25's clinical record. His most recent recorded weight was 466 pounds, as recorded on 6/5/19, and his height was 7 feet. According to the Social Service progress notes, Resident #25 complained of being depressed on 4/11/19, 4/12/19, and on 4/27/19 the resident requested psychiatric services due to depression. On 5/3/19 the facility Nurse Practitioner ordered Zoloft 50 MG every morning.	F 558	5. 8-4-2019	

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F 558	Continued From page 36 On 6/17/19 an interview was conducted with the Interim Director of Nursing (Employee B). She stated, "The proper bed should have been available at the time of the move.	F 558		
	2. For Resident #37, the facility failed to provide linen so she could receive A.M. care on 06/11/2019.			
	Resident #37, a 69-year old female, was admitted to the facility on 03/15/2016. Diagnoses included but not limited to schizophrenia, dementia, generalized muscle weakness, and ankle contractures.			
	Resident #37's most recent Minimum Data Set with an Assessment Reference Date of 03/21/2019 was coded as a quarterly review. The Brief Interview for Mental Status was not completed but cognitive skills for daily decision-making were coded as moderately impaired. Rejection of Care was coded as occurring 1 to 3 days of the 7-day look-back period. Functional status for dressing and personal hygiene were coded as requiring extensive assistance from staff.			
	On 06/11/2019 at approximately 8:40 AM, Resident #37 was observed in a hospital gown lying in her bed with the head of the bed elevated approximately 45 degrees. Resident #37 stated she wanted to get out of bed now. This surveyor returned to the nurse's station to alert staff Resident #37 would like to get out of bed. CNA F was standing at the nurse's station looking down at her cell phone. CNA F quickly put her cell phone in her pocket, shook her head and stated,			

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F 558	Continued From page 37 "We don't have any linen." CNA F went on to explain they need to bathe [Resident #37] before she gets up; otherwise, she won't cooperate later. The small linen cart by room "A" was empty. On 06/11/19 at approximately 9:00 AM, an interview with the Director of Linen Services, Employee P, was conducted. When asked about his expectation for linen par levels, Employee P stated he just started working here 4 weeks ago and has been working on "adjusting to make better par levels." Employee P stated he needed to get with nursing to "see what they need." Employee P expects there should be three sheet sets per bed. When asked how many beds are on the liberty unit [where Resident #37 resides], Employee P stated, "I don't know, I need to find out." Employee P provided a copy of a form entitled, "Linen Delivery Schedule" and it contained a list of the following linen par levels for the unit where Resident #37 resides: Flat sheets (35), fitted sheets (35), pillow cases (10), towels (60), washcloths (60), gowns (10), pads (10), blankets (6), and spreads (6). When asked if the nursing staff currently had linen on the unit where Resident #37 resides, Employee P stated, "No, because the cart is being filled now [in the laundry room] and will be transported to the unit after filling. On 06/11/19 at approximately 09:35 AM, an interview with the unit manager, Licensed Practical Nurse C [LPN C], was conducted. When asked about the census on the unit where Resident #37 resides, LPN C referred to the electronic records and stated there were 45 people on the unit and of those 45 people, 10 are continent. For incontinent residents, LPN C stated "We change their linen daily. LPN C stated for	F 558		

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F 558	Continued From page 38 approximately 6 or 7 residents, the sheets are changed at least every shift. When asked if the unit runs out of linen, she stated that the nurses do run out of linen. LPN C also stated that she has spoken with the linen department about it because "They need to provide more linen." There were 45 residents residing on the unit and a par level of 35 fitted sheets, 35 flat sheets, and 10 pillow cases. On 06/20/2019 by the end of survey, the interim administrator had no further documentation or information to offer. 3. For Resident #30 the facility staff failed to ensure a reasonable accommodation of needs. Resident #30 could not take his service dog with him in the dining room during meal service or any activities involving food but he also could not leave his service dog alone in his room in order to attend meal service in the dining room or activities that involved food. Resident #30, a 35 year old man admitted to the facility on 5/11/18 with diagnoses of but not limited to Spina Bifida, Major Depressive Disorder, and Paraplegia. Resident #30's most recent (Minimum Data Set) MDS coded as a Quarterly Assessment, with an (Assessment Reference Date) ARD of 3/14/19 codes Resident #30 as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. The MDS also codes Resident as using wheelchair for transport and is a total assist for transfers. Resident is unable to stand or bear weight.	F 558		

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F 558	Continued From page 39 On 6/5/19 at 2:00 PM during initial tour Resident #30 was observed sitting in his wheelchair in his room with a small dog in his lap. The Resident indicated that the dog was his service dog. Resident stated that the facility staff would not allow his service dog into the dining room. The Resident further elaborated that this also included any activities that included food. The Resident stated he would like to go to Bingo and the Ice Cream Socials, or other activities but was not allowed to bring his service dog and he stated he could not leave his dog alone in his room because of the "Contract" he signed with the Administrator. On 6/7/19 at 10:45 AM in an interview with Administrator she was asked if the Dog was allowed in the dining room she stated that she was not. When asked if the Dog was trained she stated that the dog was "well behaved." When asked does the dog cause a disruption in the dining room by barking or begging for food or running around the dining room, she stated that the dog stays in Resident #30's lap. When asked if the dog was being appropriately cared for walked, fed, required shots and medical care and kept clean she stated that she had no problems with the care of the dog. When asked why the dog was not allowed in the dining room she stated "Well we took a vote in Resident Council." Administrator produced a contract and copies of the Dog's Service dog certification as well as the dog's medical record.	F 558		

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F 558	Continued From page 40	F 558		
	During the end of day meeting the Administrator was made aware of the findings and no further information was provided.			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility documentation,	F 561	1. Resident #66 sent to ER per his request. Resident has not had any	8/4/19

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F 561	Continued From page 41 facility staff failed to ensure Resident right to self-determination for 1 Resident (#66) in a survey sample of 76 Residents. The Findings Include: For Resident #66 the facility staff failed to arrange transportation to medical appointments. Resident # 66 a 73 year old man admitted to the facility on 12/21/19 with diagnoses of but not limited to Peripheral Vascular Disease, Hypertension, [Chronic Obstructive Pulmonary Disease] COPD and Chronic Kidney Disease. On 6/11/19 it was noted that Resident #66 was seen by the facility (Nurse Practitioner) NP on 2/4/19. According to the note, the Resident was seen for edema to his right foot. Resident #66 was having pain rated 6/10 on the pain scale. The Resident had X-Rays that showed no fracture or traumatic injury. She also states the Resident's skin is "Erythematous [Red], cool to touch with no ulcers or lesions." She ordered a "Doppler Study" [ultrasound of foot] The nurses notes on 2/6/19 at 3:39 PM state "Order received from NP [name redacted] to start Keflex 500 [milligrams] mg. three times daily for 10 days and follow up with vascular doctor in regards to Doppler Report findings." On 2/8/19 the Resident was seen again by the facility NP her notes state: "Pt is 73 yr. old man being seen for arterial duplex ultrasound f/u [follow up]. Ultrasound results reviewed and discussed with pt. Pt reports he has pain to his right foot when it is touched. There has not been any changes in color or	F 561	appointments since survey. 2. Current residents that request ER have the potential to be affected. Resident's requiring transport to outside appointments or the Emergency Department may be at risk. Each Unit Manager will maintain a resident appointment schedule and will coordinate transport arrangements with the social worker/designee. Transfer forms will clearly identify the desired destination and transport drivers will be informed of location for all appointments. 3. The facility protocols for scheduling appointments and coordination of transport arrangements will be reviewed with Unit Managers, nursing supervisors, and Social Work by the DON or designee. Licensed nursing staff will be educated by the DON / designee on the importance of documenting when a resident leaves for an appointment or is transferred to the Emergency Department. 4. An audit will be conducted of 5 residents per week x 3 months that are sent out for appointments or transferred to Emergency Department to ensure that transfer requirements are met, that the resident was appropriately transported to the desired location. The results of the weekly audits will be reported to the DCS for tracking and a summary report of the audits will be submitted to Quality Assurance Performance Committee by the DCS for compliance	

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F 561	Continued From page 42 edema since the last visit." The NP ordered a consult with the Vascular Surgeon. Progress note entered 3/1/19 at 8:34 AM read: "Vascular consult ordered for eval and treat of right foot per NP Social Services Aware. On 3/1/19 at 3:15 PM reads: "Social Services Progress note: Social services faxed vascular lab to [facility name redacted] for possible consult Social services will follow up." On 3/14/19 at 5:45 PM the progress note reads: Social Services filed a complaint with the [transport company name redacted] about the resident not being picked up for his vascular appointment today. The resident's appointment was rescheduled for 3/21/19 at 8:15 AM Social Services confirmed that [transport company name redacted] will transport resident to his appointment on 3/15/19" [sic] According to Resident #66's face sheet the Resident has an appointed RP [Responsible Party] through a local charity organization. On 3/19/19 at 2:00 PM the progress note reads "Social Service progress note - Social Services verified with [transport company name redacted] that the resident will be transported by [name redacted] to his appointment on 3/21/19 at 8:15 AM." According to the progress notes on 3/21/19 " Patient is requesting to go to the ER for his foot, staff has tried to convince him to change his clothes and he is refusing to do so stating that his outfit is perfectly fine and he has no need to clean	F 561	8-4-2019	

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F 561	Continued From page 43 up" According to the ER notes on 3/22/19: "Resident #66 presented to the ER on 3/22/19 unkempt, cachexic, and leg swelling and pain worsening over the past few days." "He was apparently seen at [name of hospital redacted] yesterday [3/21/19] and they suggested he come here." "We will admit patient for IV antibiotics over the weekend and reassess for possible amputation on Monday." "[Physician name redacted] does not feel that this can be revascularize." 6/10/19 at 11:00 AM during an interview with Resident #66 he stated "They messed up my appointments and took me to the wrong hospital. I didn't want to go to that hospital I wanted to go to [hospital name redacted], and they lost me and sent transportation to the wrong place and I didn't get home until late." On 6/10/19 during clinical record review, it was noted that the facility records do not show resident being transported to the hospital on 3/21/19 or his return to facility and referral to go to another hospital. On 06/12/19 03:02 PM the Administrator was interviewed about the resident not being scheduled and transported to appointments in timely manner. The administrator stated "At that time Social Workers were supposed to make the appointments for transportation for doctor appointments, we now have the nurses make the medical appointments and the Social Workers arrange for transportation."	F 561		

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F 561	Continued From page 44 On 6/20/19 during the end of day conference the Administrator was made aware and no further information was provided.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the	F 565		8/4/19

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F 565	Continued From page 45 families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and facility documentation review, the facility staff failed to act promptly to, and respond to grievances of residents and resident council for 14 Residents (Resident #58, Resident #30, Resident #86, Resident #108, Resident #71, Resident #67, Resident #10, Resident #117, Resident #104, Resident #54, Resident #112, Resident #56, Resident #76, and Resident #21) in a survey sample of 76 Residents. The findings included: On 6/6/19 during a Resident Council meeting, multiple residents verbalized that the facility staff do not respond to their concerns and do not give any rationale when concerns are not acted upon. Review of the Resident Council minutes from meetings held on 4/17/19, 5/2/19, and 5/9/19 revealed that concerns shared during the resident council meeting had not been resolved/completed as of 6/6/19. Resident #58, Resident #30, Resident #86, Resident #108, Resident #10, and Resident #32 attended the resident council meeting held 4/17/19 as well as 4 other residents. Resident #71, Resident #67, Resident #10, Resident #86, Resident #117, Resident #104, Resident #54, Resident #112, Resident #56, Resident #76, Resident #21, Resident #58 and 8 other residents attended the resident council meeting held on 5/2/19.	F 565	1. Residents #58, #30, #86, #108, #71, #67, #10, #117, #104, #54, #112, #56, #76, and #21) concerns were addressed with follow up based on findings. On-going concerns are being addressed by the Grievance Officer. 2. All residents had the potential to be affected. A Resident Council was held on 7/17/19 and the residents were educated on the ongoing facility process for grievances. 3. The IDT team was educated by Divisional Executive Director on facility grievance protocol going forward. Posting of who the grievance officer is and how to contact them has been updated. Resident Council meetings will be held 2 x month for 6 months; minutes will be maintained, and feedback will be provided to individual residents and/or the Resident Council on identified concerns. 4. Minutes from the Resident Council meeting will be submitted to the Assistant Executive Director for follow-up. A summary of identified concerns and actions taken will be submitted to the monthly QAPI Committee. 5. 8/4/2019	

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F 565	Continued From page 46 Resident #30, Resident #10, Resident #112, Resident #108, Resident #58, Resident #76 and 4 other residents attended the resident council meeting held on 5/9/19. Review of the facility grievance log revealed that over one hundred complaints and grievances filed by residents and resident council for the past year had a status of: "in progress" and had not been resolved/addressed. An interview was conducted with Employee H, Regional Clinical Director on 6/6/19. When asked about the percentage completed on the grievance log, Employee H stated, "it means one of the people signed it and never followed up." Review of the facility policy, titled "Clinical Guideline- Complaint/Grievance" stated, "the intent of this guideline is to support each resident's right to voice grievance and to assure that after receiving a complaint/grievance, the center actively seeks a resolution and keeps the resident appropriately apprised of its progress towards resolution." Review of the facility policy, titled "Resident abuse" with a revision date of 2/1/17 stated, "the company has provided many avenues to address concerns, complaints, and grievances without the fear of retribution. These include: Resident Council."	F 565		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes	F 567		8/4/19

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F 567	Continued From page 47 the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and	F 567	1. Residents #10, #112, and #119 have	

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F 567	Continued From page 48 facility documentation review, the facility staff failed to ensure Residents have access to their personal funds that the facility acts as fiduciary of, for four Residents (Resident #40, Resident #112, Resident #119, Resident #10) in a survey sample of 76 Residents. The findings included: 1. For Resident #40, the facility staff failed to provide the Resident access to her personal funds. Resident #40 was admitted to the facility 12/16/15 with a most recent readmission date of 11/29/18. Resident #40 shared during the Resident Council meeting held on 6/6/19 that the facility frequently runs out of money and is not able to provide her access to her funds for several days. On 6/6/19 at 4:00pm an interview was conducted with Employee S, Receptionist. Employee S stated she is the one that gives out Resident personal funds. When asked if they run out of money she said "yes, if we run out we are out until someone goes to the bank." When asked how often this happens she stated, "it has happened twice since I have been here and I have been here a little over a week." Review of the facility policy titled, Resident Trust Fund- Banking Hours with a revision date of 6/8/17 read, "to allow residents to have access to his or her funds through the day." 2. For Resident #112, the facility staff failed to	F 567	been provided education on accessing personal funds. Resident #40 no longer lives at the facility. 2. Residents that have facility act as fiduciary manager may be at risk. Information on accessing personal fund accounts will be provided to the residents during the Resident Council meeting on 7/17/19. 3. Business Office Manager has a list of staff that can go to bank and cash checks. If one of them is out, she will adjust the schedule for another staff person to go to bank. Weekly schedule will be given to Interim ED weekly. The Business Office Manager was re-educated on the regulations regarding personal fund accounts and the facility policy and processing for ensuring resident funds are managed appropriately by the Divisional Executive Director. 4. Resident Council will meet 2x month for at least 6 weeks and identified concerns regarding personal funds will be addressed. Grievances will be reviewed and investigated with notification of actions taken to the resident or resident representative. Findings from the Resident Council and grievances will be submitted to the Assistant ED weekly and a report will be provided to the monthly QAPI Committee for additional oversight and recommendation. 5. 8/4/2019	

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F 567	Continued From page 49 provide the Resident access to his personal funds. Resident #112 was admitted to the facility on 5/1/19. During the Resident Council meeting on 6/6/19, Resident #112 stated that they run out of money on Friday and he had to wait until the next week, after someone went to the bank, to access his funds." On 6/6/19 at 4:00pm an interview was conducted with Employee S, Receptionist. Employee S stated, she is the one that gives out Resident personal funds. When asked if they run out of money she said "yes, if we run out we are out until someone goes to the bank." When asked how often this happens, she stated, "it has happened twice since I have been here and I have been here a little over a week." Review of the facility policy titled, Resident Trust Fund- Banking Hours with a revision date of 6/8/17 read, "to allow residents to have access to his or her funds through the day." 3. For Resident #119, the facility staff failed to provide the Resident access to her personal funds. Resident #119, was admitted to the facility on 12/26/14 with a readmission date of 10/20/17. On 6/6/19 during the Resident Council meeting, Resident #119 stated that she has difficulty getting money from the bank at times.	F 567		

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F 567	Continued From page 50 On 6/6/19 at 4:00pm an interview was conducted with Employee S, Receptionist. Employee S stated she is the one that gives out Resident personal funds. When asked if they run out of money she said "yes, if we run out we are out until someone goes to the bank." When asked how often this happens she stated, "it has happened twice since I have been here and I have been here a little over a week." Review of the facility policy titled, Resident Trust Fund- Banking Hours with a revision date of 6/8/17 read, "to allow residents to have access to his or her funds through the day." 4. For Resident #10 the facility staff failed to provide the Resident access to his personal funds. Resident #10 was admitted to the facility on 8/17/16. On 6/6/19, Resident #10 stated that on numerous occasions he has not been able to access his personal funds because the facility has run out of money and no one goes to the bank. On 6/6/19 at 4:00pm an interview was conducted with Employee S, Receptionist. Employee S stated, she is the one that gives out Resident personal funds. When asked if they run out of money she said "yes, if we run out we are out until someone goes to the bank." When asked how often this happens she stated, "it has happened twice since I have been here and I have been here a little over a week."	F 567		

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F 567	Continued From page 51 Review of the facility policy titled, Resident Trust Fund- Banking Hours with a revision date of 6/8/17 read, "to allow residents to have access to his or her funds through the day."	F 567		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on Resident interview and staff interview, the facility staff failed to provide quarterly statements to Residents of their personal funds entrusted to the facility on the Resident's behalf for four Residents (Resident #40, Resident #112, Resident #119 and Resident #10) in a survey sample of 76 Residents. The findings included: 1. For Resident #40, the facility staff failed to provide the Resident a quarterly statement of her personal funds. Resident #40 was admitted to the facility 12/16/15	F 568	1. Resident #40 is discharged from facility, #112 received quarterly statement on 7/9/19, #119 received her Quarterly Statement on 7/9/19and #10 received Quarterly Statement on 7/15/19. 2. All residents that have a Resident Fund Management System account have the potential to be impacted. Quarterly statements will be completed and provided to current resident and/or resident representative. 3. The Business Office Manager was re-educated by the Divisional Executive	8/4/19

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F 568	Continued From page 52 with a most recent readmission date of 11/29/18. Resident #40 shared during the Resident Council meeting held on 6/6/19 that the facility does not provide a quarterly statement of personal funds held at the facility. On 6/17/19 at 2:32pm an interview was conducted with Employee I, Business Office Manager. Employee I stated, "that was identified during my last audit, I didn't have anything showing they receive quarterly statements." 2. For Resident #112, the facility staff failed to provide the Resident a quarterly statement of her personal funds. Resident #112 was admitted to the facility on 5/1/19. Resident #112 shared during the Resident Council meeting held on 6/6/19 that the facility does not provide a quarterly statement of personal funds held at the facility. On 6/17/19 at 2:32pm an interview was conducted with Employee I, Business Office Manager. Employee I stated, "that was identified during my last audit, I didn't have anything showing they receive quarterly statements." 3. For Resident #119, the facility staff failed to provide the Resident a quarterly statement of her personal funds.	F 568	Director on the regulations regarding personal fund accounts and the facility policy and processing for ensuring resident funds are managed appropriately. 4. A Quarterly Audit will be sent to Divisional Executive Director from the Regional Director of Business Office Services. If variances are found, they will be immediately corrected and appropriate action taken. 5. 8/4/2019	

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F 568	Continued From page 53 Resident #119, was admitted to the facility on 12/26/14 with a readmission date of 10/20/17. Resident #119 shared during the Resident Council meeting held on 6/6/19 that the facility does not provide a quarterly statement of personal funds held at the facility. On 6/17/19 at 2:32pm an interview was conducted with Employee I, Business Office Manager. Employee I stated, "that was identified during my last audit, I didn't have anything showing they receive quarterly statements." 4. For Resident #10, the facility staff failed to provide the Resident a quarterly statement of her personal funds. Resident #10 was admitted to the facility on 8/17/16. Resident #10 shared during the Resident Council meeting held on 6/6/19 that the facility does not provide a quarterly statement of personal funds held at the facility. On 6/17/19 at 2:32pm an interview was conducted with Employee I, Business Office Manager. Employee I stated, "that was identified during my last audit, I didn't have anything showing they receive quarterly statements."	F 568		
F 569 SS=E	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives	F 569		8/4/19

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F 569	Continued From page 54 Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review the facility staff failed to notify residents when the amount in their account reaches $200 less than the SSI resource limit that may affect their eligibility for Medicaid for 7 Residents (Resident #65, Resident #38, Resident #117, Resident #125, Resident #55, Resident #107, and Resident #109) in a survey sample of 76 Residents. The findings included: 1. Resident #65 was admitted to the facility on 4/4/17 and was a current Medicaid recipient. Review of the facility resident trust general ledger on 6/17/19 revealed that Resident #65's balance	F 569	1. Residents #65 was made aware on 7/15/19, #38. 7/9/19, #117 was discharged from the facility, #125, #55, #107, #109 were made aware on 7/11/19 that they were approaching maximum limits in the their Resident Fund Management System (RFMS) accounts of $1800; $200 less than the Medicaid eligibility. 2. All Medicaid residents with RFMS Accounts may have been at risk. 3. The Business Office Manager (BOM) was re-educated by the Divisional Executive Director on the regulations regarding personal fund accounts and the	

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F 569	Continued From page 55 was $1.88 less than the resource limit for Medicaid eligibility. An interview was conducted with Employee I, Business Office Manager on 6/17/19. When asked if Resident #65 was made aware of the balance when it reached $200 less than the Medicaid resource limit. The Business Office Manager, stated, "no we did not." 2. Resident #38 was admitted to the facility on 4/24/17 and was a current Medicaid recipient. Review of the facility resident trust general ledger on 6/17/19 revealed that Resident #38's balance exceeded the resource limit for Medicaid eligibility by $912.53. An interview was conducted with Employee I, Business Office Manager on 6/17/19. When asked if Resident #38 was made aware of the balance when it reached $200 less than the Medicaid resource limit. The Business Office Manager, stated, "no we did not." 3. Resident #117 was admitted to the facility on 9/12/01 and was a current Medicaid recipient. Review of the facility resident trust general ledger on 6/17/19 revealed that Resident #117's balance was $74.30 less than the resource limit for Medicaid eligibility. An interview was conducted with Employee I, Business Office Manager on 6/17/19. When	F 569	facility policy and processing for ensuring resident funds are managed appropriately, including notice to resident / resident representatives are nearing the maximum amount allowed. 4. B.O.M. /designee will print RFMS weekly account summary and give to Divisional Executive Director/designee to check if any residents are $200 less than the allowable Medicaid resources. Findings from the weekly audits will be submitted to the monthly QAPI committee for review and recommendation. 5. 8/4/2019	

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F 569	Continued From page 56 asked if Resident #117 was made aware of the balance when it reached $200 less than the Medicaid resource limit. The Business Office Manager, stated, "no we did not." 4. Resident #125 was admitted to the facility on 5/24/19 and was a current Medicaid recipient. Review of the facility resident trust general ledger on 6/17/19 revealed that Resident #125's balance was $34.01 less than the resource limit for Medicaid eligibility. An interview was conducted with Employee I, Business Office Manager on 6/17/19. When asked if Resident #125 was made aware of the balance when it reached $200 less than the Medicaid resource limit. The Business Office Manager, stated, "no we did not." 5. Resident #55 was admitted to the facility on 2/2/17 and was a current Medicaid recipient. Review of the facility resident trust general ledger on 6/17/19 revealed that Resident #55's balance exceeded the resource limit for Medicaid eligibility by $470.11. An interview was conducted with Employee I, Business Office Manager on 6/17/19. When asked if Resident #55 was made aware of the balance when it reached $200 less than the Medicaid resource limit. The Business Office Manager, stated, "no we did not."	F 569		

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F 569	Continued From page 57	F 569		
	6. Resident #107 was admitted to the facility on 7/18/18 and was a current Medicaid recipient. Review of the facility resident trust general ledger on 6/17/19 revealed that Resident #107's balance exceeded the resource limit for Medicaid eligibility by $443.40. An interview was conducted with Employee I, Business Office Manager on 6/17/19. When asked if Resident #107 was made aware of the balance when it reached $200 less than the Medicaid resource limit. The Business Office Manager, stated, "no we did not."			
	7. Resident #109 was admitted to the facility on 2/20/16 and was a current Medicaid recipient. Review of the facility resident trust general ledger on 6/17/19 revealed that Resident #109's balance exceeded the resource limit for Medicaid eligibility by $1,864.73. An interview was conducted with Employee I, Business Office Manager on 6/17/19. When asked if Resident #109 was made aware of the balance when it reached $200 less than the Medicaid resource limit. The Business Office Manager, stated, "no we did not."			
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or	F 570		8/4/19

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F 570	Continued From page 58 otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility staff failed to have a surety bond to assure the security of all personal funds of residents deposited with the facility. This affects all residents whose funds are deposited with the facility. The findings included: On 6/17/19 the facility staff provided a surety bond which expired 5/1/19. On 6/17/19, Employee I, Business Office Manager, stated she had nothing else to provide.	F 570	1. A Surety Bond has been obtained on 6/17/19 and is sufficient to address the security of all personal funds of residents deposited with the facility 2. All residents at Envoy of Williamsburg may have been impacted. The new Surety Bond is sufficient to address the security of all personal funds of residents deposited with the facility. 3. Survey Bond will be monitored by the Business Office Manager and renewed annually in an amount to protect the personal funds of residents in the facility. The amount of coverage by the Surety Bond will be compared to the Quarterly personal fund accounting report to ensure there is sufficient coverage. 4. Surety Bond will be audited annually. The Quarterly accounting report will be submitted to QAPI Committee with any recommendations or actions taken. 5. 8/4/2019	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with	F 577		8/4/19

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F 577	Continued From page 59 respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility staff failed to post survey results and ensure all Residents have access to the survey results for 76 Residents in a survey sample of 76 Residents. The findings included: On 6/6/19 at approximately 3pm during the Resident Council meeting, multiple Residents expressed that they were unaware of survey results, their access to them, or where they were posted. On 6/6/19 at approximately 4pm, upon completion of the Resident Council Meeting, the	F 577	1. Recent surveys were posted in the lobby. 2. Residents at Envoy of Williamsburg wanting access to the recent surveys may have been potentially impacted. Residents were informed on the survey result information location during the Resident Council meeting. 3. Residents were informed on the survey result information location during the Resident Council meeting on 6/17/19. 4. The receptionist / designee will check daily that recent survey results are posted.	

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F 577	Continued From page 60 surveyor was unable to locate the survey results. On 6/6/19 at approximately 4pm. the Administrator was asked where the survey results are posted and the Administrator stated, "we keep them in the lobby but they are not there, we are looking for them."	F 577	In addition, data will be collected at least weekly x 3 months during leadership rounds that the survey result information is available and accessible. Findings from the weekly rounds will be submitted to the QAPI Committee monthly. 5. 8/4/2019	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		8/4/19

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F 580	Continued From page 61 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to notify the physician of a change in condition for 1 resident (Resident #120) in a survey sample of 76 residents. The findings included: For Resident #120, the facility staff failed to notify the physician of a low blood pressure reading and fall occurring on 5/13/19. Resident #120, a 65 year old male, was admitted to the facility on 4/11/19. On 6/14/19 during clinical record review, a Nursing Progress Note dated 5/13/19 at 7:20pm	F 580	1. The provider for Resident # 120 was notified on 5/14/19 of the resident's blood pressure on 5/13/19 No new orders received. 2. Current residents who have experienced a change in condition have the potential to be affected. A review of the 24-hour report from July 1 – 17 will be conducted to identify any resident who has experienced a recent change in condition; the medical record will be reviewed to determine if the provider was notified and if variances are found the provider will be notified and documented in the medical record.	

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F 580	Continued From page 62 indicated that Resident #120 was found on the floor outside of his room with no visible signs of injury. On 5/13/19 at 7:21pm a blood pressure reading 64/44 was documented. On 6/14/19, a staff interview was conducted with the interim Director of Nursing (Employee B) who stated, "the physician should have been notified immediately regarding his [Resident #120] fall and blood pressure, there is nothing documented that the doctor was contacted so I have to assume that it was not done, that is definitely not the expectation nor the standard of care, something could have been seriously wrong with the resident, the doctor must be informed".	F 580	3. The Staff Development Coordinator and or designee will educate the License nursing staff of the facility process for notification of change in condition to the provider and resident representative Resident's who experience a change in condition will be identified on the 24-hour report that will be reviewed by the Unit Managers or charge nurse daily. Licensed staff will be re-educated on the facility process for completion of the 24-hour report. 4. Unit Managers / designee will audit 5 residents per week x 3 months who have experienced a change in condition to ensure that the provider and resident representative were notified of the change in condition. If variances are found, the provider and/or resident representative will be notified, and such notification will be documented in the medical record. Findings from the weekly audits will be submitted to DON / ADON for tracking and trending; a summary report of the audits and actions taken will be submitted to the monthly QAPI Committee. 5. 8-4-2019	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		8/4/19

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F 584	Continued From page 63 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		
	§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 observations staff interviews, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide a safe, clean, home-like environment		1. Resident rooms have had all contents emptied and floors scrubbed. All furniture and contents cleaned; including Residents #121, #33, #102, #105, #152 and #108.	

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F 584	Continued From page 64 facility-wide and for 1 resident (Resident #426) in a sample size of 76 residents. The findings included: On 06/05/19 at 11:32 AM, surveyor D detected a strong smell of urine from rooms 105 and 108 while walking the hall by rooms. On 06/05/19 at approximately 2:34 PM, surveyor D observed a female resident dressed, lying in bed with empty cracker packages and crumbs in the bed all around her. On 06/05/2019 at approximately 2:35 PM, surveyor D entered room 152 and detected a strong malodorous aroma in the room. On 06/06/2019 at 2:41 PM, a resident (identified in the sample as Resident #102) was observed in her bed sleeping wearing a pink sweatshirt and brief and lying on her left side. Resident #102 was partially covered with a sheet. The food tray from lunch was on her tray table which was partially over her bed. The lunch tray had a manwich, green beans, strawberry shortcake and a peanut butter and jelly sandwich, all uneaten. There was a small bowl of macaroni salad with a spoon in it and there appeared to be approximately a spoonful of macaroni salad removed. There were bits of macaroni salad observed on her sheets next to her. On 06/06/2019 at approximately 6:30 PM, Resident #102 was observed in her bed. The bed was flat and the dinner tray was on the tray table that was positioned perpendicular to the bed over Resident #102's bed. Resident #102 was propped up on one elbow and the tray table was still at a	F 584	Linen put on beds including resident #121 and resident #33□s bed mattresses wiped down. Nursing staff received ADL training as well as resident dignity training. Resident #102 bed remote fixed and Care Plan updated to add Supervision when eating. Resident 121 Care Plan updated for Assistance, 1 person with dressing. Resident #121 screened by therapy. The hand railing by room #116 fixed and safe for use. Stained ceiling tiles replaced. And floors throughout facility scrubbed stripped and buffed. Resident #426 no longer resides in the facility. 2. All residents of Envoy of Williamsburg may have potentially been impacted. Education has been provided to housekeeping and nursing staff on maintaining a safe, clean, comfortable and home-like environment. 3. All RN's, LPN's, and CNA's were re-educated on appropriately and timely ADL care in a dignified manner. A skills fair on ADLs has been scheduled. Environmental contract vendor had a meeting with facility, Regional and Divisional leadership to define expectations. Contract environmental vendor provide daily cleaning and will maintain schedule for floor cleaning, deep cleaning schedule and tasks completed during cleaning of rooms and facility. Housekeeping, laundry staff and CNAs will be re-educated on infection control practices. 4. Rounds will be conducted 5 days a	

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F 584	Continued From page 65 height above her head. Resident #102 had an eating utensil in her other hand and was observed struggling to reach up and over to access her food. Resident #102 was attempting to scoop food and food was falling onto her head and chest and sheets. Surveyor D alerted Certified Nurse Assistant C [CNA C] that [Resident #102] needed assistance. CNA C entered the room. Resident #102 reached out to CNA C and stated, "Help." CNA C stated to Resident #102, "You can't eat like this, let me sit you up." CNA C attempted to raise the head of the bed with the bed controller but it was not functioning. Another CNA (CNA E) entered the room. CNA C stated to CNA E "This isn't good" and went on to explain that [Resident #102] was lying flat trying to eat and food was all over her. A third CNA, CNA D, entered the room and fixed the bed controller function by adjusting a cable under the bed. When CNA C left the room after rendering care, she stated to Surveyor D it would be a good idea if she had supervision when eating. On 06/06/2019 at 6:39 PM, surveyor D observed a resident (identified in the sample as Resident #124) self-propelling herself in her wheelchair down the hall near room 138. Resident #124 appeared confused and positioned herself by the wall and was attempting to stand. Resident #124 did not lock the wheels on her wheelchair nor did she appear steady on her feet. Surveyor D had to alert staff Resident #124 was attempting to stand. CNA D came to her aid, redirected her, and assisted to propel her down the hall in her wheelchair. On 06/10/2019 at approximately 9:45 AM, surveyor D observed a female resident walking down the hall in a hospital gown untied, barefoot,	F 584	week x 3 months by assigned leadership team members to observe for clean, safe, comfortable, home-like environment, resident dignity and if ADL care has been provided appropriately and timely; if variances are identified they will be corrected and/or reported to the Unit Managers for follow-up. Findings from the audits will be submitted to the DON / ADON for tracking / trending and a summary of observations and actions will be reported to QAPI. 5. 8/4/2019	

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F 584	Continued From page 66 and wearing a brief. The unit manager asked the resident her name and then redirected her to her room. On 06/11/19 at 08:45 AM, a resident identified in the sample as Resident #121 was observed getting up out of bed, ambulating to hall and asking this surveyor for a Pepsi. Resident #121 was wearing a red shirt and blue pants. There was spilled food on his pants and on the room floor that resembled oatmeal where Resident #121 was walking. Resident #121's pants fell below the level of his mid-thighs before he pulled up his pants as he left his room and ambulated down the hall with an unsteady gait unassisted. This surveyor had to alert an aide to assist Resident #121 ambulate back to his room. On 06/12/2019 at approximately 8:20 AM, surveyor D detected from the hall a strong odor of urine outside room 105. On 06/12/2019 at 8:24 AM, surveyor D entered the room of the resident identified in the sample as Resident #33. Resident #33 was not in the room at the time. There was a strong malodorous aroma in the room, there were no sheets on the bed, and trash on the floor (a soda cap, paper towels, a straw, and exam gloves). Employee P entered the room at that time and stated he was aware this room needed to be cleaned and was in the process of notifying a staff member to clean it. On 06/13/2019 at approximately 10:15 AM, the unit manager, Licensed Practical Nurse C [LPN C] was notified of findings pertaining to Resident #102 and Resident #121 and she conceded deficient practice.	F 584		

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F 584	Continued From page 67 On 06/13/2019 at 10:55 AM, surveyor D went with Registered Nurse C (RN C) to the room of Resident #121 to observe a skin assessment. Resident #121 was fully dressed, sleeping on a bare mattress; there were no bed linens. RN C stated [Resident #121] was awake earlier and willing to have a skin assessment done but now he was asleep. The skin assessment was postponed. RN C did not express concern Resident #121 was on a bare mattress. On 06/13/2019 at 1:52 PM, surveyor D went with RN C to the room of Resident #121 to observe a skin assessment. Resident #121 was in bed lying on his left side, uncovered, and wearing a hospital gown and brief. The lunch tray was on the tray table and there were bits of food all over the tray and tray table. A CNA entered the room and took away the tray. Neither the CNA nor RN C attempted to clean the bits of food from the lunch meal all over the tray table. We left the room by 2:03 PM. On 06/20/2019 by the end of survey, the interim administrator had no further information or documentation to offer. 2. The facility staff failed to maintain a safe, clean, comfortable, homelike environment for residents. The hand railing in the hallway by room 116 was broken revealing a rectangular shaped hole in the face of the hard hollow plastic railing measuring approximately 5 inches long by 3 inches wide and 2 inches deep. The broken area edges were examined, and found to be very sharp and could easily cut skin.	F 584		

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F 584	Continued From page 68 Ceiling areas were noted to be stained, and sagging in places. The floors were sticky with a substance that the surveyors shoes stuck to and pulled one shoe off as the surveyor was walking. The bathroom and bedroom in room 105 were observed during the medication pour and pass observation on 6-5-19. The observation revealed urine and feces soiled linens on the floor, the toilet was smeared with feces, and the bathroom doorway, which was a curtain had multiple, 12 inch by 12 inch stains on it. This was noted in other rooms on this hallway as well. Both beds in the 105 room were stripped of linens to reveal mattresses with cracked plastic coatings which could not be hygienically cleaned, as the soft inner portion was exposed. On 6-11-19 at approximately 10 AM, an interview was conducted with the Administrator who stated the Housekeeping and nursing staff had identified several rooms in the facility including rooms on the Liberty and Freedom Units for targeted cleaning to help diminish foul odors. She went on to say it did not feel hot in the facility to her, and the ventilation problems were because it was an old building. The Administrator stated she also noted the pungent odor on the Units and was aware of a "Few" residents who often refused showers and baths. The Administrator was made aware of the issues during her interview, and no further information was provided by the facility.	F 584		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		8/4/19

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F 600	Continued From page 69 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to ensure Residents are free from abuse, neglect, misappropriation of resident property and exploitation for 10 Residents (Resident #184, Resident #176 Resident #94, Resident #125, Resident #327, Resident #76, Resident #29, Resident #102, Resident #97, Resident #2) in a survey sample of 76 Residents. This resulted in harm for Residents #187, #176, #125, #76, #102, and #2. Immediate Jeopardy was identified on 06/18/2019 at 2:25 pm at which time the facility was notified. After verification, Immediate Jeopardy was abated on 06/20/2019 at 3:40 pm and the scope and severity was lowered to a Level three pattern. The findings included:	F 600	1. The Leadership team and corporate office is committed to ensure that residents do not experience abuse/neglect, or misappropriation of resident property. The Leadership team takes each allegation seriously and will conduct a comprehensive investigation of all allegations and ensure interventions are taken to protect the residents and minimize recurrence. Allegations will be reported to all required entities in a timely manner. Staff will be trained on abuse, neglect and misappropriation of resident property. The facility submitted an addendum to the abatement plan due to previous resident interviews were not conducted accurately. Therefore, all residents had been interviewed all residents again on the evening of 6/19/19. Education was provided to previous Interviewers. The 2	

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F 600	Continued From page 70 1. The facility failed to protect Resident #184 from being sexually abused by another Resident. This is harm. Resident #184, a 33 year old female, was admitted to the facility on 4/10/2019. Her medical history includes a CVA (Cerebral Vascular Accident-Stroke) causing right side weakness and aphasia. Her BIMS (Brief Interview of Mental Status) could not be determined and she was assessed as having severe cognitive deficiencies via a staff assessment. Resident #184 was fully ambulatory. On 4/22/2019 at approximately 4:00 PM Resident #184 was in the day room where she was assaulted by Resident #21. Resident #119 saw Resident #21 place his hand inside the front of Resident #184's pants. She summoned a nurse who intervened and stopped the assault. Resident #184 would not allow the staff to examine her for injury, and the decision was made to send her to the hospital for evaluation. Adult Protective Services and local police were notified. Hospital records were obtained and revealed that there was evidence of laceration in the vaginal area. The record stated "SANE (Sexual Assault Nurse Examiner) reports posterior fourchette laceration and other evidence of sexual activity. Patient unable to provide subjective information due to underlying medical conditions." Resident #184 was held in the hospital overnight for observation and released to another local facility on 4/23/2019.	F 600	residents that expressed concerns During the interview had investigations Initiated and FRI's submitted to State Agency. The residents that had expressed concerns in the previous resident interviews had follow –up from the facility grievance officer or Interim Administrator. Complaint forms were complete and/or FRI's had been submitted previously. The complaints and FRI's were reviewed by survey team. a. Resident #184 was sent to the hospital and was transferred to another facility per her family's request. b. Resident #21 is on 1 on 1 supervision and will continue until D/C plan is developed that will meet resident #21 needs. No further incidents of sexual abuse by resident #21 have been reported. c. Resident #176 was D/C'd prior to survey. d. Resident #94 had an FRI completed by prior Executive Director regarding this situation as well as a report to the Williamsburg Police, APS and Ombudsman. It was determined The Allegation of Abuse was not Substantiated however CNA G is not employed at the facility. . No further incidents of injury of unknown etiology has been reported. e. Resident #125 went to ER. RN was contract employee and no longer works at the facility. The Executive Director met with Resident #125 on 6/7/19 and DON met with resident on 7/17/17 and encouraged to the resident to report any additional concerns of abuse and informed the resident of initiatives to	

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F 600	Continued From page 71 On 6/5/2019 at noon an interview was conducted with Employee A, Administrator. She stated that Resident #21 was placed on 1:1 observation immediately after the incident. He remained on 1:1 observation until 6/3/2019. She stated that he did not exhibit any further behaviors to justify 1:1 observation. She stated that the local police investigated the incident and did not press charges against Resident #21 since he had dementia. She stated that Resident #21 denied any wrongdoing towards Resident # 184. On 6/5/2019 at 8:25 AM, an interview was conducted with Resident # 119. She stated that she saw Resident #21 force his hand into Resident #184's pants while in the dayroom. She summoned a nurse who stopped the assault. She further stated that, on 6/3/2019, while she was sitting in the day room, Resident #21 looked at her and grabbed and rubbed his crotch. She ignored him and he went away. This was the same day that 1:1 observation was discontinued. Resident #119 had a BIMS of 13 indicating no cognitive impairment. On 6/5/2019 at 11:45 AM Resident #21 was seen in his room eating lunch. He was alert and oriented and he was pleasant. Resident #21, an 81 year old male, was readmitted to the facility on 10/1/2018. He had diagnoses of alcohol induced psychosis, dementia, and Alzheimer's disease. He had a BIMS score of 15/15 indicating no cognitive impairment. Resident #21 had a documented history of sexual misconduct during his residence in the facility. There were 9 separate entries since 2017 in	F 600	protect the residents. f. Resident #327 is no longer a resident of the facility. CNA G is no longer employed by the facility. g. Resident #76 was screened by Therapy for positioning for pressure reduction cushion. Licensed nursing staff will be educated on signs / symptoms of sepsis by Regional Director of Clinical Services. h. Resident #29 no longer resides in the facility. I. Resident 102 Bed controller was fixed. MDS updated to reflect appropriate supervision needs while eating on 7/16/19. CNA staff will be educated on providing appropriate assistance and dignity during meals by DON/designee and external nursing consultant. j. Resident #97 Allegation of Abuse was not reported timely it was reported 6/5/19. LPN-E LPN- F, Employee M and CNA-G who were involved in the allegation of Abuse were not substantiated by previous Executive Director. CNA- G is no longer employed by the facility. k. Resident #2 was discharged prior to the survey. Licensed staff will receive education on reordering / refilling the IV box by DON/designee and external nurse consultant. Licensed nursing staff will be re-educated on process and importance of notifying the provider when an IV site cannot be accessed and/or when medications/fluids are not available by DON/designee and external nurse consultant. 2. All residents at Envoy of Williamsburg may have been affected. Residents are	

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F 600	Continued From page 72 progress notes stating "resident has a history of inappropriate sexual behavior". In 2017 there were two separate FRI's (Facility Reported Incidents) where Resident #21 was receiving oral sex from another resident. These incidents were in Resident #21's Care Plan advising of his sexual behavior. His current Care Plan states "Resident has a behavior problem related to inappropriate sexual incidents". Resident #21's behavior was well known and documented. The facility did not protect Resident #184 from being injured by Resident #21. 2. For Resident #176 the facility staff neglected to properly assess Resident #176 and seek out further medical attention. This is harm. Resident #176 a 61 year old woman admitted to the facility on 5/4/18 with diagnoses of but not limited to Atrial Fibrillation, Major Depressive Disorder, and Gastro-Intestinal Hemorrhage. The Resident's most recent (Minimum Data Set) MDS with an Assessment Reference Date of 6/28/18 coded as a Quarterly Assessment coded Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. Resident #176 was also listed as her own (Responsible Party) RP. An entry into the progress notes on 7/4/19 states that the resident requested that to be sent out to the Emergency Room due to complaints of Nausea Vomiting and Diarrhea, and having just completed antibiotics for Clostridium Difficile (an inflammation of the colon caused by bacteria). An excerpt from the progress notes dated	F 600	being educated on Resident Rights at Resident Council. Staff is being in serviced on regulations governing abuse / neglect and misappropriation of resident property. Staffs are also being educated on abuse identification, reporting, and investigative requirements by DON/designee and external nurse consultant. 3. Leadership within the facility changed. A seasoned, experienced nursing home administrator assumed the Executive Director role on 6/18/19. An Assistant Executive Director was assigned on 7/2/19. A knowledgeable and experienced long-term care DON was assigned effective 7/08/19. The facility entered into a contract on July 1, 2019, with an independent long-term care consulting company to provide additional support and services to the facility including education on abuse, neglect and misappropriation of resident property. Department managers were educated on 6/18/19 by the Division Director of Nursing on abuse, types of abuse and neglect, training, prevention, identification, investigating, protection, reporting/response, resident's rights, reporting reasonable suspicion of a crime, and the Elder Justice Act. Additional training on abuse / neglect will providing using multiple modalities including group training / discussion facilitated by an external long-term care	

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F 600	Continued From page 73 7/4/2018 at 3:22 AM reads, "she wanted to get anxiety med but wasn't due for it. she [sic] received pain and n/v [nausea/vomiting] med an hour before. she [sic] had large bm [bowel movement] loose and sm [small] amt [amount] of vomitus, she asked if she could go to the hospital since nurse could not give anxiety [sic] med, and was informed that was not an emergency. " Resident then called the rescue squad from her cell phone and according to EMS Report dated 7/4/19 the EMS squad was dispatched to the facility and was met at the door by a nurse who stated that she didn't call EMS and it must be a "false alarm." The report goes on to further state "the resident stated she called 911 because the facility staff refuse to take care of her or send her to the hospital, she stated they won't even take my blood pressure." The EMS report stated that as she was being prepared for transport they noticed a large amount of dark loose stools soaking the bed and the resident. They further state that Resident #176 stated she had been that way for a while that the staff refused to clean her up. An excerpt from the EMS report stated "While leaving [facility name redacted] some remarks are exchanged between the patient and a nurse... for calling 911." An excerpt from the medical record dated "Resident presented to the ER with Nausea Vomiting and Diarrhea. Patient states she has been ill for the last week with profuse diarrhea. Patient was admitted here from 6/17/18-6/20/18 for sepsis due to C- Diff Colitis and was discharged on Vancomycin PO [by mouth]. The	F 600	consultant, small group and 1:1 review and discussion with staff; on-line training, etc. Abuse training will be provided to new employees during orientation. HR Coordinator will track 12-month Abuse Education and turn into ED weekly to assure staff has mandated education. Staff currently working will be educated on abuse and neglect immediately and will be required to acknowledge a Freedom from Abuse notice. The Center Divisional Executive Director conducted an ADHOC Quality Assurance Performance Improvement meeting on 6/18/19 to include the Director of Nursing. MDS Nurse, Housekeeping Manager, Business Office Manager, Human Resources, Central Supply, Admissions Director, Dietary Manager, Activities Director and Environmental Services Director. Resident Council meetings will be held twice a month for 6 months. During the Resident Council, residents will be asked if they have any concerns of abuse, neglect or misappropriation that needs to be discussed. Reported allegations will be investigated and reported according to the facility policy. The Executive Director / Assistant Executive Director / DON will review all final reports prior to submission to ensure that a comprehensive investigation was completed and that appropriate actions were taken to protect the resident[s] and minimize recurrence.	

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F 600	Continued From page 74 patient finished her Antibiotics on 7/2/18. Pt has end stage renal disease and has not missed any of her dialysis sessions. Patient has appearance of dried blood on side of mouth pt. admits to having hematemesis [vomiting blood]. An excerpt from the hospital report states "Pt brief changed by this RN and [name redacted] RN and [name redacted] RN, pt. completely soiled from head to toe in black dried tarry stool." "When asked if she had contacted the staff to come and change her she stated she did multiple times but no one came. Pt states that she was also on the bedpan for 2 1/2 hours at one point tonight and finally someone came to take her off. ""She is frustrated that she hasn't received any care in the last 2 days at [facility name redacted]. Hemoglobin on arrival to ER - 4.5 Normal Range -12.0 -16.0 (grams per deciliter) gm/dl Hematocrit on arrival to ER - 15.1 % Normal Range - 37 - 47% (Hemoglobin measures protein in red blood cells responsible for delivering oxygen. Hematocrit measure the volume of red blood cells compared to the total blood volume) The Resident was admitted to the Intensive Care Unit for critically low Hemoglobin and Hematocrit due to GI Bleed. On 6/11/19 at 10:00 AM in an interview with the DON she stated "If a resident is her own RP and requests to seek emergency medical attention we should get a set of vitals and notify MD of Resident desire to be transferred to ER and then call 911. A resident should never have to call the EMS by themselves."	F 600	4. The Social Worker / designee will conduct 5 resident interviews per week x 12 weeks with alert and oriented residents to determine if they are being treated in a dignified manner and free from abuse and neglect. Family members/ responsible party of 5 residents will be interviewed x 12 weeks for those residents who are cognitively impaired to determine if they are being treated in a dignified manner and free from abuse and neglect. Findings from the weekly interviews will be shared with the appropriate department head / manager for follow up and grievances will be documented in the grievance log along with the facility's response to the resident. Findings from the weekly interviews will be submitted to the Assistant Executive Director weekly for tracking / trending and a summary report will be submitted to the monthly QAPI Committee. The Executive director / designee will review the minutes from the Resident Council meetings to identify any concerns that may be abuse, neglect or misappropriation and to ensure that all allegations are reported, investigated and appropriate interventions implemented to protect the resident[s] and minimize recurrence. The Executive Director / designee will provide a summary report of all allegations and actions taken to the monthly QAPI Committee. 5. 8/4/2019	

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F 600	Continued From page 75 When asked how often should incontinent care be provided to residents she stated "It is the expectation of the facility that CNA's make rounds a minimum of every two hours to check for incontinent needs and change the resident every two hours and PRN." She also stated that "No resident should be left on a bedpan for 2 1/2 hours that can cause breakdown." When asked what black tarry loose stools indicates she stated it is the sign of a Gastro-Intestinal bleed. On 6/20/19 during end of day meeting the facility Administrator was made aware of findings and no further information was provided. 3. For Resident #94 the facility staff failed to ensure resident was free from abuse and neglect related to injury of unknown origin. Resident #94, an 84 year old woman admitted to the facility on 2/17/14 with diagnoses of but not limited to Dementia, and Dysphagia, Resident is non-verbal and her latest (Minimum Data Set) MDS with an Assessment Reference Date of 5/1/19 coded Resident #94 as having a (Brief Interview of Mental Status) score of 99 indicating she was unable to answer questions. Her MDS also coded the Resident as a total care patient with 1 person physical assistance for bed mobility, feeding, dressing, bathing, and a 2 person physical assist for all transfers. According to a (Facility Related Incident) FRI on 5/6/19, Resident #94 was found (by family) to	F 600		

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have a hematoma to her left forehead and a discolored area to left side of her face near her left eye. The facility did an investigation and informed the authorities.

On 6/13/19 at 2:15 PM an interview was conducted with family member who stated that the bruise and swelling was found by the family. They reported it to the charge nurse and they also stated they were at the facility on the previous evening and she did not have the swelling or bruise. The facility doctor ordered x-ray but the family preferred to have her examined at the hospital.

An excerpt from the CT Scan Reports reads "Mild scalp soft tissue swelling at the left vertex without underlying skull fracture."

According to the Witness Statements provided by facility CNA G (who has been named in another abuse allegation during this survey) was assigned to the Resident and stated "I washed her up and had to roll her side to side to pull up her pants."

According to the Findings of the facility investigation, "It appears that her head hit the left side of assistance rail of the bed to cause the swelling."

On 6/13/19 during the interview the family member stated "She does not move, if you put her in a position she will stay that way. I know this because I see her every day. I come here every day to make sure she is fed and taken care of.... She couldn't have rolled over into that rail, she is not able to move her body."

During the end of day meeting on 6/20/19 the

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F 600	Continued From page 77 Administrator was made aware and no new information was provided.	F 600		
	4. For Resident #125 the facility staff neglected to assist the resident to the restroom and the resident urinate on himself (resulting in humiliation) and failed to address back pain Resident was experiencing. This is harm.			
	Resident # 125, a 63 year old man admitted to the facility on 3/15/19 with diagnoses of but not limited to Muscle weakness, and Parkinson's disease. According to Resident 125's most recent MDS dated 5/15/19, coded as a PPS 5 Day, the Resident has a (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. The MDS also codes him as Extensive Assist with 1 person physical assist needed for Bathing, Dressing, Toileting, Bed Mobility, and Transfers.			
	On 6/7/19 at 9:15 AM this surveyor was told by Resident #125 that he called 911 to go to the ER because he was in so much pain in his back. He stated "I rang that call bell and no one answered, I needed help getting to the bathroom. I had been on a metal table getting a scan today and I was hurting so bad I couldn't even sit up by myself. I kept trying to get help and get my Valium for muscle spasms but no one would come. I couldn't hold it any longer and I ended up peeing on myself that was so humiliating."			
	He further stated that he waited so long for someone to answer that he called 911 himself around 130 AM. He said "A nurse finally came in and I told her I called 911 and she said we better			

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F 600	Continued From page 78 get you cleaned up so they don't think we neglected you." According to the EMS Report the Rescue Squad arrived at the facility at 1:36 AM. In an interview with the DON on 6/7/19 at 10:30 AM she stated that she had a call out and asked the 3-11 nurse to stay and that nurse got angry left her keys and left the building. She left at 11:41 PM according to her time clock report. The DON stated she spoke with her and told her she couldn't leave her patients. The nurse did not return until 1:30 AM. In an interview with the nurse who left (an RN) she stated she did not abandon her patients that she left and came back a couple of hours later. She stated she had something to do that couldn't wait. She further stated that her coworkers were aware of her leaving and the need to cover her patients. An excerpt from a written statement provided by the Administrator "He used his cell phone to call EMS himself. Nurse assisted EMS staff and [name redacted] was transferred to the ER per his request." Nursing Progress Notes dated 6/7/19 at 7:07 AM read "Resident called 911 because of back pain refused to take medicine. Sent via Ambulance Resident is own RP. MD made aware." Nursing Progress Notes dated 6/7/19 at 2:30 PM "Resident stated that he called 911 due to increased pain. Resident stated the pain was unbearable and he felt he needed to go to the ER."	F 600		

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F 600	Continued From page 79 An excerpt from the Hospital ER Report reads " Hx of Parkinson's and chronic back pain States had a DaT Scan today at [hospital name redacted] 1:00 PM -and his chronic back pain began to hurt-- has asked the Staff at [facility name redacted] for his "Valium" and they wouldn't give him any-- thus he called 911." During the end of day meeting on 6/20/19 the Administrator was made aware of the issues and no further information was provided. 5. For Resident # 327 the facility staff failed to ensure Resident was transported safely in wheel chair by staff. Resident #327, a 56 year old man admitted to the facility on 6/11/19 with diagnoses of but not limited to Chronic Pain, Chronic Gout and acute kidney failure. Resident #327 does not have an MDS due to being a new admission. On 6/20/19 this surveyor was informed by Administrator that she sent in a FRI involving Resident #327. Administrator submitted the FRI investigation folder to survey team and it was noted that witness statement, signed by CNA G states: "Around 4 PM or after [room number] asked me to take him to therapy to get walker. Therapy grab walker & me therapist & resident went back to [room number]. When I got to the room the resident asked the therapist about help to get back to bed I stopped the chair at the door and walked back to the nurse's station. Therapist	F 600		

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came out of the room & stated that I pushed the resident into him. I said I did not push him into you the must [sic] continued to roll there after I said MY Bad it was not my intention to have him roll into you. Therapist continued to argue with me stating that I pushed him into him. I then said OK Conversation over and walked away."

According to the Witness Statement from the Therapist:

"Finished w/treatment coming back to rehab w/aid & resident went back to room with him [therapist name redacted] and CNA pushed him in the room PT asked why did you not lock the breaks to CNA and CNA said Why should I. PT assumed the wheelchair was pushed by CNA based on him flying by and unable to push chair."

According to the Witness statement by the Resident:
"She really didn't push me I was talking to the Therapist and when she pushed me in the room my wheel chair hit his leg [Therapist] but she wasn't intentionally being mean or tying to be abusive. When I turned around she was gone [resident name] OH Lord!"

Interview was conducted with the Therapist. When asked what happened he stated that they were walking back to the room and he went in first and then the next thing he knew the Resident wheelchair hit him in the leg not hard to hurt but it the CNA was gone so it was clear the CNA pushed him in the room and didn't wait to put on the breaks or see if he was safe she just pushed him in to the room and kept on walking. I asked her why she did that and she said "you were in there."

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F 600	Continued From page 81 In an interview with the Administrator she stated that CNA G had just had her abuse and neglect training on 6/18/19. She also stated this is the second allegation involving CNA G. CNA G was suspended during the investigation, attempts to contact CNA G were unsuccessful. On 6/20/19 during the end of day meeting the Administrator was made aware of the findings and provided no further information. 6. For resident # 76 the facility staff neglected to properly assess and treat wounds resulting in hospitalization. This is harm. Resident # 76, a 68 year old man who was admitted to the facility on 4/15/19 with diagnoses of but not limited to Schizophrenia, Unspecified Mood Disorder, Parkinson's disease, Neuropathy, and Lymphedema. Resident #76's Responsible Party is his sister. The most recent (Minimum Data Set) MDS coded as a quarterly with an Assessment Reference Date of 4/22/19 coded as a Quarterly coded Resident as extensive assistance for bed mobility with physical assist of 1, total dependence with a mechanical lift and physical assist of 2 + persons, bathing and dressing requires physical assist of 2 people, mobility is coded as wheelchair with physical assist of 1. On 6/7/19 Resident #76 sat in his wheelchair in the day room area legs and feet wrapped in ace bandage and very swollen. When attempting to	F 600		

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F 600	Continued From page 82 interview Resident #76 he stated "I am with the FBI and CIA and I'm undercover here." On 6/7/19 during a clinical record review it was found that Resident # 76 had been admitted to the hospital on 4/9/19. According to the Progress Notes: "4/9/19 11:42 AM- Nursing Progress Note-Resident observed slumped over in wheelchair, pillow under left arm for stablization. [sic] No change in LOC [level of consciousness] but apparent weakness and distress, able to slowly converse with undersigned. Physically unable to sit upright in wheelchair or complete ROM [range of motion], complaint of stomach hurting. Increased Edema- Bilateral Extremities. Vitals 134/73 -122 - 16- 100%. Supervisor [sic] /MD notified. 911 called. EMT arrived. unable to transfer patient with sit to stand lift due to weakness, resident sent out to ED for eval." According to the Hospital Discharge Report: "Pt brought in via EMS from [facility name redacted] for fevers and AMS [altered mental status]. [Facility name redacted] reports fevers as high as 104.5 and has not been acting himself for the last three days. Pt has lower leg swelling and lymphedema that are oozing." "Pt arrives with lower extremities wrapped in ace bandage, two stage III open wounds wrapped in lower thighs, and pt. incontinent of stool. Pt states "I don't feel good and I got bit by a snake." Pt tachycardic [rapid heart rate] on the monitor, hot to touch, temperature 103. Pt unreliable historian states " I been throwing up snakes maybe one of them bit me."	F 600		

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F 600	Continued From page 83 "Presenting from [facility name redacted] unkempt and covered in feces and urine. "Stage III decubitus ulcers on posterior thigh with chronic sever lymphedema" "Sepsis due to Streptococcus pyogenes POA [present on arrival] YES Pressure injury Stage III-POA - YES -Cellulitis of Left Thigh POA - YES - Pt was admitted with findings consistent with sepsis with acute metabolic encephalopathy, diarrhea, hypokalemia, lactic acidosis. " "Chest X-Ray Impression - Streaky bibasilar parenchymal opacity which suggests Aspiration Pneumonia." "Pt presenting from [facility name redacted] unkempt and covered in feces and urine." "He developed decubitus [pressure ulcers] in the posterior portion of his thighs also has chronic weeping wounds was diagnosed with Sepsis secondary to cellulitis left lower extremity. Later found to have out of 2/2 bottles [blood cultures] positive for Streptococcus pyogenes. Started on ceftriaxone and clindamycin with significant improvement." "Will need at least 14 days of Antibiotic therapy, was recent blood cultures drawn on 4/11/19. Will need PICC [Peripherally Inserted Central Catheter] line placed once bacteria clearance has been documented. Hospital discharge instructions stated: "Follow up with [facility name redacted] Wound Clinic is recommended" "Recommended Studies on Follow up - BMP [Basic Metabolic Panel] on 4/20/19 with dose adjustments of potassium supplement depending on serum potassium levels." On 6/17/19 at 9:45AM this surveyor requested to	F 600		

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F 600	Continued From page 84 see copies of labs done on or around 4/20/19 as per discharge instructions. On 6/19/19 at 3: 00 PM this surveyor again requested the labs recommended on discharge- DON stated "They were not done until this morning. I will get you the results." When asked if the Resident was followed up with the recommended wound clinic wound nurse Employee stated "we do his wound care in house." On 6/20/19 during end of day meeting Administrator was made aware of findings and no further information was provided. 7. For Resident #29 the facility staff neglected to provided supervision during a shower resulting in a fall with injury. Resident #29 a 59 year old man admitted to the facility on 11/27/18 with diagnoses of but not limited to bilateral below knee amputation, chronic kidney disease, and muscle weakness. His latest MDS coded as a Quarterly with an (Assessment Reference Date) ARD of 3/14/19 codes the Resident as having a (Brief Interview of Mental Status) Score of 13 indicating mild cognitive impairment. His MDS also codes this Resident as needing Supervision for Bathing Toileting and Personal Hygiene and 1 person physical assist. On 6/17/19 approximately 1:00 PM this surveyor observed Resident #29 being loaded into ambulance. Upon inquiry this surveyor was told	F 600		

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F 600	Continued From page 85 Resident #29 had fallen during his shower. Nursing progress notes from that day read: "Resident's aide reported to the nurse that he resident told her he fell in the shower room. Resident was asked by the nurse how did he get himself up? He responded that he placed some towels on the floor and got up on his knees and he got in the wheelchair. No skin tear was noted, he was alert and oriented X4, he c/o [complained of] severe back and neck pain. He rated his pain as 8-9 on a 0-10 scale. He received 2 Tylenol for pain. Resident requested to go to ER for evaluation and treatment. H was sent to the ER with care plan, transfer SBAR and bed hold. NP and MD did not answer telephone calls. Unit manager made aware and resident is the responsible party." On 6/17/19 during clinical record review it was noted that according to the care plan, the Resident was on "Fall Protocol" since 12/3/18. Resident's Physicians Orders reveal that the Resident was on the following medications: Alprazolam ER [Xanax Extended Release, an anti-anxiety medication] Trintellix [Anti-Depressant] Fentanyl Patch 50 (Micrograms) mcg/hr. [Narcotic pain patch] Robaxin [muscle relaxer] Roxicodone [narcotic pain medication] PRN Xanax 0.5 mg PRN (as needed) Gabapentin (Neurontin) [Seizure medication also given for neuropathic pain] On 6/19/19 at 10:00 AM in an interview with Resident # 29 when asked how he got into the bathroom and if he knew the code to the	F 600		

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F 600	Continued From page 86 bathroom door, he stated "No the CNA [CNA G name redacted] let me in. They always let me in to do my shower alone. All the CNA's know I shower alone." Resident #29 went on to explain how he fell, he stated that the floor drain backed up and there was a lot of water on the floor and when he went to move from the shower chair to the wheelchair the wheelchair slid and he feel injuring his back and neck. He went on to say he managed to get himself up into the wheelchair and that he then reported to the CNA that he fell. In an interview with DON on 6/19/19 at 11:00 AM, the DON was asked if a resident is taking these medications what some of the possible side effects are. She indicated that dizziness and drowsiness are side effects for the narcotics as well as the anti-anxiety and possibly the muscle relaxer and gabapentin as well. The DON stated, "No patient should be left alone to shower if they are not care planned for independent bathing and hygiene, especially on those combinations of medicines." A copy of the "Fall Protocol" mentioned in the Care Plan was requested. However, the DON stated, "We don't have an official policy for that we just notify the doctor and try to find the root cause of why they fell." During the end of day conference on 6/20/19 the Administrator was made aware of the findings and no further information was provided. 8. For Resident #102, the facility staff failed to	F 600		

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F 600	Continued From page 87	F 600		

prevent neglect, assist her with her meals, and prevent a significant weight loss of 6.26% in 13 days resulting in harm.

Resident #102, a 90-year old female, was admitted to the facility on 09/02/2004. Diagnoses included but not limited to Alzheimer's disease, depression, and generalized muscle weakness.

Resident #102's most recent Minimum Data Set with an Assessment Reference Date of 05/05/2019 was coded as a significant change in status assessment. The Brief Interview for Mental Status was coded as 9 out of possible 15 indicative of moderate cognitive impairment. Functional status for bed mobility and dressing were coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision/encouragement/cueing from staff and set-up help only for support.

On 06/06/2019 at 2:41 PM, Resident #102 was observed in her bed sleeping wearing a pink sweatshirt and brief and lying on her left side. Resident #102 was partially covered with a sheet. Resident #102 appeared thin. The food tray from lunch was on her tray table which was partially over her bed. The lunch tray had a manwich, green beans, strawberry shortcake and a peanut butter and jelly sandwich, all uneaten. There was a small bowl of macaroni salad with a spoon in it and there appeared to be approximately a spoonful of macaroni salad removed. There were bits of macaroni salad observed on her sheets next to her.

On 06/06/2019 at approximately 6:30 PM, Resident #102 was observed in her bed. The bed was flat and the dinner tray was on the tray table

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F 600	Continued From page 88 that was positioned perpendicular to the bed over Resident #102's bed. Resident #102 was propped up on one elbow and the tray table was still at a height above her head. Resident #102 had an eating utensil in her other hand and was observed struggling to reach up and over to access her food. Resident #102 was attempting to scoop food and food was falling onto her head and chest and sheets. Surveyor D alerted Certified Nurse Assistant C [CNA C] that [Resident #102] needed assistance. CNA C entered the room. Resident #102 reached out to CNA C and stated, "Help." CNA C stated to Resident #102, "You can't eat like this, let me sit you up." CNA C attempted to raise the head of the bed with the bed controller but it was not functioning. Another CNA (CNA E) entered the room. CNA C stated to CNA E "This isn't good" and went on to explain that [Resident #102] was lying flat trying to eat and food was all over her. A third CNA, CNA D, entered the room and fixed the bed controller function by adjusting a cable under the bed. When CNA C left the room after rendering care, she stated to Surveyor D it would be a good idea if [Resident #102] had supervision when eating. On 06/12/2019, the clinical record was reviewed. On 05/01/2019, Resident #102 weighed 97.6 pounds (mechanical lift). On 06/04/2019, the resident weighed 102.2 pounds (mechanical lift) which is a 4.71 % Gain in 34 days. On 12/03/2018, the resident weighed 100 lbs. [scale type not recorded]. On 06/04/2019, Resident #102 weighed 102.2 pounds (mechanical lift) which is a 2.20 % Gain in 6 months. A dietary note dated 03/27/2019 at 4:53 PM documented, "Resident discussed in weekly IDT [interdisciplinary team] meeting. Triggers for	F 600		

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F 600	Continued From page 89 7.5%, 8# [pound] weight loss x 1 month. CBW [current body weight] 99.2# [pounds] BMI 18.18 (underweight). Regular diet with fortified foods; intakes 26 to 100% of meals. Multiple supplements: Health shake with meals, Magic Cup BID [twice a day], Med Pass 120 ml TID [three times a day]. Dx [diagnosis] COPD, Alzheimer's disease, dementia; weight loss may be unavoidable r/t [related to] dx [diagnosis] and disease progression. Despite trigger for weight loss, weights have stabilized. Continue POC [plan of care]." Under the header "Subjective" on the nurse practitioner provider note dated 04/02/2019 [6 days later] , it was documented, "[Resident #102] requires total assistance with ADL [activities of daily living] care, transfers and set up with meals." In an excerpt under the header "ROS [review of systems]", it was documented, "patient denies any recent changes in weight." A dietary note dated 04/11/2019 at 11:22 AM documented, "Resident discussed in weekly IDT meeting. Triggers for a 5.4% weight gain in 2 weeks, desired gain. CBW 101.6# [pounds] BMI 18.6 (borderline). Regular diet with fortified foods; intakes 26 to 100% of meals. Multiple supplements: Health shake with meals, Magic Cup BID [twice a day], Med Pass 120 ml TID [three times a day]. Dx [diagnosis] COPD, Alzheimer's disease, dementia; weight loss may be unavoidable r/t [related to] dx [diagnosis] and disease progression. Resident noted often refusing to leave bed. On restorative feeds - discussed encouraging resident to sit up for meals. Despite trigger for weight loss, weights have stabilized. Continue POC [plan of care]."	F 600		

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F 600	Continued From page 90 On 06/13/2019 at approximately 10:15 AM, the unit manager Licensed Practical Nurse C [LPN C] was notified of observations on 06/06/2019 and stated that all residents should be set up to eat so they can get to their food. On 06/17/2019 at approximately 11:55 AM, this surveyor observed CNA K obtain a weight via mechanical lift for Resident #102. Her weight was 95.8 pounds. On 06/04/2019, Resident #102 weighed 102.2 pounds [mechanical lift]. On 06/17/2019, Resident #102 weighed 95.8 pounds [mechanical lift] which is a 6.26% weight loss in 13 days. Resident #102's height was 52 inches so body mass index [BMI] value decreased to 17.5. The facility provided a copy of their policy entitled, "Abuse, Neglect, Exploitation & Misappropriation." In an excerpt under the header "Neglect", it was documented, "Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid harm, pain, mental anguish or emotional distress. Examples include but are not limited to: Failure to provide adequate nutrition and fluids." On 06/20/2019 at the end of survey, the interim administrator had no further information or documentation to offer. 9. For Resident #97, the facility staff failed to protect her right to be free from abuse by a staff member on 05/11/2019.	F 600		

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F 600	Continued From page 91 Resident #97, a 76-year old female, was admitted to the facility on 09/26/2012. Diagnoses included but not limited to end stage renal disease. Resident #97's most recent Minimum Data Set with an Assessment Reference Date of 05/02/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for transfers and locomotion on and off unit were coded as limited assistance from staff. Mobility devices were walker or wheelchair. On 06/05/2019 at approximately 12:10 PM, an interview with Resident #97 was conducted in her room. When asked if she had any concerns about how the staff treats her, Resident #97 stated she had a problem with a nurse a few weeks ago. Resident #97 stated, "It was a Saturday morning." Resident#97 stated she was in the lobby waiting for her ride to dialysis when a nurse came and told her she couldn't wait in the lobby because it wasn't safe. Resident #97 stated she always waits in the lobby for her ride to dialysis and locked her wheelchair in place. Resident #97 stated the nurse was rude when talking to her and began pushing/pulling on the wheelchair trying to get it to move. As a result, Resident #97 stated that she "slid out" of her wheelchair to the floor. Resident #97 stated that her whole right side was still sore from the incident. Resident #97 stated she told the administrator about what happened that same day and has not seen the administrator since that day. Resident #97 stated she did not remember the nurse's name. When asked if she has seen the nurse again since the incident, Resident #97	F 600		

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F 600	Continued From page 92 stated that the Thursday following the incident, that same nurse came in her room to give medications and Resident #97 stated she refused her meds and told the nurse, "I don't even want a cup of water from you." Resident #97 denies feeling anxious or fearful and stated she had since talked to the nurse "like she was my own daughter." Resident #97 stated she told her "Don't hassle people in a wheelchair." On 06/05/2019 at approximately 1:00 PM, the administrator was notified of this allegation of abuse and entered Resident #97's room with this surveyor. Resident #97 repeated her statements to the administrator. On 06/05/2019 at approximately 1:15 PM, the administrator and this surveyor met to discuss the incident. When asked if this allegation of abuse was reported to the state agency, the administrator stated it had not been reported because "She told me something different." The administrator stated that Resident #97 told her she didn't like the way the nurse spoke to her and Resident #97 wanted her to "talk to the nurse and tell her to be nice." The administrator stated Resident #97 told her she was in the lobby waiting for transportation to dialysis when the nurse came and told her it wasn't safe to be in the lobby. The administrator stated [Resident #97] locked her own wheelchair and fell out. When asked if it is considered an allegation of abuse when a nurse speaks rude/roughly to a resident, the administrator stated, "Yes and no." When asked if this should have been reported, the administrator stated, "Because of what she said now, I will report it." When asked for notes of the investigation and statements, the administrator looked through her electronic files and stated she	F 600		

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could not find notes about the investigation. The administrator stated she asked the nurse to write a statement but was unable to locate it. The administrator did locate an incident report dated 05/14/2019 and provided a copy to this surveyor.

The incident report dated 05/14/2019 was completed by licensed Practical Nurse F [LPN F]. Under the header, "Describe objectively what was observed", it was documented, "Resident was in the front lobby with no supervision. Nurse asked president how she got out there. Resident stated she knows the code to get out. Nurse informed resident of the dangers that can happen because she is off the unit and we are unaware of who is picking her up. Nurse also informed her she care about her well-being that if someone comes into the facility they could harm her and we would be unaware. Resident got upset stating no one cares about her. I informed her that I don't know what normally goes on but I care and I can't allow her to sit out there. Nurse started taking resident back to the unit and Resident [grabbed] the side rail next to the administrator door and pulled herself out of chair. Resident did not hit floor immediately. Resident lowered herself to the floor. Nurse tried to assist resident back in wheelchair that is when resident started yelling leave her alone. Resident put herself back in chair." Under the header, "Management Review" dated 05/16/2019 at 7:49 a.m., it was documented by the administrator "I have met with resident on 05/11/2019 (Saturday) morning. She was able to stand up and walking with her W/C [wheelchair]."

The nurse's notes were reviewed. An entry by LPN F dated 05/11/2019 at 8:10 a.m. documented, "Resident knows code to door to

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(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 600	Continued From page 94 exit off unit and open front door. Resident was sitting a front door waiting for dialysis when nurse informed her she had to go back to the unit because we are not able to see resident. Resident refused to go back to unit. Resident grabbed hold to rail on wall and pulled herself out of chair so she did not have to go back to unit. ADON [assistant director of nursing] made aware. Son notified." A nurse's note entered by LPN E dated 05/11/2019 at 10:58 a.m. documented, "Resident reported to this nurse that she wanted to speak with social worker and administrator. when questioned why, she explained that she was "thrown out of wheelchair first thing this morning." Resident's skin reassessed again after dialysis and no impairments were found, resident denied any injuries, executive director made aware while in the building, patient gave her report to ED [executive director], social worker and NP [nurse practitioner] made aware. Np [sic] also made aware. " On 06/05/2019 at approximately 2:55 PM, the administrator stated the medical director was notified of Resident #97's statements. An x-ray was ordered and the administrator stated the nurse associated with the allegation, LPN F, was notified "not to come back to work until she speaks to me." On 06/14/19 at approximately 1:10 PM, an interview with Employee M, a social worker, was conducted. After reviewing the nurse's note entered by LPN E on 05/11/2019, Employee M stated she was not told [Resident #97] was thrown out of the wheelchair. Employee M stated was told [Resident #97] was waiting up front to go	F 600		

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F 600	Continued From page 95 to dialysis and the nurse was not aware that [Resident #97] sits up front that time in the morning and asked her to go back to her room. When asked who notified her of this incident, Employee M stated she could not remember. Employee M stated that she was told about it on a Saturday or Sunday. When asked what [Resident #97] told her when they met, Employee M stated that [Resident #97] told me she had already spoken to the administrator. [Resident #97] said she was sitting up front waiting on dialysis transportation and the nurse asked her to go back to her room. Employee M stated [Resident #97] told the nurse she wasn't going anywhere because this is what she does every dialysis morning. Employee M stated [Resident #97] did not say she fell or was pushed out of chair. When asked what concerned Resident #97, Employee M stated that [Resident #97] said "the person made her feel like she was crazy." Employee M stated that [Resident #97] knows the code and waits in lobby but the person would not listen. When asked if there were notes associated with this meeting with [Resident #97], Employee M stated, "No, because I came in on the weekend unscheduled and the goal was to pick up something and leave." When asked about documentation of the meeting, Employee M stated that [Resident #97] "appeared her normal self" and added it would have been appropriate to take notes and document when a resident expresses a concern. Employee M stated the IDT [interdisciplinary team] talked about it on that Monday. Employee M also stated that initially, the nurse said [Resident #97] wanted to talk to me because she missed her dialysis appointment. On 06/17/19 at 09:54 AM, a telephone interview with LPN E was conducted. When asked about	F 600		

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F 600	Continued From page 96 the morning of 05/11/2019, LPN E stated that she was talking with [Resident #97] and "she told me she had a bad morning" and added that [Resident #97] is "usually upbeat." LPN E stated [Resident #97] said she got pushed out of her chair. LPN E stated [Resident #97 explained she was up at the lobby near the front door and the nurse that was caring for her wanted her to get back on the unit. LPN E stated the nurse said she didn't belong there. [Resident #97] told her it's her normal routine. [Resident #97] told me that's when person took ahold of her chair. LPN E stated she did not speak with the nurse [LPN F] about it the incident. On 06/17/2019 at approximately 4:15 PM, the facility staff provided the employee file of LPN F. She was hired by the facility on 05/07/2019 (5 days before the incident). Her license was current and sworn statement indicated there were no pending criminal cases. Background check did not reveal a history of barrier crime convictions. On 06/20/2019 by the end of the survey, the interim administrator had no further information or documentation to offer. 10. For Resident #2, the facility staff neglected to provide IV hydration, and to have the Resident seen by a medical professional, resulting in harm for a serious change in condition, which lead to hospitalization, and death. This is harm. Resident #2 did not receive a physician ordered IV (intravenous fluid infusion) on 2-16-19 due to staff inability to access a vein to infuse the fluids, and, the Resident failed to receive Hypodermoclysis fluid injections in the	F 600		

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F 600	Continued From page 97 subcutaneous tissue as ordered due to unavailability of the IV fluids in the facility on 2-21-19. Resident #2 was admitted to the facility on 1-15-19, after treatment for a Urinary tract infection (UTI), and was discharged from the facility on 2-26-19 to the emergency room where she received a diagnosis of dehydration, sepsis, and intractable nausea and vomiting, and expired on 3-3-19 (5 days later). Resident #2's Diagnoses included; UTI, history of Cancer in hilus of left lung, uterine cancer (removed by hysterectomy in 2016), adult fail to thrive, diabetes, and hypertension. Resident #2's most recent Minimum Data Set (MDS) was an admission assessment dated 1-22-19. Cognitive skills for daily decision-making were coded as 13 of 15, and no cognitive impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as extensive dependence on staff. Review of the closed record physician progress notes and visits revealed that the final time Resident #2 was seen was on 2-12-19. The Resident denied nausea and vomiting in the note, and was being seen for a decrease in appetite. Review of the physician's orders revealed that Resident #2 was ordered to be given Promethazine hydrochloride suppository rectally for nausea and vomiting on 2-12-19, and Ondansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for nausea and vomiting.	F 600		

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F 600	Continued From page 98 Review of the nursing notes revealed that no nursing notes existed between 2-10-19, and 2-16-19. On 2-16-19 the Resident was experiencing persistent vomiting, and the physician ordered via the telephone IV 0.9% normal saline at 60 ml per hour for 1000 ml related to dehydration. The nurse was unable to establish an IV access catheter to infuse the fluids, and they were never given. There is no indication that the physician was ever notified that the order was not carried out. There are no further nursing or physician notes until 2-20-19, when new verbal/telephone physician orders are received for Hypodermoclysis fluid injections in the subcutaneous tissue 0.9% normal saline at 60 milliliters per hour for 1 liter every hour, which is also used to treat dehydration. The Resident received the fluid from 2:00 p.m. on 2-20-19, until 11:00 a.m., on 2-21-19 when it was abruptly stopped. The Medication administration record (MAR) documentation showed at 12:00 noon on 2-21-19 that the fluids were not infusing, and "Other/see nursing note", but there was no note. The IV fluids were not given after 11:00 a.m., on 2-21-19 even though the Resident received Ondansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for continuing nausea and vomiting. The fluid infusion order was Discontinued on 2-22-19 at 9:38 a.m. with no note from the physician or nurses to indicate the reason. LPN A was the nurse for the 11:00 p.m. to 7:00 a.m. shift on the nights of 2-21-19, and 2-22-19. LPN A was interviewed, and stated "We didn't have any fluids in the building to give the patient. When asked why no note was written, she stated she had written a note documenting that the fluids	F 600		

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were unavailable, and that the nurse on 3-11 p.m. shift on 2-21-19 reported to her that she had not had any in the building either, and the family was angry, so she put the fluids on hold until the pharmacy could deliver them. The fluids never arrived, and the order was discontinued.

The facility was asked for a copy of the "IV stat box contents" which contained extra bulk dose medications that could be administered until supplies for the individual could be received. The document was received, and stated the normal saline needed for Resident #2's infusion was contained in the box. LPN A stated that during the stay of Resident #2, the box was not filled and sent out to the pharmacy for refill as it should have been.

The 3-11 nurse for 2-21-19 was identified, and found to be a short term contract employee who no longer worked at the facility.

There were no nursing notes in the record for 2-21-19, and 2-22-19 to explain why the fluids were not completed through 2-21-19, and were discontinued on 2-22-19.

There were no nursing notes from 2-20-19 until 2-24-19, which documented that the resident had refused all treatments and care. On 2-25-19 the first identification of a wound with green yellow slough was documented. On 2-26-19 the Resident was sent to the hospital for nausea/vomiting and suspected dehydration at 6:35 p.m., which was requested by the family. The Resident never returned.

Weight records were reviewed and revealed a weight loss of 45 pounds in 38 days.

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F 600	Continued From page 100 The care plan was reviewed and had no interventions care planned for continued nausea, and vomiting. Hospital records document that it was reported to the hospital staff that Zofran (Ondansetron) 8 mg was given to the Resident prior to leaving the nursing home on 2-26-19, however, the nursing notes and MAR have no documentation of the medication ever having been given on 2-26-19. Hospital records were reviewed and revealed the normally oriented and alert Resident was "Disoriented and unable to identify complaints". The Resident arrived in the ER (emergency room) at 7:09 p.m.. The Resident was seen by critical care staff who surgically placed an IV catheter in the Residents "External Jugular" neck vein. The ER "Critical care note" documented "System at risk for life threatening failure: Central nervous system, cardiac and circulatory." "Associated problems: Hypotension (low blood pressure) Dehydration, Arrhythmia and infection." The hospital documents go on to say that emergency medical services ambulance first responders recorded the Resident's blood pressure to be 83/53 mmHg (millimeters mercury) at the nursing home, and at the ER measured 87/49. The Resident was admitted with "dehydration, sepsis, acute cystitis with bloody urine (urinary tract infection), intractable nausea and vomiting, hypokalemia (critically low potassium 2.2) (normal is 3.5 to 5.5)), and hypomagnesemia (critically low magnesium 0.8) (normal is 1.6 to 2.5), and lactic acidosis (critically high 6.96) (normal is 0.9 to 1.7). After placing an IV catheter the Resident was immediately placed	F 600		

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F 600	Continued From page 101 on fluid and potassium replacement infusions in the emergency room, and was later admitted to the ICU (intensive care unit), where she expired on 3-3-19 (5 days later). In summary, the Resident was last seen by the physician on 2-12-19, and had recurrent nausea and vomiting from 2-16-19 until her discharge 2-26-19. The Resident was not supplied with ordered fluid infusions, as they were unavailable, she became dehydrated, and was sent to the hospital at the behest of the family. The Resident expired in the hospital on 3-3-19 (5 days later) with the diagnoses of dehydration and sepsis. The facility policy was reviewed, and revealed the following: "Neglect is the failure of the center, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to; Failure to provide adequate nutrition and fluids....." The facility Administrator and Director of nursing were made aware of findings on 6-20-19. The facility stated they had no further information to provide. COMPLAINT DEFICIENCY	F 600		

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Immediate Jeopardy was identified on 06/18/2019 at 2:25 pm at which time facility was notified.

The facility presented the following abatement plan:

The Executive Director who is the abuse coordinator was suspended due to widespread abuse allegations and concerns. It was determined that the Administrator failed to provide a safe environment for the residents of the facility. An Interim Divisional Administrator will be put in place on 6/18/19.

All residents have the potential to be affected by this alleged deficient practice. Interviewable residents will be interviewed by 6/19/19 to identify any further allegations of abuse and/or neglect. Staff will be interviewed for any residents not interviewable. Any allegations of abuse and/or neglect during this process will be addressed by following the facility abuse and neglect policy and reporting of such to appropriate agencies.

Departmental managers were educated on 6/18/19 by the Division Director of Nursing on abuse, types of abuse and neglect, training, prevention, identification, investigating, protection, reporting/response, resident's rights, reporting reasonable suspicion of a crime, and the Elder Justice Act.

All staff currently working will be educated on abuse and neglect immediately and will be required to acknowledge a Freedom from Abuse

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F 600	Continued From page 103 notice to employees in addition to taking an abuse and neglect competency exam. No staff will be permitted to return to work until they have completed the mandatory education on abuse and neglect. Abuse and neglect training will be provided to all new employees as part of new hire orientation. Contract and agency staff will receive abuse and neglect training prior to starting work. The center Divisional Executive Director will conduct an ADHOC Quality Assurance Performance Improvement meeting on 6/18/19, to include the Director of Nursing, MDS Nurse, Housekeeping Manager, Business Office Manager, Human Resources Coordinator, Central Supply Clerk, Admissions Director, Dietary Manager, Activities Director, and Environmental Services Director regarding the plan of removal of immediacy. The Medical Director will be made aware of the immediate jeopardy abatement plan on 6/18/19. The survey team reviewed the staff training and compared this to a current staff listing as well as payroll records to ensure that all employees that had worked since IJ was called had been trained. The facility submitted an addendum to the abatement plan due to they determined the previous resident interviews were not conducted accurately. Therefore, all residents had been interviewed all residents again on the evening of 6/19/19. Education was provided to the previous interviewers.	F 600		

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F 600	Continued From page 104 The survey team reviewed resident interviews. These were compared to a BIMS listing to determine who needed a resident interview versus staff interview. This was then compared to a facility mid-night census report to ensure all residents were interviewed. The two residents that expressed concerns during the interview had investigations initiated and FRI's submitted to the state agency. The survey team verified that the investigation was actively being conducted and the FRI had been submitted. The resident's that had expressed concerns in the previous resident interviews had follow-up from the facility grievance officer, interim Administrator. Complaint forms were completed and/or FRI's had been submitted previously. The complaints and FRI's were reviewed by the survey team. The survey team interviewed staff to see if they were trained. Staff said they were trained and answered questions appropriately. After verification, Immediate Jeopardy was abated on 06/20/2019 at 3:40 pm and the scope and severity was lowered to a Level three pattern.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 602		8/4/19

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any physical or chemical restraint not required to treat the resident's medical symptoms.
This REQUIREMENT is not met as evidenced by:
Based on Resident interview, staff interview, clinical record review and facility documentation the facility staff failed to ensure Resident free from misappropriation of Residents property for 1 Resident (#30) in a survey sample of 76 Residents.

For Resident #30 the facility staff failed to safeguard his property while he was admitted to hospital.

Resident #30, a 35 year old man admitted to the facility on 5/11/18 with diagnoses of but not limited to Spina Bifida, Major Depressive Disorder, and Paraplegia. Resident #30's most recent (Minimum Data Set) MDS coded as a Quarterly Assessment, with an (Assessment Reference Date) ARD of 3/14/19 codes Resident #30 as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment.

On 6/5/19 at 2:00 PM during initial tour Resident #30 complained that while he was in the hospital in December 2018 someone had taken his property consisting of his 2 game systems, games, his DVD player and all his movies. He stated that he had told the Administrator and they had searched the building and could not find his property.

He further stated that the Administrator A told him to get prices printed out from the computer of the cost to replace the items and she would attempt to reimburse him. He stated that he gave her all

1. Resident # 30 was reimbursed for the total amount of his lost property, to include the 2 gaming systems, games, movies, and DVD player on 7/3/19.

2. Residents that have lost property may have potentially affected. A Resident Council meeting has been held to educate residents how to report misappropriation of property and on the facility, on 7/17/19

3. A Resident Council meeting has been held to educate residents how to report misappropriation of property and on the facility. Staffs have been educated on abuse policy including misappropriation of property. Resident Council meetings will be held twice a month x 6 months and residents will be asked of any concerns regarding misappropriation of personal property.

4. The Executive director / designee will review the minutes from the Resident Council meetings to identify any concerns that may be abuse, neglect or misappropriation and to ensure that all allegations are reported, investigated and appropriate interventions implemented to protect the resident[s] and minimize recurrence.

The Social Worker / designee will conduct 5 resident interviews per week x 12 weeks with alert and oriented residents to

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F 602	Continued From page 106 the information on the amount of movies and games and the game systems he had and that the total was over $2,300. He stated that the Administrator A put in for reimbursement in the amount of $900.72. The Resident then stated that "I am not allowed to attend activities with my service dog so these games and movies were my activities." O 6/7/19 at 11:15 AM an interview was conducted with Administrator A who stated Resident #30 had no proof he even had those things. She further stated that he signed a paper on admission stating that the facility is not responsible for his belongings. When asked if the facility did an inventory when Resident moved in she could not produce one. When asked if the facility had a lock out tag out policy for electronics brought into the building, she indicated they did have a policy. When asked if it was carried out with Resident #30's electronic equipment and she stated that it was not. She stated that she had met with him and gotten a list of the items and that Resident #30 had given her a print out from the computer of the value of the games and the game systems and the DVD player. When asked about all of his movies and DVD player that were lost she stated once again "He has no proof he has all those movies." She then stated "I got a check for $900.72 for him it came yesterday to replace the games and the systems." The administrator then said "Ok I will	F 602	determine if they are being treated in a dignified manner and free from abuse and neglect. Family members/ responsible party of 5 residents will be interviewed x 12 weeks for those residents who are cognitively impaired to determine if they are being treated in a dignified manner and free from abuse and neglect. The Executive Director / designee will provide a summary report of all allegations and actions taken to the monthly QAPI Committee. 5. 8/4/2019	

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ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

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F 602	Continued From page 107 talk to him and straighten this out. We will get his money for his movies." On 6/10/19 at 9:00 AM an interview was conducted with the Resident where he stated " On Friday [administrators name redacted] came to me and said that she would get with me about the money for my movies after you state leaves the building. I don't trust her she is trying to put me off and she will ignore me after you leave. You see this happened in December 2018 and I am just getting some my money now and it's June and she probably only gave it to me because y'all are here." On 6/10/19 at 9:30 AM in an interview with Administrator A the Resident's concerns were expressed regarding his movies and the time it will take to get the rest of his money reimbursed to him. The administrator stated she would work on it immediately, On 6/10/19 at 4:00 PM the Administrator showed proof that she had requested an additional $1500 dollars for the reimbursement of the rest of his missing property. On 6/20/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		8/4/19

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F 607	Continued From page 108 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview clinical record review and facility documentation the facility staff failed to implement abuse policies for 1 (Resident #97) in a survey sample of 76 Residents. The findings include: 1. For Resident #97, the facility staff failed to implement their abuse policy and suspend an employee involved in an allegation of verbal and physical abuse pending an investigation. The employee was assigned to care for her 3 times after the alleged violation occurred on 05/11/2019. Resident #97, a 76-year old female, was admitted to the facility on 09/26/2012. Diagnoses included but not limited to end stage renal disease. Resident #97's most recent Minimum Data Set with an Assessment Reference Date of 05/02/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for transfers and locomotion on and off unit were coded as limited assistance from staff. Mobility devices were walker or wheelchair.	F 607	1. Resident #97 Allegation of Abuse was not reported timely It was reported 6/5/19. LPN-E LPN- F, Employee M and CNA- G who were involved in the allegation of Abuse was not substantiated by previous Executive Director. CNA- G is no longer employed. Resident #97 was assessed on May 11,2019 when initial allegation was made; no injuries noted. 2. Residents at Envoy of Williamsburg may have potentially affected. Management team of the facility have been re-educated on the facility policies if there is an allegation of abuse, neglect or misappropriation of resident property and actions to be taken to protect the resident[s] and minimize recurrence. 3. Leadership within the facility changed. A seasoned, experienced nursing home administrator assumed the Executive Director role on 6/18/19. An Assistant Executive Director was assigned on 7/2/19. A knowledgeable and experienced long-term care DON was assigned effective 7/08/19. The facility entered into a contract on July	

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F 607	Continued From page 109 On 06/05/2019 at approximately 12:10 PM, an interview with Resident #97 was conducted in her room. When asked if she had any concerns about how the staff treats her, Resident #97 stated she had a problem with a nurse a few weeks ago. Resident #97 stated, "It was a Saturday morning." Resident #97 stated she was in the lobby waiting for her ride to dialysis when a nurse came and told her she couldn't wait in the lobby because it wasn't safe. Resident #97 stated she always waits in the lobby for her ride to dialysis and locked her wheelchair in place. Resident #97 stated the nurse was rude when talking to her and began pushing/pulling on the wheelchair trying to get it to move. As a result, Resident #97 stated that she "slid out" of her wheelchair to the floor. Resident #97 stated that her whole right side was still sore from the incident. Resident #97 stated she told the administrator about what happened that same day and has not seen the administrator since that day. Resident #97 stated she did not remember the nurse's name. When asked if she has seen the nurse again since the incident, Resident #97 stated that the Thursday following the incident, that same nurse came in her room to give medications and Resident #97 stated she refused her meds and told the nurse, "I don't even want a cup of water from you." Resident #97 denies feeling anxious or fearful and stated she had since talked to the nurse "like she was my own daughter." Resident #97 stated she told her "Don't hassle people in a wheelchair." On 06/05/2019 at approximately 1:00 PM, the administrator was notified of this allegation of	F 607	1, 2019, with an independent long-term care consulting company to provide additional support and services to the facility including education on abuse, neglect and misappropriation of resident property. Department managers were educated on 6/18/19 by the Division Director of Nursing on abuse, types of abuse and neglect, training, prevention, identification, investigating, protection, reporting/response, resident□s rights, reporting reasonable suspicion of a crime, and the Elder Justice Act. Additional training on abuse / neglect will providing using multiple modalities including group training / discussion facilitated by an external long-term care consultant, small group and 1:1 review and discussion with staff; on-line training, etc. Abuse training will be provided to new employees during orientation. HR Coordinator will track 12-month Abuse Education and turn into ED weekly to assure staff has mandated education. A listing of employees who has not completed annual abuse training will be provided to the Executive Director and the staff will be removed from the schedule until the training is completed. Reported allegations will be investigated and reported according to the facility policy. The Executive Director / Assistant Executive Director / DON will review all final reports prior to submission to ensure that a comprehensive investigation was	

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F 607	Continued From page 110 abuse and entered Resident #97's room with this surveyor. Resident #97 repeated her statements to the administrator. On 06/05/2019 at approximately 1:15 PM, the administrator and this surveyor met to discuss the incident. When asked for notes of the investigation and statements, the administrator looked through her electronic files and stated she could not find notes about the investigation. The administrator stated she asked the nurse to write a statement but was unable to locate it. The administrator did locate an incident report dated 05/14/2019 and provided a copy to this surveyor. The incident report dated 05/14/2019 was completed by LPN F. Under the header, "Describe objectively what was observed", it was documented, "Resident was in the front lobby with no supervision. Nurse asked resident how she got out there. Resident stated she knows the code to get out. Nurse informed resident of the dangers that can happen because she is off the unit and we are unaware of who is picking her up. Nurse also informed her she care about her well-being that if someone comes into the facility they could harm her and we would be unaware. Resident got upset stating no one cares about her. I informed her that I don't know what normally goes on but I care and I can't allow her to sit out there. Nurse started taking resident back to the unit and Resident grow I told to the side rail next to the administrator door and pulled herself out of chair. Resident did not hit floor immediately. Resident lowered herself to the floor. Nurse tried to assist resident back in wheelchair that is when resident started yelling leave her alone. Resident put herself back in chair." Under the header, "Management Review"	F 607	completed and that appropriate actions were taken to protect the resident[s] and minimize recurrence. 4. The Social Worker / designee will conduct 5 resident interviews per week x 12 weeks with alert and oriented residents to determine if they are being treated in a dignified manner and free from abuse and neglect. Family members/ responsible party of 5 residents will be interviewed x 12 weeks for those residents who are cognitively impaired to determine if they are being treated in a dignified manner and free from abuse and neglect. The Executive Director / designee will provide a summary report of all allegations and actions taken to the monthly QAPI Committee. 5. 8/4/2019	

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F 607	Continued From page 111 dated 05/16/2019 at 7:49 a.m., it was documented by the administrator "I have met with resident on 05/11/2019 (Saturday) morning. She was able to stand up and walking with her W/C [wheelchair]." On 06/17/2019, the facility staff provided a list of days LPN E was assigned to care for Resident #97 since 05/11/2019. There were 3 dates when LPN E was assigned to care for Resident #97 after the allegation of abuse incident (05/26/2019, 05/30/2019, and 06/02/2019). The facility provided a copy of their policy entitled, "Abuse, Neglect, Exploitation, & Misappropriation." An excerpt of the introduction to the policy documented, "No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein." Their abuse policy addresses employee screening and training; prevention and identification of abuse; reporting and investigating abuse allegations; and protecting victims of abuse. In Section 6 on page 7, their policy stated that "Any suspect who is an employee or contract service provider, once he/she has been identified, will be suspended pending the investigation." On 06/20/2019 by the end of the survey, the interim administrator had no further information or documentation to offer.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		8/4/19

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F 609	Continued From page 112 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to report allegations of abuse and neglect to the state agency for 2 residents (Resident #97 and Resident #2) in a sample size of 76 residents	F 609	1. Resident #97 Allegation of Abuse was not reported timely. It was reported 6/5/19. LPN-ELPN- F, Employee M and CNA- G who were involved in the allegation. Abuse was not substantiated by previous Executive Director. CNA- G and Executive Director are no longer employed at the facility.	

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F 609	Continued From page 113 The findings included: 1. For Resident #97, the facility staff failed to report to the state agency an allegation of abuse by a nurse on 05/11/2019. Resident #97, a 76-year old female, was admitted to the facility on 09/26/2012. Diagnoses included but not limited to end stage renal disease. Resident #97's most recent Minimum Data Set with an Assessment Reference Date of 05/02/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. On 06/05/2019 at approximately 12:10 PM, an interview with Resident #97 was conducted in her room. When asked if she had any concerns about how the staff treats her, Resident #97 stated she had a problem with a nurse a few weeks ago. Resident #97 stated, "It was a Saturday morning." Resident #97 stated she was in the lobby waiting for her ride to dialysis when a nurse came and told her she couldn't wait in the lobby because it wasn't safe. Resident #97 stated she always waits in the lobby for her ride to dialysis and locked her wheelchair in place. Resident #97 stated the nurse was rude when talking to her and began pushing/pulling on the wheelchair trying to get it to move. As a result, Resident #97 stated that she "slid out" of her wheelchair to the floor. Resident #97 stated that her whole right side was still sore from the incident. Resident #97 stated she told the administrator about what happened that same day and has not seen the administrator since that day. Resident #97 stated she did not remember the nurse's name. When asked if she has seen	F 609	Resident #2 was discharged prior to the survey. Licensed staff will receive education on reordering / refilling the IV box. Licensed nursing staff will be re-educated on process and importance of notifying the provider when an IV site cannot be accessed and/or when medications/fluids are not available. 2. Residents at Envoy of Williamsburg may have been potentially affected. All Staff have been educated on the facility policy including reporting requirements and reminded that all are mandated reporters. 3. Department managers were educated on 6/18/19 by the Division Director of Nursing on abuse, types of abuse and neglect, training, prevention, identification, investigating, protection, reporting/response, resident□s rights, reporting reasonable suspicion of a crime, and the Elder Justice Act. 2. Additional training on abuse / neglect will providing using multiple modalities including group training / discussion facilitated by an external long-term care consultant, small group and 1:1 review and discussion with staff; on-line training, etc. Abuse training will be provided to new employees during orientation. HR Coordinator will track 12-month Abuse Education and turn into ED weekly to assure staff has mandated education. A listing of employees who has not completed annual abuse training will be	

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F 609	Continued From page 114 the nurse again since the incident, Resident #97 stated that the Thursday following the incident, that same nurse came in her room to give medications and Resident #97 stated she refused her meds and told the nurse, "I don't even want a cup of water from you." Resident #97 denies feeling anxious or fearful and stated she had since talked to the nurse "like she was my own daughter." Resident #97 stated she told her "Don't hassle people in a wheelchair." On 06/05/2019 at approximately 1:00 PM, the administrator was notified of this allegation of abuse and entered Resident #97's room with this surveyor. Resident #97 repeated her statements to the administrator. On 06/05/2019 at approximately 1:15 PM, the administrator and this surveyor met to discuss the incident. When asked if this allegation of abuse was reported to the state agency, the administrator stated it had not been reported because "She told me something different." The administrator stated that Resident #97 told her she didn't like the way the nurse spoke to her and Resident #97 wanted her to "talk to the nurse and tell her to be nice." The administrator stated Resident #97 told her she was in the lobby waiting for transportation to dialysis when the nurse came and told her it wasn't safe to be in the lobby. The administrator stated [Resident #97] locked her own wheelchair and fell out. When asked if it is considered an allegation of abuse when a nurse speaks rude/roughly to a resident, the administrator stated, "Yes and no." When asked if this should have been reported, the administrator stated, "Because of what she said now, I will report it." When asked for notes of the investigation and statements, the administrator	F 609	provided to the Executive Director and the staff will be removed from the schedule until the training is completed. Reported allegations will be investigated and reported according to the facility policy. The Executive Director / Assistant Executive Director / DON will review all final reports prior to submission to ensure that a comprehensive investigation was completed and that appropriate actions were taken to protect the resident[s] and minimize recurrence. 4. The Regional Vice President of Operations/designee will review incidents/accidents and grievances weekly for 3 months to ensure any potential incidences of abuse or neglect are reported and investigated per federal regulation. The Executive Director / designee will provide a summary report of all allegations and actions taken to the monthly QAPI Committee. 5. 8/4/2019	

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F 609	Continued From page 115	F 609		

looked through her electronic files and stated she could not find notes about the investigation. The administrator stated she asked the nurse to write a statement but was unable to locate it.

On 06/20/2019 by the end of the survey, the interim administrator had no further information or documentation to offer.

2. For Resident #2, the facility Director of Nursing (DON), and nursing staff neglected to report and investigate an allegation of neglect, and the family reported neglect to them on 2-13-19.

Resident #2 was visited by family on 2-13-19, and found that the Resident had been vomiting all day on 2-12-19, and the emesis basin full of emesis was still on the bedside table. Also found were medications in a cup which had not been administered. The family went to the nurses station and spoke to the nurse who stated she would get the DON for them to speak to. The family waited for the nurse for 15 minutes, and when she did not return, went immediately to the DON and reported their findings of neglect. The DON told them she was leaving and not returning to the position, and would report it to the new DON.

On 6-11-19, the Administrator was asked to provide any and all documentation of an abuse or neglect report and investigation for this Resident during her entire stay. She returned, and stated there were none, however, she had received calls from the Residents daughter about concerns, but had not felt it was neglect. She did not report nor investigate the allegation of neglect per federal regulations.

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F 609	Continued From page 116 The facility policy was reviewed, and revealed the following: "Neglect is the failure of the center, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to; Failure to provide adequate nutrition and fluids....." The facility Administrator and Director of nursing were made aware of findings on 6-20-19. The facility stated they had no further information to provide.	F 609		
F 610 SS=G	COMPLAINT DEFICIENCY Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		8/4/19

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F 610	Continued From page 117 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on Resident interview, Family interview, staff interview, clinical record review, facility record review, and in the course of a complaint investigation, the facility staff failed to investigate, prevent further occurrences, and correct allegations of abuse, neglect, and misappropriation for 2 residents (Resident #2, #97), resulting in harm for Resident #2, in a survey sample of 76 Residents. The findings included: 1. For Resident #2, the facility Director of Nursing (DON), and nursing staff neglected to report and investigate an allegation of neglect, and the family reported neglect to them on 2-13-19. Resident #2 was visited by family on 2-13-19, and found that the Resident had been vomiting all day on 2-12-19, and the emesis basin full of emesis was still on the bedside table. Also found were medications in a cup which had not been administered. The family went to the nurses station and spoke to the nurse who stated she would get the DON for them to speak to. The family waited for the nurse for 15 minutes, and when she did not return, went immediately to the DON and reported their findings of neglect. The DON told them she was leaving and not returning to the position, and would report it to the new DON. On 6-11-19, the Administrator was asked to provide any and all documentation of an abuse or neglect report and investigation for this Resident	F 610	1. Resident #2 has been D/C from facility. The DON at the time of the incident is no longer works at the facility. Resident #97 had her concern reported to the State as a FRI. LPN-F is no longer employed at the facility. 2. All residents at Envoy of Williamsburg may have potentially been at risk. All staff have been re-educated on identifying, reporting, and investigating allegations of abuse and neglect. 3. Department managers were educated on 6/18/19 by the Division Director of Nursing on abuse, types of abuse and neglect, training, prevention, identification, investigating, protection, reporting/response, resident□s rights, reporting reasonable suspicion of a crime, and the Elder Justice Act. Additional training on abuse / neglect will providing using multiple modalities including group training / discussion facilitated by an external long-term care consultant, small group and 1:1 review and discussion with staff; on-line training, etc. Abuse training will be provided to new employees during orientation. HR Coordinator will track 12-month Abuse Education and turn into ED weekly to assure staff has mandated education. A listing of employees who has not completed annual abuse training will be provided to the Executive Director and the	

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F 610	Continued From page 118 during her entire stay. She returned, and stated there were none, however, she had received calls from the Residents daughter about concerns, but had not felt it was neglect. She did not report nor investigate an allegation of neglect per federal regulation. The facility Administrator and Director of nursing were made aware of findings on 6-20-19. The facility stated they had no further information to provide. COMPLAINT DEFICIENCY 2. For Resident #97, the facility staff failed to prevent further potential abuse after an allegation of abuse by a nurse on 05/11/2019. Resident #97, a 76-year old female, was admitted to the facility on 09/26/2012. Diagnoses included but not limited to end stage renal disease. Resident #97's most recent Minimum Data Set with an Assessment Reference Date of 05/02/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for transfers and locomotion on and off unit were coded as limited assistance from staff. Mobility devices were walker or wheelchair. On 06/05/2019 at approximately 12:10 PM, an interview with Resident #97 was conducted in her room. When asked if she had any concerns about how the staff treats her, Resident #97	F 610	staff will be removed from the schedule until the training is completed. Reported allegations will be investigated and reported according to the facility policy. The Executive Director / Assistant Executive Director / DON will review all final reports prior to submission to ensure that a comprehensive investigation was completed and that appropriate actions were taken to protect the resident[s] and minimize recurrence. 4. The Regional Vice President of Operations/designee will review incidents/accidents and grievances weekly for 3 months to ensure any potential incidences of abuse or neglect are reported and investigated per federal regulation. The Executive Director / designee will provide a summary report of all allegations and actions taken to the monthly QAPI Committee. 5. 8/4/19	

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F 610	Continued From page 119 stated she had a problem with a nurse a few weeks ago. Resident #97 stated, "It was a Saturday morning." Resident #97 stated she was in the lobby waiting for her ride to dialysis when a nurse came and told her she couldn't wait in the lobby because it wasn't safe. Resident #97 stated she always waits in the lobby for her ride to dialysis and locked her wheelchair in place. Resident #97 stated the nurse was rude when talking to her and began pushing/pulling on the wheelchair trying to get it to move. As a result, Resident #97 stated that she "slid out" of her wheelchair to the floor. Resident #97 stated that her whole right side was still sore from the incident. Resident #97 stated she told the administrator about what happened that same day and has not seen the administrator since that day. Resident #97 stated she did not remember the nurse's name. When asked if she has seen the nurse again since the incident, Resident #97 stated that the Thursday following the incident, that same nurse came in her room to give medications and Resident #97 stated she refused her meds and told the nurse, "I don't even want a cup of water from you." Resident #97 denies feeling anxious or fearful and stated she had since talked to the nurse "like she was my own daughter." Resident #97 stated she told her "Don't hassle people in a wheelchair." On 06/05/2019 at approximately 1:00 PM, the administrator was notified of this allegation of abuse and entered Resident #97's room with this surveyor. Resident #97 repeated her statements to the administrator. On 06/05/2019 at approximately 1:15 PM, the	F 610		

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F 610	Continued From page 120 administrator and this surveyor met to discuss the incident. When asked for notes of the investigation and statements, the administrator looked through her electronic files and stated she could not find notes about the investigation. The administrator stated she asked the nurse to write a statement but was unable to locate it. The administrator did locate an incident report dated 05/14/2019 and provided a copy to this surveyor. The incident report dated 05/14/2019 was completed by Licensed Practical Nurse F [LPN F]. Under the header, "Describe objectively what was observed", it was documented, "Resident was in the front lobby with no supervision. Nurse asked president how she got out there. Resident stated she knows the code to get out. Nurse informed resident of the dangers that can happen because she is off the unit and we are unaware of who is picking her up. Nurse also informed her she care about her well-being that if someone comes into the facility they could harm her and we would be unaware. Resident got upset stating no one cares about her. I informed her that I don't know what normally goes on but I care and I can't allow her to sit out there. Nurse started taking resident back to the unit and Resident grow I told to the side rail next to the administrator door and pulled herself out of chair. Resident did not hit floor immediately. Resident lowered herself to the floor. Nurse tried to assist resident back in wheelchair that is when resident started yelling leave her alone. Resident put herself back in chair." Under the header, "Management Review" dated 05/16/2019 at 7:49 a.m., it was documented by the administrator "I have met with resident on 05/11/2019 (Saturday) morning. She was able to stand up and walking with her W/C [wheelchair]."	F 610		

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F 610	Continued From page 121 On 06/17/2019, the facility staff provided a list of days LPN E was assigned to care for Resident #97 since 05/11/2019. There were 3 dates when LPN E was assigned to care for Resident #97 after the allegation of abuse incident (05/26/2019, 05/30/2019, and 06/02/2019). On 06/20/2019 by the end of the survey, the interim administrator had no further information or documentation to offer.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		8/4/19

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F 622	Continued From page 122 resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or	F 622		

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F 622	Continued From page 123 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to make to issue collection letters and failed to make any collection efforts prior to issuing a discharge notice for 2 of 76 residents. (Resident #127 and #27). The Findings included: 1. The facility staff failed to issue a Letter of Intent/Collection letter to Resident #127, prior to issuing a 30 Day Discharge Notice on 4/10/19. Resident #127 was a 59 year old who was admitted to the facility on 1/16/19. Resident #127's diagnoses include Malignant Neoplasm of Brain, Malignant Neoplasm of Breast, Adult	F 622	1. Resident #27 had their discharge letter revoked due to not following Consulate Private Pay Collection policy and Resident Trust Fund Process. Resident #127 no longer resides at the facility. 2. Current Residents who have previously been issued 30 Discharge letters may potentially be at risk and will be reviewed by the Executive Director, Social Worker or Business Office Manager for needed action. 3. The Business Office Manager and Social Service team will be reeducated by Clinical Quality Specialist on the regulations regarding discharge notice to	

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F 622	Continued From page 124 Failure to Thrive, and Generalized Anxiety Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 4/30/19 was reviewed. Resident #127 was coded as having a Brief interview of Mental Status Score of 15, indicating no cognitive impairment. On 6/7/19 a review was conducted of Resident #127's clinical record. Resident #127 was receiving hospice services. On 6/7/19 a review was conducted of facility documentation, revealing a 30 Day Discharge Letter dated 4/10/19. The letter was unsigned by the resident, who was her own responsible party. There was no documentation that Resident #127 had received a Letter of Intent/Collection Letter prior to the Discharge Notice. On 6/7/19 an interview was conducted with the Business Office Manager (Employee I). She stated that Resident 127's bill was covered by a hospital contract, then converted to Medicaid within 45 days when she was approved for long term care. Resident #127 then became eligible for hospice, and the hospice company was billed. For the past three months the outstanding balance was not covered by hospice. She stated that a Letter of Intent to demand payment was never issued to the resident. The Business Office Manager stated, "We usually issue 2 collection letters. I didn't issue the letters, I assumed that I had done so." The Private Pay Collections Policy dated 4/4/17 was reviewed. An excerpt read, "Within 30 days	F 622	residents. Prior to giving a discharge notice to a resident, for any reason other than the facility not being able to meet the medical needs of a resident in an emergency situation, the discharge notice will be reviewed by Executive Director, Assistant Executive Director, or Director of Nursing. The status of residents who have been given a discharge notice will be reviewed weekly by Social Work with the Executive Director, Assistant Executive Director and/or DON. 4. Executive Director/designee will review all involuntary discharge notices weekly x 3 months. The Business Office Manager will provide a monthly report to the QAPI Committee of the status of 30 days discharge notice for non-payment. 5. 8/4/2019	

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F 622	Continued From page 125 following the first collection letter, the Business Office Manager will send Collection Letter 2 to the resident. Within 30 days following the second collection letter, Collection Letter 3 should be signed by the Executive Director. Within 30 days following the third collection letter, the Executive Director should continue with Collection Letter 4." 2. For Resident #27, the facility staff failed to make reasonable efforts to assist him obtain financial assistance to pay the cost of care at the facility prior to issuing a discharge notice. Resident #27, a 65-year old male, was admitted to the facility on 09/06/2018. Diagnoses included but not limited to altered mental status, adult failure to thrive, chronic fatigue, difficulty in walking, and peripheral vascular disease. Resident #27's most recent Minimum Data Set with an Assessment Reference Date of 03/13/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 11 out of a possible 15 indicative of moderate cognitive impairment. Balance during Transitions and Walking were coded as not steady when moving from sitting to standing or walking. Mobility device used was coded as wheelchair. Discharge Plan and Return to Community were coded as no, meaning there was no discharge plan in place for Resident #27 to return to community nor did Resident #27 want to talk with someone about the possibility of returning to live in the community. On 06/05/19 at approximately 11:40 AM, Resident	F 622		

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F 622	Continued From page 126 #27 was observed in his room, fully dressed, and seated in his wheelchair. When asked if he had any concerns about the care he receives at the facility, Resident #27 stated, "They putting me out Monday [06/10/2019]." Resident #27 then provided a form entitled "[Facility Name and state] Involuntary Transfer/Discharge Notice." The form was dated 05/10/2019 addressed to Resident #27 from the administrator of the facility. A portion of the letter documented, "You are being discharged because: The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. The resident will be discharged to [address listed] on 06/10/2019." On 06/06/2019 at approximately 1:40 PM, Resident #27's clinical record was reviewed. Progress notes from all disciplines ranging from 04/28/2019 to 06/06/2019 were reviewed. The only social services noted written during that range was dated 05/13/2019 and documented, "Social Services Visit - Social Services and Business Office issued the resident a [state] Involuntary Transfer/Discharge Notice." This note was signed by Employee L. On 06/06/2019 at approximately 1:50 PM, an interview with Employee I, Business Office Manager, was conducted. When asked about Resident #27's planned discharge for 06/10/2019, Employee I confirmed they did issue Resident #27 a discharge notice but he has nowhere to go so "we will just issue another 30-day notice until we talk with his family member. When asked about his responsible party, Employee I stated Resident #27 is his own responsible party. Employee I also stated that the address on the issue form is no longer his address. When asked	F 622		

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F 622	Continued From page 127 about assisting Resident #27 acquiring funds, Employee I stated, "He refused to show me his Medicaid card." On 06/06/2019 at approximately 1:55 PM, an interview with Employee L from Social Services was interviewed. When asked if he was aware of Resident #27's pending discharge, he stated, "Yes." When asked where Resident #27 would be going upon discharge, Employee L stated, "I think he's going with family." When informed the business office manager just said Resident #27 has nowhere to go, Employee L stated then the 30-day discharge notice would be re-issued. When asked what would occur after that, Employee L stated the business office may set up a payment plan. When asked about discharge planning, Employee L stated he would have to meet with Resident #27 to plan a safe discharge. When asked if he had any discharge planning notes associated with Resident #27's discharge scheduled on 06/10/2019, he looked in the electronic health record and stated, "No." A social services policy on discharge planning was requested. On 06/06/2019 at approximately 5:10 PM, an interview with Employee I, Business Office Manager, was conducted. Employee I stated that the facility had a hospital agreement to pay for Resident #27's care but that agreement expired in February 2019 and private pay began in March 2019. Employee I acknowledged that the facility had failed to issue any collection letters and failed to make any collection efforts prior to issuing the discharge notice. Employee I stated that the facility staff had not applied to be representative payee for Resident #27, which would have allowed the facility to receive Resident #27's	F 622		

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F 622	Continued From page 128 monthly income to apply to towards to the cost of his care. Employee I stated that the facility staff failed to follow-up on the status of the Medicaid application for Resident #27 to offer any needed assistance to obtain financial assistance to assist with the cost of care at the facility. Employee I stated she did not issue collection letter and does not have collection notes. On 06/06/2019, the facility staff provided a copy of their policy entitled, "Resident Trust Fund - Application for Representative Payee Status." An excerpt of the introduction to the policy documented, "For residents for whom responsible party is not forwarding funds to the center appropriately, the Business Office Manager may complete and submit the form for Representative Payee." The facility staff also provided a copy of their policy entitled, "Private Pay Collections." An excerpt of Section 3 documented, "Account balances which remain unpaid 15 days following billing are considered past due. Collection Letter 1 should be issued to the resident and if applicable, the legal representative as defined in the admission process." Section 12 documented, "Copies of private pay statements and collection letters are to be retained in the resident's financial file at the care center." On 06/20/2019 at the end of survey, the administrator had no further information or documentation to offer.	F 622		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 636		8/4/19

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F 636	Continued From page 129 reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.	F 636		

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F 636	Continued From page 130 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record interview, and facility documentation review, the facility staff failed to document an accurate MDS assessment for 2 of 76 residents (Resident #25 and #121). The Findings included: 1. The facility staff failed to assess and Resident #25's mood disorders in the Minimum Data Set, and failed to provide evidence of his participation in the assessment process, including his preference for the services of a psychiatrist. Resident #25 was a 45 year old who was admitted to the facility in 10/4/17. His diagnoses included Bipolar Disorder, Insomnia, Major Depressive Disorder and Anxiety. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date	F 636	1. Resident #25 was interviewed by Social Services on 7/12/19. The interview included completion of a mood interview to determine depression symptoms. Findings were reviewed with the physician on 7/15/19 by the Consulate travel MDS Coordinator. No Appointment for Psych services outside of the facility has been made per resident's wishes expressed on 7/12/19. An Interdisciplinary care conference will be held on 7/18/19 with resident and IDT members to discuss resident's discharge goals. Resident #121 had a review of the pressure ulcer documentation completed in the nursing notes on 5/9/2019 and 5/15/2019 as well as the pressure ulcer wound round documentation completed on 5/9/2019 and 5/15/2019. A review of the Minimum Data Set (MDS)	

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F 636	Continued From page 131 of 3/11/19 was reviewed. Resident #25 was incorrectly coded 0 (zero) for depressed mood. On 6/05/19 at 2:34 P.M., during a facility tour, Resident #25's door was observed to be open. From the hallway, the resident was observed with his legs (from the knee down) and feet hanging over the foot of his bed. Upon entering the room, the resident was interviewed. Resident #25 stated that his bed was too short, and that it had caused him to feel humiliated, anxious and frustrated. He stated that the facility had refused to set up transportation and help him obtain outside psychiatric services, as was his preference. Resident #25 stated that he was too young to be at the facility, and wanted a more age-appropriate placement. On 6/5/19 a review was conducted of Resident #25's clinical record. There was no evidence of his participation in the assessment process regarding his preference for the services of a psychiatrist, or his discharge goals. Since admission, the facility had not referred him to a psychiatrist. On 6/5/19 an interview was conducted with the Director of Social Services (Employee M), and the Social Services Assistant (Employee L). The social services staff were asked for evidence that Resident #15 had participated in his assessment of his mood, and that the facility had documented his preferences and discharge goals. The Director of Social Services stated that she worked full time as the Admissions Coordinator. The Social Services Assistant stated that he did not have any documentation. On 6/5/19 a review was conducted of facility	F 636	Assessment with an assessment reference date (ARD) of 5/15/2019 was completed on 7/10/19 by The Division Director of MDS to ensure the assessment was coded per the Resident Assessment Instrument (RAI) guidelines. Facility MDS Coordinator was reeducated regarding pressure ulcer coding per RAI manual guidelines. 2. A review of MDS assessments with ARDs since the survey end date of 6/20/2019 is being completed for accuracy by Regional MDS coordinators team and this review is ongoing. Modifications completed per RAI guidelines as identified. 3. Education was provided to the Interdisciplinary team on 7/11/19 by Consulate Travel MDS Coordinator to include completion of accurate resident assessments based on any observations, staff interviews and clinical record documentation and ensuring supportive documentation of resident participation in the assessment process was present in the clinical record. 4. A random sample of 5 MDS assessments completed each week will be reviewed by Regional MDS Coordinator team to ensure the assessments are accurate and capture resident participation in the assessment process. Any corrections will be made per RAI guidelines as identified. Findings of the MDS reviews will be reported during the monthly Quality Assessment Process	

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F 636	Continued From page 132 documentation, revealing a Transportation Policy dated 11/30/14. An excerpt read, "It is the policy of The Company to ensure residents access to medical services." 2. For Resident #121, the facility failed to document an accurate MDS assessment for pressure injuries. Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to dementia. Resident #121's most recent Minimum Data Set with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Current number of unhealed pressure ulcers were coded as 0 [meaning none] for Stage I pressure injuries, 0 for Stage II pressure injuries, 1 [meaning 1] for Stage III pressure injuries, and 0 for Stage IV pressure injuries. A nurse's note dated 05/09/2019 at 10:00 AM documented, "Resident with Stage III to right superior hip 1x1.5x0.1 20% pink wound base 80% white slough, Stage III to middle right hip 0.5 x 0.5 x 0.1 20% pink wound base 80% white slough, Stage III to right inferior hip 0.2 x 0.2 x 0.1 50% pink wound bed 50% white slough, Stage II to right trochanter upper 1.5 x 2 x 0.1 pink wound base, Stage II right trochanter lower 0.2 x 0.2 x 0.1. Pink wound base. All wounds above in close proximity of one another. Stage III to right upper buttock 1.7 x 0.7 x 0.2 20% pink wound base	F 636	Improvement (QAPI) meeting for review and recommendation. 5. 8/4/19	

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F 636	Continued From page 133 80% white slough. RP and NP aware. New treatments in place in performed by this nurse." A nurse's note dated 5/15/2019 at 11:15 AM documented, "Stage III to right hip superior to other wounds 1 x 1 x 0.1, decreased in size, no slough present, pink wound bed, Stage III to right hip (middle) in between superior and inferior hip wound 0.1 x 0.1 x 0 pink area, no longer open. Stage III to right hip inferior to other wounds 0.1 x 0.1 x 0 pink area, no longer open, Stage III to right upper buttock 1.5 x 1.5 x 0 red area, no longer open, Stage II to right trochanter superior to other wound to same area 1 x 1 x 0 red area, no longer open, Stage II to right trochanter inferior to other wound of same area 0.1 x 0.1 x 0 red area, no longer open. Will continue to monitor closed areas for reoccurrence. Current treatment to open area with hydrogel. NP in RP aware." Four Stage III wounds and two Stage II wounds with slough in the wound beds were discovered during the 7-day lookback period. There was also a note documenting that three of the Stage III wounds healed during the 7-day look-back period. On 06/14/19 at 12:33 PM, an interview with the MDS coordinator, Registered Nurse A (RN A), was conducted. RN A stated she has been employed with the facility for 2 weeks. When notified of concerns with the discovery of four Stage III wounds and two Stage II wounds during the 7-day look-back period, RN A stated the wounds should have been documented on the MDS assessment. The facility staff presented a copy of the Centers for Medicare and Medicaid (CMS)'s Resident	F 636		

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F 636	Continued From page 134 Assessment Instrument (RAI) Version 3.0 Section M0210 entitled, "Unhealed Pressure Ulcers." The last bulleted point documented, "If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment." On 06/20/2019 by the end of the survey, the administrator had no further information or documentation to offer.	F 636		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within	F 640		8/4/19

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F 640	Continued From page 135 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to transmit Resident assessment data, for one Resident (Resident #2) in a survey sample of 76 Residents. The findings included: Resident #2 was admitted to the facility on 1/15/19 and discharged on 2/25/19. On 6/17/19 during a clinical record review, it was identified that the MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/25/19 was coded as a discharge return anticipated assessment for Resident #2. The	F 640	1. Resident #2's Discharge MDS Assessment with an ARD of 2/25/2019 was transmitted to the CMS system on 7/9/2019 by Consulate Travel MDS Coordinator. 2. An MDS 3.0 Missing Assessment Report was obtained on 7/11/19 to identify any further MDS assessments that were not transmitted. One assessment on the missing assessment report was modified by Consulate Travel MDS coordinator and submitted to the CMS system by the Regional MDS Coordinator on 7/15/19. Regional MDS will check missing	

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F 640	Continued From page 136 assessment had not been transmitted to the CMS system as required. An interview with RN A, MDS Coordinator confirmed this assessment had not been transmitted as per regulations.	F 640	assessment report again on 7/16/19 to ensure no assessments are still showing as missing. 3. Education was provided to the MDS Coordinators regarding timely submission of MDS assessments per the RAI guidelines, how to obtain MDS Missing Assessment Report, and how to find and print validation reports on 7/18/19 by Regional MDS Coordinator. 4. MDS Coordinator will print the MDS 3.0 NH Final Validation reports after each MDS batch submission to review for late submission warnings. MDS Coordinator will obtain an MDS 3.0 Missing Assessment Report weekly to review for any missing MDS Assessments. Corrective measures will be taken with any identified issues. MDS Coordinator will report finding during the monthly QAPI meeting for review and recommendation. 5. 8/4/19	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		8/4/19

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F 644	Continued From page 137 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record interview, facility documentation review, and in the course of investigating a complaint, the facility staff failed to obtain a PASARR Level 2 for 2 residents (Resident #25 and #76) of 76 sampled residents. The Findings included: 1. Resident #25 was a 45 year old who was admitted to the facility in 10/4/17. His diagnoses included Bipolar Disorder, Insomnia, Major Depressive Disorder, Anxiety, Diabetes Mellitus Type 2 , and Morbid Obesity. Upon admission, Resident #25 was admitted without a Level 1 PASARR. On 6/5/18, the facility Director of Social Services (Employee M) completed a Level 1 PASARR, which incorrectly concluded that a Level 2 PASARR was not required. The following excerpt from Question 2. (C) on the PASARR read, "the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? NO." In fact during the previous year, Resident #25's mental health declined and he was no longer able to live independently. According to the Virginia Uniform Assessment	F 644	1. Resident #68 PASSAR Level I was completed 5/21/19 and a request for a Level II screening was submitted to ASCEND via Fax on 5/21/19. The Level II PASSAR for Resident #76 was requested from ASCEND on 5/24/19. 2. All residents may be at risk for not having a Level 1 PASSAR completed prior to admission. A review of current residents will be completed to ensure that all residents have a Level I PASSAR and that if a Level II PASSAR was recommended it has been obtained from ASCEND. Any variances identified will be corrected and ASCEND will be requested to complete any needed Level II PASSARs. 3. The Admissions Coordinator and Social Worker have been educated on the processes related to Level I and Level II screenings by the Clinical Quality Specialist. 4. Admission Coordinator will submit a list of all Admissions for the week to the Executive Director/designee along with	

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F 644	Continued From page 138 Instrument dated 1/30/19 Resident #25 received Social Security Disability income due to mental illness. The care plan was not revised until 5/22/19 to state the need for a PASARR Level 2. The clinical record did not contain documentation about any new diagnoses of mental illness, or new inappropriate behaviors. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/11/19 was reviewed. Resident #25 was incorrectly coded 0 (zero) for depressed mood. On 6/05/19 at 2:34 P.M., during a facility tour, Resident #25's door was observed to be open. From the hallway, the resident was observed with his legs (from the knee down) and feet hanging over the foot of his bed. Upon entering the room, the resident was interviewed. Resident #25 complained of not being able to move in the bed. He stated that he cut his foot on the footboard because he couldn't stretch his leg out. He said because of the injury, the staff had removed the footboard and placed against the wall. He pointed to the footboard, which was on the floor, placed against the wall opposite the foot of his bed. A observation was made of second toe of his right foot, which had a laceration on it. Resident #25 stated that his bed was too short, and that it had caused him to feel humiliated, anxious and frustrated. He stated that his room had been moved in February, and that had an appropriately long bed in his former room. He stated that the facility did not transfer the bed with him. He further stated that he was frustrated due to his inability to move around and shift his weight in the bed. He stated that the facility had refused to set up transportation and help him obtain outside psychiatric services, as was his	F 644	copy of PASSAR I or II. The findings from the weekly review will be submitted to the monthly QAPI Committee for additional oversight and review. 5. 8/4/2019	

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F 644	Continued From page 139 preference. Resident #25 stated that he was too young to be at the facility, and wanted a more age-appropriate placement. On 6/5/19 a review was conducted of Resident #25's clinical record. There was no evidence that the facility attempted to obtain a PASARR Level 2 until 5/21/19. On 6/5/19 an interview was conducted with the Director of Social Services (Employee M), and the Social Services Assistant (Employee L). The Director of Social Services stated that she worked full time as the Admissions Coordinator. The Social Services Assistant stated that his educational background was in public administration, not human services. He did not know why Resident #25 had not been referred for a PASARR Level 2 in a timely manner. 2. For Resident #76 the facility staff failed to obtain a follow up Level II PASARR. Resident # 76, a 68 year old man who was admitted to the facility on 4/15/19 with diagnoses of but not limited to Schizophrenia, Unspecified Mood Disorder, Parkinson's disease, Neuropathy, and Lymphedema. On 6/8/19 during clinical record review Resident #76's record was found to have a LEVEL I PASARR dated 1/2/15 that stated:	F 644		

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F 644	Continued From page 140 5. Recommendation [the following boxes were checked] a. Refer for secondary assessment (NF Placement - Level II refer to DDM Ascend) b. MI (#2 above is checked) The PASARR Level I was signed and dated 1/2/15 (prior to admission to facility) The Resident had a Level II on 2/11/15 however the last page of the Level II states the following: 7. Potential Resident Review: YES Number of days -120 days On 6/7/19 at 10:00 AM in an interview with the Administrator she stated the follow up to Level II document states the Resident should have had Level II review screening 120 days after the initial Level II screening. She also stated that she did not pursue the follow up screening because she was not aware that it was her responsibility to do so. On 6/20/19 at 5:30 PM during the end of day meeting the Acting Administrator was made aware of the findings and no further documentation was submitted.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		8/4/19

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F 645	Continued From page 141	F 645		

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a

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F 645	Continued From page 142 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview clinical record review and facility documentation the facility staff failed to obtain PASARR screening for 2 Residents (#68, and #38) in a survey sample of 76 Residents. The findings include: 1. Resident #68, a 53 year old man admitted to the facility on 1/9/19 with diagnoses of but not limited to Major Depressive Disorder, Anxiety Disorder and Schizophrenia. During clinical record review it was discovered that the facility admitted Resident #68 without first obtaining a PASARR Level I	F 645	1. Resident #68 PASSAR Level I was completed 5/21/19 and a request for a Level II screening was submitted to ASCEND via Fax on 5/21/19. Resident #38's Level I PASSAR completed 3/10/19 after admission. 2. All residents may be at risk for not having a Level 1 PASSAR completed prior to admission. A review of current residents will be completed to ensure that all residents have a Level I PASSAR and that if a Level II PASSAR was recommended it has been obtained from ASCEND. Any variances identified will be corrected and ASCEND will be requested to complete any needed Level II	

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F 645	Continued From page 143 On 6/10/19 at 11:00 AM in an interview with the acting DON she stated that when she got to the facility she realized that the LEVEL I was not done prior to admission, the Social Worker at the facility then completed the Level I screening on 5/21/19. The DON provided copies of the PASARR Level I completed by the Social Worker and a copy of the fax to Ascend dated 5/21/19 requesting the Level II. On 6/20/19 at 5:30 PM during the end of day meeting the Acting Administrator was made aware of the findings and no further documentation was submitted. 2. Resident #38, a 68 year old woman admitted to the facility on 11/30/15 with diagnoses of but not limited to Schizoaffective Disorder, Anxiety Disorder, Unspecified Psychosis not due to a substance or known physiological condition, Major Depressive Disorder and Cognitive Communication Deficit. On 6/10/19 during clinical record review it was found that Resident #38 did not have a PASARR Level I screening prior to admission. On 6/10/19 at 11:00 AM in an interview with the acting DON she stated that when she got to the facility she realized that the LEVEL I screening was not done prior to admission, the Social Worker at the facility then completed the Level I screening on 3/10/19. On 6/20/19 at 5:30 PM during the end of day	F 645	PASSARs. 3. The Admissions Coordinator and Social Work have been educated on the processes related to Level I and Level II screenings by an outside independent consultant. 4. Admission Coordinator will submit a list of all Admissions for the week to the Executive Director/designee along with copy of PASSAR I or II. The findings from the weekly review will be submitted to the monthly QAPI Committee for additional oversight and review. 5. 8/4/2019	

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F 645	Continued From page 144 meeting the Administrator was made aware of the findings and no further information was provided.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		8/4/19

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F 655	Continued From page 145 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation and clinical record review the facility staff failed to develop a completed baseline care plan for 1 Resident (#327) in a survey sample of 76 Residents. The findings include: 1. For Resident #327 the facility staff failed to address, dietary, and discharge planning and social service goals in the baseline care plan. Resident #327, a 56 year old man admitted to the facility on 6/11/19 with diagnoses of but not limited to Chronic Pain, Chronic Gout and Acute Kidney Failure and Morbid Obesity. On 6/19/19 during clinical record review it was noted that the Resident was a new admission and had a baseline care plan dated 6/11/19. Page 1 of baseline care plan reads: Dietary Orders/ Instructions- Regular Dietary Preferences- [left blank] Therapy Orders - OT /PT / ST Resident's goals for therapy- [left blank] Social Services - [Left blank]	F 655	1. Resident #327 discharged from the facility. 2. There have been no new admissions to the facility requiring development of a baseline care plan. 3. Education provided to the Interdisciplinary team on the requirements of the baseline care plan and its completion on 7/18/19 by Regional MDS Coordinator. 4. New admissions will have a review of their baseline care plan completed at the morning meeting following the admission to ensure completion. Corrective measure will occur at the time of the review. Findings will be reported during the monthly QAPI meeting for review and recommendation. 5. 8/4/19	

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F 655	Continued From page 146 Page 2 of Care Plan reads "Areas marked with X are required to be addressed." X -Discharge Planning- Left blank On 6/18/19 at 11:45 AM in an interview with ADON, the ADON stated that if a Resident has acute kidney failure and gout he or she should probably not be on a regular diet as care plan states. According to the Admission Data Collection Document dated 6/11/19 "Resident is a full code and on cardiac diet" On 6/18/19 at 3:00PM in an interview with DON, she stated all of the areas with dietary, social service a discharge planning should have been addressed in the baseline care plan. On 6/19/19 during end of day conference Administrator was made aware of the finding and no further information was provided	F 655		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		8/4/19

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F 656	Continued From page 147 (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: Based on observations, resident interviews, staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to develop a comprehensive, resident-centered care plan for 6 residents (Resident #40, Resident #121, Resident #65, Resident #376, Resident #29, Resident #15) in a sample size of 76	F 656	1. Resident #40 discharged from the facility. Resident #121 had a care plan review and revision completed to include a focus for actual skin breakdown and potential skin breakdown on 7/3/19 by Consulate Travel MDS Coordinator. Resident #65 had a care plan review and	

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F 656	Continued From page 148 residents. This resulted in harm for Resident #40. The findings included: 1a. For Resident #40, the facility staff failed to assess for fall risk or have preventative measures in place when she fell and hit her head resulting in face swelling and laceration. This is harm. Resident #40, a 61-year old female was admitted to the facility on 02/05/2018 and discharged on 10/31/2018. Diagnoses included but not limited to altered mental status, diabetes, and kidney failure. The most recent Minimum Data Set associated with this complaint had an Assessment Reference Date of 10/15/2018 and was coded as a quarterly review. The Brief Interview for Mental Status was 12 out of possible 15 indicative of moderate cognitive impairment. Functional status for dressing and personal hygiene coded as requiring extensive assistance from staff. Transfers coded as requiring extensive assistance from staff and one-person physical assist for support. Bowel and bladder coded as always incontinent. Fall history in the last 2-6 months was not coded. On 06/18/2019 at 3:10 PM, in the course of a complaint investigation, fall investigations from June - October 2018 were requested. The event was dated 06/16/18 at 1:30 PM and the description documented, "patient was trying to get in the bed without assistance and fell on her buttocks. No injuries noted denies pain." There was no evidence in the documentation that preventative measures were put in place after the	F 656	revision completed on 7/9/19 by Activities Coordinator to include development of a focus for activities that was individualized to the resident's needs. Resident #376 discharged from the facility. Resident #29 discharged from the facility. Resident #15 had a care plan review and revisions completed to ensure interventions on the care plan are current per resident status. A physician's order clarification was obtained on 5/28/2019 by the Regional Clinical Nurse to reflect care for the suprapubic catheter. 2. A review of care plans completed with MDS assessments completed since the survey end date of 6/20/2019 will be completed for accuracy. Revisions will be made as appropriate by Regional MDS Coordinator team. 3. Education provided to the interdisciplinary team on development and implementation of comprehensive care plans on 6/25/19 by Regional MDS Coordinator. Care plans will be reviewed at each morning clinical meeting and updated with changes. Care plans are also reviewed when MDS assessments are completed and updated based on the assessment findings. 4. A weekly review of 5 random care plans will be completed by Regional MDS Coordinator team to ensure care plans are up to date and address the resident's current needs, person-centered goals and interventions. Findings will be reviewed	

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F 656	Continued From page 149 fall. A nurse's note associated with this event dated 06/16/18 at 1:00 PM documented, "patient was trying to get in the bed unassisted. She fell on floor, no injuries noted, denies pain or discomfort. Unit manager notified, [name] [nurse practitioner] notified." The facility staff verified there were no other fall investigations in addition to the fall event on 06/16/18. The nurse's notes from June - October 2018 were reviewed. A nurse's note dated 08/18/2018 at 5:16 AM documented, "At approximately 0425 heard resident yelling for nurse. This nurse finished rounds at 0345. Upon entering room found resident on floor withshe [sic] blood coming from the left side of her head. Resident state [sic] she was looking for her wheelchair. Resident was assessed and 911 was called d/t [due to] head resident [sic] never lose consciousness injury [sic]. Vital signs 130/82 [blood pressure], 76 [pulse], 18 [respirations], o2 sat 97% [oxygen saturation]. No other injuries noted. Resident was clean new hospital gown and brief. EMT's [emergency medical technicians] arrived and resident taken to hospital. DON and nurse practitioner [name] notified." A nurse's note dated 08/19/2018 at 9:30 AM documented, "Resident returned from ED [emergency department] with "glue" closure of left eye, some swelling noted to area. Ice applied for comfort. Per ED note, resident had a CT [computed tomography, CAT scan] which was normal. Neuro WNL." An excerpt of a nurse's note dated 08/19/18 at 12:40 PM documented, "Resident has ice in place	F 656	during the monthly QAPI meeting for review and recommendations. 5. 8/4/19	

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F 656	Continued From page 150 to eye and received Tylenol for her discomfort and reports comfortable at this time." A nurse's note by a wound care RN dated 08/20/18 at 10:17 AM documented, "I assessed [Resident #40]'s face today s/p [status post] fall. She has a laceration above her left eye that has been glued closed by the emergency department, no drainage, purple and color. She has a hematoma above her left eye. The left eye is swollen almost shut. The area around her right eye is also swollen but not to the same degree. Left side of face is swollen and purple in color. Measurements taken." On 06/19/2019 at 10:38 AM, the DON verified that there was no fall risk assessment before or after the event and no fall risk or actual fall problems addressed in the care plan. The DON stated that all patients are a fall risk and should have a risk assessment done on admission and quarterly. The DON also stated fall risk and actual falls should be addressed on the care plan. On 06/20/2019 by the end of survey, the interim administrator had no further information or documentation to offer. 1b. For Resident #40, ADL (activities of daily living) care was not on the care plan. Resident #40, a 61-year old female was admitted to the facility on 02/05/2018 and discharged on 10/31/2018. Diagnoses included but not limited to altered mental status, diabetes, and kidney failure.	F 656		

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F 656	Continued From page 151 The most recent Minimum Data Set associated with this complaint had an Assessment Reference Date of 10/15/2018 and was coded as a quarterly review. The Brief Interview for Mental Status was 12 out of possible 15 indicative of moderate cognitive impairment. Functional status for dressing and personal hygiene coded as requiring extensive assistance from staff. Eating coded as requiring limited assistance from staff and a one-person physical assist for support. Bathing was coded as total dependence on staff. Transfers coded as requiring extensive assistance from staff and one-person physical assist for support. Bowel and bladder coded as always incontinent. Rejection of Care was coded as behavior not exhibited. In the course of a complaint investigation, the bathing logs from June through October 2018 were reviewed. Resident #40 was at the facility for 28 days in June 2018. Of those 28 days, there were 9 days Resident #40 did not receive either a bed bath, partial bath, or shower. The longest gap in bathing care was 3 days. Resident #40 was at the facility for 25 days in July 2018. Of those 25 days, there were 9 days Resident #40 did not receive either a bed bath, partial bath, or shower. The longest gap in bathing care was 3 days. Resident #40 was at the facility for 31 days in August 2018. Of those 31 days, there were 18 days Resident #40 did not receive either a bed bath, partial bath, or shower. The longest gap in bathing care was 9 days. There was one instance where Resident $30 refused care and received a	F 656		

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F 656	Continued From page 152 partial bath later in the day. For the 30 days in September that Resident #40 was at the facility, there were 27 days Resident #40 did not receive either a bed bath, partial bath, or shower. Resident #40 received a bed bath on 09/01/18, 09/06/18, and a partial and bed bath on 09/14/18. For the 28 days in October that Resident #40 was at the facility, there were 23 days Resident #40 did not receive either a bed bath, partial bath, or shower. Resident #40 received a partial bath on 10/03/2018 and a bed bath on 10/15/18, 10/26/18, and 10/31/18. There was one instance where Resident #40 refused care and received a partial bath later in the day. The care plan was reviewed. A focus addressing ADL care and bathing was initiated on 11/20/18, over 9 months after her admission to the facility and 3 weeks after this complaint was received. There was a focus addressing behaviors for refusing meds/care but that was initiated on 11/20/18. On 06/19/19 at 10:38 AM, the DON was notified of findings. When reviewing Resident #40's care plan, the DON stated the ADL care should've been on the care plan. On 06/20/19 at the end of the survey, the interim administrator had no further information or documentation to offer. 2. For Resident #121's care plan did not address actual skin breakdown due to pressure injuries.	F 656		

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F 656	Continued From page 153 Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to dementia and psychotic disorder other than schizophrenia. Resident #121's most recent Minimum Data Set with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Physical/verbal behaviors toward self/others was coded as not exhibited, Behaviors of psychosis or wandering were coded as not exhibited. Resident #121 had actual skin breakdown due to pressure injuries as documented in the nurse's notes and skin assessments forms. The care plan was reviewed and there was no focus addressing potential or actual skin breakdown. On 06/13/2019 at approximately 3:10 PM, an interview with unit manager, LPN C, was conducted. When asked about expectations regarding pressure injury prevention, LPN C stated she would expect to see preventative measures in place before it was discovered. She also stated she would expect the resident to have an air mattress and "meal intake supplemented to help with healing process." She also stated she would expect to see it on the care plan. On 06/20/2019 at the conclusion of the survey, the administrator had no further information or documentation to offer.	F 656		

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F 656	Continued From page 154	F 656		

3. For Resident #65, the facility staff failed to include a comprehensive list of her activity preferences on the care plan.

Resident #65, an 89-year old female, was admitted to the facility on 04/04/2017. Diagnoses included but not limited to chronic obstructive pulmonary disease, generalized muscle weakness, anxiety, depression, and unspecified psychosis.

Resident #65's most recent Minimum Data Set with an Assessment Reference Date of 04/18/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 3 out of possible 15 indicative of severe cognitive impairment.

On 06/14/2019 at approximately 11:15 AM, an interview with Employee N, the Activities Director, was conducted. When asked about activities for Resident #65, Employee N stated that [Resident #65] she likes to reminisce; she likes music, and she likes to sit outside. Employee N stated [Resident #65] does not do well in large group activities. Employee N stated "we do one-on-one in smaller settings in the blue room." Employee N also stated that [Resident #65] should have one-on-one three times a week on Tuesday/Thursday/Saturday schedule. A copy of [Resident #65]'s activity schedule and a facility policy on activities were requested.

On 06/14/2019 at approximately 12:00 PM, the activities schedule and activity notes were reviewed. An activity note dated 04/18/2019 at 9:57 AM documented, "[Resident #65] receives 2-3 friendly visits per week, she enjoys people watching she [sic] is independent in her room with

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F 656	Continued From page 155 activities of her choice which including [sic] watching TV and walking to and from her bed to door." The activities flowsheet for May 2019 was reviewed. There were no on-on-one activities documented from 05/10/2019 through 05/20/2019. During that time, there was one group activity documented (05/15/2019). On 06/14/2019, the care plan was reviewed. A focus dated 05/15/2019 and initiated by Employee N documented, "The resident is independent for meeting emotional, intellectual, physical, and social needs r/t [related to] cognitive deficits, depression, and anxiety. An interventions associated with this focus documented, "The resident's preferred activities are : socializing with peers, friendly visits." There was no evidence in the care plan Resident #65 likes to reminisce, listen to music, sit outside, or watch TV. On 06/14/2019, the facility provided an Activity policy entitled, "Completion of Resident Participation Record." The policy addressed documentation of activities. It did not address the development, scheduling, or implementation of resident-centered activities. On 06/20/2019 by the end of survey, the interim administrator had no further information or documentation to offer. 4. For Resident #376, pressure-reducing measures were not on the care plan before and after an unstageable wound was discovered with slough in the wound bed on 07/03/2018. Resident #376, an 82-year old male, was	F 656		

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F 656	Continued From page 156 admitted to the facility on 10/23/2017 and discharged on 10/31/2018. Diagnoses included but not limited to diabetes, contracture left hand, generalized muscle weakness, and cognitive communication deficit. Resident #376's most recent Minimum Data Set associated with the timeframe of the complaint had an Assessment Reference Date of 10/31/2018 and was coded as a discharge assessment. The Brief Interview for Mental Status was coded as an 8 out of possible 15 indicative of moderate cognitive impairment. Skin conditions were coded as "0" meaning no unhealed pressure ulcers present. Nurse's notes from July 2018 through October 2018 were reviewed. A nurse's note dated 07/03/2018 at 1:23 PM documented, "I assessed [Resident #376]'s scrotum today after his nurse informed me he had an ulcer there. Measurements taken, unstageable pressure ulcer with slough, orders received from NP [nurse practitioner] and put in computer. He has been added to the weekly pressure wound rounds." The Minimum Data Set prior to the discovery of the unstageable scrotal wound had an Assessment Reference Date of 05/17/2018 and was coded as a quarterly review. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff. Mobility devices were walker and wheelchair. Risk for Pressure Ulcer was coded as "yes." The physician's orders were reviewed. An order dated 02/15/2018 documented, "Weekly skin assessments Thursday 7-3 every day shift." An order dated 05/09/2018 documented, "Apply	F 656		

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F 656	Continued From page 157 moisture barrier to reddened bony prominences as needed." An order dated 05/24/2018 documented, "Consistent Carbohydrate diet mechanical soft texture, thin liquid consistency, double protein portions for diet." An order dated 06/10/2018 documented, "Nystatin powder to scrotum topically every shift for itching, apply to scrotum and groin every shift until healed." The care plan was reviewed. A focus initiated on 11/20/2017 documented, "The resident has the potential for impaired skin integrity r/t [related to] frequent bladder/bowel incontinence." Interventions associated with this focus documented, "Administer treatments as ordered and monitor for effectiveness; apply barrier cream post incontinence care; Braden scale quarterly; float heels as tolerated when in bed; and weekly skin checks." There were no other interventions such as a pressure-reducing mattress or cushion for the wheelchair. A focus on the care plan initiated 7/26/18 (3 weeks after the unstageable pressure ulcer was discovered). It documented "The resident has impaired skin integrity to scrotum." Interventions associated with this focus documented, "Administer treatments as ordered in monitor for effectiveness; apply Barrier cream post incontinence care; assess/record/monitor wound healing weekly. Measure length, width, and depth where possible; Assist resident with turning in position frequently each shift; encourage adequate nutrition and hydration and order to promote healthier skin; follow physician order for preventative treatment; if resident refuses treatment interventions, wait and try again;	F 656		

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F 656	Continued From page 158 incontinence care post episode; inform the resident family caregivers of any new area of skin breakdown; keep skin clean and dry; monitor changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and/or stage; monitor dressing (FREQ) to ensure it is intact and adhering. Report loose dressing to nurse; monitor for and Report any new skin impairment noted during care." There were no pressure-reducing measures listed. On 06/20/2019 at approximately 9:25 AM, an interview with the DON was conducted. When asked about expectations for pressure injury prevention, she stated she would expect to see a skin breakdown risk assessment, air mattress, cushion on the wheelchair, diet supplements and expect to see it all on the care plan. The DON verified there was no skin breakdown risk assessment documentation and the only preventative measures in place were "barrier cream and nystatin." In summary, there were no pressure-reducing interventions implemented before or after the scrotal wound was discovered when unstageable with slough in the wound bed. Wound treatments were not administered daily as ordered (missed treatments). On 06/20/2018 at the end of survey, the interim administrator had no further information or documentation to offer. 5. For Resident #29 the care plan failed to address the behavioral health needs of Resident #29 as it relates to his diagnoses of PTSD, Anxiety and Depression	F 656		

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F 656	Continued From page 159 Resident #29 a 59 year old man admitted to the facility on 11/27/18 with diagnoses of but not limited to bilateral below knee amputation, chronic kidney disease, and PTSD [Post Traumatic Stress Disorder related to military service] Anxiety disorder and Major Depressive Disorder. His latest MDS coded as a Quarterly with an (Assessment Reference Date) ARD of 3/14/19 codes the Resident as having a (Brief Interview of Mental Status) Score of 13 indicating mild cognitive impairment. On 6/16/19 during clinical record review it was noted that Resident #29's care plan does not adequately address his mental health / behavioral health needs. Review of Care Plan states: Focus- Resident has a behavior problem refuses nicotine patch and suicidal ideation--Initiated 6/3/19 GOAL-- Resident will have no evidence of behavioral problems to be reviewed by 6/20/19 INTERVENTIONS Administer medications as ordered and document for side effects and effectiveness.--Date initiated 6/3/19 Anticipate and meet resident needs-- Date initiated 6/3/19 Caregivers to provide opportunity of positive interaction, attention. Stop and talk with him or her when passing by -Date initiated 6/3/19 Educate the resident on successful coping interaction strategies --Date initiated 6/3/19 Psych Eval at times when needed.--Date initiated 6/3/19	F 656		

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F 656	Continued From page 160 The care plan failed to assess, identify and specify coping strategies specific to this Resident and the care plan failed to identify PTSD on the care plan and have regular mental health visits. The Administrator was made aware on 6/20/19 during the end of day meeting no further information was provided. 6. For Resident #15, the facility staff failed to implement his Care Plan for catheter care. Resident #15 was a 66 year old who was admitted to the facility on 12/11/18. Resident #15's diagnoses included Neuromuscular dysfunction of the Bladder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/4/19 was reviewed. Resident #15 was coded as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. On 6/10/19 at 1:19 P.M. an interview was conducted with Resident #15. He complained of not receiving care, in a timely manner. Resident #15's care plan was reviewed. An excerpt from the care plan read, "5/22/19. The resident has Suprapubic catheter. The resident will remain free from catheter-related trauma. Catheter care as ordered." Resident #15's Treatment Administration Record for April, 2019 was reviewed. Foley Catheter care was scheduled for every shift and as needed "18	F 656		

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F 656	Continued From page 161 F/10 cc balloon size". Foley Catheter was not provided on the following days/shifts: 4/1/19 Day 4/5/19 Evening 4/9/19 Day 4/16/19 Day 4/19/19 Night 4/20/19 Day 4/21/19 Day 4/23/19 Evening 4/26/19 Night 4/28/19 Day	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		8/4/19

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F 657	Continued From page 162 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 observation, staff interview, facility documentation, and clinical record review the facility staff failed to review and revise care plans for 4 Residents (#124, #94, #122, and #113) in a survey sample of 76 Residents. The Findings Include: 1. For Resident #124 the facility staff failed Review and revise care plan to include knee immobilizer after fall that resulted in Tibial fracture or her PRN use of Oxygen. Resident #124 a 98 year old woman admitted to the facility on 4/20/16 with diagnoses of but not limited to chronic respiratory failure, Peripheral Vascular disease, Chronic Gout, Difficulty in Walking History of falls and neuropathy. Resident #124's most recent (Minimum Data Set) MDS coded as a Quarterly codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 0 (unable to assess). Resident is coded as needing extensive assistance with 1 person physical assistance for all ADL activities and Resident is coded as unable to walk. Resident uses a wheelchair for mobility. On 6/17/19 during clinical record review it was noted that Resident #124 has treatment orders on current (Treatment Administration Record) TAR that read:	F 657	1. Resident #124 care plan was revised to include current interventions, including knee immobilizer and as needed oxygen on 7/9/19 and 7/10/19 by Consulate Travel MDS Coordinator. Resident #94 care plan was reviewed and revised to address activities needs on 5/24/19 by Activities Coordinator. Resident #122 care plan was reviewed and revised to address interventions for weight loss on 7/3/19 by Registered Dietitian. Resident #113 care plan was reviewed and revised to address interventions for weight loss on 7/2/19 by Regional Dietitian. 2. A review of care plans completed with MDS assessments completed since the survey end date of 6/20/2019 is being completed for accuracy. Revisions will be made as appropriate. This is ongoing and being completed by Regional MDS Coordinators team. 3. Education provided to the interdisciplinary team on development and implementation of comprehensive care plans. Care plans will be reviewed at each morning clinical meeting and updated with changes. Care plans are also reviewed when MDS assessments are completed	

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F 657	Continued From page 163 Knee Immobilizer to LLE [left lower extremity] one time a day. O2 [Oxygen] 2L as needed PRN every 1 hr. as needed for shortness of breath. The Care Plan for Resident #124 was never updated to include the use of the immobilizer, or the PRN oxygen use. On 6/17/19 an interview with RN B was conducted and she stated that oxygen use and the use of an immobilizer should be on the care plan. On 6/20/19 during end of day meeting the Administrator (Employee R) was made aware and no further information was provided. 2. For Resident #94 the facility staff failed to review and revise care plan to include activities appropriate for cognitively impaired Resident. Resident #94, an 84 year old woman admitted to the facility on 2/17/14 with diagnoses of but not limited to Dementia, and Dysphagia, Resident is non-verbal and her latest (Minimum Data Set) MDS with an Assessment Reference Date of 5/1/19 coded Resident #94 as having a (Brief Interview of Mental Status) score of 99 indicating she was unable to answer questions. On 6/12/19 during clinical record review it was noted that the Resident's care plan stated: 'Focus: Activities Resident is dependent on staff for activities, cognitive stimulation, social	F 657	and updated based on the assessment findings. Care Plan education completed on 6/25/19 by Regional MDS Coordinator and on 7/11/19 by Consulate Travel MDS Coordinator. 4. A weekly review of 5 random care plans will be completed by Regional MDS Coordinator team to ensure care plans are up to date and address the resident's current needs, person-centered goals and interventions. Findings will be reviewed during the monthly QAPI meeting for review and recommendations. 5. 8/4/19	

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F 657	Continued From page 164 interaction, r/t [related to] Cognitive deficits." "RESOLVED 10/2/18" (all interventions involving activities were marked as resolved 10/2/18) On 6/18/19 at 3:00 PM in an interview with employee N when asked why the Activities were marked Resolved on 10/2/19 she stated that the resident was no longer able to actively participate in activities. When asked what activities the Resident participated in from 10/2/18 until the update on 5/23/19 she stated that the family came visit daily. The care plan was updated on 5/23/19 to state: "Resident is dependent on staff for meeting emotional, intellectual, physical and social needs r/t cognitive deficits." She stated that she now provides in room activities and brings the resident to activities that don't require active participation. During the end of day meeting on 6/20/19 the Administrator was made aware and no new information was provided. 3. For Resident #122, the facility staff failed to revise the care plan a severe weight loss. Resident #122 is a 90 year old female who was admitted to the facility on 8/30/10. Resident #122's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/18/19 was coded as a quarterly	F 657		

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F 657	Continued From page 165 review. Resident #122 was coded with a Brief Interview of Mental Status (BIMS) score of "3" out of possible 15, indicating severely impaired cognition. The Resident was also coded as needing supervision and set up assistance with meals. Weight records were reviewed and revealed a severe weight loss of 10.84% within the last 3 months from 3/7/19 at 145.8 pounds to 130 pounds on 6/4/19. Review of the care plan revealed a Focus for "Sig [Significant] Wt [Weight] loss" with a revision date 5/29/19 however the Goals target date had expired on 5/27/19 and there have been no changes in Interventions to prevent weight loss in over a year (5/10/18). 4. For Resident #113, the facility staff failed to revise the care plan a severe weight loss. Resident #113 is an 88 year old male who was admitted to the facility on 6/25/13. Resident #113's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/19 was coded as an Annual assessment. Resident #113 was coded with a Brief Interview of Mental Status (BIMS) score of "3" out of possible 15, indicating severely impaired cognition. The Resident was also coded as needing supervision and set up assistance with meals. Weight records were reviewed and revealed a severe weight loss of 9.19% within the last 3	F 657		

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F 657	Continued From page 166 months from 3/6/19 at 123 pounds to 111.7 pounds on 6/11/19. Review of the care plan revealed a lack of current Goals (last target date 3/27/19) or changes in Interventions (last revised 2/8/16) to prevent weight loss.	F 657		
F 658 SS=G	COMPLAINT DEFICIENCY Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to ensure that services provided met professional standards for 19 residents (#111, #54, #104, #2, #180, #98, #47, #68, #15, #181, #42, #60, #57, #97, #33, #40, #376, #68, #183), resulting in harm for Resident #111, #2, in a survey sample of 76 residents. The findings included: 1. For Resident #111, the facility staff failed to follow physician orders for: a) labwork, resulting in harm; b) dressing changes; c) Insulin administration.	F 658	1. Residents #2, #40, #180, #181, #183 and #376 were discharged prior to survey no corrective actions taken. Resident #54 and Resident #111 has been discharged from the facility. Resident #33 blood sugar was obtained during the survey and MD notified; orders were obtained no ill effects noted for this resident. Resident #33 has had no further episodes of hypoglycemia since survey. LPN-D will be re-educated on the facility protocol on what to do when a resident has hypoglycemia. Resident #104□s physician was notified on potential drug-to-drug interaction on	8/4/19

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F 658	Continued From page 167 Resident #111, a 60 year old female, was admitted to the facility on 5/2/19 for IV (intravenous) antibiotic treatment, wound care, and physical therapy following right foot surgery for a bone infection. Her diagnoses included but are not limited to diabetes, cellulitis, and bone infection. 1a) On 6/5/19 during initial tour, Resident #111 expressed concerns regarding the nursing care she was receiving by stating, "the nurses are not following my doctor's orders, I saw him [Infectious Disease physician] just a couple of weeks ago and he was looking for my lab work results that he had ordered for me, I told him that they have not done any, he was upset.....the nurses here are also not giving me my insulin like I am supposed to get, it is never on time and my blood sugars are all over the place, I have had problems in the past and have been in ICU before because of my blood sugars and I am sitting here constantly worried that something is going to happen to me, I don't even go outside my room, I wish I wasn't here, I will never come back to this place". On 6/10/19, during clinical record review, admission orders received from the hospital on 5/2/19 was reviewed and weekly lab work to include a BUN (blood urea nitrogen) and creatinine level with results to be faxed to the Infectious Disease (ID) Specialist was verified. Resident #111's BUN and creatinine levels were noted to be within normal limits on 4/25/19 per hospital records dated 5/2/19. Resident #111 saw the ID Specialist for a follow-up appointment on 5/30/19 with no labwork being performed by the	F 658	7/15/19, The provider was notified of medications that were not documented as being administered and late on 7/15/19. For Residents #98, # 47, #68, #15, #42, #60, the physician was notified on 6/20/2019 by the DON of medication being administered late, omitted doses and of medication that was found at the bedside no adverse effects were noted for these residents. LPN A and LPN D were educated on 6/26/19 by the DON regarding medication administration to include timeliness, omission, medications at bedside and possible interactions of newly ordered medication interaction and MD Notification. 2. All residents have the potential to be affected by this alleged deficient practice. A facility wide audit will be conducted for diabetic resident□s blood sugar readings for the past 30 days to ensure that parameters were followed and physicians were updated and the insulin was administered as ordered. Licensed nurses were educated on the six rights of medication administration including. An audit will be conducted for late administered medications, medications at the bedside, missed medications, and potential drug to drug interactions for all residents and physician and RP□s will be notified as indicated. A 30 day look back was done to ensure labs that were ordered were obtained, and physicians were notified of the results. An audit will be conducted on current residents with wounds to ensure their treatments were	

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F 658	Continued From page 168 facility. The ID Specialist sent written orders back to the facility with Resident #111 that read in large, bolded writing, "please draw labs today (5/30/19), pts (patient's) IV abx (intravenous antibiotics) stop date for now is June 5th 2019, stop date will be based on lab results!!". The facility obtained labwork from Resident #111 on 5/31/19. Resident #111's BUN and creatinine levels were elevated above normal limits. The lab results were faxed to the ID Specialist on 6/7/19. The facility had stopped the IV antibiotic medication on 6/5/19. 1b) On 6/10/19, during review of treatment records for Resident #111, an order for dressing changes to the right heel every Monday, Wednesday, and Friday beginning 5/15/19 was verified. From 5/15/19 to 6/10/19, Resident #111 only received 3 dressing changes (5/22, 5/29, and 6/5) to the surgical wound on her right heel with a total of 8 dressing changes not performed. A staff interview was conducted with Assistant Director of Nursing (ADON, RN G) who stated, "if wound care is not done as ordered, the wound could get worse, a person can become septic, and infection can spread". 1c) On 6/11/19, a review the Medication Administration Record (MAR) and Medication Administration Audit Report regarding insulin administration to Resident #111 was conducted and revealed that from date of admission on 5/2/19 to 6/11/19 there were 78 scheduled doses of insulin to be given per physician order. Only 27	F 658	changed according to physician□s orders. An audit will be conducted for the past 30 days for any change in condition to ensure physician notification and documentation of the event. 3. The Director of Nursing/designee, including external nurse consultant will re-educate licensed nursing staff on following blood sugar parameters, the six rights of medication administration, administering medications timely, medications at the bedside, missed medications, drug-to-drug interactions, lab draws and MD notification of results, wound treatments, and documentation and assessment of a change in condition of a resident. The facility will review their protocol of management of residents who experience hypoglycemia and licensed nursing staff will be re-educated on the protocol by a licensed nurse. 4. Unit Managers/ designee will conduct medication administration observations 5x/week x 3 months to ensure medications are available, no drug to drug interactions are present, and administered per physician order. Variances will be addressed, and corrective action and/or education will be provided. Provider will be notified when medications were not administered. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings UM/designee will audit 5 residents and	

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F 658	Continued From page 169 insulin doses (33%) were given that met professional and facility guidelines to administer medication at the correct time. A staff interview was conducted with the Regional Clinical Director (Employee H) who stated, "An acceptable time range to give a scheduled medication dose is within an hour before or an hour after a scheduled time on the MAR, anything other than that is not acceptable as it does not meet our expectations or comply with professional practice and more importantly with insulin, the right time is essential to controlling blood sugar, if not given at the right time it can be detrimental to the resident, it can cause serious harm". 2. For Resident #54, the facility staff failed to notify the ordering physician of potential drug to drug interactions for a medication ordered on 3/23/19. Resident #54, an 85 year old male, was admitted to the facility on 1/28/15. On 6/17/19, during clinical record review, an Orders Progress Note dated 3/23/19 documented a new medication order that triggered a drug protocol alert/warning related to potential drug to drug interactions with 4 medications already on Resident #54's medication administration record (MAR). The potential interactions range from mild to severe which included an increased risk for GI (gastrointestinal) toxicity. There was no documentation that indicated that the ordering physician was notified of the drug alerts/warnings. On 6/17/19, an interview with the Director of Nursing (DON, Employee B) was conducted. She	F 658	residents records per week physicians orders to ensure physicians orders are followed to include labs, wound dressing changes, blood sugar parameters, treatment changes, change of condition, medications at the bedside, and notification of changes for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. QA schedule modified based on findings. 5. 8-4-2019	

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F 658	Continued From page 170 stated, "the physician should have been notified of these warnings so he can decide whether or not it is okay for the resident to take them, it could hurt them otherwise; the nurse should document that she notified the doctor".	F 658		
	3a. For Resident #104, the facility staff failed to notify the ordering physician of potential drug to drug interactions for a medication ordered on 6/8/19.			
	Resident #104, a 67 year old female, was admitted to the facility on 7/2/17.			
	On 6/14/19, during clinical record review, an Orders Progress Note dated 6/8/19 documented 2 new medication orders that triggered a drug protocol alert/warning related to potential drug to drug interactions with 7 medications already on Resident #104's medication administration record (MAR). The potential interactions range from moderate to severe which included an increased risk for GI (gastrointestinal) toxicity, increased risk for kidney failure and lactic acidosis, GI bleeding, and development of serotonin syndrome. There was no documentation that indicated that the ordering physician was notified of the drug alerts/warnings.			
	On 6/17/19, an interview with the Director of Nursing (DON, Employee B) was conducted. She stated, "the physician should have been notified of these warnings so he can decide whether or not it is okay for the resident to take them, it could hurt them otherwise; the nurse should document that she notified the doctor".			

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3b. For Resident #104, the facility staff failed to administer medication as ordered by the physician.

Resident #104, a 67 year old female, was admitted to the facility on 7/2/17 with diagnoses including but not limited to wedge compression fracture of unspecified lumbar vertebra, right shoulder pain, and depression.

On 6/14/19, an interview was conducted with Resident #104 who stated, "a couple of weeks ago, they did not give me my pain patch for almost a week". A review of Resident #104's clinical record and medication administration record (MAR) revealed no documentation for the administration of a "Fentanyl patch 72 hour 75 mcg/hr, apply 1 patch transdermally every 72 hours" for 2 consecutive occurrences (5/18/19 and 5/21/19). A Nursing Progress Note dated 5/21/19 at 22:28 indicated "Fentanyl patches on order from the pharmacy. Refill request was faxed and telephoned to pharmacy....". The next documented administration for the Fentanyl patch was 5/24/19 at 11:55pm.

An interview was conducted with the Regional Clinical Director (Employee H) on 6/14/19. She stated, "I have no idea what happened here, it's unacceptable".

COMPLAINT DEFICIENCY

4. Resident #2 did not receive a physician ordered IV (intravenous fluid infusion) on 2-16-19 due to staff inability to access a vein to infuse the

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F 658	Continued From page 172 fluids, and, the Resident failed to receive Hypodermoclysis fluid injections in the subcutaneous tissue as ordered due to unavailability of the IV fluids in the facility on 2-21-19, resulting in harm. Resident #2 was admitted to the facility on 1-15-19, after treatment for a Urinary tract infection (UTI), and was discharged from the facility on 2-26-19 to the emergency room where she received a diagnosis of dehydration, sepsis, and intractable nausea and vomiting, and expired on 3-3-19 (5 days later). Resident #2's Diagnoses included; UTI, history of Cancer in hilus of left lung, uterine cancer (removed by hysterectomy in 2016), adult fail to thrive, diabetes, and hypertension. Resident #2's most recent Minimum Data Set (MDS) was an admission assessment dated 1-22-19. Cognitive skills for daily decision-making were coded as 13 of 15, and no cognitive impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as extensive dependence on staff. Review of the closed record physician progress notes and visits revealed that the final time Resident #2 was seen was on 2-12-19. The Resident denied nausea and vomiting in the note, and was being seen for a decrease in appetite. Review of the physician's orders revealed that Resident #2 was ordered to be given Promethazine hydrochloride suppository rectally for nausea and vomiting on 2-12-19, and Ondansetron 8 milligram tablet orally on 2-21-19	F 658		

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F 658	Continued From page 173 at 6:28 p.m., for nausea and vomiting. Review of the nursing notes revealed that no nursing notes existed between 2-10-19, and 2-16-19. On 2-16-19 the Resident was experiencing persistent vomiting, and the physician ordered via the telephone IV 0.9% normal saline at 60 ml per hour for 1000 ml related to dehydration. The nurse was unable to establish an IV access catheter to infuse the fluids, and they were never given. There is no indication that the physician was ever notified that the order was not carried out. There are no further nursing or physician notes until 2-20-19, when new verbal/telephone physician orders are received for Hypodermoclysis fluid injections in the subcutaneous tissue 0.9% normal saline at 60 milliliters per hour for 1 liter every hour, which is also used to treat dehydration. The Resident received the fluid from 2:00 p.m. on 2-20-19, until 11:00 a.m., on 2-21-19 when it was abruptly stopped. The Medication administration record (MAR) documentation showed at 12:00 noon on 2-21-19 that the fluids were not infusing, and "Other/see nursing note", however, there was no note. The IV fluids were not given after 11:00 a.m., on 2-21-19 even though the Resident received Ondansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for continuing nausea and vomiting. The fluid infusion order was Discontinued on 2-22-19 at 9:38 a.m. with no note from the physician or nurses to indicate the reason. LPN A was the nurse for the 11:00 p.m. to 7:00 a.m. shift on the nights of 2-21-19, and 2-22-19. LPN A was interviewed, and stated "We didn't	F 658		

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have any fluids in the building to give the patient. When asked why no note was written, she stated she had written a note documenting that the fluids were unavailable, and that the nurse on 3-11 p.m. shift on 2-21-19 reported to her that she had not had any in the building either, and the family was angry, so she put the fluids on hold until the pharmacy could deliver them. The fluids never arrived, and the order was discontinued.

The facility was asked for a copy of the "IV stat box contents" which contained extra bulk dose medications that could be administered until supplies for the individual could be received. The document was received, and stated the normal saline needed for Resident #2's infusion was contained in the box. LPN A stated that during the stay of Resident #2, the box was not filled and sent out to the pharmacy for refill as it should have been.

The 3-11 nurse for 2-21-19 was identified, and found to be a short term contract employee who no longer worked at the facility.

There were no nursing notes in the record for 2-21-19, and 2-22-19 to explain why the fluids were not completed through 2-21-19, and were discontinued on 2-22-19.

There were no nursing notes from 2-20-19 until 2-24-19, which documented that the resident had refused all treatments and care. On 2-25-19 the first identification of a wound with green yellow slough was documented. On 2-26-19 the Resident was sent to the hospital for nausea/vomiting and suspected dehydration at 6:35 p.m., which was requested by the family. The Resident never returned.

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F 658	Continued From page 175 Hospital records were reviewed and revealed the normally oriented and alert Resident was "Disoriented and unable to identify complaints". The Resident arrived in the ER (emergency room) at 7:09 p.m.. The Resident was seen by critical care staff who surgically placed an IV catheter in the Residents "External Jugular" neck vein. The ER "Critical care note" documented "System at risk for life threatening failure: Central nervous system, cardiac and circulatory." "Associated problems: Hypotension (low blood pressure) Dehydration, Arrhythmia and infection." The hospital documents go on to say that emergency medical services ambulance first responders recorded the Resident's blood pressure to be 83/53 mmHg (millimeters mercury) at the nursing home, and at the ER measured 87/49. The Resident was admitted with "dehydration, sepsis, acute cystitis with bloody urine (urinary tract infection), intractable nausea and vomiting, hypokalemia (critically low potassium 2.2) (normal is 3.5 to 5.5)), and hypomagnesemia (critically low magnesium 0.8) (normal is 1.6 to 2.5), and lactic acidosis (critically high 6.96) (normal is 0.9 to 1.7). After placing an IV catheter the Resident was immediately placed on fluid and potassium replacement infusions in the emergency room, and was later admitted to the ICU (intensive care unit), where she expired on 3-3-19 (5 days later). The Resident was not supplied with ordered fluid infusions, as they were unavailable, she became dehydrated, and was sent to the hospital at the behest of the family. The Resident expired in the hospital on 3-3-19 (5 days later) with the diagnoses of dehydration and sepsis.	F 658		

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F 658	Continued From page 176 The facility Administrator and Director of nursing were made aware of findings on 6-20-19. The facility stated they had no further information to provide. COMPLAINT DEFICIENCY 5. Resident #180 did not receive significant medications on the evening of 7-11-18 after being hospitalized for stroke, and respiratory failure. Resident #180, was admitted to the facility on 7-11-18, and discharged on 7-30-18. Diagnoses included; stroke, cardiac arrest, hypertension, congestive heart failure, high cholesterol, emphysema, and heart attack. Resident #180's most recent Minimum Data Set (MDS) was dated 7-18-18, and was an admission assessment Cognitive skills for daily decision-making were coded as no impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as limited to extensive dependence on staff. The hospital discharge, and nursing home entire closed record review revealed that the Resident was admitted to the facility on 7-11-19 at approximately 5:00 p.m. The physician's orders, nursing notes, and Medication Administration records (MARs) for the time period from admission to discharge (19 days), were reviewed. Those records revealed that the Resident did not receive the following medications in the evening of 7-11-18. The medications were ordered, by	F 658		

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the physician on 7-10-18, before his discharge from the hospital, and communicated to the facility on 7-10-18, the day before he arrived at the facility:

9:00 p.m. Elicitor 40 mg (milligrams) at bedtime for high cholesterol.
9:00 p.m. Ativan 0.5 mg at bedtime for high cholesterol (anxiety medication)
9:00 p.m. Melatonin 0.5 mg at bedtime for emphysema (insomnia medication)
5:00 p.m. Calcium carbonate plus Vitamin D 500-200 mg twice per day (heart supplement)
5:00 p.m. Carvedilol 6.25 mg twice per day (for heart attack)
5:00 p.m. Fluticasone/Salmeterol inhalant 250/50 mcg (micrograms) twice per day (for Respiratory failure/emphysema)
5:00 p.m. Gabapentin 400 mg three times per day (for neuropathy)
6:00 p.m. Duo-neb 0.5/2.5 inhale 3 ml (milliliters) via hand held nebulizer every 6 hours (for respiratory failure/emphysema).

The DON, and Administrator were made aware of findings, and stated they had no further information to present.

COMPLAINT DEFICIENCY

6. Resident #98's significant medications, that were ordered for multiple doses per day, were given late.

Resident #98, was admitted to the facility on 10-26-18. Diagnoses included; Back pain, protein

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F 658	Continued From page 178 calorie malnutrition, anemia, low sodium, hypotension, Gastro-esophageal reflux disease, muscle weakness, recurrent depression, and pressure ulcer. Resident #98's most recent Minimum Data Set (MDS) Cognitive skills for daily decision-making were coded as impaired. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as extensive to total dependence on staff. On 6-5-19 at 12:30 p.m., after lunch, LPN A was observed at a medication cart preparing to administer medications to Resident #98. The medications that LPN A prepared to administer were; Midodrine, citalopram, ferrous sulfate (Iron), aspirin, sodium chloride, and a multivitamin. LPN A was asked why so many pills were being given at lunch time, and she replied "these are all the 9:00 a.m., morning pills." "We don't have enough staff to get it all done." The current physician's orders and medication administration record (MAR) were reviewed in the computerized program. The following is a list of the errors noted which were all given at least 2 hours late, and or omitted; 12:00 p.m. Resident #98 - Midodrine 10 mg (milligrams) one tablet 3 times per day at 9:00 a.m., 1:00 p.m., and 5:00 p.m. for low blood pressure, Iron 325 mg twice per day at 9:00 a.m., and 5:00 p.m. for anemia, Pro-stat (protein) liquid 30 ml (milliliters) twice per day at 9:00 a.m., and 5:00 p.m. for supplement for a stage 3 pressure ulcer and protein malnutrition, and sodium chloride 1 gram twice per day at 7:30 a.m., and 5:30 p.m. for low sodium, which can lead to	F 658		

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(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 658	Continued From page 179 dehydration. On 6-11-19 at approximately 12:05 p.m., the DON (director of nursing) was asked what references are utilized for professional practice standards and she stated, "CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), AMA (American Medical Association), and for nurses: "Potter Perry". On 6-11-19 at approximately 3:45 p.m., the DON was asked about the expectation of nurses when administering medications and she stated that the nurse should administer the medications on time, and that if given late the resulting dose would be late, and may have to be omitted all together so as to not double dose the patient, which could lead to symptoms of the illness that the medications were necessary for, to prevent and treat. On 6-11-19 at approximately 4:00 p.m., the Administrator and DON were notified of findings and they offered no further documentation or information. Complaint DEFICIENCY 7. Resident #47's significant medications, that were ordered for multiple doses per day, were given late. Resident #47, was admitted to the facility on 4-14-17. Diagnoses included; stroke, disability, dysphagia, weakness, hypertension, mood disorder, insomnia, arthropathy, and subluxation of left wrist and hand (contractures).	F 658		

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F 658	Continued From page 180 Resident #47's most recent Minimum Data Set (MDS) Cognitive skills for daily decision-making were coded as severely impaired. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as extensive to total dependence on staff. On 6-5-19, after Resident #98's medications were administered at 12:30pm, LPN A was observed preparing to administer medications to Resident #47. They were; aspirin, vitamin B complex, topiramate, toviaz, citalopram, divalproex, and carvedilol. The current physician's orders and medication administration record (MAR) were reviewed in the computerized program. The following is a list of the errors noted which were all given at least 2 hours late, and or omitted; 12:10 p.m. Resident #47 - Topiramate F/C 50 mg twice per day at 9:00a.m., and 5:00 p.m. for migraine headache prevention after a stroke, Divalproex 500 mg twice per day at 9:00 a.m., and 9:00 p.m. for mood disorder (anti-seizure medication), and Carvedilol F/C 3.125 mg twice per day at 9:00 a.m., and 5:00 p.m., for high blood pressure. for a Resident with a history of stroke. On 6-11-19 at approximately 12:05 p.m., the DON (director of nursing) was asked what references are utilized for professional practice standards and she stated, "CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), AMA (American Medical Association), and for nurses: "Potter Perry". On 6-11-19 at approximately 3:45 p.m., the DON	F 658		

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F 658	Continued From page 181	F 658		

was asked about the expectation of nurses when administering medications and she stated that the nurse should administer the medications on time, and that if given late the resulting dose would be late, and may have to be omitted all together so as to not double dose the patient, which could lead to symptoms of the illness that the medications were necessary for, to prevent and treat.

On 6-11-19 at approximately 4:00 p.m., the Administrator and DON were notified of findings and they offered no further documentation or information.

Complaint DEFICIENCY

8. Resident #68's significant medications, that were ordered for multiple doses per day, were given late, and 2 medications were omitted.

Resident #68, was admitted to the facility on 1-9-19. Diagnoses included; Chronic obstructive pulmonary disorder (COPD), anxiety, recurrent major depression, high cholesterol, gastro-esophageal reflux disease, cataracts diabetes, schizophrenia, and hypertension.

Resident #68's most recent Minimum Data Set (MDS) Cognitive skills for daily decision-making were coded as impaired. Functional status for bed mobility, transfers, eating (tube feedings), dressing, and personal hygiene were all coded as limited to extensive dependence on staff.

On 6-5-19 after Resident #98's and 47's medications were administered at 12:30pm LPN

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F 658	Continued From page 182 A was observed at a medication cart preparing to administer medications to Resident #68. The medications that LPN A prepared to administer to Resident #68 were; ativan, aspirin, thiamine, januvia, metoprolol, metformin, and wixela (advair inhaler). LPN A stated "Oh, his prilosec and prozac are missing, I ordered those yesterday, I guess I will have to order them again, they must not have been delivered." She then administered the medications. The current physician's orders and medication administration record (MAR) were reviewed in the computerized program. The following is a list of the errors noted which were all given at least 2 hours late, and or omitted; 12:15 p.m. Resident #68 - Ativan 0.5 mg twice per day at 9:00a.m., and 5:00 p.m. for anxiety and for a Resident who suffers from schizophrenia, Metoprolol 100 mg twice per day at 9:00 a.m., and 5:00 p.m. for high blood pressure, Metformin 1000 mg twice per day at 9:00 a.m., and 5:00 p.m., of diabetes, and Wixela (advair inhaler) one puff every 12 hours at 9:00 a.m., and 9:00 p.m., for shortness of breath with (COPD). On 6-5-19 at 3:30 p.m. LPN A was preparing to leave for the day, and was asked if the prilosec and prozac for Resident #68 had arrived from the pharmacy, and she replied "no, it will probably come in tonight." Both medications were documented on the MAR as having not been given. On 6-11-19 at approximately 12:05 p.m., the DON (director of nursing) was asked what references are utilized for professional practice standards	F 658		

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F 658	Continued From page 183 and she stated, "CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), AMA (American Medical Association), and for nurses: "Potter Perry". On 6-11-19 at approximately 3:45 p.m., the DON was asked about the expectation of nurses when administering medications and she stated that the nurse should administer the medications on time, and that if given late the resulting dose would be late, and may have to be omitted all together so as to not double dose the patient, which could lead to symptoms of the illness that the medications were necessary for, to prevent and treat. On 6-11-19 at approximately 4:00 p.m., the Administrator and DON were notified of findings and they offered no further documentation or information. Complaint DEFICIENCY 9. For Resident #15, the facility staff failed to administer medication in a timely manner. Resident #15 was a 66 year old who was admitted to the facility on 12/11/18. Resident #15's diagnoses included Neuromuscular dysfunction of the Bladder, and Type 2 Diabetes Mellitus. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/4/19 was reviewed. Resident #15 was coded as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.	F 658		

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F 658	Continued From page 184 On 6/10/19 at 1:19 P.M. an interview was conducted with Resident #15. He complained of not receiving care, and medications in a timely manner. He stated "The facility is always short of staff, and they can't keep the one's they have because they work them to death." Resident #15's signed physician orders dated 6/1/19 read, "NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML. Inject 15 unit subcutaneously three times a day related to Type 2 Diabetes." His doses were scheduled for specific times of administration. On 6/10/19 a review was conducted of Resident #15's clinical record, revealing Resident #15's Medication Audit Report. Resident #15 received his insulin between approximately 2 to 5 hours late on the following days: 6/1/19 Scheduled for 4:00 P.M. Administered at 7:27 P.M. 6/3/19 Scheduled for 11:00 A.M. Administered at 1:04 P.M. 6/3/19 Scheduled for 4:00 P.M. Administered at 9:52 P.M. 6/7/19 Scheduled for 4:00 P.M. Administered at 9:17 P.M. 6/9/19 Scheduled for 4:00 P.M. Administered at 7:50 P.M. On 6/10/19 at approximately 3:00 P.M., an interview was conducted with the Director of Nursing (Employee B). When asked to describe the possible consequences of Residents not receiving insulin as ordered, she stated, "They can either have a adverse reaction, including a diabetic coma or hyperglycemia."	F 658		

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F 658	Continued From page 185 No further information was received. 10. For Resident #181, the facility staff failed to document the administration of medication. Resident #181 was a 59 year old who was admitted to the facility on 2/21/18, and Discharged to the hospital on 3/8/18. Resident # 181's diagnoses included Lung Cancer, Chronic Obstructive Pulmonary Disease, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 2/28/18, coded Resident #181 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. On 6/11/19 a review was conducted of Resident #181's clinical record, revealing his Medication Administration Record (MAR) for February, 2018. Medication administration was not documented as having been administered as follows: MS Contin /Morphine Extended Release 60 MG. every 8 hours - 2/5/18 at 10 P.M. 2/6/18 at 6 A.M., 2 P.M., 10 P.M. Flomax Capsule 0.4 MG 1 time daily 2/5/18 at 9 P.M. 2/6/18 at 9 P.M. Budesonide Suspension 0.25 MG/2 ML. 2 ML inhale orally via nebulizer 2 x daily 2/5/18 at 5	F 658		

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F 658	Continued From page 186 P.M. 2/6/18 at 9 A.M., 5 P.M. Check lung sounds pre-admission 2 x daily for monitoring lung sounds 2/5/18 at 5 P.M. 2/6/18 at 9 A.M., 5 P.M. On 6/10/19 at approximately 3:00 P.M., an interview was conducted with the Director of Nursing (Employee B). She said that she was unable to state why the medications had not been documented as having been administered. She said that the facility's policy was to document the administration of medications immediately after the administration is completed. 11. For Resident #42, the facility staff failed to document the administration of medication. Resident #42 was a 41 year old who was admitted to the facility on 9/27/12. Resident #42's diagnoses included Urinary Tract Infection. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/29/19 was reviewed. Resident #42 was coded as having a Brief Interview of Mental Status Score of 14, indicating no cognitive impairment. On 6/6/19 a review was conducted of Resident #42's clinical record, revealing his Medication Administration Record for May, 2019. The following medication had not been documented as having been administered:	F 658		

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F 658	Continued From page 187 Amikacin Sulfate 500 MG/2ML. Inject 3 ML intramuscularly every 8 hours related to Urinary Tract Infection. 5/23/19 at 6 A.M. On 6/10/19 at approximately 3:00 P.M., an interview was conducted with the Director of Nursing (Employee B). She said that she was unable to state why the medications had not been documented as having been administered. She said that the facility's policy was to document the administration of medications immediately after the administration is completed. 12. For Resident #60, the facility staff failed to document the administration of medication. Resident #60 was a 62 year old who was admitted to the facility on 9/7/17. Resident #60's diagnoses included Diabetes Mellitus Type 2. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 4/9/19 was reviewed. Resident #60 was coded as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. On 6/10/19 a review was conducted of Resident #60's clinical record, revealing a signed physician order for April, 2019. It read, "GilpiZIDE Extended Release 10 MG. Give 1 by mouth once daily." In addition, his Medication Administration Record was reviewed for April, 2019. The following diabetic management medications had not been documented as having been administered: GilpiZIDE Extended Release Tablet 10 MG. Give	F 658		

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F 658	Continued From page 188 one tablet by mouth once daily for Diabetes Mellitus 4/18/19 at 9 A.M. MetFORMIN HCI Tablet 1000 MG. Give one tablet by mouth every 12 hours related to Type 2 Diabetes Mellitus 4/18/19 at 9 A.M. On 6/10/19 at approximately 3:00 P.M., an interview was conducted with the Director of Nursing (Employee B). She said that she was unable to state why the medications had not been documented as having been administered. She said that the facility's policy was to document the administration of medications immediately after the administration is completed. No further information was received. 13. For Resident #57, the facility staff left 2 white pills in a medicine cup at the bedside on 06/05/2019. Resident #57, a 68-year old male, was admitted to the facility on 08/09/2018. Diagnoses included but not limited to altered mental status, depression, human immunodeficiency virus, and hypertension. Resident #57's most recent Minimum Data Set with an Assessment Reference Date of 04/09/2019 was coded as a quarterly review. The Brief Interview for Mental Status was 4 out of possible 15 indicative of severe cognitive impairment.	F 658		

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F 658	Continued From page 189 On 06/05/2019 at approximately 12:00 PM, Resident #57 was not in his room but there were 2 white pills observed in a med cup on his tray table by his bed. On 06/05/2019 at 12:02 PM, an interview with LPN B was conducted. When asked if she gave Resident #57 his medications today, she stated, "Yes." LPN B and this surveyor went to Resident #57's bedside to observe the 2 white pills in the med cup. The pills appeared whole and dry. There was no medication residue on the inside of the cup. When LPN B saw the pills in the cup, she stated she saw [Resident #57] swallowing when he took his pills and added that he must have taken the pills out of his mouth. When asked the name of the medications in the cup, LPN B stated she didn't know, picked up the cup, and left the room. On 06/06/2019 at approximately 2:10 PM, the DON was notified of findings and she stated that no residents in the facility self-administer medications. She also stated that nurses are not supposed to leave medications at the bedside. The facility staff indicated their reference for professional standards was Potter & Perry. According to Potter & Perry's "Fundamentals of Nursing", 4th Edition, 2013, page 584, under the header "Standards", it is documented "Take appropriate actions to ensure that patients receive medications as prescribed and within the time prescribed in the appropriate environment. On 06/20/2019 at the end of survey, the administrator had no further documentation or information to offer.	F 658		

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14. For Resident #97, the facility staff left 3 blue and white capsules on her tray table next to her bed on 06/05/2019

Resident #97, a 76-year old female, was admitted to the facility on 09/26/2012. Diagnoses included but not limited to end stage renal disease.

Resident #97's most recent Minimum Data Set with an Assessment Reference Date of 05/02/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition.

On 06/05/2019 at approximately 12:10 PM, an interview with Resident #97 was conducted in her room. A medicine cup with 3 blue and white capsules was observed on her tray table next to her bed. When asked about the pills, Resident #97 stated that the nurse brought them to her "about 20 minutes ago." Resident #97 then self-administered the pills with a drink at her bedside.

On 06/06/2019 at approximately 12:55 PM, an interview with LPN B was conducted. When asked if she gave Resident #97 her medications that morning, she stated, "Yes." When she was informed Resident #97 was observed taking the 3 blue and white capsules that were in a medicine cup on her tray table, LPN B stated that "she took her calcium acetate with me this morning; maybe those were her own meds."

On 06/06/2019 at approximately 2:10 PM, the DON was notified of findings and she stated that no residents in the facility self-administer

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F 658	Continued From page 191 medications. She also stated that nurses are not supposed to leave medications at the bedside. The facility staff indicated their reference for professional standards was Potter & Perry. According to Potter & Perry's "Fundamentals of Nursing", 4th Edition, 2013, page 584, under the header "Standards", it is documented "Take appropriate actions to ensure that patients receive medications as prescribed and within the time prescribed in the appropriate environment. On 06/20/2019 at the end of survey, the administrator had no further documentation or information to offer. 15. For Resident #33, the facility failed to promptly assess/treat hypoglycemia and notify MD as ordered on 06/10/2019. Resident #33, a 51-year old female, was admitted to the facility on 03/12/2019. Diagnoses included but not limited to diabetes and schizophrenia. Resident #33's most recent Minimum Data Set with an Assessment Reference Date of 03/22/2019 was coded as an admission assessment. The Brief Interview for Mental Status was 15 out of possible 15 indicative of intact cognition. On 06/10/19 at approximately 09:33 AM, an interview with Resident #33 was conducted. When asked how she was feeling, she stated her "blood sugar was 51 this morning." When asked if she ate breakfast this morning, Resident #33 stated she didn't want the breakfast they sent; she wanted a salad, some fruit, and some broth	F 658		

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F 658	Continued From page 192 instead. She also stated she didn't feel well. On 06/10/19 at approximately 09:36 AM, the unit manager, Licensed Practical Nurse C [LPN C], was notified of Resident #33's statements. LPN C looked at Resident #33's electronic health record and stated that her blood sugar was 54 at 8:14 AM. When asked what was done about that, LPN C stated there was no documentation about that. LPN C went on to say that the nurse was supposed to inform the MD. Looking through the electronic health record, LPN C also stated that the nurse gave Resident #33 her Magic Cup and ProStat (sugar-free protein supplements) this morning and stated she would find Resident #33's nurse and find out what was done about the low blood glucose level. On 06/10/19 at approximately 09:42 AM, this surveyor and LPN C went to talk with Resident #33. Resident #33 confirmed again that she didn't eat breakfast and wanted a salad, fruit, and broth. When LPN C asked Resident #33 if she was feeling "woozy", Resident #33 stated, "Yes." LPN C and this surveyor then approached LPN D near the nurse's station. When asked what was done to address the low blood glucose, LPN D stated she still needed to notify the MD and recheck her blood sugar. On 06/10/19 at 09:47 AM, LPN D was observed rechecking the blood sugar for Resident #33 and stated her blood sugar was now 73. When asked if she assessed whether or not Resident #33 ate her breakfast, LPN D stated she didn't ask if [Resident #33] and went on to say she set her up with her breakfast this morning and she ate eggs. When LPN D was told Resident #33 stated she did not eat breakfast, LPN D stated, "She ate her	F 658		

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F 658	Continued From page 193 oatmeal." LPN D then stated she would still call MD to see what he wants her to do and then walked away from the nurse's station. The unit manager, LPN C, was asked about expectations when a resident presents with a low blood sugar. The unit manager stated that the nurse should have called the MD and followed up a lot quicker than what she did. She should make sure there is something like glucagon in place and also make sure [Resident #33] eats her food. On 06/10/2019 at approximately 10:30 AM, the clinical record was reviewed. An active physician's order dated 03/14/2019 documented, "Blood glucose check two times a day related to Type 2 diabetes mellitus. Notify MD if BG [blood glucose] less than 70 or greater than 400. An active physician's order dated 06/04/2019 documented, "Glucose Gel 40% Give 15 gram by mouth every 24 hours as needed for hypoglycemia related to type 2 diabetes mellitus. Give to alert res [resident] with BS [blood sugar] less than 70." The Medication Administration Record was reviewed. The blood glucose check was signed off as completed at 0900 for 06/10/2019 and the value recorded was 54. The Glucose Gel 40% was not administered on 06/09/2019 or 06/10/2019. A nurse's noted dated 6/10/2019 at 10:24 AM by LPN D documented, "Resident BS [blood sugar] was 54 at 0817, NP has been made aware. BS was 73 on recheck." On 06/10/19 at 11:00 AM, the DON was notified	F 658		

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F 658	Continued From page 194 of findings. When asked about expectations for management of low blood glucose values, the DON stated she expects the nurse to assess what the resident ate, recheck the level, give something with protein to stabilize, give glucagon, recheck blood glucose level, and notify the MD. A copy of their policy/protocol on monitoring blood glucose levels was requested. On 06/10/2019 at 3:20 PM, Employee J verified they don't have a policy related to hypoglycemia and stated, "We just follow MD orders." The facility staff indicated their reference for professional standards was Potter & Perry. According to Potter & Perry's "Fundamentals of Nursing", 4th Edition, 2013, page 192, under the header, "Clinical Decisions in Nursing Practice", it was documented, "For example a professional nurse observes for changes in patients, recognizes potential problems, identifies new problems as they arise, and take immediate action when a patient's clinical condition worsens." On 06/20/2019 by the end of survey, the administrator had no further information or documentation to offer. 16. For Resident #40, the facility staff failed to assess, treat, and notify MD in timely fashion a skin injury to her right thigh on 06/11/2018. Resident #40, a 61-year old female was admitted to the facility on 02/05/2018 and discharged on 10/31/2018. Diagnoses included but not limited to altered mental status, diabetes, and kidney	F 658		

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F 658	Continued From page 195 failure. The most recent Minimum Data Set associated with this complaint had an Assessment Reference Date of 10/15/2018 and was coded as a quarterly review. The Brief Interview for Mental Status was 12 out of possible 15 indicative of moderate cognitive impairment. Functional status for eating was coded as requiring supervision/encouragement from staff and set-up help only for support. On 06/18/2019 at 3:10 PM, in the course of a complaint investigation, the nurse's notes from June - October 2018 were reviewed. An excerpt of a nurse's note dated 06/13/2018 at 10:05 AM documented, "patient was sitting up in wheelchair on 06/11/18 eating a bowl of soup and spilled it on her right upper thigh. Zero bruising or tears noted at this time. Can [sic] this AM noted to have a blister in that area. Res [resident] complain mild pain and given PRN [as needed] pain meds. Blister is intact. Will notify NP [nurse practitioner] upon arrival." There was not a nurse's note addressing the incident on the day it happened and there was no subsequent note to document when the NP/MD was notified. The physician's orders were reviewed. An order entry dated 06/13/2018 documented, "Silvadene cream 1% apply to right upper thigh topically one time a day for intact blister." The order was discontinued on 06/14/2018. An order entry dated 06/14/2018 with a start date of 06/15/2018 documented, "Treatment skin - right anterior thigh - apply silvadene cream to burn and cover with telfa and 4x4 and hypafix tape daily and as needed until healed every day shift for burn." The order was discontinued on	F 658		

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F 658	Continued From page 196 06/19/2018. An order dated 06/19/2018 with a start date of 06/20/2018 documented, "Skin treatment - right upper thigh - cleanse with mild soap and water, pat dry, apply xeroform, cover with ABD [abdominal pad], kerlix if needed or cover with hypafix tape. Change dressing daily and as needed. Every day shift." The order was discontinued on 06/28/2018. The Medication Administration Record was reviewed for June 2018. From 06/13/2018 through 06/29/2019, there was no skin treatment administered on Saturday 06/16/2018, Tuesday 06/19/2018, Friday 06/22/2018, or Thursday 06/28/2018. An excerpt of a nurse's note dated 06/26/2018 at 1:24 PM documented, "I assessed [Resident #40]'s right thigh wound today. Measurements are improving and there are no signs or symptoms of infection." In summary, a skin assessment was not done at time of incident and the physician was not notified at time of incident. There was a two-day delay in treatment and the treatment was not administered as ordered. On 06/19/2019 at approximately 3:35 PM, the DON was notified of findings and she stated she expect the provider to notified at time of incident and treatments to be administered as ordered. The facility staff indicated their reference for professional standards was Potter & Perry. According to Potter & Perry's "Fundamentals of Nursing", 4th Edition, 2013, page 192, under the header, "Clinical Decisions in Nursing Practice", it	F 658		

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was documented, "For example a professional nurse observes for changes in patients, recognizes potential problems, identifies new problems as they arise, and take immediate action when a patient's clinical condition worsens."

On 06/20/2019 at end of survey, the interim administrator had no further documentation or information to offer.

17. For Resident #376, the facility staff missed wound care treatments as ordered.

Resident #376, an 82-year old male, was admitted to the facility on 10/23/2017 and discharged on 10/31/2018. Diagnoses included but not limited to diabetes, contracture left hand, generalized muscle weakness, and cognitive communication deficit.

Resident #376's most recent Minimum Data Set associated with the timeframe of the complaint had an Assessment Reference Date of 10/31/2018 and was coded as a discharge assessment. The Brief Interview for Mental Status was coded as an 8 out of possible 15 indicative of moderate cognitive impairment. Functional status for transfers and locomotion were coded as not occurring (or any part of the ADL was not performed at all over the entire 7-day look-back period). Bathing was coded as total dependence on staff. Bowel and bladder function were coded as always incontinent. Skin conditions were coded as "0" meaning no unhealed pressure ulcers present.

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The Minimum Data Set prior to the discovery of the unstageable scrotal wound had an Assessment Reference Date of 05/17/2018 and was coded as a quarterly review. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff. Mobility devices were walker and wheelchair. Risk for Pressure Ulcer was coded as "yes."

In the course of a complaint investigation, the nurse's notes from July 2018 through October 2018 were reviewed. A nurse's note dated 07/03/2018 at 1:23 PM documented, "I assessed [Resident #376]'s scrotum today after his nurse informed me he had an ulcer there. Measurements taken, unstageable pressure ulcer with slough, orders received from NP [nurse practitioner] and put in computer. He has been added to the weekly pressure wound rounds."

The physician's orders were reviewed. An order dated 07/04/2018 documented, "Treatment skin - pressure ulcer scrotum - cleanse with NS [normal saline], pat dry, apply therahoney and cover with foam dressing daily and as needed until healed."

The Treatment Administration Record was reviewed. Wound care was not administered as ordered on 07/13/2018, 07/16/2018, 07/17/2018, 07/29/2018, 07/30/2018, 08/09/2018, and 08/10/2018.

On 06/20/2019 at approximately 9:25 AM, an interview with the DON was conducted. In reference to the treatment record where wound care was not administered as ordered, the DON stated that it should've been done daily as ordered and documented.

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F 658	Continued From page 199 On 06/20/2018 at the end of survey, the interim administrator had no further information or documentation to offer.	F 658		
	18. For Resident #68 the facility staff failed to ensure medication was administered according to professional standards of practice. The facility failed to clarify an order for Tegretol causing the Resident to get more than the ordered amount. Resident #68, a 53 year old man admitted to the facility on 1/9/19 with diagnoses of but not limited to Major Depressive Disorder, Anxiety Disorder and Schizophrenia. On 6/8/19 during clinical record review it was noted that the resident had 2 co-existing orders for Tegretol (a seizure medication) The first order read: Tegretol XR Tablet Extended Release 12 hour 100 (milligrams) mg Give 1 tablet by mouth in the evening related to Major Depressive Disorder Unspecified (f 33.9) -Start date-3/21/19 at 5:00 PM The second order read: Tegretol XR Tablet Extended Release 12 hour 200 (milligrams) mg Give 1 tablet by mouth at bedtime related to Major Depressive Disorder Unspecified (f 33.9) -Start date-3/20/19 at 9:00 PM Excerpts from a psych consult read: "3/1/19 - This is an [sic] 53 year old male with a history of schizophrenia being seen for a routine follow up visit. Per staff pt. is having increased			

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F 658	Continued From page 200 aggression and making threats. Pt is currently taking Ativan 0.5 mg PO [by mouth] Q [every] 8 hrs. As needed, Ativan 0. 5mg po BID [twice a day] Risperdal 1 mg po bid Tegretol XR 100 mg Q is [bedtime] and Lexapro 20 mg po QD [every day] Pt has been taking RISPERDAL since 2/8/19 and has not had a reduction in aggression/ behaviors Will D/C [discontinue] RISPERDAL and initiate Zyprexa will also increase Tegretol to help with his mood." Medication: D/C RISPERDAL 1 mg PO BID, start Zyprexa 10 mg qhs, D/C Tegretol XR 100 mg Start Tegretol XR 200 mg qhs On 4/1/19 the Psych consult read: Medication: Continue Lexapro 5mg PO QD, Tegretol ER 100 mg QAM [every morning] and 200 mg PO Q HS Ativan 0.5 mg Q 8H PRN anxiety and Ativan 0.5mg BID. The MAR (Medication Administration Record) shows the Resident at getting Tegretol ER 100 mg at 5:00 PM Tegretol ER 200 mg at 9:00 PM On 6/11/19 at 2:00 PM in an interview with Unit Manager when asked are 12 hour extended release tablets usually given 4 hours apart, she stated that they would not be administered that way. When shown the copy of the MAR she stated she would look into it and get back to me. On 6/13/19 at 9:45 AM Unit in an interview with the unit manager she stated that she had spoken with the Nurse practitioner and the Psych NP's	F 658		

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and that there was an error in the order and it should have read:
Tegretol 100 mg Q AM and 200 mg Q Hs however since the resident was doing ok with the dose she would give him 300 mg at hs.

An Excerpt from Perry and Potter 9th Edition box 32.4
"Steps to Take to Prevent Medication Errors"

· Follow the six rights of medication administration.
· Be sure to read labels at least 3 times (comparing medication administration record [MAR] with label) before administering the medication
· Do not interpret illegible handwriting; clarify with health care provider.
· Question unusually large or small doses.
· Document all medications as soon as they are given.

During end of day meeting on 6/20/19 the Administrator was made aware of the findings and no further information was provided.

19. For Resident # 183, the facility staff failed to complete a Nurses Note upon discharge/transfer to the Emergency Room on 7/14/2018 to include assessment information, interventions attempted and transfer information .

Review of the closed clinical record was conducted on 6/18/2019. Review of the Nurses Progress Notes revealed no documentation of

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F 658	Continued From page 202 Resident # 183's discharge from the facility on 7/14/2018 to the Hospital Emergency Room and Admission to the hospital. There was no documentation of what information was given to the receiving hospital. On 7/13/218 at 14:40 (2:40 PM), a Nursing Progress note was a note written by a nurse who documented that Resident # 183 appears to need more assistance than usual with adl (Activities of Daily Living) care, pt appears to have a decrease in appetite, ate less than 25 % for lunch, denies pain when assessed by nurse, is oriented to self only which is pt's normal cognition,.....NP (Nurse Practitioner___ notified of changes by writer, order received to obtain ua&cns (urinalysis and culture and sensitivity) to rule out uti, pt is own rp (responsible party), attempted to contact emergency contact ____but she was not available, will continue to further monitor pt." Further review revealed there was no note from the nurse who discharged Resident #183 from the facility on 7/14/2018. There was no documentation of Resident # 183's condition at discharge, how the resident was transported, where, with whom or what time. On 6/18/2019 at approximately 3:30 PM, the Director of Nursing was informed there was no nursing note nor Discharge Summary in the clinical record. The Director of Nursing stated the facility staff should have written a nurses note upon discharge or transfer to the hospital Emergency Room. The Director of Nursing reviewed the documentation and stated the nurses did not document in the nurses notes anything about Resident # 183's condition or events leading to Resident # 183's discharge.	F 658		

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F 658	Continued From page 203 The Administrator cited Potter Perry as its Nursing professional guidance used by the facility. According to the American Nurses Association-Standards of documentation accessed online 6/25/19 at www.nursing center.com: Nurses are expected to provide documentation for "transfer times, modes of transfer, and patient status during and following transfer." On 6/18/2019 at approximately 4:00 PM, the Director of Nursing stated the expectation was that nurses would document in the Nurses Notes anytime a resident left the facility and include any assessment information regarding changes in condition, and interventions attempted prior to transfer. No further information was provided.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each	F 660		8/4/19

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F 660	Continued From page 204 resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care	F 660		

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F 660	Continued From page 205 provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement an effective discharge planning process for 1 resident (Resident #27) in a sample size of 76 residents. The findings included: For Resident #27, the facility staff failed to make reasonable efforts to assist him obtain financial assistance to pay the cost of care at the facility prior to issuing a discharge notice or provide services for a safe discharge that was pending for 06/10/2019. Resident #27, a 65-year old male, was admitted	F 660	1. Resident #27 discharge notice was revoked on 6/10/19 and the resident was not discharged. The Social Worker will re-evaluate Resident #27□s discharge plan and update his care plan. Assistance with discharge planning will be provided as appropriate and needed. 2. Current Residents who have previously been issued 30 Discharge letters may potentially be at risk and will be reviewed by the Executive Director, Social Worker or Business Office Manager for needed action. Any resident who is being discharged will be assessed for appropriate discharge planning.	

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F 660	Continued From page 206 to the facility on 09/06/2018. Diagnoses included but not limited to altered mental status, adult failure to thrive, chronic fatigue, difficulty in walking, and peripheral vascular disease. Resident #27's most recent Minimum Data Set with an Assessment Reference Date of 03/13/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 11 out of a possible 15 indicative of moderate cognitive impairment. Balance during Transitions and Walking were coded as not steady when moving from sitting to standing or walking. Mobility device used was coded as wheelchair. Discharge Plan and Return to Community were coded as no, meaning there was no discharge plan in place for Resident #27 to return to community nor did Resident #27 want to talk with someone about the possibility of returning to live in the community. On 06/05/19 at approximately 11:40 AM, Resident #27 was observed in his room, fully dressed, and seated in his wheelchair. When asked if he had any concerns about the care he receives at the facility, Resident #27 stated, "They putting me out Monday [06/10/2019]." Resident #27 then provided a form entitled "[Facility Name and state] Involuntary Transfer/Discharge Notice." The form was dated 05/10/2019 addressed to Resident #27 from the administrator of the facility. A portion of the letter documented, "You are being discharged because: The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. The resident will be discharged to [address listed] on 06/10/2019." On 06/06/2019 at approximately 1:40 PM,	F 660	3. The Business Office Manager and Social Service team will be reeducated by Clinical Quality Specialist on the regulations regarding discharge notice to residents. Prior to giving a discharge notice to a resident, for any reason other than the facility not being able to meet the medical needs of a resident in an emergency situation, the discharge notice will be reviewed by Executive Director, Assistant Executive Director, or Director of Nursing. The status of residents who have been given a discharge notice will be reviewed weekly by Social Work with the Executive Director, Assistant Executive Director and/or DON. 4. Executive Director/designee will review all involuntary discharge notices weekly x 3 months. The Business Office Manager will provide a monthly report to the QAPI Committee of the status of 30 days discharge notice for non-payment. 5. 8/4/2019	

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F 660	Continued From page 207 Resident #27's clinical record was reviewed. Progress notes from all disciplines ranging from 04/28/2019 to 06/06/2019 were reviewed. The only social services noted written during that range was dated 05/13/2019 and documented, "Social Services Visit - Social Services and Business Office issued the resident a [state] Involuntary Transfer/Discharge Notice." This note was signed by Employee L. The care plan was reviewed. There were no entries on the care plan by social services. A focus initiated by the MDS Coordinator dated 09/21/2018 documented, "The resident wishes to remain a LTC (long-term care) resident. The goal associated with this focus was revised on 03/11/2019 and documented, "The resident's discharge goals are to remain at facility for long term care through next review." Interventions associated with this goal documented, "Discuss resident/family goals for discharge quarterly and PRN (as needed). On 06/06/2019 at approximately 1:55 PM, an interview with Employee L from Social Services was interviewed. When asked if he was aware of Resident #27's pending discharge, he stated, "Yes." When asked about discharge planning, Employee L stated he would have to meet with Resident #27 to plan a safe discharge. When asked if he had any discharge planning notes associated with Resident #27's discharge scheduled on 06/10/2019, he looked in the electronic health record and stated, "No." A social services policy on discharge planning was requested. On 06/06/2019 at approximately 4:30 PM, an interview with Employee L and Employee M of	F 660		

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F 660	Continued From page 208 social services was conducted. When asked about the process for discharge planning, Employee L stated that discharge planning is team effort. He went on to say he collaborates with the team to make sure it's a safe discharge and works with nursing, therapy, and the business office. Employee L verified there was no evidence of discharge planning such as clinical record notes or team meeting notes for Resident #27. Employee M stated that his discharge planning should have started 30 days ago. The facility provided a copy of their policy entitled, "Discharge Planning." In the introduction under the header, "Policy", it is documented, "To evaluate the resident's health status and formulate the best plan of discharge for each resident. Discharge planning begins the day of admission. The process involves the resident and family, Care Management/Social Services and other members of the clinical team." Section 5 documented, "Residents discharged to home will be made aware of, understand, and agree with the proposed discharge plan, discharge date, and other home care needs." On 06/20/2019 at the end of survey, the administrator had no further information or documentation to offer.	F 660		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		8/4/19

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F 677	Continued From page 209 Based on observation, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide necessary services to maintain good nutrition and grooming for 5 resident (Resident #65, Resident #40, Resident #376, Resident #176, and Resident #76) in a sample size of 76 residents. The findings included: 1. For Resident #65, the facility staff failed to provide attentive bathing/grooming services. Resident #65, an 89-year old female, was admitted to the facility on 04/04/2017. Diagnoses included but not limited to chronic obstructive pulmonary disease, generalized muscle weakness, anxiety, depression, and unspecified psychosis. Resident #65's most recent Minimum Data Set with an Assessment Reference Date of 04/18/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 3 out of possible 15 indicative of severe cognitive impairment. Rejection of Care was coded as not exhibited. Functional status for dressing and personal hygiene were coded as requiring extensive assistance from staff. Bathing was coded as total dependence on staff. Eating was coded as requiring limited assistance from staff and one-person physical assist for support. On 06/05/19 at approximately 2:05 PM, Resident #65 was observed in her bed, awake, dressed and sitting on the side of her bed. Her hair was approximately shoulder-length and appeared	F 677	1. Resident #65 was bathed / showered, including having her hair washed on 7/9/19; the resident will be bathed at least 2x week and have appropriate hair care daily. Resident #40, #176 and Resident # 376 are no longer in the facility. Resident #76 was offered every 2 hours incontinent care during the survey and continues to be offered incontinent care every 2 hours throughout the day. 2. Residents who are dependent or require assistance with ADLs, including bathing and incontinence care, may have the potential to be affected with this alleged deficient practice. 3. The Director of Clinical services / designee will educate CNA staff on providing and documenting appropriate and timely care to residents who require assistance with or are dependent in ADL such as bathing / grooming and incontinent care, answering the call bells timely and adhering to a bathing schedule. A skill fair will be conducted that will include education and competency ADLs. 4. The Unit Managers / designee will monitor bath/shower compliance 3x week x 3 months to ensure that bath/showers are being provided. Variances will be investigated, and appropriate correction and/or education will be provided. Findings from the weekly audits will be submitted to the DON / ADON for tracking	

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F 677	Continued From page 210 disheveled and oily. There was a comb tangled up in her hair near the crown of head. When asked if she had combed her hair recently, Resident #65 stated, "Yes, honey, I brushed it this morning." Resident #65 appeared unaware of the comb tangled in her hair. On 06/05/19 at approximately 2:45 PM, Resident #65 was observed in her bed slowly rocking, chatting to herself, and still had the comb all tangled up in her hair. On 06/05/2019 at approximately 3:50 PM, Resident #65 was observed in her room on her bed rocking, chatting to herself, the comb was still tangled in her hair. On 06/06/2019 at approximately 9:05 AM, Resident #65 was observed in her room, sitting her bed fully clothed. The comb was no longer in her hair and her hair looked brushed. On 06/11/2019 at approximately 01:43 PM, Resident #65 was fully dressed lying in bed with the head of her bed elevated approximately 60 degrees and a cup in her hand. Her hair looked oily and disheveled. On 06/11/19 at approximately 02:03 PM, this surveyor and Licensed Practical Nurse [LPN C] went to observe Resident #65 and LPN C agreed that Resident #65's hair looked oily/greasy. A copy of the bathing logs were requested. On 06/11/2019, the care plan was reviewed. A focus initiated on 04/18/2017 by the Minimum Data Set [MDS] Coordinator documented, "The resident has impaired ADL [activities of daily living] functioning R/T [related to] depression,	F 677	/ trending and further action. Rounds will be conducted 5 days / week x 3 months by assigned leadership team members to observe for resident dignity and if ADL care has been provided appropriately and timely; if variances are identified they will be corrected and/or reported to the Unit Managers/designee for follow-up. Findings from the audits will be submitted to the DON / ADON for tracking / trending and a summary of observations and actions will be reported to QAPI. 5. 8/4/19	

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F 677	Continued From page 211 psychosis, anxiety, impaired cognition." An intervention associated with this focus dated 04/18/2017 documented, "Bathing: Provide the resident with assistance to bathe daily and PRN [as needed]. On 06/11/2019 at approximately 3:20 PM, the bathing documentation for May and June 2019 for Resident #65 was reviewed with LPN C. According to bathing flowsheet, bathing did not occur for 21 out of 31 days in the month of May and 8 out of the 11 days in June. On the days there was documentation, it did not specify whether it was partial bath, bed bath, or shower. LPN C stated that [Resident #65] is totally dependent on staff for being bathed and it looks like it's not being done. LPN C stated the expectation is showers twice a week when the hair should be washed and as needed. LPN C also stated that oral care, washing face, and brushing hair should occur daily and as needed. A copy of the facility's bathing policy was requested. On 06/18/2019 at 4:15 PM, the facility staff provided a copy of their bathing policy. In the introduction of the policy, it was documented, "Assistance with showering and bathing will be provided at least twice a week and PRN [as needed] to cleanse and refresh the resident." On 06/20/2019 by the end of survey, the interim administrator had no further information or documentation to offer. 2. For Resident #40, the facility staff failed to provide consistent ADL (activities of daily living) care.	F 677		

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F 677	Continued From page 212 Resident #40, a 61-year old female was admitted to the facility on 02/05/2018 and discharged on 10/31/2018. Diagnoses included but not limited to altered mental status, diabetes, and kidney failure. The most recent Minimum Data Set associated with this complaint had an Assessment Reference Date of 10/15/2018 and was coded as a quarterly review. The Brief Interview for Mental Status was 12 out of possible 15 indicative of moderate cognitive impairment. Functional status for dressing and personal hygiene coded as requiring extensive assistance from staff. Eating coded as requiring limited assistance from staff and a one-person physical assist for support. Bathing was coded as total dependence on staff. Transfers coded as requiring extensive assistance from staff and one-person physical assist for support. Bowel and bladder coded as always incontinent. Rejection of Care was coded as behavior not exhibited. In the course of a complaint investigation, the bathing logs from June through October 2018 were reviewed. Resident #40 was at the facility for 28 days in June 2018. Of those 28 days, there were 9 days Resident #40 did not receive either a bed bath, partial bath, or shower. The longest gap in bathing care was 3 days. Resident #40 was at the facility for 25 days in July 2018. Of those 25 days, there were 9 days Resident #40 did not receive either a bed bath, partial bath, or shower. The longest gap in bathing care was 3 days.	F 677		

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F 677	Continued From page 213 Resident #40 was at the facility for 31 days in August 2018. Of those 31 days, there were 18 days Resident #40 did not receive either a bed bath, partial bath, or shower. The longest gap in bathing care was 9 days. There was one instance where Resident $30 refused care and received a partial bath later in the day. For the 30 days in September that Resident #40 was at the facility, there were 27 days Resident #40 did not receive either a bed bath, partial bath, or shower. Resident #40 received a bed bath on 09/01/18, 09/06/18, and a partial and bed bath on 09/14/18. For the 28 days in October that Resident #40 was at the facility, there were 23 days Resident #40 did not receive either a bed bath, partial bath, or shower. Resident #40 received a partial bath on 10/03/2018 and a bed bath on 10/15/18, 10/26/18, and 10/31/18. There was one instance where Resident #40 refused care and received a partial bath later in the day. The care plan was reviewed. A focus addressing ADL care and bathing was initiated on 11/20/18, over 9 months after her admission to the facility and 3 weeks after this complaint was received. There was a focus addressing behaviors for refusing meds/care but that was initiated on 11/20/18. On 06/19/19 at 10:38 AM, the DON was notified of findings. When asked about expectations for bathing frequency, she stated she expects residents will get a shower or bath two times a week at least and as needed. When reviewing Resident #40's care plan, the DON stated the	F 677		

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F 677	Continued From page 214 ADL care should've been on the care plan. On 06/18/2019 at 4:15 PM, the facility staff provided a copy of their bathing policy. In the introduction of the policy, it was documented, "Assistance with showering and bathing will be provided at least twice a week and PRN [as needed] to cleanse and refresh the resident." On 06/20/19 at the end of the survey, the interim administrator had no further information or documentation to offer. 3. For Resident #376, the facility staff failed to provide sufficient ADL (activities of daily living) care. Resident #376, an 82-year old male, was admitted to the facility on 10/23/2017 and discharged on 10/31/2018. Diagnoses included but not limited to diabetes, contracture left hand, generalized muscle weakness, and cognitive communication deficit. Resident #376's most recent Minimum Data Set associated with the timeframe of the complaint had an Assessment Reference Date of 10/31/2018 and was coded as a discharge assessment. The Brief Interview for Mental Status was coded as an 8 out of possible 15 indicative of moderate cognitive impairment. Functional status for transfers and locomotion were coded as not occurring (or any part of the ADL was not performed at all over the entire 7-day look-back period). Bathing was coded as total dependence on staff. Bowel and bladder function were coded as always incontinent. Skin	F 677		

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F 677	Continued From page 215 conditions were coded as " 0 " meaning no unhealed pressure ulcers present. In the course of a complaint investigation, the bathing logs from June through October 2018 were reviewed. For the month of June 2018, the only day bathing was signed off as administered was on 06/28/2018 although the documentation did not indicate if it was a bed bath, partial bath, or shower. For the month of July 2018, bathing was signed off as administered on 07/05/2018, 07/19/2018, 07/26/2018 but the documentation did not indicate if it was a bed bath, partial bath, or shower. A bed bath was documented as given 07/12/2018. For the month of August 2018, Resident #376 did not receive bathing 29 out of 31 days. Resident #376 received a bed bath on 08/02/2018 and 08/23/2018. For the month of September, Resident #376 did not receiving bathing 29 out of 30 days. Resident #376 received a bed bath on 09/03/2018. For the month of October 2018, Resident #376 did not receiving bathing for 30 out of 31 days. Resident #376 received a partial bath on 10/25/2018. The care plan was reviewed. A focus initiated on 11/10/2017 and revised on 11/06/2018 documented, "The resident has an actual ADL impairment and is moderate assist of one for most ADL tasks. Intervals of refusing showers."	F 677		

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F 677	Continued From page 216 There was no documentation on the bathing flowsheets from June through October 2018 that Resident #376 refused care. On 06/19/19 at 10:38 AM, the DON was notified of findings. When asked about expectations for bathing frequency, she stated she expects residents will get a shower or bath two times a week at least and as needed. The DON also stated that even if a resident is refusing care, the family should be notified or try to find a CNA [certified nursing assistant] that has a good rapport with the resident to assist with bathing. On 06/18/2019 at 4:15 PM, the facility staff provided a copy of their bathing policy. In the introduction of the policy, it was documented, "Assistance with showering and bathing will be provided at least twice a week and PRN [as needed] to cleanse and refresh the resident." On 06/20/19 at the end of the survey, the interim administrator had no further information or documentation to offer. 4. For Resident #176 the facility staff failed to clean her up after she had been incontinent of loose stools. Resident #176 a 61 year old woman admitted to the facility on 5/4/18 with diagnoses of but not limited to Atrial Fibrillation, Major Depressive Disorder, and Gastro- Intestinal Hemorrhage. The Resident's most recent (Minimum Data Set) MDS with an Assessment Reference Date of 6/28/18 coded as a Quarterly Assessment coded	F 677		

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F 677	Continued From page 217 Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. On 6/11/19 during investigation of complaint it was found that according to facility documentation Resident #176 was her own Responsible Party. An entry into the progress notes on 7/4/19 states that she requested that to be sent out to the Emergency Room due to complaints of Nausea Vomiting and Diarrhea, and having just completed antibiotics for Clostridium Difficile [an inflammation of the colon caused by bacteria]. Resident then called the rescue squad from her cell phone and according to EMS Report dated 7/4/19 the EMS squad was dispatched to the facility and was met at the door by a nurse who stated that she didn't call EMS and it must be a "false alarm." An excerpt from the EMS report stated "The resident stated she called 911 because the facility staff refuse to take care of her or send her to the hospital, she stated they won't even take my blood pressure." The EMS report stated that as she was being prepared for transport they noticed a large amount of dark loose stools soaking the bed and the resident. They further state that Resident #176 stated she had been that way for a while that the staff refused to clean her up. The Report from the hospital "Pt brief changed by this RN and [name redacted] RN and [name redacted] RN, pt. completely soiled from head to toe in black dried tarry stool." "When asked if she had contacted the staff to	F 677		

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come and change her she stated she did multiple times but no one came. Pt states that she was also on the bedpan for 2 1/2 hours at one point tonight and finally someone came to take her off. "

On 6/11/19 at 10:00 in an interview with the DON when asked how often should incontinent care be provided to residents she stated "It is the expectation of the facility that CNA's make rounds a minimum of every two hours to check for incontinent needs and change the resident every two hours and PRN." She also stated that "No resident should be left on a bedpan for 2 1/2 hours as this can cause breakdown."

On 6/20/19 the Administrator was made aware of the findings and no new information was provided.

5. For resident # 76 the facility staff failed to provide incontinent care to resident incontinent of urine and loose stools.

Resident # 76, a 68 year old man who was admitted to the facility on 4/15/19 with diagnoses of but not limited to Schizophrenia, Unspecified Mood Disorder, Parkinson's disease, Neuropathy, and Lymphedema. Resident #76 has an appointed guardian from a local charity organization.

The most recent (Minimum Data Set) MDS coded as a quarterly with an Assessment Reference Date of 4/22/19 coded as a Quarterly coded Resident as extensive assistance for bed mobility with physical assist of 1, total dependence with a

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F 677	Continued From page 219 mechanical lift and physical assist of 2 + persons, bathing and dressing requires physical assist of 2 people, mobility is coded as wheelchair with physical assist of 1. On 6/7/19 during a clinical record review it was found that Resident # 76 had been admitted to the hospital on 4/9/19. According to the ER Report: "Presenting from [facility name redacted] unkempt and covered in feces and urine. On 6/11/19 at 10:00 in an interview with the DON when asked how often should incontinent care be provided to residents she stated "It is the expectation of the facility that CNA's make rounds a minimum of every two hours to check for incontinent needs and change the resident every two hours and PRN." On 6/20/19 during end of day meeting Administrator was made aware of findings and no further information was provided.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.	F 679		8/4/19

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F 679	Continued From page 220 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to provide an on-going, activities program to support resident preferences for 1 resident (Resident #65) in a sample size of 76 residents. The findings included: 1. For Resident #65, the facility staff failed to provide one-on-one activities for a 10-day period in May 2019. They also failed to provide a TV which was a preferred in-room activity for her. Resident #65, an 89-year old female, was admitted to the facility on 04/04/2017. Diagnoses included but not limited to chronic obstructive pulmonary disease, generalized muscle weakness, anxiety, depression, and unspecified psychosis. Resident #65's most recent Minimum Data Set with an Assessment Reference Date of 04/18/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 3 out of possible 15 indicative of severe cognitive impairment. Rejection of Care was coded as not exhibited. Functional status for dressing and personal hygiene were coded as requiring extensive assistance from staff. Bathing was coded as total dependence on staff. On 06/05/19 at approximately 2:05 PM, Resident #65 was observed in her bed, awake, dressed and sitting on the side of her bed. There was no TV or music playing in the room.	F 679	1. Resident #65 had her TV moved to her room and her Care Planned updated on 7/2/19. Resident #65 will receive 1:1 2-3 times weekly 2. Residents at Envoy of Williamsburg may have potentially been affected. Residents will be interviewed for activity preferences. 3. Activity department was re-educated by Regional Director of Clinical Services on identifying and honoring resident preferences for participation in activities. Executive Director has increased Resident Council to meet 2 twice per month and to develop a Resident Ad Hoc Activity Meeting to implement activities of Interest to the residents. Recommendations from the Resident Ad Hoc Activity Meeting will be reviewed by the Activity Director and the Executive Direction for potential implementation. Resident specific activity preferences will be reviewed through the care planning process. 4. The Social Worker / designee will conduct 5 interviews per week x 12 weeks with alert and oriented residents to determine if activities are being provided that honor resident□s preference. Social Worker/ Designee will conduct audit residents activities log of 5 Residents per week x 12 weeks with a BIMS of eight or below for to ensure residents receiving specified activities. Findings from the	

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F 679	Continued From page 221 On 06/05/19 at approximately 2:45 PM, Resident #65 was observed in her bed slowly rocking, and chatting to herself. There was no TV or audible stimulation in the room On 06/05/2019 at approximately 3:50 PM, Resident #65 was observed in her room on her bed rocking, and chatting to herself. There was no TV in the room or music playing. On 06/06/2019 at approximately 9:05 AM, Resident #65 was observed in her room, sitting her bed fully clothed. There was no TV in the room or music playing. On 06/11/2019 at approximately 01:43 PM, Resident #65 was fully dressed lying in bed with the head of her bed elevated approximately 60 degrees and a cup in her hand. There was no TV in the room or music playing. On 06/12/2019 at approximately 8:30 AM, Resident #65 was observed lying in her bed, awake, in a hospital gown. There was no TV in the room or music playing. On 06/13/2019 at approximately 3:55 PM, Resident #65 was seated in a wheelchair, dressed, holding a white stuffed animal and staring at the floor. There was no TV in the room or music playing. On 06/14/2019 at approximately 11:15 AM, an interview with Employee N, the Activities Director, was conducted. When asked about activities for Resident #65, Employee N stated that [Resident #65] she likes to reminisce; she likes music, and she likes to sit outside. Employee N stated [Resident #65] does not do well in large group	F 679	weekly interviews will be submitted to the Activity Director and Assistant Executive Director weekly for tracking / trending and a summary report will be submitted to the monthly QAPI Committee. 5. 8/4/2019	

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F 679	Continued From page 222 activities. Employee N stated "we do one-on-one in smaller settings in the blue room." Employee N also stated that [Resident #65] should have one-on-one three times a week on Tuesday/Thursday/Saturday schedule. A copy of [Resident #65]'s activity schedule and a facility policy on activities were requested. On 06/14/2019 at approximately 12:00 PM, the activities schedule and activity notes were reviewed. An activity note dated 04/18/2019 at 9:57 AM documented, "[Resident #65] receives 2-3 friendly visits per week, she enjoys people watching she [sic] is independent in her room with activities of her choice which including [sic] watching TV and walking to and from her bed to door." The activities flowsheet for May 2019 was reviewed. There were no on-on-one activities documented from 05/10/2019 through 05/20/2019. During that time, there was one group activity documented (05/15/2019). On 06/14/2019 at approximately 12:20 PM, Employee N and this surveyor went to observe that Resident #65 did not have a TV in her room. Employee N confirmed she does like TV and stated that Resident #65 had a TV but also had a recent room change. Employee N stated she would see about getting a TV for Resident #65. On 06/14/2019 at 12:45 PM, Employee N stated Resident #65 moved to her current room on 06/04/2019 and that a TV is currently being put in her new room. When asked again about Resident #65's activity schedule, Employee N stated, "We don't have activities scheduled, we just ask [residents] every day." On 06/14/2019, the care plan was reviewed. A	F 679		

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F 679	Continued From page 223 focus dated 05/15/2019 and initiated by Employee N documented, "The resident is independent for meeting emotional, intellectual, physical, and social needs r/t [related to] cognitive deficits, depression, and anxiety. An interventions associated with this focus documented, "The resident's preferred activities are : socializing with peers, friendly visits." There was no evidence in the care plan Resident #65 likes to reminisce, listen to music, sit outside, or watch TV. On 06/14/2019, the facility provided an Activity policy entitled, "Completion of Resident Participation Record." The policy addressed documentation of activities. It did not address the development, scheduling, or implementation of resident-centered activities. On 06/20/2019 by the end of survey, the interim administrator had no further information or documentation to offer.	F 679		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility documentation, and in the course of a complaint	F 684	1. Resident #120 MD/NP evaluated resident 6/26/19, follow up urology appointment 7/19/19, catheter care	8/4/19

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F 684	Continued From page 224 investigation, the facility staff failed to ensure the highest practicable well being for 3 residents (#120, #15, and #33), resulting in harm for Resident #120, in a survey sample of 76 residents. The findings included: 1. For Resident #120, the facility staff failed to provide care and treatment resulting in harm. Resident #120, a 65 year old male, was admitted to the facility on 4/11/19 with diagnoses including but not limited to a urinary bladder disorder requiring the use of an indwelling urinary catheter. Review of the clinical record for Resident #120 found Nursing Progress Notes on 4/29/19 at 3:49pm that noted blood in the Foley [urinary catheter] collection bag. The Nurse Practitioner was contacted and an order was given to make an appointment with Urology. A Nursing Progress Note on 4/30/19 at 06:40am noted bloody urine in the catheter bag and communication to Social Services regarding the previous order to make an appointment with a Urologist. At 10:15pm on 4/30/19, the Nurse Practitioner was notified again of bloody urine in the Foley bag with no new orders noted. A Nursing Progress Note dated 5/4/19 at 11:04am read, "Resident sent out non emergent ambulance to [redacted] ER due to what appears to be a large amount of blood and pus in foley leg bag...resident baseline is usually oriented...staring off at the ceiling so sent to the ER to be evaluated". Resident #120 was admitted to the hospital and returned to the facility on 5/8/19. Review of the hospital Discharge Summary dated	F 684	provided every shift and as needed. Resident #15 has had no adverse reactions, MD/RP notified of deficient practice and are receiving ordered diabetic management. Resident #33 has had no adverse reactions, MD/RP notified of deficient practice and are receiving ordered diabetic management . 2. All residents who are diabetic or have a Foley catheter have the potential to be affected by this deficient practice. Unit Managers/designee will complete an audit of diabetic residents to ensure they receive insulin per Physician orders and MD is notified in a timely manner when blood glucose results are less than or greater than parameters. Providers will be notified of variances. Unit Managers/ designee will complete audit of residents with Foleys to ensure catheter care is provided as needed and Urology appointments are scheduled as ordered. Follow up based on findings. 3. Nursing staff educated on providing care to residents with Foleys catheters, including documentation of catheter care by DON/Designee. Nursing staff will schedule appointments for provider consults and coordinate transportation arrangements with Social Work. Facility protocol for hypoglycemia, insulin administration and diabetic management will be reviewed with licensed nursing staff by DON/Designee. Licensed nursing staff will be re-educated on insulin	

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F 684	Continued From page 225 5/8/19 noted that Resident #120 arrived to the ER with a "urinary tract infection associated with catheterization of the urinary tract that was present on admission" and "pustular drainage from dirty chronic indwelling Foley....presented with obstructed indwelling catheter [that] had appeared grossly dirty" and "acute kidney failure-present on admission". The follow-up instructions on the hospital Discharge Summary included: "follow up with provider [Urologist name redacted], targeted follow up time: 2-3 weeks, instructions for follow up: schedule an appointment with Urology for re-evaluation of your urinary retention". On 6/17/19, clinical record review revealed an active physician order to provide catheter [indwelling urinary] care every shift and as needed for Resident #120. Review of the Treatment Administration Record (TAR) shows no documentation of catheter care given on 6 shifts in April. On 6/17/19, a staff interview was conducted with the Regional Clinical Director (Employee H) who stated, "the Social Services department never made an appointment with Urology because they said he [Resident #120] went to the hospital, I don't know what has happened here, it should have been done, I also don't know why the Nurse Practitioner didn't see him when bloody urine was reported, I have no answers". All physician notes were requested and five physician notes were provided, however there was no documentation regarding assessments or treatment plans related to nursing reports of Resident #120's change in condition prior to his hospitalization for a urinary tract infection with obstruction related to his indwelling urinary catheter and acute kidney	F 684	administration by DON/Designee. 4. Unit Managers/designee will conduct audits of residents with Foleys to ensure catheter care is provided and Urology appointments are scheduled as ordered, 3 times per week for three months Unit Managers/designee will conduct audits of at least 4 diabetic residents weekly x 3months to ensure they receive insulin per Physician orders and MD is notified in a timely manner when blood glucose results are less than or greater than parameters. Findings of the weekly audits will be submitted to the DON / ADON weekly for tracking / trending and further action as needed and a summary will be reported to the monthly QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. 8/4/19.	

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2. For Resident #15, the facility staff failed to implement physician ordered diabetic management in a timely manner.

Resident #15 was a 66 year old who was admitted to the facility on 12/11/18. Resident #15's diagnoses included Type 2 Diabetes Mellitus.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/4/19 was reviewed. Resident #15 was coded as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.

On 6/10/19 a review was conducted of Resident #15's clinical record, revealing a A1C lab test result which is obtained for diabetic management. The test was dated 1/24/19. The Reference Range of normal levels was 4.0 - 6.0. Resident #15's level was 11.2, which was coded as being "High."

Resident #15's signed physician orders dated 6/1/19 read, "NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML. Inject 15 unit subcutaneously three times a day related to Type 2 Diabetes." His doses were scheduled for specific times of administration.

On 6/10/19 a review was conducted of Resident #15's clinical record, revealing Resident #15's Medication Audit Report. Resident #15 received

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his insulin between approximately 2 to 5 hours late on the following days:

Date Scheduled Administered

6/1/19 4:00 P.M. 7:27 P.M.
6/3/19 11:00 A.M. 1:04 P.M.
6/3/19 4:00 P.M. 9:52 P.M.
6/7/19 4:00 P.M. 9:17 P.M.
6/9/19 4:00 P.M. 7:50 P.M.

On 6/10/19 at approximately 3:00 P.M., an interview was conducted with the Director of Nursing (Employee B). When asked to describe the possible consequences of Residents not receiving insulin as ordered, she stated, "They can either have a adverse reaction, including a diabetic coma or hyperglycemia."

No further information was received.

3. For Resident #33, the facility failed to promptly assess/treat hypoglycemia and notify MD as ordered on 06/10/2019.

Resident #33, a 51-year old female, was admitted to the facility on 03/12/2019. Diagnoses included but not limited to diabetes and schizophrenia.

Resident #33's most recent Minimum Data Set with an Assessment Reference Date of 03/22/2019 was coded as an admission assessment. The Brief Interview for Mental Status was 15 out of possible 15 indicative of intact cognition.

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F 684	Continued From page 228 On 06/10/19 at approximately 09:33 AM, an interview with Resident #33 was conducted. When asked how she was feeling, she stated her "blood sugar was 51 this morning." When asked if she ate breakfast this morning, Resident #33 stated she didn't want the breakfast they sent; she wanted a salad, some fruit, and some broth instead. She also stated she didn't feel well. On 06/10/19 at approximately 09:36 AM, the unit manager, Licensed Practical Nurse C [LPN C], was notified of Resident #33's statements. LPN C looked at Resident #33's electronic health record and stated that her blood sugar was 54 at 8:14 AM. When asked what was done about that, LPN C stated there was no documentation about that. LPN C went on to say that the nurse was supposed to inform the MD. Looking through the electronic health record, LPN C also stated that the nurse gave Resident #33 her Magic Cup and ProStat (sugar-free protein supplements) this morning and stated she would find Resident #33's nurse and find out what was done about the low blood glucose level. On 06/10/19 at approximately 09:42 AM, this surveyor and LPN C went to talk with Resident #33. Resident #33 confirmed again that she didn't eat breakfast and wanted a salad, fruit, and broth. When LPN C asked Resident #33 if she was feeling "woozy", Resident #33 stated, "Yes." LPN C and this surveyor then approached LPN D near the nurse's station. When asked what was done to address the low blood glucose, LPN D stated she still needed to notify the MD and recheck her blood sugar. On 06/10/19 at 09:47 AM, LPN D was observed rechecking the blood sugar for Resident #33 and	F 684		

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F 684	Continued From page 229 stated her blood sugar was now 73. When asked if she assessed whether or not Resident #33 ate her breakfast, LPN D stated she didn't ask if [Resident #33] and went on to say she set her up with her breakfast this morning and she ate eggs. When LPN D was told Resident #33 stated she did not eat breakfast, LPN D stated, "She ate her oatmeal." LPN D then stated she would still call MD to see what he wants her to do and then walked away from the nurse's station. The unit manager, LPN C, was asked about expectations when a resident presents with a low blood sugar. The unit manager stated that the nurse should have called the MD and followed up a lot quicker than what she did. She should make sure there is something like glucagon in place and also make sure [Resident #33] eats her food. On 06/10/2019 at approximately 10:30 AM, the clinical record was reviewed. An active physician's order dated 03/14/2019 documented, "Blood glucose check two times a day related to Type 2 diabetes mellitus. Notify MD if BG [blood glucose] less than 70 or greater than 400. An active physician's order dated 06/04/2019 documented, "Glucose Gel 40% Give 15 gram by mouth every 24 hours as needed for hypoglycemia related to type 2 diabetes mellitus. Give to alert res [resident] with BS [blood sugar] less than 70." The Medication Administration Record was reviewed. The blood glucose check was signed off as completed at 0900 for 06/10/2019 and the value recorded was 54. The Glucose Gel 40% was not administered.	F 684		

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F 684	Continued From page 230 A nurse's noted dated 6/10/2019 at 10:24 AM by LPN D documented, "Resident BS [blood sugar] was 54 at 0817, NP has been made aware. BS was 73 on recheck." On 06/10/19 at 11:00 AM, the DON was notified of findings. When asked about expectations for management of low blood glucose values, the DON stated she expects the nurse to assess what the resident ate, recheck the level, give something with protein to stabilize, give glucagon, recheck blood glucose level, and notify the MD. A copy of their policy/protocol on monitoring blood glucose levels was requested. On 06/20/2019 by the end of survey, the administrator had no further information or documentation to offer.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview,	F 686	1. Resident #121 Skin Integrity review	8/4/19

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F 686	Continued From page 231 clinical record review and facility documentation review, the facility staff failed to prevent and or promote healing of pressure areas for 2 Residents (121 and 376) in a survey sample of 76 Residents. This resulted in harm for Resident 121 and 376. The findings include: 1. For Resident #121, the facility staff discovered 4 wounds that were Stage III pressure injuries with slough in the wound beds. This is harm. Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to dementia. Resident #121's most recent Minimum Data Set with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff. Walking in room and corridor were coded as not occurring. Functional status for eating was coded as requiring supervision from staff (one-person physical assist for support). Current number of unhealed pressure ulcers were coded as 0 [meaning none] for Stage I pressure injuries, 0 for Stage II pressure injuries, 1 [meaning 1] for Stage III pressure injuries, and 0 for Stage IV pressure injuries. On 06/12/2019, the clinical record was reviewed. The physician orders were reviewed. There were 5 skin treatment orders obtained by phone by the wound nurse from the nurse practitioner dated	F 686	completed 7/02/19, resident no longer presents with pressure ulcers at this time. Resident #376 discharged from facility prior to survey, no corrective actions taken. 2. Unit Managers/Wound Care Nurse will complete facility wide audits of resident's skin integrity. If a resident is found to have pressure injury, the physician will be notified, and treatment initiated. Weekly skin observations will be completed, and findings reported to a licensed nurse and medial provider as appropriate. Pressure ulcer risk assessments will be completed per facility protocol. 3. CNAs will be educated on their role and responsibility for pressure ulcer prevention and care by a licensed nurse including education by an independent nursing consultant. Licensed nursing staff will be educated on pressure ulcer prevention, assessment, treatment, investigation, and documentation. Licensed nursing staff will be re-educated on the facility policy for weekly evaluation and documentation of pressure ulcers by DON/Designee. 4. The Unit Managers / Wound Care Nurse will audit 6 weekly skin observations x 3 months to monitor for compliance; variances will be addressed, and findings reported weekly to DON/ADON. The Unit Manager / designee will conduct	

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F 686	Continued From page 232 05/09/2019 that documented as follows: "Right hip inferior wound - cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right hip Superior wound - cleanse with wound cleanser, pat dry, apply a hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right hip wound - cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right trochanter superior wound - cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right upper buttock wound, cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift." An active order dated 05/07/2019 documented, "Weekly skin checks." Two active orders dated 05/07/2019 documented, "Pressure reducing mattress" and "Pressure reducing cushion to wheelchair." An order dated 04/30/2019 documented, "Regular diet, mechanical soft texture, honey thickened fluids consistency, for dysphagia." The diet was changed in an order dated 05/13/2019 that documented, "Regular diet mechanical soft texture, thin liquids consistency, double portions related to dysphagia." An order dated 04/23/2019 documented, "Vitamin D3 tablet 1000 unit Give 1 tablet by mouth on time a day for supplement. There were no other	F 686	5 resident observations weekly x 3 months to validate that pressure ulcer care interventions are appropriate and are being implemented. If variances are found, they will be immediately corrected, and responsible staff re-educated. Findings from the weekly observations will be submitted to the DON / ADON for tracking / trending and further action as needed. The DON/designee will conduct review of 3 completed wound assessments per weeks x 3 months to ensure accurate evaluation and full documentation of the wounds; this review will also include a visualization of the pressure ulcer and interventions in place for pressure reduction. Variances found will be reviewed with the appropriate staff person for education and/or correction. Findings from the above weekly observations and record review will be reported to the DON for tracking/trending. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule may be modified based on findings. 5. 8/4/19.	

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F 686	Continued From page 233	F 686		

orders for supplements or vitamins.

The weight flowsheet was reviewed. Resident #121's height was 77 inches on date of admission (04/22/2019) and a standing weight value dated 04/23/2019 was 161.2 pounds. On 05/01/2019, a standing weight of 158 pounds was documented. On 05/15/2019, a standing weight of 157.6 pounds was documented. On 05/22/2019, a wheelchair weight of 155.2 pounds was documented. A wheelchair weight dated 05/22/2019 was 158.8 pounds and a standing weight dated 06/04/2019 was 164.4 pounds.

A nurse's note dated 05/09/2019 at 10:00 AM entered by RN C documented, "Resident with Stage III to right superior hip 1x1.5x0.1 20% pink wound base 80% white slough, Stage III to middle right hip 0.5 x 0.5 x 0.1 20% pink wound base 80% white slough, Stage III to right inferior hip 0.2 x 0.2 x 0.1 50% pink wound bed 50% white slough, Stage II to right trochanter upper 1.5 x 2 x 0.1 pink wound base, Stage II right trochanter lower 0.2 x 0.2 x 0.1. Pink wound base. All wounds above in close proximity of one another. Stage III to right upper buttock 1.7 x 0.7 x 0.2 20% pink wound base 80% white slough. RP and NP aware. New treatments in place in performed by this nurse."

The skin assessment documents were reviewed. Each Stage III wound discovered on 05/09/2019 was evaluated by RN C weekly as follows:

Right hip superior:
05/09/2019: 1 x 1.5 x 0.1, Stage III, 20% pink wound bed, 80% white slough
05/15/2019: 1 x 1 x 0.1, wound bed granulation
05/28/2019: wound has closed

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F 686	Continued From page 234 Right hip middle: 05/09/2019: 0.5 x 0.5 x 0.1, Stage III, 20% pink wound bed, 80% white slough 05/15/2019: 0.1 x 0.1 x 0, wound bed epithelial Right hip inferior: 05/09/2019: 0.2 x 0.2 x 0.1, Stage III, 50% pink wound bed, 50% white slough 05/15/2019: 0.1 x 0.1 x 0, wound bed epithelial Right buttock: 05/09/2019: 1.7 x 0.7 x 0.2, Stage III, 20% pink wound bed, 80% white slough 05/15/2019: 1.5 x 0.5 x 0, wound bed epithelial A provider progress note dated 05/11/2019 (by the nurse practitioner that ordered the wound treatments on 05/09/2019) documented under the header entitled, "Skin:" "Normal, no rashes, no lesions noted." A nurse's note dated 5/15/2019 at 11:15 AM written by RN C documented, "Stage III to right hip superior to other wounds 1 x 1 x 0.1, decreased in size, no slough present, pink wound bed, Stage III to right hip (middle) in between superior and inferior hip wound 0.1 x 0.1 x 0 pink area, no longer open. Stage III to right hip inferior to other wounds 0.1 x 0.1 x 0 pink area, no longer open, Stage III to right upper buttock 1.5 x 1.5 x 0 red area, no longer open, Stage II to right trochanter superior to other wound to same area 1 x 1 x 0 red area, no longer open, Stage II to right trochanter inferior to other wound of same area 0.1 x 0.1 x 0 red area, no longer open. Will continue to monitor closed areas for reoccurrence. Current treatment to open area with hydrogel. NP in RP aware."	F 686		

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F 686	Continued From page 235 On 06/13/2019 at approximately 1:50 PM, Registered Nurse C [RN C, wound care nurse] and this surveyor performed a skin assessment on Resident #121. There were no open pressure areas visualized on right hip and buttocks. Resident #121 was in bed lying on his left side (on a pressure reducing mattress) and refused to turn over to complete skin check. On 06/13/2019 at approximately 2:00 PM, an interview with RN C was conducted. When asked how she discovered the above wounds, RN C stated a nurse told her Resident #121 had wounds that needed to be evaluated. RN C stated that the same day, she assessed the wounds, put new treatments in place, and documented her findings. She also stated she could not remember the nurse that told her about the wounds. The facility staff provided a copy of their policy entitled, Clinical Guideline Skin & Wound." Under the header, "Overview", it was documented, "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury." Under the header, "Process", the first two items listed "On admission/re-admission the resident's skin will be evaluated for baseline skin condition and documented in the medical record." "Braden Risk Evaluation to be completed on admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition." On 06/13/2019 at approximately 3:10 PM, an interview with unit manager, Licensed Practical	F 686		

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F 686	Continued From page 236 Nurse C [LPN C], was conducted. When asked about expectations regarding pressure injury prevention, LPN C stated she would expect to see preventative measures in place before it was discovered. She also stated she would expect the resident to have an air mattress and "meal intake supplemented to help with healing process." She also stated she would expect to see it on the care plan. On 06/20/2019 by then end of survey, the administrator had no further documentation or information to offer. 2. For Resident #376, the facility staff discovered an unstageable scrotal wound with slough in the wound bed on 07/03/2018. This is harm. Resident #376, an 82-year old male, was admitted to the facility on 10/23/2017 and discharged on 10/31/2018. Diagnoses included but not limited to diabetes, contracture left hand, generalized muscle weakness, and cognitive communication deficit. Resident #376's most recent Minimum Data Set associated with the timeframe of the complaint had an Assessment Reference Date of 10/31/2018 and was coded as a discharge assessment. The Brief Interview for Mental Status was coded as an 8 out of possible 15 indicative of moderate cognitive impairment. Functional status for transfers and locomotion were coded as not occurring (or any part of the ADL was not performed at all over the entire 7-day look-back period). Bathing was coded as total dependence on staff. Bowel and bladder	F 686		

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F 686	Continued From page 237	F 686		

function were coded as always incontinent. Skin conditions were coded as "0" meaning no unhealed pressure ulcers present.

The Minimum Data Set prior to the discovery of the unstageable scrotal wound had an Assessment Reference Date of 05/17/2018 and was coded as a quarterly review. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff. Mobility devices were walker and wheelchair. Risk for Pressure Ulcer was coded as "yes."

The physician's orders were reviewed. An order dated 02/15/2018 documented, "Weekly skin assessments Thursday 7-3 every day shift." An order dated 05/09/2018 documented, "Apply moisture barrier to reddened bony prominences as needed." An order dated 05/24/2018 documented, "Consistent Carbohydrate diet mechanical soft texture, thin liquid consistency, double protein portions for diet."

An order dated 06/10/2018 documented, "Nystatin powder to scrotum topically every shift for itching, apply to scrotum and groin every shift until healed."

In the course of a complaint investigation, the nurse's notes from July 2018 through October 2018 were reviewed. A nurse's note dated 07/03/2018 at 1:23 PM documented, "I assessed [Resident #376]'s scrotum today after his nurse informed me he had an ulcer there. Measurements taken, unstageable pressure ulcer with slough, orders received from NP [nurse practitioner] and put in computer. He has been added to the weekly pressure wound rounds."

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F 686	Continued From page 238 The care plan was reviewed. A focus initiated on 11/20/2017 documented, "The resident has the potential for impaired skin integrity r/t [related to] frequent bladder/bowel incontinence." Interventions associated with this focus documented, "Administer treatments as ordered and monitor for effectiveness; apply barrier cream post incontinence care; Braden scale quarterly; float heels as tolerated when in bed; and weekly skin checks." There were no other interventions such as a pressure-reducing mattress or cushion for the wheelchair. A focus on the care plan initiated 7/26/18 (3 weeks after the unstageable pressure ulcer was discovered). It documented "The resident has impaired skin integrity to scrotum." Interventions associated with this focus documented, "Administer treatments as ordered in monitor for effectiveness; apply Barrier cream post incontinence care; assess/record/monitor wound healing weekly. Measure length, width, and depth where possible; Assist resident with turning in position frequently each shift; encourage adequate nutrition and hydration and order to promote healthier skin; follow physician order for preventative treatment; if resident refuses treatment interventions, wait and try again; incontinence care post episode; inform the resident family caregivers of any new area of skin breakdown; keep skin clean and dry; monitor changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and/or stage; monitor dressing (FREQ) to ensure it is intact and adhering. Report loose dressing to nurse; monitor for and Report any new skin impairment noted during care." There were no pressure-reducing measures listed.	F 686		

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F 686	Continued From page 239 The Treatment Administration Record was reviewed. Wound care as ordered was not administered on 07/13/2018, 07/16/2018, 07/17/2018, 07/29/2018, 07/30/2018, 08/09/2018, and 08/10/2018. An excerpt of a nurse's note dated 08/15/2018 at 9:26 AM documented, "[Resident #376]'s pressure ulcer on his scrotum has healed." The facility staff provided a copy of their policy entitled, Clinical Guideline Skin & Wound." Under the header, "Overview", it was documented, "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury." Under the header, "Process", the first two items listed "On admission/re-admission the resident's skin will be evaluated for baseline skin condition and documented in the medical record." "Braden Risk Evaluation to be completed on admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition." On 06/20/2019 at approximately 9:25 AM, an interview with the DON was conducted. When asked about expectations for pressure injury prevention, she stated she would expect to see a skin breakdown risk assessment, air mattress, cushion on the wheelchair, diet supplements and expect to see it all on the care plan. The DON verified there was no skin breakdown risk assessment documentation and the only preventative measures in place were "barrier cream and nystatin." In reference to the treatment record where wound care was not	F 686		

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F 686	Continued From page 240 administered as ordered, the DON stated that it should've been done daily as ordered and documented. In summary, there were no pressure-reducing interventions implemented before or after the scrotal wound was discovered when unstageable with slough in the wound bed. Wound treatments were not administered daily as ordered (missed treatments). On 06/20/2018 at the end of survey, the interim administrator had no further information or documentation to offer.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to prevent actual/potential accident hazards facility-wide and for 2 residents (Resident #40, Resident #121) in a sample size of 76 residents. This resulted in Harm for Resident #40 The Findings Include:	F 689	1. Resident #40 discharged from facility prior to survey, no corrective actions taken. Resident #121 fall risk assessment completed 7/12/19 Physical Therapy completed screen on 7/12/19 related to ambulation and unsteady gait; Interdisciplinary Team (IDT) met to review care plan and update as indicated with interventions in place. Liberty Day Room sliding glass door replaced on 6/11/19.	8/4/19

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F 689	Continued From page 241 1. For Resident #40, the facility staff failed to assess for fall risk or have preventative measures in place when she fell and hit her head resulting in face swelling and laceration. This is harm. Resident #40, a 61-year old female was admitted to the facility on 02/05/2018 and discharged on 10/31/2018. Diagnoses included but not limited to altered mental status, diabetes, and kidney failure. The most recent Minimum Data Set associated with this complaint had an Assessment Reference Date of 10/15/2018 and was coded as a quarterly review. The Brief Interview for Mental Status was 12 out of possible 15 indicative of moderate cognitive impairment. Functional status for dressing and personal hygiene coded as requiring extensive assistance from staff. Transfers coded as requiring extensive assistance from staff and one-person physical assist for support. Bowel and bladder coded as always incontinent. Fall history in the last 2-6 months was not coded. On 06/18/2019 at 3:10 PM, in the course of a complaint investigation, fall investigations from June - October 2018 were requested. The facility staff provided a fall investigation dated 06/21/2018 that documented details not consistent with the allegations in the complaint. The event was dated 06/16/18 at 1:30 PM and the description documented, "patient was trying to get in the bed without assistance and fell on her buttocks. No injuries noted denies pain." There was no evidence in the documentation that preventative measures were put in place after the fall. A nurse's note associated with this event dated 06/16/18 at 1:00 PM documented, "patient	F 689	2. Unit Managers/designee will complete audit of fall risk assessments to ensure those at risk have appropriate interventions in place. Falls are reviewed during Morning meeting by IDT. Maintenance will complete quality review of facility windows/doors to ensure they are free of broken glass. Follow up based on findings. 3. Licensed nursing staff will be re-educated by DON/designee on the facility protocol for completing a fall risk assessment per facility protocol. Resident specific interventions will be developed from the risk assessment and investigation of falls. The interdisciplinary team will be re-educated by DON or designee on fall prevention, investigations and care planning for resident specific interventions to minimize falls. Falls will be discussed daily during Morning meeting and investigations will be completed post falls; findings from the investigation will be utilized to develop a person-centered care plan. Fall prevention interventions will be communicated to direct care staff and CNAs will be re-educated on the importance of following the fall prevention interventions by DON or designee. Administrator and Maintenance re-educated by Divisional Executive Director on repairs to broken windows/door glass.	

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F 689	Continued From page 242 was trying to get in the bed unassisted. She fell on floor, no injuries noted, denies pain or discomfort. Unit manager notified, [name] [nurse practitioner] notified." The facility staff verified there were no other fall investigations in addition to the fall event on 06/16/18. The nurse's notes from June - October 2018 were reviewed. A nurse's note dated 08/18/2018 at 5:16 AM documented, "At approximately 0425 heard resident yelling for nurse. This nurse finished rounds at 0345. Upon entering room found resident on floor withshe [sic] blood coming from the left side of her head. Resident state [sic] she was looking for her wheelchair. Resident was assessed and 911 was called d/t [due to] head resident [sic] never lose consciousness injury [sic]. Vital signs 130/82 [blood pressure], 76 [pulse], 18 [respirations], o2 sat 97% [oxygen saturation]. No other injuries noted. Resident was clean new hospital gown and brief. EMT's [emergency medical technicians] arrived and resident taken to hospital. DON and nurse practitioner [name] notified." A nurse's note dated 08/19/2018 at 9:30 AM documented, "Resident returned from ED [emergency department] with "glue" closure of left eye, some swelling noted to area. Ice applied for comfort. Per ED note, resident had a CT [computed tomography, CAT scan] which was normal. Neuro WNL." An excerpt of a nurse's note dated 08/19/18 at 12:40 PM documented, "Resident has ice in place to eye and received Tylenol for her discomfort and reports comfortable at this time."	F 689	4. Unit Manager / designee will review 5 falls per week x 3 months to ensure that fall risks and findings from the fall investigation are addressed on the resident's plan of care and are being implemented. Variances will be investigated, and correction and/or re-education will be done as appropriate. Findings from the weekly reviews will be submitted to DON/ADON for tracking / trending. A summary report will be submitted to QAPI Committee for additional recommendation. The Unit Manager / designee will conduct 5 resident observations weekly x 3 months to validate that fall prevention interventions are being implemented. If variances are found, they will be immediately corrected, and responsible staff re-educated. Findings from the weekly observations will be submitted to the DON / ADON for tracking / trending and further action as needed. Maintenance will conduct 2x month checks on windows/doors to ensure they are free of broken glass, for 3 months. Repairs will be made as identified. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. 8/4/19.	

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F 689	Continued From page 243	F 689		

A nurse's note by a wound care RN dated 08/20/18 at 10:17 AM documented, "I assessed [Resident #40]'s face today s/p [status post] fall. She has a laceration above her left eye that has been glued closed by the emergency department, no drainage, purple and color. She has a hematoma above her left eye. The left eye is swollen almost shut. The area around her right eye is also swollen but not to the same degree. Left side of face is swollen and purple in color. Measurements taken."

On 06/19/2019 at 10:38 AM, the DON verified that there was no fall risk assessment before or after the event and no fall risk or actual fall problems addressed in the care plan. The DON stated that all patients are a fall risk and should have a risk assessment done on admission and quarterly. The DON also stated fall risk and actual falls should be addressed on the care plan.

On 06/20/2019 by the end of survey, the interim administrator had no further information or documentation to offer.

2. For Resident #121, the facility staff failed to provide adequate supervision to prevent a potential accident/fall. Resident #121 was observed ambulating in the hall unassisted with bare feet and had an unsteady gait on 06/06/2019.

Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to dementia, difficulty in walking, and unsteadiness on feet.

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F 689	Continued From page 244 Resident #121's most recent Minimum Data Set with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Functional status for locomotion on unit was coded as not occurring. Balance During Transitions was coded as not steady when moving from seated to standing position. Functional status for eating was coded as requiring supervision from staff (one-person physical assist for support). Behaviors for psychosis or wandering were coded as not exhibited. On 06/06/19 at 08:26 AM, this surveyor observed Resident #121 in another resident's room (a female resident identified in the sample as Resident #37). Resident #121 was seated on the side of her bed eating her breakfast that was on her tray table. Resident #37 was not in her room (room "A") and her roommate was asleep in her bed by the window. This surveyor alerted Licensed Practical nurse D [LPN D] at the nurse's station, and LPN D went to room "A" and redirected Resident #121 back to his room (room "B"). Resident #121 was barefoot and wearing a hospital gown that was open in the back exposing his bare back, legs, and a loosely-fitted brief. When they reached the doorway of room "B", LPN D instructed Resident #121 to go sit down and then LPN D walked back toward the nurse's station. At 08:30 AM, Resident #121 entered his room and sat down in a chair in front of his tray table. The breakfast plates/tray on top of the table were empty. There were bits of food on the floor under the table, the chair, and under and around the feet of Resident #121. Resident #121 then stood up, walked out into the hall, and asked	F 689		

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F 689	Continued From page 245 this surveyor for pancakes. This surveyor alerted nearby staff and the wound nurse, Registered Nurse C [RN C], stated she would find out how to order more pancakes for Resident #121. On 06/06/19 at 09:07 AM, this surveyor observed Resident #121 standing outside room "C". Resident #121 had a hospital gown on, open in the back, exposing his back, legs, and loosely-fitted brief. Employee K, a housekeeper, also saw Resident #121 and told him to go back to his room and pointed in the direction of which hall to walk down to get to his room. There were no nurses seen at the nurse's station by room "C" or down either hall. The housekeeper and this surveyor observed Resident #121 walking with an unsteady gait into and out of room "C". The housekeeper stated that room "D" used to be Resident #121's room. Resident #121 continued to walk down the hall and entered room "E", walked to the food tray and picked up an unwrapped straw. At that time, certified nursing assistant B (CNA B) entered room "E", saw Resident #121, redirected him, and walked alongside Resident #121 headed toward his room. On 06/06/2019 at approximately 9:15 AM, LPN D was asked about Resident #121 and she stated "Sometimes he gets confused where his room is, we redirect him." On 06/11/19 at 08:45 AM, Resident #121 was observed getting up out of bed, ambulating to hall and asking this surveyor for a Pepsi. Resident #121 was wearing a red shirt and blue pants. There was spilled food on his pants and on the room floor that resembled oatmeal where Resident #121 was walking. Resident #121's	F 689		

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F 689	Continued From page 246 pants fell below the level of his mid-thighs before he pulled up his pants as he left his room and ambulated down the hall with an unsteady gait unassisted. This surveyor had to alert an aide to assist Resident #121 ambulate back to his room. On 06/12/2019, the care plan was reviewed. The focus initiated by the MDS Coordinator dated 05/09/2019 documented, "The resident is at risk for falls r/t [related to] gait/balance problems." Interventions associated with this focus documented, "Anti-tipper on W/C [wheelchair]; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; bed in low position; DUMP W/C [sloped wheelchair, higher in the front]; wedge cushion in W/C." Resident #121 was not observed in a wheelchair throughout the survey process. On 06/13/2019 at approximately 10:15 AM, an interview with the unit manager, LPN C, was conducted. When notified of observations on 06/06/2019, LPN C stated all staff should make sure his dignity remains intact, covering him up, ensuring safety, making sure he had skid-proof socks on, making sure his room is tidy, and also check on him if he's still hungry, get him something to eat. When asked how long this behavior had been occurring, LPN C stated that staff said [Resident #121] "does this from time to time" and went on to say "but there's no documentation about it." When asked about expectations for documenting behaviors, LPN C stated she expects to see documentation "any and all behaviors each shift and follow-up so the IDT [interdisciplinary team] can make adjustments and meet their needs." She stated she would also expect to see it on the care plan as it happens.	F 689		

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F 689	Continued From page 247 On 06/20/2019 at the conclusion of the survey, the administrator had no further documentation or information to offer. 3. The facility staff failed to provide repair to a broken sliding glass door, and prevent resident access to the broken glass. On 6/5/19 at approximately 2:15pm it was observed that in the Liberty Day Room one of the sliding glass doors had broken glass. At the bottom, about 1 1/2 feet from the floor, there was an area of impact with an object that broke the glass causing a spider web pattern of glass breakage that extended all the way to the top of the door and across each side. The height of the door was approximately 6 1/2 feet tall and the width was approximately 3 feet. A thin flexible material, the Maintenance Director stated the material was "bubble wrap" had been put over the broken glass but had become unadheared, leaving it accessible. The material that was over the door, had been secured with duct tape at some point, but it had come unsecured and the material was hanging down. When the window blind was opened the material fell allowing full access to the broken glass. On 6/5/19 at approximately 2:20pm an interview was conducted with Resident #114 who was sitting in the Liberty Day Room. Resident #114 stated the sliding glass door had been broken for about 2 months. On 6/5/19 at 2:52pm an interview was conducted with Employee F, Maintenance Director. The maintenance director said, "I know it is dangerous	F 689		

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F 689	Continued From page 248 that is why I put that bubble wrap up." On 6/5/19 at 3:15pm the facility Administrator was asked about the sliding glass door. The Administrator stated, "I actually checked it the other day." The Administrator was asked to go look at the door. She returned to the conference room and stated, "I didn't know it had fallen down, we will get it replaced, I have someone watching the door until we can get it put back up."	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility	F 692	1. Resident #102 evaluated by MD on 6/26/19, evaluated by Registered Dietician	8/4/19

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F 692	Continued From page 249 documentation, the facility staff failed to maintain the nutritional status of 1 resident (Residents #102), resulting in harm for Resident #102 in a survey sample of 76 residents. The findings include: 1. For Resident #102, the facility staff failed to assist her with her meals and prevent a significant weight loss of 6.26% in 13 days resulting in harm. Resident #102, a 90-year old female, was admitted to the facility on 09/02/2004. Diagnoses included, but not limited to, Alzheimer's disease, depression, and generalized muscle weakness. Resident #102's most recent Minimum Data Set with an Assessment Reference Date of 05/05/2019 was coded as a significant change in status assessment. The Brief Interview for Mental Status was coded as 9 out of possible 15 indicative of moderate cognitive impairment. Functional status for bed mobility and dressing were coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision/encouragement/cueing from staff and set-up help only for support. On 06/06/2019 at 2:41 PM, Resident #102 was observed in her bed sleeping wearing a pink sweatshirt and brief and lying on her left side. Resident #102 was partially covered with a sheet. Resident #102 appeared thin. The food tray from lunch was on her tray table which was partially over her bed. The lunch tray had a manwich, green beans, strawberry shortcake and a peanut butter and jelly sandwich, all uneaten. There was a small bowl of macaroni salad with a spoon in it	F 692	on 6/29/19, resident was on speech therapy case load. Resident is receiving assistance as need with meals. Bed control replaced. 2. Unit Mangers/designee will complete audits of residents to identify those who require assistance or set-up with meals. Type of assistance needed will be communicated to the direct care staff and be reflected in the resident□s care plan. 3. The interdisciplinary team will be educated on obtaining accurate weights / nutritional parameters and investigation of unplanned weight change, by an outside long-term care consultant. Resident need for assistance with feeding will be communicated to the direct care staff and reflected in the resident's plan of care. CNAs will be re-educated on providing appropriate assistance and dignity during meal service and accurate documentation of meal consumption. Registered Dietician will complete audits of those residents that trigger for significant weight loss to ensure appropriate interventions are in place. The IDT will participate in the development of the resident's plan of care for unplanned weight loss. Maintenance will complete audits review facility beds to ensure bed controls are in good working order. Follow up based on findings.	

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F 692	Continued From page 250 and there appeared to be approximately a spoonful of macaroni salad removed. There were bits of macaroni salad observed on her sheets next to her. On 06/06/2019 at approximately 6:30 PM, Resident #102 was observed in her bed. The bed was flat and the dinner tray was on the tray table that was positioned perpendicular to the bed over Resident #102's bed. Resident #102 was propped up on one elbow and the tray table was still at a height above her head. Resident #102 had an eating utensil in her other hand and was observed struggling to reach up and over to access her food. Resident #102 was attempting to scoop food and food was falling onto her head and chest and sheets. Surveyor D alerted Certified Nurse Assistant C [CNA C] that Resident #102 needed assistance. CNA C entered the room. Resident #102 reached out to CNA C and stated, "Help." CNA C stated to Resident #102, "You can't eat like this, let me sit you up." CNA C attempted to raise the head of the bed with the bed controller but it was not functioning. Another CNA (CNA E) entered the room. CNA C stated to CNA E "This isn't good" and went on to explain that Resident #102 was lying flat trying to eat and food was all over her. A third CNA, CNA D, entered the room and fixed the bed controller function by adjusting a cable under the bed. When CNA C left the room after rendering care, she stated to Surveyor D it would be a good idea if [Resident #102] had supervision when eating. On 06/12/2019, the clinical record was reviewed. On 05/01/2019, Resident #102 weighed 97.6 pounds (mechanical lift). On 06/04/2019, the resident weighed 102.2 pounds (mechanical lift) which is a 4.71 % Gain in 34 days. On	F 692	4. Unit Managers / designee will conduct 5 meal observations per weekly x 3 months to ensure that residents are receiving appropriate assistance during meals. If variances are observed, the responsible staff will be re-educated. Findings from the weekly observations will be submitted to DON / ADON for tracking / trending and further action as appropriate. A summary of the observations will be submitted to the monthly QAPI Committee for additional oversight and recommendation. Maintenance will conduct inspection of 10 beds weekly x 3 months to ensure bed controls are in good working order. If any malfunction is found, the bed control will be replaced and/or repaired. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. 8/4/19.	

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F 692	Continued From page 251 12/03/2018, the resident weighed 100 lbs. [scale type not recorded]. On 06/04/2019, Resident #102 weighed 102.2 pounds (mechanical lift) which is a 2.20 % Gain in 6 months. A dietary note dated 03/27/2019 at 4:53 PM documented, "Resident discussed in weekly IDT [interdisciplinary team] meeting. Triggers for 7.5%, 8# [pound] weight loss x 1 month. CBW [current body weight] 99.2# [pounds] BMI 18.18 (underweight). Regular diet with fortified foods; intakes 26 to 100% of meals. Multiple supplements: Health shake with meals, Magic Cup BID [twice a day], Med Pass 120 ml TID [three times a day]. Dx [diagnosis] COPD, Alzheimer's disease, dementia; weight loss may be unavoidable r/t [related to] dx [diagnosis] and disease progression. Despite trigger for weight loss, weights have stabilized. Continue POC [plan of care]." Under the header "Subjective" on the nurse practitioner provider note dated 04/02/2019 [6 days later] , it was documented, "[Resident #102] requires total assistance with ADL [activities of daily living] care, transfers and set up with meals." In an excerpt under the header "ROS [review of systems]", it was documented, "patient denies any recent changes in weight." A dietary note dated 04/11/2019 at 11:22 AM documented, "Resident discussed in weekly IDT meeting. Triggers for a 5.4% weight gain in 2 weeks, desired gain. CBW 101.6# [pounds] BMI 18.6 (borderline). Regular diet with fortified foods; intakes 26 to 100% of meals. Multiple supplements: Health shake with meals, Magic Cup BID [twice a day], Med Pass 120 ml TID [three times a day]. Dx [diagnosis] COPD,	F 692		

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F 692	Continued From page 252 Alzheimer's disease, dementia; weight loss may be unavoidable r/t [related to] dx [diagnosis] and disease progression. Resident noted often refusing to leave bed. On restorative feeds-discussed encouraging resident to sit up for meals. Despite trigger for weight loss, weights have stabilized. Continue POC [plan of care]." The physician's orders were reviewed. An active order dated 07/03/2018 documented, "Regular diet, regular texture, thin liquids consistency, add fortified foods for diet." An active order dated 12/17/2018 documented, "Health Shake put amount ordered PO [by mouth] in add direc [directions] two times a day with breakfast and lunch." An active order dated 12/17/2018 documented, "Magic Cup amt [amount] ordered PO in add direc [directions] two times a day with breakfast and lunch." An active order dated 12/17/2018 documented, "Med Pass 120 ml [milliliters] three times a day for supplement." The Medication Administration Record for May 2019 and June 2019 were reviewed. The Health Shake, the Magic Cup, and the Med Pass were all signed off as administered as ordered. The Meal Consumption Flowsheet for May 2019 through June 11, 2019 were reviewed. Out of the 31 days in May, there were 16 days where no meals were recorded. Out of the 15 days where meals were recorded, there were 7 days where one or more meals weren't recorded. Resident #102 ate 50% or less of 4 out of 14 breakfast meals documented. Resident #102 ate 50% or less for 12 out of 14 lunch meals documented. Resident #102 ate 50% or less for 5 out of the 9 dinner meals documented.	F 692		

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F 692	Continued From page 253 Out of the 11 days in June, there were 3 days where no meals were recorded. Out of the 8 days where meals were recorded, there were 6 days where one or more meals weren't recorded. Resident #102 ate 50% or less of 2 out of 5 breakfast meals documented. Resident #102 ate 50% or less for 5 out of 8 lunch meals documented. Resident #102 ate 50% or less for 4 out of the 5 dinner meals documented. The care plan was reviewed. Interventions associated with Activities of Daily Living, Nutrition, Skin Integrity, and Metabolic Complications included but not limited to: "Assist with feeding as needed (initiated on 02/25/2016), encourage to eat meal (initiated on 06/14/2016), eating-open and set up items (initiated on 06/14/2016), monitor and report decline in abilities (initiated on 06/14/2016 and revised on 02/13/2017)." On 06/13/2019 at approximately 10:15 AM, the unit manager Licensed Practical Nurse C [LPN C] was notified of observations on 06/06/2019 and stated that all residents should be set up to eat so they can get to their food. On 06/17/2019 at approximately 11:55 AM, this surveyor observed CNA K obtain a weight via mechanical lift for Resident #102. Her weight was 95.8 pounds. On 06/04/2019, Resident #102 weighed 102.2 pounds [mechanical lift]. On 06/17/2019, Resident #102 weighed 95.8 pounds [mechanical lift] which is a 6.26% weight loss in 13 days. Resident #102's height was 52 inches so body mass index [BMI] value decreased to 17.5. On 06/20/2019 at the end of survey, the interim	F 692		

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F 692	Continued From page 254 administrator had no further information or documentation to offer.	F 692		
F 694 SS=G	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, clinical record review, facility document review, hospital record review, and in the course of a complaint investigation, the facility staff failed to provide intravenous fluids ordered by a physician for one Resident (Resident #2) resulting in harm, in a sample of 76 Residents. The findings included: Resident #2 did not receive a physician ordered IV (intravenous fluid infusion) on 2-16-19 due to staff inability to access a vein to infuse the fluids, and, the Resident failed to receive Hypodermoclysis fluid infusion in the subcutaneous tissue as ordered due to unavailability of the IV fluids in the facility on 2-21-19. Resident #2 was admitted to the facility on 1-15-19, after treatment for a Urinary tract infection (UTI), and was discharged from the facility on 2-26-19 to the emergency room where she received a diagnosis of dehydration, sepsis, and intractable nausea and vomiting, and expired	F 694	1. Resident #2 discharged form facility prior to survey, no corrective actions taken. 2. Unit Managers/designee will complete audits of current facility residents with Physician orders for IV fluids to ensure they receive medications/fluids as ordered. Unit Managers will complete quality review of IV Stat box to ensure availability of IV fluids. Follow up based on findings. 3. License staff will receive education on reordering / refilling the IV box. Licensed nursing staff will be re-educated on process and importance of notifying the provider when an IV site cannot be accessed and/or when medications/fluids are not available. Residents who have new orders for IV fluids and if there are instances in which IV fluids cannot be administered as ordered will be communicated on the	8/4/19

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F 694	Continued From page 255 on 3-3-19 (5 days later). Resident #2's Diagnoses included; UTI, history of Cancer in hilus of left lung, uterine cancer (removed by hysterectomy in 2016), adult fail to thrive, diabetes, and hypertension. Resident #2's most recent Minimum Data Set (MDS) was an admission assessment dated 1-22-19. Cognitive skills for daily decision-making were coded as 13 of 15, and no cognitive impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as extensive dependence on staff. Review of the closed record physician progress notes and visits revealed that the final time Resident #2 was seen was on 2-12-19. The Resident denied nausea and vomiting in the note, and was being seen for a decrease in appetite. Review of the physician's orders revealed that Resident #2 was ordered to be given Promethazine hydrochloride suppository rectally for nausea and vomiting on 2-12-19, and Ondansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for nausea and vomiting. Review of the nursing notes revealed that no nursing notes existed between 2-10-19, and 2-16-19. On 2-16-19 the Resident was experiencing persistent vomiting, and the physician ordered via the telephone IV 0.9% normal saline at 60 ml per hour for 1000 ml related to dehydration. The nurse was unable to establish an IV access catheter to infuse the fluids, and they were never given. There is no indication that the physician was ever notified that	F 694	24-hour report and discussed during the morning meetings. Unit Managers will follow up to ensure that orders are implemented. 4. Unit Managers / designee will conduct weekly audits of residents with Physician orders for IV fluids to ensure they receive IV medications/fluids as ordered, 3 times per week for 3 months. If variances are found, the pharmacy will be notified, and the provider will be notified for further direction. Findings from the weekly monitoring will be submitted to DON/ADON for tracking/trending and a summary report will be submitted to the QAPI Committee monthly. Unit Managers / designee will conduct monitoring of IV Stat box to ensure availability of IV fluids, 3 times per week for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. 8/4/19	

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F 694	Continued From page 256 the order was not carried out.	F 694		

There are no further nursing or physician notes until 2-20-19, when new verbal/telephone physician orders are received for Hypodermoclysis fluid infusion in the subcutaneous tissue 0.9% normal saline at 60 milliliters per hour for 1 liter every hour, which is also used to treat dehydration. The Resident received the fluid from 2:00 p.m. on 2-20-19, until 11:00 a.m., on 2-21-19 when it was abruptly stopped. The Medication administration record (MAR) documentation showed at 12:00 noon on 2-21-19 that the fluids were not infusing, and "Other/see nursing note", and there was no note. The IV fluids were not given after 11:00 a.m., on 2-21-19 even though the Resident received Ondansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for continuing nausea and vomiting. The fluid infusion order was Discontinued on 2-22-19 at 9:38 a.m. with no note from the physician or nurses to indicate the reason.

Licensed Practical Nurse-LPN A was the nurse for the 11:00 p.m. to 7:00 a.m. shift on the nights of 2-21-19, and 2-22-19. Licensed Practical Nurse-LPN A was interviewed, and stated "We didn't have any fluids in the building to give the patient. When asked why no note was written, she stated she had written a note documenting that the fluids were unavailable, and that the nurse on 3 p.m.-11 p.m. shift on 2-21-19 reported to her that she had not had any in the building either, and the family was angry, so she put the fluids on hold until the pharmacy could deliver them. The fluids never arrived, and the order was discontinued.

The facility was asked for a copy of the "IV stat

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F 694	Continued From page 257 box contents" which contained extra bulk dose medications that could be administered until supplies for the individual could be received. The document was received, and stated the normal saline needed for Resident #2's infusion was contained in the box. LPN A stated that during the stay of Resident #2, the box was not filled and sent out to the pharmacy for refill as it should have been. The 3-11 nurse for 2-21-19 was identified, and found to be a short term contract employee who no longer worked at the facility. There were no nursing notes in the record for 2-21-19, and 2-22-19 to explain why the fluids were not completed through 2-21-19, and were discontinued on 2-22-19. There were no nursing notes from 2-20-19 until 2-24-19, which documented that the resident had refused all treatments and care. On 2-25-19 the first identification of a wound with green yellow slough was documented. On 2-26-19 the Resident was sent to the hospital for nausea/vomiting and suspected dehydration at 6:35 p.m., which was requested by the family. The Resident never returned. Weight records were reviewed and revealed a weight loss of 45 pounds in 38 days. The care plan was reviewed and had no interventions care planned for continued nausea, and vomiting. Hospital records document that it was reported to the hospital staff that Zofran (Ondansetron) 8 mg was given to the Resident prior to leaving the	F 694		

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F 694	Continued From page 258 nursing home on 2-26-19, however, the nursing notes and MAR have no documentation of the medication ever having been given on 2-26-19. Hospital records were reviewed and revealed the normally oriented and alert Resident was "Disoriented and unable to identify complaints". The Resident arrived in the ER (emergency room) at 7:09 p.m.. The Resident was seen by critical care staff who surgically placed an IV catheter in the Residents "External Jugular" neck vein. The ER "Critical care note" documented "System at risk for life threatening failure: Central nervous system, cardiac and circulatory." "Associated problems: Hypotension (low blood pressure) Dehydration, Arrhythmia and infection." The hospital documents go on to say that emergency medical services ambulance first responders recorded the Resident's blood pressure to be 83/53 mmHg (millimeters mercury) at the nursing home, and at the ER measured 87/49. The Resident was admitted with "dehydration, sepsis, acute cystitis with bloody urine (urinary tract infection), intractable nausea and vomiting, hypokalemia (critically low potassium 2.2-normal is 3.5 to 5.5), and hypomagnesemia (critically low magnesium 0.8-normal is 1.6 to 2.5), and lactic acidosis (critically high 6.96-normal is 0.9 to 1.7). After placing an IV catheter the Resident was immediately placed on fluid and potassium replacement infusions in the emergency room, and was later admitted to the ICU (intensive care unit), where she expired on 3-3-19 (5 days later). The Resident was last seen by the physician on 2-12-19, and had recurrent nausea and vomiting from 2-16-19 until her discharge 2-26-19. The	F 694		

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F 694	Continued From page 259 Resident was not supplied with ordered fluid infusions, as they were unavailable, she became dehydrated, and was sent to the hospital at the behest of the family. The Resident expired in the hospital on 3-3-19 (5 days later) with the diagnoses of dehydration and sepsis. The facility Administrator and Director of nursing were made aware of findings on 6-20-19. The facility stated they had no further information to provide.	F 694		
	COMPLAINT DEFICIENCY			
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility documentation the facility staff failed to provide adequate pain management for 1 Resident (Resident #125) in a survey sample of 76 Residents. The findings include: For Resident #125 the facility staff failed to address the Resident's back pain resulting in Resident #125 calling 911 himself to get help. Resident #125, a 63 year old man was admitted to the facility on 3/15/19 with diagnoses of, but	F 697	1. Resident #125 had pain assessment completed on 7/2/19. Nurse Practitioner evaluated resident's pain medication and additional medication was ordered on 6/24/2019. 2. Unit Managers / designee will complete audits of residents who receive PRN (as needed) pain medications to ensure pain medication is available and administered as requested. Follow up based on findings. 3. Licensed nursing staff will receive Pain	8/4/19

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F 697	Continued From page 260 not limited to, Muscle weakness and Parkinson's disease. According to Resident #125's most recent MDS dated 5/15/19, coded as a PPS 5 Day, the Resident had a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. The MDS also coded him as Extensive Assist with 1 person physical assist needed for Bathing, Dressing, Toileting, Bed Mobility, and Transfers. On 6/7/19 at 9:15 AM, Resident #125 stated that he called 911 to go to the ER because he was in so much pain in his back. He stated "I rang that call bell and no one answered, I needed help getting to the bathroom. I had been on a metal table getting a scan today and I was hurting so bad I couldn't even sit up by myself. I kept trying to get help and get my Valium for muscle spasms but no one would come. I couldn't hold it any longer and I ended up peeing on myself that was so humiliating." He further stated that he waited so long for someone to answer that he called 911 himself around 1:30 AM. He said "A nurse finally came in and I told her I called 911 and she said we better get you cleaned up so they don't think we neglected you." According to the EMS Report the Rescue Squad arrived at the facility at 1:36 AM. In an interview with the DON on 6/7/19 at 1030 AM she stated that she had a call out and asked the 3 PM-11 PM nurse to stay and that nurse got angry, left her keys and left the building. She left at 11:41 PM according to her time clock report. The DON stated she spoke with her and told her she couldn't leave her patients. The nurse did not	F 697	Management education by an external nurse consultant. The staff will receive education on the importance of answering calls timely and what to do if the request is outside their scope of practice / work. 4. Unit Managers / designee will conduct interviews of 5 residents who receive PRN pain medications to ensure pain medication is available; administered as requested and medication effective, 2 times per week for 3 months. Variances will be investigated, and corrective / educational interventions will be implemented as appropriate. Findings from the submitted to the DON / ADON for tracking / trending and additional action as needed. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 697	Continued From page 261 return until 1:30 AM. In an interview with Registered Nurse-RN F she stated she did not abandon her patients that she left and came back a couple of hours later. She stated she had something to do that couldn't wait. She further stated that her coworkers were aware of her leaving and the need to cover her patients. An excerpt from a written statement provided by the Administrator included: "He used his cell phone to call EMS himself. Nurse assisted EMS staff and [name redacted] was transferred to the ER per his request." Nursing Progress Notes dated 6/7/19 at 7:07 AM read "Resident called 911 because of back pain refused to take medicine. Sent via Ambulance Resident is own RP. MD made aware." Nursing Progress Notes dated 6/7/19 at 2:30 PM "Resident stated that he called 911 due to increased pain. Resident stated the pain was unbearable and he felt he needed to go to the ER." An excerpt from the Hospital ER Report reads "Hx of Parkinson's and chronic back pain States had a DaT Scan today at [hospital name redacted] 1:00 PM -and his chronic back pain began to hurt...has asked the Staff at [facility name redacted] for his "Valium" and they wouldn't give him any...thus he called 911." On 6/11/19 at 10:00 AM in an interview with the DON she stated "A resident should never have to call the EMS by themselves." During the end of day meeting on 6/20/19 the	F 697		

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F 697	Continued From page 262 Administrator was made aware of the issues and no further information was provided.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and facility record reviews the facility staff failed to have sufficient nursing staff to provide nursing and related services.	F 725	1. Residents in rooms 105, 108 and 152 have been provided appropriate ADL care and housekeeping services to address the odors. Resident #124 is being provided	8/4/19

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F 725	Continued From page 263 The findings included: On 06/05/19 at 11:32 AM, Surveyor D detected a strong smell of urine from rooms 105 and 108 while walking in the hallway by rooms. On 06/05/2019 at approximately 2:30 PM, the resident in room 149 was asking for help to get back in bed. Surveyor D alerted the staff and Licensed Practical Nurse-LPN C stated that the CNA (Certified Nursing Assistant) assigned to that room had left for the day. When asked about the CNA currently assigned to care for that resident, LPN C stated she should be here now but she's not here. LPN C then asked another CNA to assist the resident to get into bed. On 06/05/2019 at approximately 2:35 PM, Surveyor D entered room 152 and detected a strong malodorous aroma in the room. On 06/06/19 during the resident council meeting, numerous Residents verbalized that the facility didn't have adequate staff to provide for their needs. On 06/06/2019 at approximately 8:45 AM, CNA A stated to Surveyor D that there were supposed to be 6 aides and 3 nurses working but there were only 4 aides working currently, 2 called out. CNA A also stated that 7 people needed assistance with eating and that she was assigned "the whole hall." On 06/06/2019 at approximately 10:30 AM, a daily assignment sheet was requested and the facility staff provided a copy. There were 3 spaces for LPN's and 6 spaces for CNA's. The	F 725	care to minimize falls. Resident #33's room has been cleaned and the bed is being made daily. 2. All residents may have been potentially impacted. The facility staffing model and Facility Assessment has been reviewed and revised to a model that will provide sufficient staff to meet the resident's needs. 3. The facility has entered into "agency" contracts to support availability of staff to meet resident needs. The Executive Director is working on staffing 13-week contracts to fill any open Full-Time positions. Open schedule will be discussed daily in the morning meeting for the next 24-hours and/or weekend to assist in filling in open opportunities. The facility recruitment process is ongoing. Facility Assessment and staffing model have been reviewed by the Executive Director and DON to ensure there are sufficient staff to meet resident needs. Nursing staff will be educated on assisting residents when needed. Staff will be held accountable from an HR perspective regarding leaving Early, coming in late and calling out. Staffing will be discussed at Resident Council, so residents understand there is sufficient staff. 4. The Executive Director will provide a weekly staffing update to Regional Vice President of Operations. A staffing report of vacant full-time positions and actions taken to fill those opportunities will be	

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F 725	Continued From page 264 assignment sheet dated 06/06/2019 showed 2 LPN's and 4 CNA's were assigned. Employee J confirmed that 2 CNA's called out and were replaced. On 06/06/2019 at 6:39 PM, Surveyor D observed a resident (identified in the sample as Resident #124) self-propelling herself in her wheelchair down the hall near room 138. Resident #124 appeared confused and positioned herself by the wall and was attempting to stand. Resident #124 did not lock the wheels on her wheelchair nor did she appear steady on her feet. Surveyor D had to alert staff Resident #124 was attempting to stand. On 06/10/2019 at approximately 9:45 AM, Surveyor D observed a female resident walking down the hall in a hospital gown untied, barefoot, and wearing a brief. The unit manager asked the resident her name and then redirected her to her room. On 06/12/2019 at approximately 8:20 AM, Surveyor D detected from the hall a strong odor of urine outside room 105. On 06/12/2019 at 8:24 AM, Surveyor D entered the room of the resident identified in the sample as Resident #33. Resident #33 was not in the room at the time. There was a strong malodorous aroma in the room, there were no sheets on the bed, and trash on the floor (a soda cap, paper towels, a straw, and exam gloves). On 6/18/19 Registered Nurse-RN E, Vice President of Clinical Services stated that she had called agency staff back into the facility because they didn't have enough staff.	F 725	submitted to the monthly QAPI Committee for additional oversight and recommendation. 5. 8/4/2019	

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F 725	Continued From page 265 The facility assessment completed 3/1/19 stated "based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Licensed nurses providing direct care: 17 per day. nurse aides: 32 per day with an average daily census of: 124-126." On 6/5/19 the facility had 13 licensed nurses and 26 CNA's working to provide direct care to 119 residents. On 6/6/19 the facility had 11 licensed nurses and 27 CNA's working to provide direct care to 122 residents. On 6/7/19 the facility had 11 licensed nurses and 24.5 CNA's working to provide direct care to 121 residents. On 6/8/19 the facility had 13 licensed nurses and 20 CNA's working to provide direct care to 123 residents. On 6/9/19 the facility had 12 licensed nurses and 21.5 CNA's working to provide direct care to 124 residents. On 6/10/19 the facility had 12 licensed nurses and 23 CNA's working to provide direct care to 123 residents. On 6/11/19 the facility had 16 licensed nurses and 31 CNA's working to provide direct care to 123 residents. On 6/12/19 the facility had 14 licensed nurses	F 725		

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F 725	Continued From page 266	F 725		

and 28.5 CNA's working to provide direct care to 122 residents.

On 6/13/19 the facility had 16 licensed nurses and 28.6 CNA's working to provide direct care to 122 residents.

On 6/14/19 the facility had 10 licensed nurses and 22 CNA's working to provide direct care to 121 residents.

On 6/15/19 the facility had 16 licensed nurses and 23.5 CNA's working to provide direct care to 123 residents.

On 6/16/19 the facility had 13 licensed nurses and 20.5 CNA's working to provide direct care to 121 residents.

On 6/17/19 the facility had 14 licensed nurses and 26 CNA's working to provide direct care to 120 residents.

On 6/18/19 the facility had 17 licensed nurses and 29.6 CNA's working to provide direct care to 120 residents

Review of the as worked schedules from 6/5/19-6/18/19 revealed only one day that the facility had sufficient nurse staffing based on the required staffing identified in the facility assessment. During this time frame the facility had no days that certified nursing assistants (CNA) staffing was sufficient to meet resident needs.

During review of the CNA assignment sheets for June there were only 2 days that had Resident showers indicated to be given. There was a day

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F 725	Continued From page 267 that there was a line and "no showers" written due to the lack of sufficient staff to provide showers. During the survey of this facility it was identified that the Director of Nursing (DON) and Unit Manager were on-site in an interim role from another facility. The facility also had a vacant educator and infection control nurse position vacant.	F 725		
F 726 SS=E	Complaint deficiency Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		8/4/19

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F 726	Continued From page 268 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interview, facility documentation review and clinical record review the facility administration failed to provide competent staff to provide services to Residents residing in the facility. The findings included: The facility administration failed to ensure staff had the appropriate competencies and skill sets to provide services to residents to assure their safety while maintaining their highest practicable well-being. During review of staff education records it was identified that 50 employees did not have abuse, neglect and exploitation training and competency testing. Staff had not been trained in types of abuse, how to identify abuse, how to protect the resident from abuse or how to report abuse and neglect. During observations, resident interviews and staff interviews conducted 6/5/19-6/20/19, as identified throughout this statement of deficiencies (SOD) report, there was lack of evidence that facility staff were competent to provide care and services to Residents, which included but were not limited to:	F 726	1. Education initiated during the survey. All staff was educated on Abuse and Neglect during survey. 2. Current residents have the potential to be affected. Extensive education will be done with nursing, social work, business office, maintenance, dietary, and the interdisciplinary team to ensure knowledge and skills to provide care and services to the residents. 3. Facility staff will be re-educated on abuse prevention and reporting by an external nurse consultant as well as on-going education by facility leadership. Competencies will be validated in various ways through return demonstration, post test and education based modules. Nursing staff [licensed / CNAs] will be educated on the skills needed to address pressure ulcer prevention / care, medication administration, and weight loss investigation / interventions by external nurse consultants as well as Health Quality Initiatives. The DON / designee will facilitate a skills fair for CNAs to include but not be limited to: Handwashing, Foley catheter care,	

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F 726	Continued From page 269 * Preventing pressure injuries/ulcers. * Medication Administration, which resulted in a medication error rate of: 38.46 % and residents receiving expired insulin. * Significant weight loss with lack of interventions being implemented. * Discharge planning, which resulted in 1 resident being scheduled for discharge with no identified place to go and no services being arranged for a safe and orderly discharge. * Financial Management, resulting in 7 Residents not receiving notification when their funds reach $200 below the resource limit, which would affect their continued Medicaid eligibility. * Grievances: which resulted in Resident and family complaints not being addressed in a period of over a year based on the facility grievance log. * Facility maintenance as evidenced by failure to secure broken glass to prevent resident access which could result in injury. * Sanitation, as evidenced by dietary staff's failure to ensure cook ware, utensils and plates are properly sanitized. Staff were unaware of checking for sanitation levels in the dish machine and ensuring proper temperatures to effectively sanitize. Upon review of the employee training and education files and upon request of the employee training calendar, Employee B, the Director of Nursing (DON) stated that the Human Resources Coordinator was now in charge of employee education. The Human Resources Coordinator, Employee O is not a clinical person and holds no clinical license but is in charge of training for clinical staff to include but not limited to: nursing assistants, licensed practical nurses, registered nurses and social services staff.	F 726	incontinence care, turning/reposition; mech lift use; vital signs, ADL documentation, use of Stop/Watch/ pink skin sheet / isolation [donning/doffing PPE], etc. In addition, CNAs will be educated on abuse identification / reporting, and assisting residents with meals. The social worker and the IDT team will be re-educated on discharge planning and responsiveness to grievances by Executive Director/Designee. The Maintenance team will be re-educated on importance of repairing furnishing that are broken and may cause injury to residents by Executive Director/Designee. The Business Office Manager will be educated on management of personal care funds for residents by Regional Business Office Manager/Designee The Human Resource Coordinator / designee is responsible to scheduling and monitoring that required education is provided in collaboration with the appropriate department head and the administrator; this person is not responsible for conducting the education. The Human Resource Coordinator will be responsible to ensure that education training hours are appropriately entered in the computer system and will notify the DON when required training hours are not met for staff.	

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F 726	Continued From page 270 Review of the Education Calendar for 2018-2019 revealed that there was no facility oversight to ensure facility staff complete the scheduled/required training and competencies.	F 726	4. The Director of Nursing/designee will audit the required education weekly x 3 months to ensure that CNAs are scheduled and are completing the required hours of annual training. Variances will be investigated, and appropriate education and/or disciplinary action will be taken. The Director of Nursing / Executive Director or Assistant Executive Director will audit the education calendar monthly for six months to ensure that other departments are receiving appropriate education based on audits and performance. The QAPI Committee will be apprised of educational activities and status monthly. 5. 8/4/2019	
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review the facility staff failed to ensure CNA's (Certified Nursing Assistants) received 12 hours of in-service training per year based on the outcome of performance reviews for 7 CNA's (CNA A, CNA B, CNA D, CNA F, CNA H, CNA I, and CNA J) of 13 sampled CNA's.	F 730	1. Review initiated during the survey of current compliance for 12 hour CNA education. CNA□s A,B,D,F,H,I, and J will be educated by July 31,2019. 2. Current residents have the potential to be affected. CNAs will be scheduled to receive a minimum 12 hours per year of	8/4/19

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F 730	Continued From page 271 The findings included: 1. The facility staff failed to ensure that CNA A received a minimum of 12 hours of in-service training per year based on performance reviews. CNA A was hired 7/13/16. Review of training records reveal that CNA A received 2.75 hours of training in 2018. An interview was conducted with Employee H, Regional Clinical Director; Employee H stated she had no further education documentation to provide. 2. The facility staff failed to ensure that CNA B received a minimum of 12 hours of in-service training per year based on performance reviews. CNA B was hired 9/21/15. Review of training records reveal that CNA B received 2.75 hours of training in 2018. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 3. For CNA D, the facility staff failed to ensure the CNA received 12 hours of education annually based on performance reviews. CNA D was hired 2/4/16. Review of employee education records revealed that CNA D received 11.5 hours of in-service education in 2018. An interview was conducted with Employee H,	F 730	education. 3. The DON / designee will facilitate a skills fair for CNAs to include but not be limited to: Handwashing, Foley catheter care, incontinence care, turning/reposition; mech lift use; vital signs, ADL documentation, use of Stop/Watch/ pink skin sheet / isolation [donning/doffing PPE], etc. In addition, CNAs will be educated on abuse identification / reporting, and assisting residents with meals. CNA□s will receive full twelve hours a year of education. The Human Resource Coordinator will be responsible to ensure that education training hours are appropriately entered in the computer system and will notify the DON when required training hours are not met for staff. Performance evaluations will be scheduled for each CNA annually. 4. The Director of Nursing/designee will audit the required education weekly x 3 months, and monthly thereafter. Variances will be investigated, and appropriate education and/or disciplinary action will be taken. The Director of nursing will audit the education calendar monthly for six months, Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings 5. 8/4/2019	

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F 730	Continued From page 272 Regional Clinical Director, Employee H stated she had no further education documentation to provide. 4. For CNA F, the facility staff failed to ensure the CNA received 12 hours of education annually based on performance reviews. CNA F was hired 4/12/17. Review of employee education records revealed that CNA F received 11.75 hours of in-service education in 2018. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 5. For CNA H, the facility staff failed to ensure the CNA received 12 hours of education based on performance reviews. CNA H was hired 11/25/07. Review of employee education records revealed that CNA H received 1.5 hours of in-service education in 2018. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 6. For CNA I, the facility staff failed to ensure the CNA received 12 hours of education annually based on performance reviews. CNA I was hired	F 730		

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F 730	Continued From page 273 9/11/12. Review of employee education records revealed that CNA I received 11.5 hours of in-service education in 2018. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 7. For CNA J, the facility staff failed to ensure the CNA received 12 hours of education annually based on performance reviews. CNA J was hired 10/24/17. Review of employee education records revealed that CNA J received 1 hour of in-service education in 2018. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide.	F 730		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These	F 741		8/4/19

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F 741	Continued From page 274 competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review, the facility staff failed to provide sufficient staff with knowledge, training, competencies and skill sets to address behavioral health care needs for 1 of 76 sampled residents (resident #25) The findings included: Resident #25 was a 45 year old who was admitted to the facility in 10/4/17. His diagnoses included Bipolar Disorder, Insomnia, Major Depressive Disorder, Anxiety, Diabetes Mellitus Type 2, and Morbid Obesity. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/11/19 was reviewed. Resident #25 was incorrectly coded 0 (zero) for depressed mood. His Brief Interview of Mental Status Score was 15, indicating, no cognitive impairment.	F 741	1. Resident #25 was seen by a psychiatrist on 7/3/19. The facility is engaging in a new contract for behavioral health services beginning August 2019 and the resident will be offered to be seen by that group of clinicians or will be set up with an appointment with an outside mental health professional. If the resident desires an outside professional, nursing will assist the resident in making an appointment and social worker will assist with making transportation arrangements for the appointment. The Social Worker will meet with Resident #25 to determine if any actions are needed to restore the resident's SSI eligibility. Behavioral Care Plan was created 7/8/19 and a progress note of the Social Worker of the resident's preferences for psychiatric services and actions needed to restore SSI.	

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F 741	Continued From page 275	F 741		
	On 6/05/19 at 2:34 P.M., during a facility tour, Resident #25's door was observed to be open. From the hallway, the resident was observed with his legs (from the knee down) and feet hanging over the foot of his bed. Upon entering the room, the resident was interviewed. Resident #25 stated that the facility had refused to set up transportation and help him obtain outside psychiatric services, as was his preference. Resident #25 stated, "The Social Worker told me to just get my friend to take me. My friend is from out of town." He further stated that his SSI disability had lapsed in January due to the facility not helping him obtain an evaluation by a psychiatrist. Resident #25 stated that he was too young to be at the facility, and wanted a more age-appropriate placement. Review of the clinical record showed that Resident #25 did not have a behavioral health care plan to address his feelings of anxiety, humiliation, and frustration. On 6/5/19 a review was conducted of Resident #25's clinical record. There was no documentation of facility staff facilitating an outside appointment for a psychiatric evaluation until 5/22/19. According to the Social Services Assistant (Employee L) the transportation company did not come to the facility as expected. On 6/5/19 a review was conducted of facility documentation, revealing a Transportation Policy dated 11/30/14. An excerpt read, "It is the policy of The Company to ensure residents access to medical services." On 6/5/19 an interview was conducted with the		2. Other residents with behavioral needs may have potentially been affected. Residents with current behaviors will be identified and the IDT will make recommendations to the provider for referrals to a mental health professional as needed. 3. The facility has entered into a new contract with a mental health group to address behavioral and psychiatric needs of the residents; the new vendor is to start August 2019. Staff will be educated, by an external long-term care consultant, on identifying, documenting, and responding to resident behaviors including the use of non-pharmacological interventions. Unit Manager / designee will review behavioral monitoring records weekly and residents with new or who have a significant change in behaviors will be discussed in the weekly behavior meeting to ensure that the resident mental health and behavioral needs are being addressed. New of significant change in behaviors will be reported to the provider for additional assessment and recommendation and the resident's plan of care will be modified. 4. Unit Manager / designee will review behavioral monitoring records weekly x 12 weeks and will review 4 care plans per week x 12 weeks of residents with behaviors to ensure that the resident mental health and behavioral needs are being addressed. If variances are found,	

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F 741	Continued From page 276 Director of Social Services (Employee M), and the Social Services Assistant (Employee L). The Director of Social Services stated that she also worked full time as the Admissions Coordinator. The Social Services Assistant stated that his educational background was in public administration, not human services. He did not know why Resident #25 had not been referred for an outside psychiatric evaluation from January thru May of 2019. In addition, he could not state why the facility made no further attempts to arrange for transportation after 5/22/19. When asked if he had told Resident #25 to have his friend who had visited him recently from out of state arrange for his medical transportation, the Social Services Assistant stated, "It was either me or [Employee M] that told him to have them take him."	F 741	they will be discussed with the IDT and the resident's plan of will be updated as appropriate. Findings from the weekly findings will be submitted to the DON / ADON and a summary will be provided to the monthly QAPI Committee meeting. 5. 8/4/2019	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide appropriate treatment and services associated with dementia care for 1 resident (Resident #121) in a sample size of 76 residents. The findings included: For Resident #121, the facility staff failed to	F 744	1. Resident #121 was referred to Psych Services on 6/25/19. Resident's medications were reviewed and adjusted. Resident #121 is receiving snacks in addition to meals daily. Resident is receiving 1:1 activities 2-3 times weekly. 2. All residents with Dementia have the potential to be affected by the alleged deficient practice. The facility conducted	8/4/19

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F 744	Continued From page 277 identify, assess, address, or develop interventions for resident-specific triggers or behaviors of agitation or entering other residents' rooms and eating off other meal trays. Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to dementia and psychotic disorder other than schizophrenia. Resident #121's most recent Minimum Data Set with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Functional status for eating was coded as requiring supervision from staff (one-person physical assist for support). Physical/verbal behaviors toward self/others was coded as not exhibited, Behaviors of psychosis or wandering were coded as not exhibited. On 06/06/19 at 08:26 AM, this surveyor observed Resident #121 in another resident's room (a female resident identified in the sample as Resident #37). Resident #121 was seated on the side of her bed eating her breakfast that was on her tray table. Resident #37 was not in her room (room "A") and her roommate was asleep in her bed by the window. This surveyor alerted Licensed Practical nurse D [LPN D] at the nurse's station, and LPN D went to room "A" and redirected Resident #121 back to his room (room "B"). Resident #121 was barefoot and wearing a hospital gown that was open in the back exposing his bare back, legs, and a loosely-fitted brief. When they reached the doorway of room "B", LPN D instructed Resident #121 to go sit down and then LPN D walked back toward the nurse's	F 744	an audit of residents with Dementia that exhibit behaviors that impact others; referrals for psych services were made as appropriate. 3. RN's, LPN's and CNA will be provided education on Residents with Dementia to include behavior identification and interventions to minimize behaviors by DON/designee and outside independent contractor. 4. An audit will be conducted of residents with Dementia with behaviors impacting others to ensure current interventions are appropriate and effective for 5 residents Weekly times 3 months by the DON/designee. Findings of audit will be brought to the IDT team for follow-up. Findings brought to QA monthly for review and recommendations. 5. 8/4/2019	

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F 744	Continued From page 278 station. At 08:30 AM, Resident #121 entered his room and sat down in a chair in front of his tray table. The breakfast plates/tray on top of the table were empty. There were bits of food on the floor under the table, the chair, and under and around the feet of Resident #121. Resident #121 then stood up, walked out into the hall, and asked this surveyor for pancakes. This surveyor alerted nearby staff and the wound nurse, Registered Nurse C [RN C], stated she would find out how to order more pancakes for Resident #121. On 06/06/19 at 09:07 AM, this surveyor observed Resident #121 standing outside room "C". Resident #121 had a hospital gown on, open in the back, exposing his back, legs, and loosely-fitted brief. Employee K, a housekeeper, also saw Resident #121 and told him to go back to his room and pointed in the direction of which hall to walk down to get to his room. There were no nurses seen at the nurse's station by room "C" or down either hall. The housekeeper and this surveyor observed Resident #121 walking with an unsteady gait into and out of room "C". The housekeeper stated that room "D" used to be Resident #121's room. Resident #121 continued to walk down the hall and entered room "E", walked to the food tray and picked up an unwrapped straw. At that time, certified nursing assistant B (CNA B) entered room "E", saw Resident #121, redirected him, and walked alongside Resident #121 headed toward his room. On 06/11/19 at 08:45 AM, Resident #121 was observed getting up out of bed, ambulating to hall and asking this surveyor for a Pepsi. Resident #121 was wearing a red shirt and blue pants. There was spilled food on his pants and on the	F 744		

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F 744	Continued From page 279 room floor that resembled oatmeal where Resident #121 was walking. Resident #121's pants fell below the level of his mid-thighs before he pulled up his pants as he left his room and ambulated down the hall with an unsteady gait unassisted. This surveyor had to alert an aide to assist Resident #121 ambulate back to his room. On 06/11/2019 at approximately 9:25 AM, Certified Nursing Assistant B [CNA B] saw this surveyor in the hall and stated she tried to clean up [Resident #121] but "He started swinging and going crazy." On 06/11/2019 at approximately 1:40 PM, there were three aides and a nurse with Resident #121 in his room. When asked if he was ok, the nurse in the room, Registered Nurse-RN B, stated they were getting him cleaned up and sometimes he gets combative. On 06/12/2019 at approximately 10:00 AM, an interview with Licensed Practical Nurse-LPN D was conducted. When asked if she was familiar with Resident #121, she stated yes. When asked about behaviors exhibited by Resident #121, she stated she had not seen any behaviors. She went on to say that sometimes he moves his arms involuntarily and that may be interpreted as behaviors. She also stated she had not seen him get combative and added, "I don't have problems with him." On 06/12/2019, the clinical record was reviewed. A completed physician's order entry initiated on 05/14/2019 and discontinued on 05/28/2019 documented, "Lorazepam 1 mg [milligram] by mouth every 6 hours as needed for agitation until 05/28/2019." An active physician's order	F 744		

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F 744	Continued From page 280 (communicated by phone) dated 06/11/2019 documented, "Lorazepam 1 mg [milligram] give 1 tablet by mouth every 6 hours as needed for agitation and sun-downing." There was no stop date. Physician's order entries dated 05/07/2019 documented, "Psych to evaluate and treat as indicated", "Psychiatry as needed", and "Psychology as needed." The most recent provider note by a nurse practitioner dated 05/11/2019 documented under the header "Psych": "Mental status: patient's speech has normal rate and rhythm and responds to questions appropriately. There are no auditory or visual hallucinations or any homicidal or suicidal thoughts." On 06/12/2019, the nurse's notes dated April through June 2019 were reviewed. A nurse's noted dated 06/02/2019 documented, At this time, CNA's came to nurse's station to report that resident was being hostile with them by cursing at them to "get away from him" and attempting to "hit" them with his hands. They were not able to provide care for him at this time and will wait until he is calmer if he will allow them to assist him with his ADL's." A nurse's note dated 06/08/2019 at 2:53 PM documented, "Resident alert an [sic] verbal a/o [alert and oriented] x 1 received in bed. Resident received all routine medications without difficulty. Resident is incontinent of bowel and bladder and a set up with all meals. Resident continues to go in out [sic] of resident rooms looking for food and eating off resident lunch trays that have already been eaten off. Resident redirected multiple times and given snacks and A peanut butter an [sic] jelly sandwiches and resident continues to walk with unsteady gait an [sic] in an [sic] out off [sic] rooms." There were no	F 744		

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F 744	Continued From page 281 notes addressing the behaviors and wandering observed by this surveyor on 06/06/2019. An interdisciplinary team [IDT] note dated 06/10/2019 at 11:23 AM documented, "Resident observed eating food from meals trays that had already been eaten off of. Resident was redirected and given snacks. Team will have dietary to provided [sic] a sandwich to all meal trays to satisfy resident's dietary needs. This resident is not diabetic. Also will consult dietician to ensure needs are met. MD/RP made aware." This was the only IDT note since Resident #121's admission. On 06/12/2019, the care plan was reviewed. A focus initiated by Social Services dated 04/29/2019 documented, "[Resident #121] has impaired cognition and/or impaired thought processes r/t [related to] dementia AEB [as evidenced by] impaired short an [sic] long term memory." Interventions associated with that focus documented, "Administer meds as ordered; ask yes/no questions in order to determine [Resident #121]'s needs; assist as needed with decision-making; monitor and report to MD any changes in cognitive function; specifically changes in: decision-making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status prn [as needed]." A focus initiated by the MDS Coordinator dated 06/11/2019 documented, "This resident has a behavior problem eating food on trays that is not his [sic]." This focus is dated 5 days after this surveyor observed the behavior on 06/06/2109. Interventions associated with this focus documented, "Administer medications as	F 744		

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F 744	Continued From page 282 ordered; Monitor/document for side effects and effectiveness; anticipate and meet the resident's needs; intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed." A focus initiated by the MDS Coordinator dated 05/15/2019 documented, "The resident uses anti-anxiety medications r/t anxiety disorder." Interventions associated with that focus documented, "Administer anti-anxiety medications as ordered by physician, monitor for side effects and effectiveness q-shift; monitor/document/report prn any adverse reactions to anti-anxiety therapy; the resident is taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips, and legs." This focus was not addressed based on the physician's order dated 05/14/2019 to discontinue Lorazepam on 05/28/2019 or revised based on the physician's order dated 06/11/2019. Timely resident-specific behaviors of eating off other residents' meal trays were not addressed on care plan. Behaviors of attempting to hit staff were not addressed on care plan. Triggers were not assessed or included on care plan. On 06/12/2019 at approximately 10:30 AM, an interview with LPN C was conducted. When asked about behaviors for Resident #121, she stated she had not seen behaviors in Resident #121 and stated staff needs more education on dementia care and mental illness. When asked about expectations for dementia care on care plan, LPN C stated she expects to see interventions such as approach in calm manner,	F 744		

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F 744	Continued From page 283 allow him time to communicate needs, engage him in care, speak calmly to him, and find out what his triggers are. On 06/13/2019 at approximately 10:15 AM, an interview with the unit manager, LPN C, was conducted. When notified of observations on 06/06/2019, LPN C stated all staff should make sure his dignity remains intact, covering him up, ensuring safety, making sure he had skid-proof socks on, making sure his room is tidy, and also checking on him if he's still hungry, get him something to eat. When asked how long this behavior had been occurring, LPN C stated that staff said [Resident #121] "does this from time to time" and went on to say "but there's no documentation about it" when it happened. When asked about expectations for documenting behaviors, LPN C stated she expects to see documentation "any and all behaviors each shift and follow-up so the IDT [interdisciplinary team] can make adjustments and meet their needs." She stated she would also expect to see it on the care plan as it happens. On 06/17/2019 at 3:58 PM, the Director of Nursing (DON) verified there were no psych notes for Resident #121. A copy of the facility policy on behavioral management was requested and the facility staff provided a policy entitled, "Behavioral Management/Psychotropic Management." In the policy introduction, it was documented, "The facility will review residents with behaviors and psychoactive medications weekly through an interdisciplinary team process meeting. The interdisciplinary team meeting will review residents' current behaviors, causative factors,	F 744		

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F 744	Continued From page 284 and non-pharmacological and pharmacological interventions." On 06/20/2019 at the conclusion of the survey, the Administrator had no further information or documentation to offer.	F 744		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide social services addressing a facility-initiated discharge scheduled for 06/10/2019 for 1 resident (Resident #27) of 76 residents in the survey sample. The findings included: For Resident #27, the facility staff failed to make reasonable efforts to assist him to obtain financial assistance to pay the cost of care at the facility prior to issuing a discharge notice and failed to provide/arrange services for a safe discharge that was pending for 06/10/2019. Resident #27, a 65-year old male, was admitted to the facility on 09/06/2018. Diagnoses included, but not limited to, altered mental status, adult failure to thrive, chronic fatigue, difficulty in walking, and peripheral vascular disease.	F 745	1. Resident #27 had their discharge letters revoked due to not following Consulate Private Pay Collection policy and Resident Trust Fund Process. Social worker will meet resident to establish a discharge plan, including discussion of remaining in the facility. 2. Current Residents who have previously been issued 30 day discharge letters may potentially be at risk and will be reviewed by the Executive Director, Social Worker or Business Office Manager for needed action. 3. Social Service team will be reeducated by Clinical Quality Specialist on the regulations regarding discharge planning and giving a discharge notice to residents. Prior to giving a discharge notice to a resident, for any reason other than the facility not being able to meet the medical needs of a resident in an emergency	8/4/19

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F 745	Continued From page 285 Resident #27's most recent Minimum Data Set with an Assessment Reference Date of 03/13/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 11 out of a possible 15 indicative of moderate cognitive impairment. Balance during Transitions and Walking were coded as not steady when moving from sitting to standing or walking. Mobility device used was coded as wheelchair. Discharge Plan and Return to Community were coded as "no" meaning there was no discharge plan in place for Resident #27 to return to community nor did Resident #27 want to talk with someone about the possibility of returning to live in the community. On 06/05/19 at approximately 11:40 AM, Resident #27 was observed in his room, fully dressed, and seated in his wheelchair. When asked if he had any concerns about the care he receives at the facility, Resident #27 stated, "They putting me out Monday [06/10/2019]." Resident #27 then provided a form entitled "[Facility Name and state] Involuntary Transfer/Discharge Notice." The form was dated 05/10/2019 addressed to Resident #27 from the administrator of the facility. A portion of the letter documented, "You are being discharged because: The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. The resident will be discharged to [address listed] on 06/10/2019." On 06/06/2019 at approximately 1:40 PM, Resident #27's clinical record was reviewed. Progress notes from all disciplines ranging from 04/28/2019 to 06/06/2019 were reviewed. The only social services noted written during that range was dated 05/13/2019 and documented,	F 745	situation, the discharge notice will be reviewed by Executive Director, Assistant Executive Director, or Director of Nursing. The status of residents who have been given a discharge notice will be reviewed weekly by Social Work with the Executive Director, Assistant Executive Director and/or DON. 4. Executive Director/designee will review all involuntary discharge notices weekly x 3 months. The Business Office Manager will provide a monthly report to the QAPI Committee of the status of 30 days discharge notice for non-payment. Care plans will be reviewed weekly x 12 week by MDS nurse/designee to validate that discharge planning is included in the plan and is reflective of the resident's preferences. Identified variances will be reviewed with the assigned social worker and corrected. Findings from the weekly audits will be reported to the monthly QAPI Committee for review and recommendation. 5. 8/4/2019	

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F 745	Continued From page 286 "Social Services Visit-Social Services and Business Office issued the resident a [state] Involuntary Transfer/Discharge Notice." This note was signed by Employee L. The care plan was reviewed. There were no entries on the care plan by social services. A focus initiated by the MDS Coordinator dated 09/21/2018 documented, "The resident wishes to remain a LTC (long-term care) resident. The goal associated with this focus was revised on 03/11/2019 and documented, "The resident's discharge goals are to remain at facility for long term care through next review." Interventions associated with this goal documented, "Discuss resident/family goals for discharge quarterly and PRN (as needed). On 06/06/2019 at approximately 1:50 PM, an interview with Employee I, Business Office Manager, was conducted. When asked about Resident #27's planned discharge for 06/10/2019, Employee I confirmed they did issue Resident #27 a discharge notice but he has nowhere to go so "we will just issue another 30-day notice until we talk with his family member." When asked about his responsible party, Employee I stated Resident #27 is his own responsible party. Employee I also stated that the address on the issue form is no longer his address. When asked about assisting Resident #27 acquiring funds, Employee I stated, "He refused to show me his Medicaid card." On 06/06/2019 at approximately 1:55 PM, an interview with Employee L from Social Services was interviewed. When asked if he was aware of Resident #27's pending discharge, he stated, "Yes." When asked where Resident #27 would be	F 745		

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F 745	Continued From page 287	F 745		

going upon discharge, Employee L stated, "I think he's going with family." When informed the business office manager just said Resident #27 has nowhere to go, Employee L stated then the 30-day discharge notice would be re-issued. When asked what would occur after that, Employee L stated the business office may set up a payment plan. When asked about discharge planning, Employee L stated he would have to meet with Resident #27 to plan a safe discharge. When asked if he had any discharge planning notes associated with Resident #27's discharge scheduled on 06/10/2019, he looked in the electronic health record and stated, "No." A social services policy on discharge planning was requested.

On 06/10/2019 at approximately 9:30 AM, Resident #27 was observed fully dressed in his wheelchair by his bed. There were several bags on top of his bed. When asked about the bags, Resident #27 stated he is packed and ready to go. He stated no staff has talked to him about leaving today or where he is going.

On 06/10/2019 at 4:00 PM, Resident #27 was in his room, the bags of clothes still on his bed. Resident #27 asked this surveyor if I knew if they will be providing transportation to wherever they are discharging him to. When asked how he was feeling about leaving, Resident #27 stated that whether he left or stayed, he would be ok and denied feeling upset, sad, fearful, or anxious.

On 06/10/2019 at approximately 4:05 PM, this surveyor located Employee L in the social services office. When told Resident #27 still thinks he's being discharged, Employee L stated, "He still thinks that? I'll tell him."

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F 745	Continued From page 288 The facility provided a copy of their policy entitled, "Discharge Planning." In the introduction under the header, "Policy", it is documented, "To evaluate the resident's health status and formulate the best plan of discharge for each resident. Discharge planning begins the day of admission. The process involves the resident and family, Care Management/Social Services and other members of the clinical team." Section 5 documented, "Residents discharged to home will be made aware of, understand, and agree with the proposed discharge plan, discharge date, and other home care needs." On 06/20/2019 at the end of survey, the Administrator had no further information or documentation to offer.	F 745		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		8/4/19

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F 755	Continued From page 289 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, clinical record review, facility document review, hospital record review, and in the course of a complaint investigation, the facility staff failed to ensure medications were available for 3 residents (Residents #2, #180, #68), resulting in harm for Resident #2, in a sample size of 76 residents. The findings included: 1. Resident #2 did not receive a physician ordered IV (intravenous fluid infusion) on 2-16-19 due to staff inability to access a vein to infuse the fluids, and, the Resident failed to receive Hypodermoclysis fluid infusion in the subcutaneous tissue as ordered due to unavailability of the IV fluids in the facility on 2-21-19. This is harm. Resident #2 was admitted to the facility on 1-15-19, after treatment for a Urinary tract infection (UTI), and was discharged from the	F 755	1. Resident #2 discharged from facility prior to survey. Resident #180 discharged from facility prior to survey. Resident #68 current medications are available and administered as ordered, MD notified of deficient practice. 2. Unit Managers / designee will complete audits of current facility residents with Physician orders for IV fluids to ensure they receive medications/fluids as ordered. Unit Managers / designee will complete quality review of IV Stat box to ensure availability of IV fluids. Unit Managers / designee will complete Medication Administration Record (MAR) to medication cart comparison to ensure medication availability. 3. Nursing staff re-educated by independent nurse consultant / designee related to medication availability and medication administration times.	

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F 755	Continued From page 290 facility on 2-26-19 to the emergency room where she received a diagnosis of dehydration, sepsis, and intractable nausea and vomiting, and expired on 3-3-19 (5 days later). Resident #2's Diagnoses included; UTI, history of Cancer in hilus of left lung, uterine cancer (removed by hysterectomy in 2016), adult fail to thrive, diabetes, and hypertension. Resident #2's most recent Minimum Data Set (MDS) was an admission assessment dated 1-22-19. Cognitive skills for daily decision-making were coded as 13 of 15, and no cognitive impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as extensive dependence on staff. Review of the closed record physician progress notes and visits revealed that the final time Resident #2 was seen was on 2-12-19. The Resident denied nausea and vomiting in the note, and was being seen for a decrease in appetite. Review of the physician's orders revealed that Resident #2 was ordered to be given Promethazine hydrochloride suppository rectally for nausea and vomiting on 2-12-19, and Odansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for nausea and vomiting. Review of the nursing notes revealed that no nursing notes existed between 2-10-19, and 2-16-19. On 2-16-19 the Resident was experiencing persistent vomiting, and the physician ordered via the telephone IV 0.9% normal saline at 60 ml (milliliters) per hour for 1000 ml related to dehydration. The nurse was	F 755	Licensed nurse will be re-educated on what to do when medications are not available including notifying the provider and the pharmacy. 4. Medications that were not available to be administered will be reported on the 24-hour report and reviewed during the morning meeting. Unit Manager / designee will investigate reason for unavailable meds and coordinate correction with pharmacy and ensure that the provider has been notified 4. Licensed nurse will conduct medication administration observations for 5 residents 2x per week for 3 months to ensure medications are available and administered per physician order. Variances will be addressed, and corrective action and/or education will be provided. Provider will be notified when medications were not administered due to availability. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. Unit Managers / designee will conduct audits monitoring of IV Stat box to ensure availability of IV fluids, 2x per week for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings 5. 8/4/2019	

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F 755	Continued From page 291 unable to establish an IV access catheter to infuse the fluids, and they were never given. There is no indication that the physician was ever notified that the order was not carried out. There are no further nursing or physician notes until 2-20-19, when new verbal/telephone physician orders are received for Hypodermoclysis fluid infusion in the subcutaneous tissue 0.9% normal saline at 60 milliliters per hour for 1 liter every hour, which is also used to treat dehydration. The Resident received the fluid from 2:00 p.m. on 2-20-19, until 11:00 a.m., on 2-21-19 when it was abruptly stopped. The Medication Administration Record (MAR) documentation showed at 12:00 noon on 2-21-19 that the fluids were not infusing, and "Other/see nursing note" but there was no note. The IV fluids were not given after 11:00 a.m. on 2-21-19 even though the Resident received Odansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for continuing nausea and vomiting. The fluid infusion order was Discontinued on 2-22-19 at 9:38 a.m. with no note from the physician or nurses to indicate the reason. Licensed Practical Nurse-LPN A was the nurse for the 11:00 p.m. to 7:00 a.m. shift on the nights of 2-21-19, and 2-22-19. LPN A was interviewed, and stated "We didn't have any fluids in the building to give the patient. When asked why no note was written, she stated she had written a note documenting that the fluids were unavailable, and that the nurse on 3 p.m.-11 p.m. shift on 2-21-19 reported to her that she had not had any in the building either, and the family was angry, so she put the fluids on hold until the pharmacy could deliver them. The fluids never arrived, and the order was discontinued.	F 755		

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F 755	Continued From page 292 The facility was asked for a copy of the "IV stat box contents" which contained extra bulk dose medications that could be administered until supplies for the individual could be received. The document was received, and stated the normal saline needed for Resident #2's infusion was contained in the box. LPN A stated that during the stay of Resident #2, the box was not filled and sent out to the pharmacy for refill as it should have been. The 3-11 nurse for 2-21-19 was identified, and found to be a short term contract employee who no longer worked at the facility. There were no nursing notes in the record for 2-21-19, and 2-22-19 to explain why the fluids were not completed through 2-21-19, and were discontinued on 2-22-19. There were no nursing notes from 2-20-19 until 2-24-19, which documented that the resident had refused all treatments and care. On 2-25-19 the first identification of a wound with green yellow slough was documented. On 2-26-19 the Resident was sent to the hospital for nausea/vomiting and suspected dehydration at 6:35 p.m., which was requested by the family. The Resident never returned. Hospital records document that it was reported to the hospital staff that Zofran (Odansetron) 8 mg was given to the Resident prior to leaving the nursing home on 2-26-19, however, the nursing notes and MAR have no documentation of the medication ever having been given on 2-26-19. Hospital records were reviewed and revealed the	F 755		

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F 755	Continued From page 293 normally oriented and alert Resident was "Disoriented and unable to identify complaints." The Resident arrived in the ER (emergency room) at 7:09 p.m.. The Resident was seen by critical care staff who surgically placed an IV catheter in the Residents "External Jugular" neck vein. The ER "Critical care note" documented "System at risk for life threatening failure: Central nervous system, cardiac and circulatory." "Associated problems: Hypotension (low blood pressure) Dehydration, Arrhythmia and infection." The hospital documents go on to say that emergency medical services ambulance first responders recorded the Resident's blood pressure to be 83/53 mmHg (millimeters mercury) at the nursing home, and at the ER measured 87/49. The Resident was admitted with "dehydration, sepsis, acute cystitis with bloody urine (urinary tract infection), intractable nausea and vomiting, hypokalemia (critically low potassium 2.2) (normal is 3.5 to 5.5)), and hypomagnesemia (critically low magnesium 0.8) (normal is 1.6 to 2.5), and lactic acidosis (critically high 6.96) (normal is 0.9 to 1.7). After placing an IV catheter the Resident was immediately placed on fluid and potassium replacement infusions in the emergency room, and was later admitted to the ICU (intensive care unit), where she expired on 3-3-19 (5 days later). The Resident was last seen by the physician on 2-12-19, and had recurrent nausea and vomiting from 2-16-19 until her discharge 2-26-19. The Resident was not supplied with ordered fluid infusions, as they were unavailable, she became dehydrated, and was sent to the hospital at the behest of the family. The Resident expired in the hospital on 3-3-19 (5 days later) with the	F 755		

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F 755	Continued From page 294 diagnoses of dehydration and sepsis. The facility Administrator and Director of nursing were made aware of findings on 6-20-19. The facility stated they had no further information to provide. COMPLAINT DEFICIENCY 2. Resident #180, was admitted to the facility on 7-11-18, and discharged on 7-30-18. Diagnoses included; stroke, cardiac arrest, hypertension, congestive heart failure, high cholesterol, emphysema, and heart attack. Resident #180's most recent Minimum Data Set (MDS) was dated 7-18-18, and was an admission assessment Cognitive skills for daily decision-making were coded as no impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as limited to extensive dependence on staff. The hospital discharge, and the entire nursing home closed record review revealed that the Resident was admitted to the facility on 7-11-18 at approximately 5:00 p.m. The physician's orders, nursing notes, and Medication Administration records (MARs) for the time period from admission to discharge (19 days), were reviewed. Those records revealed that the Resident did not receive the following medications in the evening of 7-11-18. The medications were ordered, by the physician on 7-10-18, before his discharge from the hospital, and communicated to the facility on 7-10-18, the day before he arrived at	F 755		

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F 755	Continued From page 295 the facility: 9:00 p.m. Lipitor 40 mg (milligrams) at bedtime for high cholesterol. 9:00 p.m. Ativan 0.5 mg at bedtime for high cholesterol (anxiety medication) 9:00 p.m. Melatonin 0.5 mg at bedtime for emphysema (supplement used to regulate sleep-wake cycles) 5:00 p.m. Calcium carbonate plus Vitamin D 500-200 mg twice per day 5:00 p.m. Carvedilol 6.25 mg twice per day (for heart attack) 5:00 p.m. Fluticasone/Salmeterol inhalant 250/50 mcg (micrograms) twice per day (for Respiratory failure/emphysema) 5:00 p.m. Gabapentin 400 mg three times per day (for neuropathy) 6:00 p.m. Duo-neb 0.5/2.5 inhale 3 ml (milliliters) via hand held nebulizer every 6 hours (for respiratory failure/emphysema). The Director of Nursing (DON), and Administrator were made aware of findings, and stated they had no further information to present. COMPLAINT DEFICIENCY 3. Resident #68, was admitted to the facility on 1-9-19. Diagnoses included; Chronic obstructive pulmonary disorder (COPD), anxiety, recurrent major depression, high cholesterol, gastro-esophageal reflux disease, cataracts diabetes, schizophrenia, and hypertension. Resident #68's most recent Minimum Data Set (MDS) Cognitive skills for daily decision-making	F 755		

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F 755	Continued From page 296	F 755		

were coded as impaired. Functional status for bed mobility, transfers, eating (tube feedings), dressing, and personal hygiene were all coded as limited to extensive dependence on staff.

On 6-5-19 at 12:30 p.m., after lunch, Licensed Practical Nurse-LPN A was observed at a medication cart preparing to administer medications, and was asked why so many pills were being given at lunch time, and she replied "these are all the 9:00 a.m., morning pills." "We don't have enough staff to get it all done." After administering pills for 2 other residents, and administering them, she continued on to Resident #68. The medications that LPN A prepared to administer to Resident #68 were; ativan, aspirin, thiamine, januvia, metoprolol, metformin, and wixela (advair inhaler). LPN A stated "Oh, his prilosec and prozac are missing, I ordered those yesterday, I guess I will have to order them again, they must not have been delivered." She then administered the medications that she did have available.

The current physician's orders and medication administration record (MAR) were reviewed in the computerized program. The following is a list of the errors noted for Resident #68 who received his medications over 2 hours late, and the 2 medications which were omitted on 6-5-19;

12:15 p.m., was the administration time for Resident #68 for Ativan 0.5 mg twice per day at 9:00 a.m., and 5:00 p.m. for anxiety, Metoprolol 100 mg twice per day at 9:00 a.m., and 5:00 p.m. for high blood pressure, Metformin 1000 mg twice per day at 9:00 a.m., and 5:00 p.m., of diabetes, and Wixela (advair inhaler) one puff every 12 hours at 9:00 a.m., and 9:00 p.m., for shortness

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F 755	Continued From page 297 of breath (COPD). On 6-5-19 at 3:30 p.m. LPN A was preparing to leave for the day, and was asked if the prilosec and prozac for Resident #68 had arrived from the pharmacy, and she replied "no, it will probably come in tonight." Both medications were documented on the MAR as having been omitted. On 6-11-19 the nursing notes, MAR, and the "Medication Administration Audit Report" were requested, and copies were delivered for Resident # 68's medication administration errors. The reports were reviewed and documented the approximate time the medications were observed as given for 6-5-19, with one exception, the prozac which was unavailable and omitted on 6-5-19 for Resident #68 was marked as administered on the audit report. The MAR received on 6-11-19 showed the prozac and prilosec documented as not given. Nursing notes revealed that the medication was unavailable. On 6-11-19 at approximately 3:45 p.m., the DON was asked about the expectation of nurses when administering medications and she stated that the nurse should administer the medications on time, and that if given late the resulting dose would be late, and may have to be omitted all together so as to not double dose the patient, which could lead to symptoms of the illness that the medications were necessary for, to prevent and treat.. On 6-11-19 at approximately 4:00 p.m., the Administrator and DON were notified of findings and they offered no further documentation or information.	F 755		

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F 755	Continued From page 298 COMPLAINT DEFICIENCY	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to ensure 1 resident (Resident #176) of 76 Residents in the survey sample, was free from unnecessary medication. The findings include: For Resident # 176, the facility staff failed to have laxative use discontinued while Resident was	F 757	1. Resident #176 discharged from facility prior to survey. 2. Unit Manager/designee will complete audits of resident with the diagnosis of Clostridium Difficile (C-Diff) to ensure they are not receiving a laxative and/or stool softeners. Follow up based on findings. Providers will be notified, and orders clarified if	8/4/19

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F 757	Continued From page 299	F 757		

being actively treated for (Clostridium Difficile) C-Diff, a bacteria that causes severe diarrhea.

Resident #176 a 61 year old woman was admitted to the facility on 5/4/18 with diagnoses of, but not limited, to Atrial Fibrillation, Major Depressive Disorder, End Stage Renal Disease and Gastro Intestinal Hemorrhage. The Resident's most recent (Minimum Data Set) MDS with an Assessment Reference Date of 6/28/18 coded as a Quarterly Assessment coded Resident #176 as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment.

During the course of a complaint investigation it was discovered that Resident #176 was still receiving a laxative and stool softeners as well as diuretics while being treated for C- Diff (a bacteria that causes extreme diarrhea) and having nausea, and vomiting.

Progress note dated 6/22/19 at 6:13 AM read: "Resident to start ABX [antibiotic] therapy today for C-Diff [Clostridium Difficile] contact precautions in place."

Progress note dated 6/22/19 at 7:10 AM read "Resident reported to have loose stools X 1 this shift. Stool reported as loose and watery."

According to the (Electronic Medication Administration Record) EMAR and the POS (physicians order sheet) Resident #176 was ordered the following medications and that they were administered while the Resident had Diarrhea in spite of the following warnings:

Senna 8.6 mg daily (stimulant laxative)

needed.

3. Nursing staff re-educated by DON/designee on potential unnecessary drugs for residents with a diagnosis of Clostridium Difficile. When a resident is diagnosed with Clostridium Difficile, the nurse will review the resident's current medications with the provider and obtain clarification for medication administration. Resident's with new diagnosis of Clostridium Difficle will be noted on the 24-hour report and Unit Manager / designee will review record to validate that current medication orders have been reviewed with the provider.

4. Unit Managers / designee will conduct audits of resident with the diagnosis of Clostridium Difficile (C-Diff) to ensure they are not receiving a laxative and/or stool softener, weekly x 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. 8/4/2019

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F 757	Continued From page 300 WARNING INFORMATION: Do not use laxative products when abdominal pain, nausea, or vomiting is present unless directed by a physician. If you have noticed a sudden change in bowel movements that persists over a period of two weeks, consult a physician before using a laxative. Do not use laxative products for longer than 1 week unless told to do so by a doctor. Rectal bleeding or failure to have a bowel movement after use of a laxative may indicate a serious condition; discontinue use and consult your physician Biscodyl 5 mg daily (stimulant laxative) If any of these effects persist or worsen, tell your doctor or pharmacist promptly: Stomach/abdominal pain or cramping Nausea Diarrhea Weakness Tell your doctor right away if any of these unlikely but serious side effects occur: Persistent nausea/vomiting/diarrhea Muscle cramps/weakness Irregular heartbeat Dizziness Linzess 145 (Micrograms) mcg (medication to treat chronic constipation) According to the manufacturer's instructions: LINZESS can cause serious side effects, including diarrhea, the most common side effect, which can sometimes be severe. Diarrhea often begins within the first 2 weeks of LINZESS treatment. Stop taking LINZESS and call your doctor right away if you get severe diarrhea during treatment	F 757		

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F 757	Continued From page 301 with LINZESS Miralax 17 gm, daily (osmotic laxative) According to manufactures instructions: Do not use if you have kidney disease, except under the advice and supervision of a doctor. Ask a doctor before use if you have: Nausea, vomiting, or abdominal pain A sudden change in bowel habits that lasts over 2 weeks Irritable bowel syndrome Stop use and ask a doctor if: You have rectal bleeding or your nausea, bloating, cramping or abdominal pain gets worse. You get diarrhea A review of the Nurse Practitioner (NP) Progress Notes [check off sheet] dated 7/2/19 revealed: Pt Complaint/Staff concern: Script/ Med renewal HPI [History/ Physical Information]-Pt seen & chart reviewed . She has chronic pain and anxiety. She takes Norco and Ativan. Boxes Checked for Medication Reviewed, Medical History Reviewed #8-Under GI-only loss of appetite and pain are checked [boxes for diarrhea, nausea and vomiting not checked] According to the NP Notes [check off sheet] dated 7/3/19: Pt Complaint/Staff concern: F/U [follow up] Constipation HPI- Pt seen to F/U chronic constipation. She denies constipation, She admits she has been having loose stools. I discussed C-Diff & the importance of compliance with meds. She has been refusing meds.	F 757		

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F 757	Continued From page 302 Boxes checked for Meds Reviewed and Medical Record Reviewed. #8-Under GI-only loss of appetite and pain are checked [boxes for diarrhea, nausea and vomiting not checked] Under Assessments/Status / Plan: Miralax D/C [discontinued] Florastor [probiotic] added daily Continue Vancomycin [Resident record shows Vancomycin therapy was completed on 7/2/19] On 6/12/19 a review of clinical record revealed that the MAR showed no instances of refusing meds. The MAR revealed the only meds that were missed were coded as being missed due to LOA (leave of absence) for dialysis, and Hospitalization, and the Miralax stop date was 7/9/19. On 6/20/19 during the end of day meeting the Administrator was advised of the issues and no further information was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		8/4/19

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F 758	Continued From page 303 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, and facility documentation review, the facility staff failed to manage psychotropic	F 758	1. Resident #121 psychotropic medications evaluated on 6/25/2019, resident Ativan was stopped on 7/16/19.	

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F 758	Continued From page 304 medications to maintain residents' highest practicable mental, physical, and psychosocial well-being for 3 residents(Resident #121,176 & #29) in a sample size of 76 residents. The findings included: 1. For Resident #121, the facility staff obtained a phone order for PRN (as needed) Lorazepam without a stop date. Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to dementia and psychotic disorder other than schizophrenia. Resident #121's most recent Minimum Data Set with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Physical/verbal behaviors toward self/others was coded as not exhibited, Behaviors of psychosis or wandering were coded as not exhibited. On 06/12/2019, the clinical record was reviewed. A completed physician's order entry initiated on 05/14/2019 and discontinued on 05/28/2019 documented, "Lorazepam 1 mg [milligram] by mouth every 6 hours as needed for agitation until 05/28/2019." An active physician's order (communicated by phone) dated 06/11/2019 documented, "Lorazepam 1 mg [milligram] give 1 tablet by mouth every 6 hours as needed for agitation and sun-downing." There was no stop date. Physician's order entries dated 05/07/2019 documented, "Psych to evaluate and treat as indicated", "Psychiatry as needed", and	F 758	Resident #176 discharged from facility prior to survey. Resident #29 discharged from facility prior to survey. 2. Unit Managers / designee will complete audits of PRN psychotropic to ensure they have stop date. If variances are found, the physician will be contacted and order clarification including stop date and documentation of continued need will be noted in the medical record. 3. Licensed nursing staff re-educated by licensed nurse and/or pharmacy representative related to PRN orders for psychotropic drugs are limited to 14 days (Unnecessary Psychotropic Meds/PRN Use). Providers will be reminded of the need to include stop dates for orders of PRN psychotropic medications. Pharmacy will assist in reviewing orders for PRN psychotropic medications and will report any identified irregularities in the monthly drug regimen review. 4. Unit Managers / designee will conduct random audits of PRN psychotropic to ensure they have stop date, 3 times per week for 3 months. If variances are found, the provider will be contact for clarification of the order including a stop date. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. 8/04/2019	

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F 758	Continued From page 305 "Psychology as needed." The most recent provider note by a nurse practitioner dated 05/11/2019 documented under the header "Psych": "Mental status: patient's speech has normal rate and rhythm and responds to questions appropriately. There are no auditory or visual hallucinations or any homicidal or suicidal thoughts." An interdisciplinary note dated 06/10/2019 at 11:23 AM documented, "Resident observed eating food from meals trays that had already been eaten off of. Resident was redirected and given snacks. Team will have dietary to provided [sic] a sandwich to all meal trays to satisfy resident's dietary needs. This resident is not diabetic. Also will consult dietician to ensure needs are met. MD/RP made aware." On 06/17/2019 at 3:58 PM, the DON verified there were no psych notes for Resident #121. A copy of the facility policy on psychotropic management was requested and the facility staff provided a policy entitled, "Behavioral Management/Psychotropic Management." The policy does not address PRN psychotropic medication management. On 06/20/2019 at the conclusion of the survey, the Administrator had no further information or documentation to offer. 2. For Resident #176 the facility failed to have accurate diagnosis for administration of Seroquel [an anti-psychotic medication] and also gave PRN (as needed) Ativan longer than 14 days; Ativan and Klonopin (both Anti-Anxiety medications)	F 758		

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F 758	Continued From page 306	F 758		

were administered on a scheduled basis at 9 AM and 5 PM.

Resident #176 was a 61 year old woman admitted to the facility on 5/4/18 with diagnoses of, but not limited to, Major Depressive Disorder, and Anxiety. The Resident's most recent (Minimum Data Set) MDS with an Assessment Reference Date of 6/28/18 coded as a Quarterly Assessment coded Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment.

On 6/7/19 at 10:50 AM during a complaint investigation the Physician Orders were reviewed and revealed that Resident #176 had the following PRN orders:

Lorazepam Tablet [Ativan-an anti-anxiety medication]
Give 1 tablet by mouth every 4 hours as needed for anxiety related to Anxiety Disorder.
Start Date 5/4/18 at 8:00 PM D/C Date- 6/23/18 (49 days)

The Physician Orders also show that during this same time period Resident #176 also had the following scheduled orders:

Klonopin Tablet 0.5 MG [Clonazepam] Give 1 tablet by mouth two times a day related to Major Depressive Disorder (9 AM & 5 PM).
Start Date 5/5/18 at 9:00 AM-D/C Date-6/23/18 at 6:38 PM

Ativan Tablet 0.5 MG (Lorazepam)
Give 0.5 mg by mouth 2 times a day for Anxiety
Date Started-6/27/18 at 5:00 PM
Until 7/12/18 at 11:59 PM

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F 758	Continued From page 307 Connate (Looping) Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety Start Date 6/27/18 at 5:00 PM D/Date - 6/28/19 According to the (Medication Administration Record) MAR on 6/21/19 the Resident was given: Klonopin 0.5 MG at 5:00 PM On 6/22/18 the MAR shows the following meds were given to Administered: At 9:00 AM-Klonopin 0.5 MG [anti-anxiety] At 9:37 AM-Ativan 1.0 MG [anti-anxiety] At 5:00 PM-Klonopin 0.5 MG According to the MAR on 6/27/18 following meds were given to Administered Klonopin O.5 MG at 5:00 PM Ativan 0.5 MG at 5:00 PM According to the MAR on 6/28/18 following meds were given to Administered Ativan 0.5 MG at 9:00 AM Klonopin 0.5 MG at 9:00 AM Ativan 0.5 MG at 5:00 PM Klonopin 0.5 MG at 5:00 PM Resident #176 also had the following order Seroquel [antipsychotic] 25 MG at bedtime related to Major Depressive Disorder According to the Psychiatric Consult dated 6/26/18 Resident #176: Intervention-Continue Zoloft 25 mg tablets-3 PO [by mouth] daily for Anxiety Disorder. D/C Quetiapine [Seroquel] Not appropriate for use for	F 758		

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F 758	Continued From page 308 sleep at this time. D/C Klonopin Continue Ativan once daily for one more week then discontinue as this is high risk with pain medication in terms of RESPIRATORY SUPPRESSION. Discussed with nursing staff. If anxiety and air hunger becomes a concern I will restart Ativan at that time. According to the MAR and Physicians Orders the Klonopin was not D/C'd until 6/28/19 Seroquel was not D/C'd and nor was the Ativan. In an interview with DON (Director of Nursing) on 6/18/19 at 11:10 AM, she stated I was brought in to assist with the survey I am not really sure of what happened in 2018. An interview was conducted with the ADON (Assistant Director of Nursing) on 6/18/19 when asked about the medications orders she stated she was not employed there at that time. On 6/22/19 during the end of day conference the Administrator was made aware and no new information was submitted 3. For Resident # 29 the facility staff administered PRN (as needed) Psychotropic medication without a stop date for more than 14 days. Resident #29 was a 59 year old man admitted to the facility on 11/27/18 with diagnoses of, but not limited to, bilateral below knee amputation, chronic kidney disease, and muscle weakness, PTSD [Post Traumatic Stress Disorder], Anxiety disorder. The resident's latest MDS coded as a Quarterly with an (Assessment Reference Date) ARD of 3/14/19 coded the Resident as having a	F 758		

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F 758	Continued From page 309 BIMS(Brief Interview of Mental Status) Score of 13 indicating mild cognitive impairment. On 6/12/19 during clinical record review it was noted that Resident #29 had PRN Xanax According to Physicians orders Resident #29 had the following orders for Xanax: Xanax (Alprazolam) 0.5 MG Give 1 Tablet by mouth every 8 hours as needed for Anxiety. Start Date-5/1/19 at 5:15 PM D/C [discontinue date] 5/24/19 at 6:45 PM Xanax Tablet 0.5 MG (Alprazolam) Give 1 tablet by mouth as needed for Anxiety related to ANXIETY DISORDER UNSPECIFIED (F41.9) give BID (twice daily) Start Date: 6/5/19 D/C Date : [none] Interview conducted with DON on 6/12/19 at 11:40 the DON stated "I knew when I saw this chart that we needed to fix that PRN and get it D/C'd so I did. I don't know why they restarted that after I got it D/C'd they know its only supposed to be 14 days for a PRN." On 6/22/19 during the end of day conference the Administrator was made aware and no new information was submitted	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5	F 759		8/4/19

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F 759	Continued From page 310	F 759		

percent or greater;
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 the medication pour and pass observation error rate was less than 5% for 3 residents (Residents #98, #47, and #68) in a sample size of 76 residents. There were 12 medication errors (wrong time/and or omitted) in 26 opportunities resulting in an 46.15% error rate.

The findings included:

1. Resident #98, was administered medications late, which were ordered to be given multiple times per day.

Resident #98 was admitted to the facility on 10-26-18. Diagnoses included; Back pain, protein calorie malnutrition, anemia, low sodium, hypotension, Gastro-esophageal reflux disease, muscle weakness, recurrent depression, and pressure ulcer.

2. Resident #47, was administered medications late, which were ordered to be given multiple times per day.
Resident #47, was admitted to the facility on 4-14-17. Diagnoses included; stroke, disability, dysphagia, weakness, hypertension, mood disorder, insomnia, arthropathy, and subluxation of left wrist and hand (contractures).

3. Resident #68, was administered medications late, or omitted, which were ordered to be given multiple times per day. Resident #68, was admitted to the facility on 1-9-19. Diagnoses included; Chronic obstructive pulmonary disorder

1. Resident #98 MD notified of deficient practice, no adverse reactions. Resident #47 MD notified of deficient practice, no adverse reactions. Resident #68 MD notified of deficient practice, no adverse reactions.

2. All residents have the potential to be impacted. Licensed nursing staff will be educated on the 6 Rights of Medication Administration

3. Licensed nursing staff will be re-educated by external nurse consultant / licensed nurse on the 6 Rights of Medication Administration.

4. Licensed nurse will conduct medication administration observations 5x week x 3 months to ensure medications are available and administered per physician order. Variances will be addressed, and corrective action and/or education will be provided. Findings of the weekly audits will be submitted to the DON/ADON for trending / tracking and analysis for further education and/or disciplinary action. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. 8/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 759	Continued From page 311 (COPD), anxiety, recurrent major depression, high cholesterol, gastro-esophageal reflux disease, cataracts diabetes, schizophrenia, and hypertension. On 6-5-19 at 12:30 p.m., after lunch, LPN A was observed at a medication cart preparing to administer medications to Resident #98. The medications that LPN A prepared to administer were; Midodrine, citalopram, ferrous sulfate (Iron), aspirin, sodium chloride, and a multivitamin. LPN A was asked why so many pills were being given at lunch time, and she replied "these are all the 9:00 a.m., morning pills." "We don't have enough staff to get it all done." After administering the pills, she continued to Resident #47. The medications that LPN A prepared to administer to Resident #47 were; aspirin, vitamin B complex, topiramate, toviaz, citalopram, divalproex, and carvedilol. After administering the pills, she continued on to Resident #68. The medications that LPN A prepared to administer to Resident #68 were; ativan, aspirin, thiamine, januvia, metoprolol, metformin, and wixela (advair inhaler). LPN A stated "Oh, his prilosec and prozac are missing, I ordered those yesterday, I guess I will have to order them again, they must not have been delivered." She then administered the medications. A fourth resident was also observed to receive medications with no error noted. The current physician's orders and medication administration record (MAR) were reviewed in the computerized program for the 4 Residents observed during the medication pour and pass observation. The last resident was found to have no error in administration of her medications, which were all due at lunch time. The following is	F 759		

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F 759	Continued From page 312 a list of the errors noted for the other 3 Residents medications which were all given at least 2 hours late; 1. 12:00 p.m. Resident #98-Midodrine 10 mg (milligrams) one tablet 3 times per day at 9:00 a.m., 1:00 p.m., and 5:00 p.m. for low blood pressure, Iron 325 mg twice per day at 9:00 a.m., and 5:00 p.m. for anemia, Pro-stat liquid 30 ml (milliliters) twice per day at 9:00 a.m., and 5:00 p.m. for supplement, and sodium chloride 1 gram twice per day at 7:30 a.m., and 5:30 p.m. 2. 12:10 p.m. Resident #47-Topiramate F/C 50 mg twice per day at 9:00 a.m., and 5:00 p.m. for migraine headache prevention, Divalproex 500 mg twice per day at 9:00 a.m., and 9:00 p.m. for mood disorder (seizure medication), and Carvedilol F/C 3.125 mg twice per day at 9:00 a.m., and 5:00 p.m., for high blood pressure. 3. 12:15 p.m. Resident #68-Ativan 0.5 mg twice per day at 9:00 a.m.., and 5:00 p.m. for anxiety, Metoprolol 100 mg twice per day at 9:00 a.m., and 5:00 p.m. for high blood pressure, Metformin 1000 mg twice per day at 9:00 a.m., and 5:00 p.m., of diabetes, and Wixela (advair inhaler) one puff every 12 hours at 9:00 a.m., and 9:00 p.m., for shortness of breath (COPD). On 6-5-19 at 3:30 p.m. LPN A was preparing to leave for the day, and was asked if the prilosec and prozac for Resident #68 had arrived from the pharmacy, and she replied "no, it will probably come in tonight." Both medications were documented on the MAR as having not been given. On 6-11-19 the nursing notes, MAR, and the	F 759		

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F 759	Continued From page 313 "Medication Administration Audit Report" were requested, and copies were delivered for the 3 Residents with found medication administration errors. The reports were reviewed and documented the approximate time the medications were observed as given for 6-5-19, with one exception, the prozac which was unavailable and omitted on 6-5-19 for Resident #68 was marked as administered on the audit report. The MAR received on 6-11-19 showed the prozac and prilosec documented as not given. Nursing notes revealed that the medication was unavailable. On 6-11-19 at approximately 12:05 p.m., the DON (Director of Nursing) was asked what references are utilized for professional practice standards and she stated, "CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), AMA (American Medical Association), and for nurses: "Potter Perry". On 6-11-19 at approximately 3:45 p.m., the DON was asked about the expectation of nurses when administering medications and she stated that the nurse should administer the medications on time, and that if given late the resulting dose would be late, and may have to be omitted all together so as to not double dose the patient, and which was necessary to prevent recurrent illness, or treat it. In the Seventh Edition of Potter and Perry Nursing Procedures under the section entitled "Safe Medication Administration Practices, General", it documented, "To promote a culture of safety and to prevent medication errors, nurses must avoid distractions and interruptions when preparing and administering medications, and adhere to the "five rights" of medication	F 759		

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F 759	Continued From page 314 administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route." On 03/28/2019 at approximately 5:45 PM, the Administrator and DON were notified of findings and they offered no further documentation or information.	F 759		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Family interview, Resident interview, clinical record review, facility document review, Hospital record review, and in the course of a complaint investigation, the facility staff failed to ensure Resident were free from significant medication errors for 10 residents in a sample size of 76 residents. (Residents #2, #180, #98, #47, #68, #76, #68 and separate issues for #111, #29 & #15) resulting in harm for Resident #2. The findings included: 1. Resident #2 did not receive a physician ordered IV (intravenous fluid infusion) on 2-16-19 due to staff inability to access a vein to infuse the fluids, and, the Resident failed to receive Hypodermoclysis fluid infusion in the subcutaneous tissue as ordered due to unavailability of the IV fluids in the facility on	F 760	1. Resident #2 discharged from facility. Resident #180 discharged from facility. Resident #98 MD notified of deficient practice, no adverse reactions. Resident #47 MD notified of deficient practice, no adverse reactions. Resident #68 MD/NP notified of medication error on 6/12/19, orders received to continue current dose of medication; no adverse reactions noted. Resident #76 MD notified of deficient practice, no adverse reactions. Resident #111 discharged from facility. Resident #29 discharged from facility. Resident #15 MD notified of deficient practice, no adverse reactions. 2. All residents have the potential to be impacted. Licensed nursing staff will be educated on the 6 Rights of Medication Administration. A MD audit to MAR order	8/4/19

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F 760	Continued From page 315 2-21-19. This is harm. Resident #2 was admitted to the facility on 1-15-19, after treatment for a Urinary tract infection (UTI), and was discharged from the facility on 2-26-19 to the emergency room where she received a diagnosis of dehydration, sepsis, and intractable nausea and vomiting, and expired on 3-3-19 (5 days later). Resident #2's Diagnoses included; UTI, history of Cancer in hilus of left lung, uterine cancer (removed by hysterectomy in 2016), adult fail to thrive, diabetes, and hypertension. Resident #2's most recent Minimum Data Set (MDS) was an admission assessment dated 1-22-19. Cognitive skills for daily decision-making were coded as 13 of 15, and no cognitive impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as extensive dependence on staff. Review of the closed record physician progress notes and visits revealed that the final time Resident #2 was seen was on 2-12-19. The Resident denied nausea and vomiting in the note, and was being seen for a decrease in appetite. Review of the physician's orders revealed that Resident #2 was ordered to be given Promethazine hydrochloride suppository rectally for nausea and vomiting on 2-12-19, and Odansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for nausea and vomiting. Review of the nursing notes revealed that no nursing notes existed between 2-10-19, and	F 760	audit was conducted for all current residents. Variances identified MD and RP notified, and assessment conducted to ensure no negative effects. 3. Licensed nursing staff re-educated by external nurse consultant / licensed nurse on the 6 Rights of Medication Administration including caution on high-risk medications. 4. Licensed nurse will conduct medication administration observations 5x week x 3 months to ensure medications are available and administered per physician order. Variances will be addressed, and corrective action and/or education will be provided. Findings of the weekly audits will be submitted to the DON/ADON for trending / tracking and analysis for further education and/or disciplinary action. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. 8/04/2019	

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F 760	Continued From page 316 2-16-19. On 2-16-19 the Resident was experiencing persistent vomiting, and the physician ordered via the telephone IV (intravenous) 0.9% normal saline at 60 ml (milliliters) per hour for 1000 ml related to dehydration. The nurse was unable to establish an IV access catheter to infuse the fluids, and they were never given. There is no indication that the physician was ever notified that the order was not carried out. There were no further nursing or physician notes until 2-20-19, when new verbal/telephone physician orders were received for Hypodermoclysis fluid infusion in the subcutaneous tissue 0.9% normal saline at 60 milliliters per hour for 1 liter every hour, which is also used to treat dehydration. The Resident received the fluid from 2:00 p.m. on 2-20-19, until 11:00 a.m., on 2-21-19 when it was abruptly stopped. The Medication administration record (MAR) documentation showed at 12:00 noon on 2-21-19 that the fluids were not infusing, and "Other/see nursing note" and there was no note. The IV fluids were not given after 11:00 a.m., on 2-21-19 even though the Resident received Odansetron 8 milligram tablet orally on 2-21-19 at 6:28 p.m., for continuing nausea and vomiting. The fluid infusion order was Discontinued on 2-22-19 at 9:38 a.m. with no note from the physician or nurses to indicate the reason. LPN A was the nurse for the 11:00 p.m. to 7:00 a.m. shift on the nights of 2-21-19, and 2-22-19. LPN A was interviewed, and stated "We didn't have any fluids in the building to give the patient. When asked why no note was written, she stated she had written a note documenting that the fluids were unavailable, and that the nurse on 3 p.m-11	F 760		

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F 760	Continued From page 317 p.m. shift on 2-21-19 reported to her that she had not had any in the building either, and the family was angry, so she put the fluids on hold until the pharmacy could deliver them. The fluids never arrived, and the order was discontinued. The facility was asked for a copy of the "IV stat box contents" which contained extra bulk dose medications that could be administered until supplies for the individual could be received. The document was received, and stated the normal saline needed for Resident #2's infusion was contained in the box. LPN A stated that during the stay of Resident #2, the box was not filled and sent out to the pharmacy for refill as it should have been. The 3-11 nurse for 2-21-19 was identified, and found to be a short term contract employee who no longer worked at the facility. There were no nursing notes in the record for 2-21-19, and 2-22-19 to explain why the fluids were not completed through 2-21-19, and were discontinued on 2-22-19. There were no nursing notes from 2-20-19 until 2-24-19, which documented that the resident had refused all treatments and care. On 2-25-19 the first identification of a wound with green yellow slough was documented. On 2-26-19 the Resident was sent to the hospital for nausea/vomiting and suspected dehydration at 6:35 p.m., which was requested by the family. The Resident never returned. Weight records were reviewed and revealed a weight loss of 45 pounds in 38 days.	F 760		

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F 760	Continued From page 318 The care plan was reviewed and had no interventions care planned for continued nausea, and vomiting. Hospital records document that it was reported to the hospital staff that Zofran (Odansetron) 8 mg was given to the Resident prior to leaving the nursing home on 2-26-19, however, the nursing notes and MAR have no documentation of the medication ever having been given on 2-26-19. Hospital records were reviewed and revealed the normally oriented and alert Resident was "Disoriented and unable to identify complaints". The Resident arrived in the ER (emergency room) at 7:09 p.m.. The Resident was seen by critical care staff who surgically placed an IV catheter in the Residents "External Jugular" neck vein. The ER "Critical care note" documented "System at risk for life threatening failure: Central nervous system, cardiac and circulatory." "Associated problems: Hypotension (low blood pressure) Dehydration, Arrhythmia and infection." The hospital documents state that emergency medical services ambulance first responders recorded the Resident's blood pressure to be 83/53 mmHg (millimeters mercury) at the nursing home, and at the ER measured 87/49. The Resident was admitted with "dehydration, sepsis, acute cystitis with bloody urine (urinary tract infection), intractable nausea and vomiting, hypokalemia (critically low potassium 2.2-normal is 3.5 to 5.5)), and hypomagnesemia (critically low magnesium 0.8-normal is 1.6 to 2.5), and lactic acidosis (critically high 6.96-normal is 0.9 to 1.7). After placing an IV catheter the Resident was immediately placed on fluid and potassium replacement infusions in the emergency room,	F 760		

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F 760	Continued From page 319 and was later admitted to the ICU (intensive care unit), where she expired on 3-3-19 (5 days later). The Resident was last seen by the physician on 2-12-19, and had recurrent nausea and vomiting from 2-16-19 until her discharge 2-26-19. The Resident was not supplied with ordered fluid infusions, as they were unavailable, she became dehydrated, and was sent to the hospital at the behest of the family. The Resident expired in the hospital on 3-3-19 (5 days later) with the diagnoses of dehydration and sepsis. The facility Administrator and Director of nursing were made aware of findings on 6-20-19. The facility stated they had no further information to provide. COMPLAINT DEFICIENCY 2. Resident #180 did not receive significant medications on the evening of 7-11-18 after being hospitalized for stroke, and respiratory failure. Resident #180, was admitted to the facility on 7-11-18, and discharged on 7-30-18. Diagnoses included; stroke, cardiac arrest, hypertension, congestive heart failure, high cholesterol, emphysema, and heart attack. Resident #180's most recent Minimum Data Set (MDS) was dated 7-18-18, and was an admission assessment Cognitive skills for daily decision-making were coded as no impairment. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were all coded as limited to extensive dependence on staff.	F 760		

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F 760	Continued From page 320 The hospital discharge record and nursing home entire closed record review revealed that the Resident was admitted to the facility on 7-11-18 at approximately 5:00 p.m. The physician's orders, nursing notes, and Medication Administration records (MARs) for the time period from admission to discharge (19 days), were reviewed. Those records revealed that the Resident did not receive the following medications in the evening of 7-11-18. The medications were ordered, by the physician on 7-10-18, before his discharge from the hospital, and communicated to the facility on 7-10-18, the day before he arrived at the facility: 9:00 p.m. Lipitor 40 mg (milligrams) at bedtime for high cholesterol. 9:00 p.m. Ativan 0.5 mg at bedtime for high cholesterol (anxiety medication) 9:00 p.m. Melatonin 0.5 mg at bedtime for emphysema (insomnia medication) 5:00 p.m. Calcium carbonate plus Vitamin D 500-200 mg twice per day 5:00 p.m. Carvedilol 6.25 mg twice per day (for heart attack) 5:00 p.m. Fluticasone/Salmeterol inhalant 250/50 mcg (micrograms) twice per day (for Respiratory failure/emphysema) 5:00 p.m. Gabapentin 400 mg three times per day (for neuropathy) 6:00 p.m. Duo-neb 0.5/2.5 inhale 3 ml (milliliters) via hand held nebulizer every 6 hours (for respiratory failure/emphysema). The DON, and Administrator were made aware of findings, and stated they had no further information to present. COMPLAINT DEFICIENCY.	F 760		

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F 760	Continued From page 321 3a. Resident #98's significant medications, that were ordered for multiple doses per day, were given late. 3b. Resident #47's significant medications, that were ordered for multiple doses per day, were given late. 3c. Resident #68's significant medications, that were ordered for multiple doses per day, were given late, and 2 medications were omitted. On 6-5-19 at 12:30 p.m., after lunch, LPN A was observed at a medication cart preparing to administer medications to Resident #98. The medications that LPN A prepared to administer were; Midodrine, citalopram, ferrous sulfate (Iron), aspirin, sodium chloride, and a multivitamin. LPN A was asked why so many pills were being given at lunch time, and she replied "these are all the 9:00 a.m., morning pills." "We don't have enough staff to get it all done." After administering the pills, she continued to Resident #47. The medications that LPN A prepared to administer to Resident #47 were; aspirin, vitamin B complex, topiramate, toviaz, citalopram, divalproex, and carvedilol. After administering the pills, she continued on to Resident #68. The medications that LPN A prepared to administer to Resident #68 were; ativan, aspirin, thiamine, januvia, metoprolol, metformin, and wixela (advair inhaler). LPN A stated "Oh, his prilosec and prozac are missing, I ordered those yesterday, I guess I will have to order them again, they must not have been delivered." She then administered the medications. A fourth resident was also observed to receive medications with no error noted.	F 760		

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F 760	Continued From page 322 The current physician's orders and medication administration record (MAR) were reviewed in the computerized program for the 4 Residents observed during the medication pour and pass observation. The last resident was found to have no error in administration of her medications, which were all due at lunch time. The following is a list of the errors noted for the other 3 Residents significant medications which were all given at least 2 hours late, and or omitted; 3a. 12:00 p.m. Resident #98-Midodrine 10 mg (milligrams) one tablet 3 times per day at 9:00 a.m., 1:00 p.m., and 5:00 p.m. for low blood pressure, Iron 325 mg twice per day at 9:00 a.m., and 5:00 p.m. for anemia, Pro-stat (protein) liquid 30 ml (milliliters) twice per day at 9:00 a.m., and 5:00 p.m. for supplement for a stage 3 pressure ulcer and protein malnutrition, and sodium chloride 1 gram twice per day at 7:30 a.m., and 5:30 p.m. for low sodium, which can lead to dehydration. 3b. 12:10 p.m. Resident #47-Topiramate F/C 50 mg twice per day at 9:00 a.m., and 5:00 p.m. for migraine headache prevention after a stroke, Divalproex 500 mg twice per day at 9:00 a.m., and 9:00 p.m. for mood disorder (anti-seizure medication), and Carvedilol F/C 3.125 mg twice per day at 9:00 a.m., and 5:00 p.m., for high blood pressure. for a Resident with a history of stroke. 3c. 12:15 p.m. Resident #68-Ativan 0.5 mg twice per day at 9:00 a.m., and 5:00 p.m. for anxiety and for a Resident who suffers from schizophrenia, Metoprolol 100 mg twice per day at 9:00 a.m., and 5:00 p.m. for high blood	F 760		

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F 760	Continued From page 323 pressure, Metformin 1000 mg twice per day at 9:00 a.m., and 5:00 p.m., of diabetes, and Wixela (advair inhaler) one puff every 12 hours at 9:00 a.m., and 9:00 p.m., for shortness of breath with (COPD). On 6-5-19 at 3:30 p.m. LPN A was preparing to leave for the day, and was asked if the prilosec and prozac for Resident #68 had arrived from the pharmacy, and she replied "no, it will probably come in tonight." Both medications were documented on the MAR as having not been given. On 6-11-19 the nursing notes, MAR, and the "Medication Administration Audit Report" were requested, and copies were delivered for the 3 Residents with found medication administration errors. The reports were reviewed and documented the approximate time the medications were observed as given for 6-5-19, with one exception, the prozac which was unavailable and omitted on 6-5-19 for Resident #68 was marked as administered on the audit report. The MAR received on 6-11-19 showed the prozac and prilosec documented as not given. Nursing notes revealed that the medication was unavailable. On 6-11-19 at approximately 12:05 p.m., the DON (director of nursing) was asked what references are utilized for professional practice standards and she stated, "CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), AMA (American Medical Association), and for nurses: "Potter Perry". On 6-11-19 at approximately 3:45 p.m., the DON was asked about the expectation of nurses when	F 760		

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F 760	Continued From page 324	F 760		

administering medications and she stated that the nurse should administer the medications on time, and that if given late the resulting dose would be late, and may have to be omitted all together so as to not double dose the patient, which could lead to symptoms of the illness that the medications were necessary for, to prevent and treat.

On 6-11-19 at approximately 4:00 p.m., the Administrator and DON were notified of findings and they offered no further documentation or information.

COMPLAINT DEFICIENCY
4. For resident #76 the facility staff failed to document IV antibiotic X 1 dose and failed to notify MD of the resident refusing IV antibiotics for 6 consecutive days after returning to the facility after a hospital stay for sepsis.

Resident #76, was a 68 year old man who was admitted to the facility on 4/15/19 with diagnoses of but not limited to Schizophrenia, Unspecified Mood Disorder, Parkinson's disease, Neuropathy, and Lymphedema.

On 6/7/19 during clinical record review it was noted that the Resident went to the hospital for Sepsis from beta strep infected pressure wounds. Documentation included:
Pt was placed in the hospital for Sepsis to pressure areas from 4/9/19 to 4/15/19 and according to Hospital Discharge summary the Resident had LARGE decubitis to left posterior thigh and Multiple Areas of skin breakdown. Resident was discharged back to the facility with a PICC (Peripherally Inserted Central Catheter) line and orders for IV (intravenous) Antibiotics.

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F 760	Continued From page 325 He began the treatment while he was in the hospital and it was ordered daily until 4/23/19. Physician order sheet read "Ceftriaxone Sodium Solution Reconstituted 2 gm (grams) intravenously one time a day." The (Medication Administration Record) MAR showed that the Resident was on Ceftriaxone Sodium Solution Reconstituted 2 gm (grams) intravenously one time a day. It was to begin on 4/16/19 at 9:00 AM. The MAR revealed that the medication was administered on 4/16/19 and 4/17/19 and was also documented as follows: On 4/18/19 it is coded 2 which means Refused. On 4/19/19 it is coded as 5 which means see nurses note. On 4/20/19 it is coded as 2 which means Refused On 4/21/19 it is not signed or coded. On 4/22/19 it is coded as 2 which means Refused On 4/23/19 it is coded as 2 which means Refused Upon review of Progress notes there is no mention of medication refusal or MD notification. On 4/18/19 and 4/19/19 there is no nurses note at all only notes from Activities and Staff Development RN. On 4/20 /19 and 4/21/19 there are no nurses notes at all On 4/22/19 The Skilled nurses note states "Resident accepted and tolerated skilled care with 0 adverse med effects." The IV antibiotic began in the hospital however the Resident missed 6 days of the 8 remaining days of ordered antibiotic therapy	F 760		

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F 760	Continued From page 326 On 6/15/19 at 11:00 AM the Director of Nursing was asked what the expectation is of the nurses when Resident refuse medications. She answered "The nurse should find out why they are refusing, document the refusal, and notify the MD of the refusal." When asked should she document physician notification she stated that they should make a note in the progress notes that they have notified the physician and nay new orders" When asked if that was done in this case she stated "No it was not." During end of day meeting on 6/20/19 the Administrator was made aware of the findings and no further information was provided. 5. For resident #68 the facility failed to clarify an order for Tegretol causing Resident to get more than the ordered amount. Resident #68, a 53 year old man admitted to the facility on 1/9/19 with diagnoses of but not limited to Major Depressive Disorder, Anxiety Disorder and Schizophrenia. On 6/8/19 during clinical record review it was noted that the resident had 2 co-existing orders for Tegretol (a seizure medication). The first order read: Tegretol XR Tablet Extended Release 12 hour 100 mg (milligrams). Give 1 tablet by mouth in the evening related to Major Depressive Disorder Unspecified (f 33.9) -Start date-3/21/19 at 5:00 PM The second order read: Tegretol XR Tablet Extended Release 12 hour	F 760		

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F 760	Continued From page 327 200 mg. Give 1 tablet by mouth at bedtime related to Major Depressive Disorder Unspecified (f 33.9) -Start date-3/20/19 at 9:00 PM Excerpts from the psych consult: "3/1/19-This is an [sic] 53 year old male with a history of schizophrenia being seen for a routine follow up visit. Per staff pt. is having increased aggression and making threats. Pt is currently taking Ativan 0.5 mg PO [by mouth] Q [every] 8 hrs. As needed, Ativan 0. 5mg po BID [twice a day] Risperdal 1 mg po bid Tegretol XR 100 mg Q HS [bedtime] and Lexapro 20 mg po QD [every day] Pt has been taking RISPERDAL since 2/8/19 and has not had a reduction in aggression/ behaviors Will D/C [discontinue] RISPERDAL and initiate Zyprexa will also increase Tegretol to help with has mood." Medication: D/C RISPERDAL 1 mg PO BID, start Zyprexa 10 mg qhs, D/C Tegretol XR 100 mg Start Tegretol XR 200 mg qhs On 4/1/19 the Psych consult read: Medication: Continue Lexapro 5mg PO QD, Tegretol ER 100 mg QAM [every morning] and 200 mg PO Q HS Ativan 0.5 mg Q 8H PRN anxiety and Ativan 0.5mg BID. The MAR (Medication Administration Record) showed the Resident as receiving Tegretol ER 100 mg at 5:00 PM Tegretol ER 200 mg at 9:00 PM On 6/11/19 at 2:00 PM in an interview with Unit Manager when asked are 12 hour extended	F 760		

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F 760	Continued From page 328 release tablets usually given 4 hours apart, she stated that they would not be administered that way. When shown the copy of the MAR she stated she would look into it and get back to me. On 6/13/19 at 9:45 AM Unit in an interview with the unit manager she stated that she had spoken with the Nurse practitioner and the Psych NP's and that there was an error in the order and it should have read: Tegretol 100 mg Q AM and 200 mg Q Hs however since the reassigned was doing ok with the dose she would give him 300 mg at hs. 6/12/19 4:35 PM "Writer contacted NP regarding resident per Psych note to D/C Tegretol XR 100 mg Q HS and start Tegretol 200 mg at QHS dated 3/1/19. NP state to contact psych NP. Writer contacted Psych NP for [name of psych practice redacted] and was informed of above. N.O. Give Tegretol XR 300 mg One PO QHS and will see resident on next visit. Resident shows no obvious signs or symptoms of injury. VS 132/77 18/76 98.1 O2 sat 97% Alert and oriented X 2/3. Resident propel [sic] self in wheel chair as desired. Participates in choice activities. Denies abd [abdominal] discomfort, headaches or nausea/vomiting. Tolerates meal self fed after set up. No adverse reactions noted at this time." During end of day meeting on 6/20/19 the Administrator was made aware of the findings and no further information was provided. 6. For Resident #111, the facility staff failed to administer insulin as scheduled. Resident #111, a 60 year old female, was	F 760		

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F 760	Continued From page 329 admitted to the facility on 5/2/19. Her diagnoses included but are not limited to diabetes, cellulitis, and bone infection. On 6/5/19 during initial tour, Resident #111 expressed concerns regarding the nursing care she was receiving by stating, ".....the nurses here are also not giving me my insulin like I am supposed to get, it is never on time and my blood sugars are all over the place, I have had problems in the past and have been in ICU before because of my blood sugars and I am sitting here constantly worried that something is going to happen to me, I don't even go outside my room, I wish I wasn't here, I will never come back to this place". On 6/11/19, a review the Medication Administration Record (MAR) and Medication Administration Audit Report regarding insulin administration to Resident #111 was conducted and revealed that from date of admission on 5/2/19 to 6/11/19 there were 78 scheduled doses of insulin to be given per physician order. Only 27 insulin doses (33%) were given that met professional and facility guidelines to administer medication at the correct time. A staff interview was conducted with the Regional Clinical Director (Employee H) who stated, "An acceptable time range to give a scheduled medication dose is within an hour before or an hour after a scheduled time on the MAR, anything other than that is not acceptable as it does not meet our expectations or comply with professional practice and more importantly with insulin, the right time is essential to controlling blood sugar, if not given at the right time it can be detrimental to the resident, it can cause serious harm".	F 760		

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F 760	Continued From page 330 COMPLAINT DEFICIENCY 7. For Resident #29 the facility staff administered insulin that was expired. On 6/5/19 at 1:05 p.m. during review of the Liberty 1 medication cart the following was observed: A multi-dose vial of Humalog belonging to Resident #29 was noted with an open date of 5/4/19. This Humalog should have been discarded 28 days after opening. Review of the Medication administration record (MAR) for Resident #29 revealed that Resident #29 had received 8 doses of Humalog after the date it should have been discarded. An interview was conducted with LPN A, who was present during the review of the Liberty 1 medication cart. LPN A stated, "it should have been thrown out after 28 days." On 6/5/19 at 2:40 p.m. when LPN A was asked if the expired insulin had been administered to Resident #29, LPN said, "I am going to say yes." On 6/6/19 at 2:19 p.m. an interview was conducted with the facility Director of Nursing (DON). The DON stated her expectation is, "insulin is discarded 28 days after opened, when they open it they are to put the date on it." Review of the facility policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with a revision date of 10/31/16 read, "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."	F 760		

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F 760	Continued From page 331 Review of the facility policy titled, "6.0 General Dose Preparation and Medication Administration" with a revision date of 1/1/13 read under the number 3.11, "facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins)" Review of the "Medication Storage Guidance" provided by the facility on 6/5/19 read, "multiple-dose vials for injection: date when opened and discard unused portion after 28 days." Page 10 of this document addressed insulin storage and stated, Humalog, Humalog mix, and Lantus all have a storage recommendation of 28 days after opening. The drug information sheets and manufacture recommendations were reviewed and indicate to discard any unused product 28 days after opening. COMPLAINT DEFICIENCY 8. For Resident #15, the facility staff failed to ensure that he was free of Significant Medication Errors related to diabetic management. Resident #15 was a 66 year old who was admitted to the facility on 12/11/18. Resident #15's diagnoses included Neuromuscular dysfunction of the Bladder, and Type 2 Diabetes Mellitus. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/4/19 was reviewed. Resident #15 was coded as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.	F 760		

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F 760	Continued From page 332 On 6/10/19 at 1:19 P.M. an interview was conducted with Resident #15. He complained of not receiving care, and medications in a timely manner. He stated "The facility is always short of staff, and they can't keep the one's they have because they work them to death." On 6/10/19 a review was conducted of Resident #15's clinical record, revealing a A1C lab test result which is obtained for diabetic management. The test was dated 1/24/19. The Reference Range of normal levels was 4.0 - 6.0. Resident #15's level was 11.2, which was coded as being "High." Resident #15's care plan was reviewed. An excerpt from the care plan read, "5/22/19. The resident has Suprapubic catheter. The resident will remain free from catheter-related trauma. Catheter care as ordered." "The Resident is at risk for Metabolic Complications r/t [related to] Diabetes. Medications as ordered." Resident #15's signed physician orders dated 6/1/19 read, "NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML. Inject 15 unit subcutaneously three times a day related to Type 2 Diabetes." His doses were scheduled for specific times of administration. On 6/10/19 a review was conducted of Resident #15's clinical record, revealing Resident #15's Medication Audit Report. Resident #15 received his insulin between approximately 2 to 5 hours late on the following days: Date 6/1/19, Time Scheduled 4:00 P.M., Time Administered 7:27 P.M. Date 6/3/19, Time Scheduled 11:00 A.M., Time	F 760		

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F 760	Continued From page 333 Administered 1:04 P.M. Date 6/3/19 Time Scheduled 4:00 P.M., Time Administered 9:52 P.M. Date 6/7/19 Time Scheduled 4:00 P.M., Time Administered 9:17 P.M. Date 6/9/19 Time Scheduled 4:00 P.M., Time Administered 7:50 P.M. On 6/10/19 at approximately 3:00 P.M., an interview was conducted with the Director of Nursing (Employee B). When asked to describe the possible consequences of Residents not receiving insulin as ordered, she stated, "They can either have a adverse reaction, including a diabetic coma or hyperglycemia." No further information was received.	F 760		
F 761 SS=E	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	F 761		8/4/19

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F 761	Continued From page 334 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,staff interview and facility documentation review, the facility staff failed to label insulin as to when it was opened and/or when it was to be discarded as per manufacturer recommendations of after 28 days, for 7 vials of insulin located in the Liberty 1 medication cart. On 6/5/19 at 1:05 p.m. during review of the Liberty 1 medication cart the following was observed: * A multi-dose vial of Humulin R was noted with no open date * Two Lantus Solostar pens were noted with no open date * A multi-dose vial of Humalog was noted with an open date of 5/4/19 and should have been discarded 28 days after opening. * A multi-dose vial of Lantus was noted with no open date. * A multi-dose vial of Humalog was noted with an open date of 4/13/19 and should have been discarded 28 days after opening. * A multi-dose vial of Humalog was noted with no open date. An interview was conducted with LPN A, who was present during the review of the Liberty 1 medication cart. LPN A stated, "they should be labeled." When asked about the expiration dates, LPN A stated "they have to be discarded after 28	F 761	1. Insulin pens and vials removed and discarded. Medication / treatment carts and medication storage areas for over-the-counter [OTC] medications will be inspected to ensure that medications have not expired, are appropriately labeled/dated, and stored. 2. Current Residents receiving medication have the potential to be affected. Medication / treatment carts and medication storage areas for all medications will be inspected by DON/designee to ensure that medications have not expired, and are appropriately labeled/dated, and stored. 3. Licensed nursing staff will be re-educated on proper medication storage, including discarding of expired medications by DON/designee and external nurse consultant. Medication / treatment carts will be inspected weekly by licensed nurses to ensure that opened medications have been dated and that expired medications have been discarded per facility policy. 4. The DON and or designee will audit medication and treatment carts 2x weekly	

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F 761	Continued From page 335 days." On 6/6/19 at 2:19 p.m. an interview was conducted with the facility Director of Nursing (DON). The DON stated her expectation is "insulin is discarded 28 days after opened, when they open it they are to put the date on it." Review of the facility policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with a revision date of 10/31/16 read, "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." Review of the facility policy titled, "6.0 General Dose Preparation and Medication Administration" with a revision date of 1/1/13 read under the number 3.11, "facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins)." Review of the "Medication Storage Guidance" provided by the facility on 6/5/19 read, "multiple-dose vials for injection: date when opened and discard unused portion after 28 days." Page 10 of this document addressed insulin storage and stated, Humalog, Humalog mix, and Lantus all have a storage recommendation of 28 days after opening. The drug information sheets and manufacture recommendations were reviewed and indicate to discard any unused product 28 days after opening.	F 761	x 3 month to ensure expired medications are discarded and proper medication storage is achieved. Variances will be corrected, and responsible staff will be re-educated. The results will be reported to the Quality Assurance Performance Committee by the DCS for 4 months for further compliance and / or revisions 5. 8/4/2019	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/4/19

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F 812	Continued From page 336 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to store food and maintain the kitchen and equipment in a sanitary manner. The findings included: The facility staff failed to store food, maintain the kitchen and kitchen equipment in a clean and sanitary manner. An inspection of the kitchen was conducted on 6/5/19 at 11:26 a.m. with Employee C, dietary manager, and Employee D, dietary district manager. During the observation the following was noted and confirmed by Employee C and Employee D:	F 812	1. The kitchen floors were cleaned under the tables and equipment. The three compartment sink is now testing at the appropriate parts per million. Tray carts have been thoroughly cleaned and placed on a daily cleaning schedule. Tray lid racks has been cleaned and will be added to a daily cleaning schedule. Pans identified on survey have been cleaned. Coffee carafes have been removed form area and cleaned. Expired food has been thrown out. Cooler has been temped at the correct temperature of below 41 degrees, and was cleaned and placed on a daily cleaning schedule. Dry food is now being stored and labeled correctly. The dish machine is being checked for proper temperature prior to use; if	

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F 812	Continued From page 337 * the kitchen floors were observed to be heavily soiled, specifically under tables and equipment. * the 3 compartment sink, which contained 2 whisks, a pot and a bread pan, tested 0 parts per million (ppm) on sanitizer. * tray carts were soiled. *the rack that holds the tray lids was soiled. * pans stored on the bottom shelf of a table had debris on them. * two coffee carafes beside the juice machine had splatters on them. * rice and potato chips were observed stored in the dry storage room, opened and undated. * the cooler on the same wall as the 3 compartment sink had a temperature of 48 degrees Fahrenheit (F) and the bottom of the cooler was soiled with spilled liquids (refrigerated storage must be maintained at or below 41 degrees F). On 6/5/19 at 12:02 p.m. during observation of the dish room, the dish machine was observed with a maximum rinse temperature of 174 degrees. The plate simulator was put on a rack by Employee C and ran through the dish machine after it had ran 5 cycles to heat up. The plate simulator read that the maximum temperature was 147.7 degrees (per federal requirements, 160 degrees at the rack/dish surface reflects 180 degrees required at the manifold). Employee D then said that they have had problems with the booster heater and use bleach to sanitize as an extra precaution. Employee D used test strips and tested multiple surface areas in the dish machine as well as water drips from inside the machine and a plate that had been washed in the dish machine. All areas tested, tested as 0 ppm of sanitizer. On 6/5/19 at 12:02 p.m. an interview was	F 812	temperature does not reach correct temperature, chemical process is used to clean dishes. 2. Residents of the center may have had the potential to be affected by the deficient practice. Inspection of the kitchen was done by Assistant Executive Director and Divisional Executive Director and follow up based on findings were corrected by Dietary Manager 3. Dietary staff to be educated by Executive Director/designee on proper sanitizing levels for dishwasher, 3 compartment sink, dating/labeling/discarding of food, cleaning schedules, and proper temperatures of coolers and dishwashing machine. 4. An audit will be conducted 3x a week for three months on sanitizing levels of three compartment sink and dishwasher, documentation of temperatures and sanitization levels, cleanliness of floors/pots/pans/carts and racks, expiration dates of food in dry storage by the Executive Director/designee. Results of findings will be submitted to the QAPI committee for review and recommendations. 5. 8/4/19	

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F 812	Continued From page 338 conducted with Employee E, a dietary aide who indicated she just starts using the dish machine and starts running dishes through, she doesn't do several cycles for the machine to heat up before washing dishes nor does she check the chemical sanitation levels. On 6/5/19 at 12:05 p.m. Employee E, the dietary aide was observed to take a rag out of her employee locker and went into the dish room and put the rag into the bus pan which was filled with liquid and came back into the hallway and began using the rag to wipe down the inside of the tray carts. Employee E stated she had put bleach into the bus pan with water to create a sanitizer solution. Employee C, dietary manager used a test strip to test the bus pan water and it tested 0 ppm of chemical sanitizer. On 6/5/19 at 12:57 p.m. Employee D used a test strip to again test the sanitizer in the dish machine water and it again tested 0 ppm. On 6/5/19 at 1:01 p.m. Employee C and Employee D used the plate simulator to identify the maximum temperature of the dish machine rinse water and the plate simulator indicated the maximum temperature was 152.9 degrees. The outside gauge on the dish machine gave a reading of 155 degrees rinse temperature and a wash temperature of 135 degrees. Review of the dish machine temperatures log for June 2019 revealed that on 4 occasions from 6/1/19-6/4/19 the dish machine had failed to reach the appropriate rinse temperature to sanitize dishes. There was no recordings in the PPM boxes to indicate the chemical sanitation had been checked.	F 812		

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F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on facility document review, and staff interview, the facility staff failed to have an active contractual agreement with one dialysis provider for their Residents in need of hemodialysis. The findings included; The facility Administrator kept on file a contract for hemodialysis with a dialysis company (Name) which was entered into by the previous occupants of the building. The previous occupant was not owned by, nor in partnership with, the current corporate owner of the facility. All contracts were reviewed for the facility and it	F 840	1. The contract for hemodialysis with the dialysis company has been amended to replace Envoy of Williamsburg as the owner of the Nursing Home. 2. Residents receiving dialysis may have potentially affected. 3. The DON / admission coordinator will advise the Executive Director of any new admissions who have orders for dialysis care and the Executive Director will ensure that the facility has a contract with the providing dialysis center.If no contract exists, the Executive Director will initiate a	8/4/19

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F 840	Continued From page 340 was noted that the (Dialysis Company) hemodialysis contract was with a different company, other than the current owner, and had no relationship to them. The Administrator was asked why no new contract for services had been negotiated with the current company. She stated "We don't need one, it's the same service." The contract was reviewed and revealed no signature page between the dialysis company and the facility. The Administrator stated "I don't have one." The dialysis contract was entered into on 9-18-2008, by the dialysis center and the previous owner of the building. "Owner" is described in the contract as referring to the previous occupant of the nursing home building, and "Company" is described in the contract as the dialysis center. On page 4 of the contract, under heading #11, the contract stated the following; "Successors and Assigns", the contract stated; "This agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party, except that (dialysis) Company may assign this agreement to one of it's (dialysis) affiliates or subsidiaries without the consent of (previous nursing home) Owner. This agreement shall be binding upon and inure to the benefit of the successors, permitted assigns, heirs, and representatives of the (previous nursing home) Owner and (dialysis) Company. Any attempted assignment of this agreement is in violation of the provisions of this section and is void." The new Owners of the nursing home are not in any way related to the Owners of this contract, and so the contract can not be re-assigned to	F 840	contract immediately. An audit for current and accurate contracts will be performed for current dialysis centers. 4. The Executive Director will report new contracts to the monthly QAPI Committee. 5.8/4/2019	

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F 840	Continued From page 341 them, voiding the contract. The dialysis company was contacted, and the "Specialist/Licensure & Certification Maintenance" Representative was interviewed via telephone. He stated that the contract must be between the parties actively doing business. He referred surveyors to the "Senior Paralegal Justice League of (Name) Inc." representative via email, and included the surveyors on the email. The senior paralegal was contacted by telephone and messages were left on her voice mail on 6-18-19 at 2:15 p.m., on 6-19-19 at 11:00 a.m., and 6-20-19 at 1:00 p.m. The calls, and email, were never returned. No current contract between the current owners of the nursing home and the dialysis company could be produced by either party. The facility Administrator was made aware of findings, and presented no further information.	F 840		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		8/4/19

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F 842	Continued From page 342	F 842		

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

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

§483.70(i)(5) The medical record must contain-

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F 842	Continued From page 343 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to maintain an accurate clinical record for 1 resident (Resident #121) in a sample size of 76 residents. The findings included: For Resident #121, the provider documented his skin was intact 2 days following the discovery of four Stage III pressure wounds. Resident #121, a 63-year old male, was admitted to the facility on 04/22/2019. Diagnoses included but not limited to, dementia. Resident #121's most recent Minimum Data Set with an Assessment Reference Date of 05/15/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 00 out of 15 indicative of severe cognitive impairment. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff. Walking in room and corridor were coded as not occurring. Functional status for eating was coded as requiring supervision from staff (one-person physical assist	F 842	1. Resident #121 has no current skin issues as of 7/15/19. The nurse practitioner who wrote the original note was re-educated on accurate documentation by Regional Director of Clinical Services date 6/26/19. 2. All Residents have the potential to be affected for inaccurate documentation. An audit of current residents will be completed to ensure that provider documentation within the past 30 days reflects the resident's current condition by DON/designee. 3. The nurse practitioner who wrote the original note was re-educated on accurate documentation by Regional Director of Clinical Services. The physician was also educated by the Regional Director of Clinical Services on accurate documentation which reflects the current condition of the resident. 4. The Unit Managers / designee will audit 3 residents per week x 3 months to	

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F 842	Continued From page 344 for support). Current number of unhealed pressure ulcers were coded as 0 [meaning none] for Stage I pressure injuries, 0 for Stage II pressure injuries, 1 [meaning 1] for Stage III pressure injuries, and 0 for Stage IV pressure injuries. On 06/12/2019, the clinical record was reviewed. The physician orders were reviewed. There were 5 skin treatment orders obtained by phone by the wound nurse from the nurse practitioner dated 05/09/2019 that documented as follows: "Right hip inferior wound-cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right hip Superior wound-cleanse with wound cleanser, pat dry, apply a hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right hip wound-cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right trochanter superior wound-cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift for wound care. Right upper buttock wound, cleanse with wound cleanser, pat dry, apply hydrogel to wound bed and cover with foam dressing daily and as needed. Every day shift." A nurse's note dated 05/09/2019 at 10:00 AM entered by (Registered Nurse) RN C documented, "Resident with Stage III to right superior hip 1x1.5x0.1 20% pink wound base 80% white slough, Stage III to middle right hip 0.5 x 0.5 x 0.1 20% pink wound base 80% white	F 842	ensure provider documentation of resident's condition is accurate. Identified variances will be discussed with and/or corrected by the provider. Findings from the weekly audits will be submitted to the DON / ADON for tracking and trending. A report of the w eekly audits will be submitted to the monthly QAPI Committee for additional oversight and recommendation. 5. 8/4/2019	

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F 842	Continued From page 345 slough, Stage III to right inferior hip 0.2 x 0.2 x 0.1 50% pink wound bed 50% white slough, Stage II to right trochanter upper 1.5 x 2 x 0.1 pink wound base, Stage II right trochanter lower 0.2 x 0.2 x 0.1. Pink wound base. All wounds above in close proximity of one another. Stage III to right upper buttock 1.7 x 0.7 x 0.2 20% pink wound base 80% white slough. RP and NP aware. New treatments in place in performed by this nurse." A provider progress note dated 05/11/2019 (by the nurse practitioner that ordered the wound treatments on 05/09/2019) documented under the header entitled "Skin:" "Normal, no rashes, no lesions noted." On 06/20/2019 by then end of survey, the administrator had no further documentation or information to offer.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §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 observation, resident interviews, staff interviews, facility documentation review and clinical record reviews the facility staff failed to have a quality assessment and assurance committee that implements appropriate plans of action to correct identified quality deficiencies. The findings included:	F 867	1. The facility has re-established the QAPI Committee; the facility QAPI plan and policy have been reviewed by the leadership team. Plans of action have been developed to address the following areas: Staff education; Resident fund management□ Medication storage; Medication administration; Grievance	8/4/19

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F 867	Continued From page 346 The facility staff failed to have a quality assessment and assurance committee that self identified and implemented plans of action to correct identified quality deficiencies. During the course of the survey from 6/5/19-6/20/19 it was identified that the facility had multiple system failures. These system failures included, but were not limited to: * Staff education * Resident fund management * Medication storage * Medication administration * Grievance Management * Abuse and Neglect prevention * Staffing levels * Infection Control * Pressure ulcer prevention * Careplanning * Nutrition and hydration * Quality of care The facility quality assessment and assurance committee failed to take actions aimed at performance improvement and failed to measure its success, and track performance to ensure that improvements are realized and sustained. The Administrator and Director of Nursing were unable to provide the quality assessment and assurance committee actions related to the multiple system failures found deficient on the survey and included in this statement of deficiencies (SOD) report.	F 867	Management; Abuse and Neglect prevention; Staffing levels; Infection Control; Pressure ulcer prevention; Care planning; Nutrition and hydration; Quality of care. 2. All residents at the facility may have been impacted. The facility is committed to re-establishing a sustainable QAPI process to identify and respond to potential areas of concerns or opportunities for improvement in a proactive manner. 3. The facility QAPI plan and policy will reviewed by the leadership team and revised to meet the current needs of the facility. Facility leadership team will be re-educated on QAPI by the Quality Improving Education to include overview of QAPI and self assessment. The leadership team will meet weekly to review established plans of correction / action. The QAPI committee will meet monthly. 4. The Regional Vice President of Operations/Designee will attend Monthly QAPI meeting x 3 months and review Monthly QAPI minutes monthly to ensure the facility identifies and responds to potential areas of concern and opportunities for improvement in a proactive manner. 5. 8/4/2019	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/4/19

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F 880	Continued From page 347 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 348 (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. §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 resident interview, staff interview, facility documentation and clinical record review the facility staff failed to establish and maintain a safe, and sanitary infection control program for 1 Resident (#176), failed to maintain an active facility wide antibiotic stewardship, and Infection Prevention Control Program (IPCP), and failed to follow infection prevention measures in laundry services. The findings included:	F 880	1. Resident #176 discharged from facility prior to survey, no corrective action taken. Employee Q re-educated on proper hand hygiene and Linens- Personnel must handle and store, process and transport linens so as to prevent the spread of infection. Facility obtained correct Infection Control surveillance documents and Antibiotic Stewardship Report from pharmacy.	

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F 880	Continued From page 349 1. For Resident #176 the facility staff failed to notify EMS of Resident positive C Diff Status (Clostridium difficile, often called C. difficile or C. diff, is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon, Illness from C. difficile most commonly affects older adults in hospitals or in long-term care facilities and typically occurs after use of antibiotic medications. www.mayoclinic.org). Resident #176 a 61 year old woman admitted to the facility on 5/4/18 with diagnoses of, but not limited to, Atrial Fibrillation, Major Depressive Disorder, and Gastro-Intestinal Hemorrhage. The Resident's most recent (Minimum Data Set) MDS with an Assessment Reference Date of 6/28/18 which was a quarterly assessment, coded Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. Resident #176 was also listed as her own (Responsible Party) RP. An entry into the progress notes on 7/4/18 stated that she requested that to be sent out to the Emergency Room due to complaints of Nausea Vomiting and Diarrhea, and having just completed antibiotics for Clostridium Difficile [an inflammation of the colon caused by bacteria]. An excerpt from the progress notes dated 7/4/2018 at 3:22 AM, "she wanted to get anxiety med but wasn't due for it. She [sic] received pain and n/v [nausea/vomiting] med an hour before. She [sic] had large bm loose and sm amt of vomitus, she asked if she could go to the hospital since nurse could not give anxiety [sic] med, and was informed that was not an emergency."	F 880	2. All residents may have potentially been impacted. Assistant Director of Nursing/designee completed a quality review of June 2019 Infection Control log comparing Physician orders with the Antibiotic/Antimicrobial report and tracking and trending surveillance. This information will be reported to the QAPI Committee. Laundry staff re-educated by Housekeeping Manager/ Designee on proper hand hygiene and Linens- Personnel must handle and store, process and transport linens so as to prevent the spread of infection safe handling of soiled and clean linen / clothing when in the laundry room to minimize transmission of infection 3. The DON at the time of the survey is no longer employed at the facility. The current Assistant Director of Nursing has been educated by Divisional Director of Clinical Services on current infection control to include written standards, policy and procedures and how to obtain, analyze and organize infection data for accurate for monitoring of an infective control program and an Antibiotic Stewardship program. The current monthly report will carryover names of residents who initiated but continued on antibiotic therapy from the previous month. The monthly report and analysis of infections and use of antibiotics will be submitted to the QAPI program for further review / analysis.	

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F 880	Continued From page 350 Resident then called the rescue squad from her cell phone and according to the EMS Report dated 7/4/19, the EMS squad was dispatched to the facility and was met at the door by a nurse who stated that she didn't call EMS and it must be a "false alarm." The report further stated "the resident stated she called 911 because the facility staff refuse to take care of her or send her to the hospital, she stated they won't even take my blood pressure." The EMS report stated that as she was being prepared for transport they noticed a large amount of dark loose stools soaking the bed and the resident. They further state that Resident #176 stated she had been that way for a while that the staff refused to clean her up. An excerpt from the EMS report stated "While leaving [facility name redacted] some remarks are exchanged between the patient and a nurse that seemed inappropriate and as if grief were being cast on the patient for calling 911." "Upon arrival at ED [Emergency Dept.] Patient was transferred to bed in room 10 and turnover was given to ED RN and ED Dr. [physician name redacted]. The [hospital name redacted] staff states that the pt. has C-Diff and is concerned for the risk [Facility Name] placed [EMS] Crew at by not advising [EMS Crew] that pt. had C Diff. [EMS Squad] deconned [Decontaminated] the medic unit and equipment before returning to service." On 6/20/19 during end of day meeting the facility Administrator was made aware of findings and no further information was provided.	F 880	Licensed nursing staff were re-educated by DON/designee on the importance of notifying EMS and transport teams of precautions when a resident with infectious condition is being transferred. This information will also be included in the transfer information sent with the resident. Laundry staff re-educated by Housekeeping Manager/Designee on proper hand hygiene and safe handling of soiled and clean linen / clothing when in the laundry room to prevent transmission of infection. 4. Director of Nursing/designee will conduct audit of Infection Control log and tracking and trending surveillance, weekly for 3 months. If variances are found, the log will be corrected, and the responsible staff person will be re-educated. Findings from the audits will be submitted to the monthly QAPI Committee for additional review and oversight. Housekeeping Manager/designee will conduct audit / observations 3 times weekly for 3 months. If variances are observed, staff will be re-educated. Weekly findings will be submitted to Assistant Executive Director for tracking / trending. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 880	Continued From page 351 2. The facility staff failed to maintain an active facility wide antibiotic stewardship, and Infection Prevention Control Program (IPCP). On 6-14-19 at approximately 11:00 am., the Administrator was asked who surveyors should speak with, in regard to the facility infection control program. The Administrator stated the Assistant Director of Nursing (ADON) was in charge of it, and she was an interim employee from a sister facility. The Administrator stated the previous Director of Nursing (DON) had been responsible for it, however, she was no longer employed. On 6-14-19 at 12:00 p.m., the Registered Nurse (ADON) came into the conference room and stated she would be in charge of infection control. She brought in with her a 3 ring binder with "the infection control program" she stated, in it. The ADON was interviewed in the conference room by surveyors. The ADON was asked to show us her tracking and trending for the infection surveillance, and she began to read from the book. She was again asked to provide the documents for surveyor review. She handed the surveyor the binder and contained within were the infection control surveillance documents from a sister facility. She was asked where the documents were for this facility, and she stated that these were the documents, that the pharmacy had just made an error and printed the wrong facility name on the documents. The Pharmacy was called and the "Antibiotic Stewardship Report" for the last quarter was requested for this facility. Both facility documents were received, and compared. The review revealed completely different numbers for both	F 880	5. 8/4/2019.	

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F 880	Continued From page 352 the new resident admissions, and for those residents receiving antimicrobials, from the sister facility numbers. Copies of the facility "Infection control logs" for April and May 2019 were received, and there was no log for June. The ADON was then asked for the physician's orders for the last quarter for all ordered antimicrobials/antibiotics, and it was received. The physicians orders were compared to the "Infection control logs." In April 2019 there were 10 Residents receiving physician ordered antimicrobial therapy that were not documented on the log, in May 2019 there were 10 residents receiving antimicrobial therapy that were not documented on the log, and after the ADON completed the log for June on 6-14-19 at 2:15 p.m., there were 6 residents receiving antimicrobial therapy that were not documented on the log. The facility policy was requested and reviewed. The standard for the facility infection control program and policy was the national standard from the Center's for Disease Control (CDC). The facility staff was asked to provide the following 5 documents, and they stated they did not have them. 1. Corrective actions related to infections, tracking information about their antibiotic stewardship program. 2. The facility process for communicating with acute care institutions when transfers (to and from) occurred, involving, multi-drug resistant organisms (MDRO's), Labs, diagnoses,	F 880		

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F 880	Continued From page 353 discharge summaries, organism colonization, and health care associated infections (HAI's). 3. Protocols for making adjustments to antibiotic therapy. 4. Identify and produce infection assessment tools or management algorithms used for infections. 5. Notes from the QAPI committee on data review, and follow up planning. The ADON, DON, and Corporate RN were interviewed and stated that the infection control program, and antibiotic stewardship program, had not been active programs with the previous DON, and that oversight would be corrected immediately. For April, May, and June of 2019 (second quarter), nothing had been brought to the Facility Quality Assurance program committee from the Infection Control, nor the antibiotic stewardship programs. On 6-14-19 the Administrator was made aware of the findings. No further information was provided by the facility. 3. The facility staff failed to follow infection prevention measures in laundry services. On 06/13/19 at 08:32 AM, this surveyor observed Employee Q, from the laundry department process soiled linen. Employee Q transported a covered cart of soiled linen to the sorting room. The sorting room had a strongly offensive malodorous aroma of urine and feces. There were already 2 laundry carts of personal clothing items and 2 empty yellow laundry carts in the sorting room. Employee Q, opened the door of the sorting	F 880		

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F 880	Continued From page 354 room, and entered the adjoined laundry room. The laundry room contained 3 industrial washers situated to the right, 4 industrial dryers straight ahead, and two folding tables to the left. There was a pathway 52 inches wide between the washers where the soiled linen was loaded into washers and the folding tables where clean linen was folded and loaded on clean linen carts. There was a yellow and black line on the floor to designate the dirty zone from the clean zone. The clean folding table was 14 inches from the dirty zone. There was a distance of 70 inches from the dirty zone to the dryer in closest proximity. The personal protective equipment (PPE) was stored on the clean folding table. Employee Q donned the yellow gown, gloves, and mask (PPE), and walked back to the sorting room. While sorting personal clothing and facility linen, Employee Q had to lean against the carts to reach items inside with the yellow gown on her sleeves and torso making contact with the laundry cart and soiled linen. After sorting, Employee Q removed her gloves but kept the yellow gown and mask on. Employee Q then opened the door, entered the laundry room, walked through the dirty zone past the washers, walked into the clean zone around the folding tables to a clean laundry bin, reached inside and took 2 laundry covers out, then walked back around the clean folding table, back through the dirty zone, opened the door, and returned to the sorting room. Employee Q then placed the laundry bin covers over the soiled linen. Employee Q then opened the door, walked back into the laundry room beyond the dirty zone, walked around the tables and approached a clean linen cart by the dryers and reached into the shelf to retrieve another cart cover. Employee	F 880		

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F 880	Continued From page 355 Q then returned to the sorting room and covered a third linen cart of soiled laundry. Employee Q then put gloves on and pulled the covered cart of soiled linen into the laundry room. Because the door hinges were on the right, Employee Q directed the linen cart toward the clean folding tables on the left until the entire cart was in the room. This surveyor observed the soiled linen cart cross over the yellow and black line into the clean zone and it bumped into the white table where clean linen was located. Employee Q filled the washer with dirty linen from the cart, covered the cart, and returned it to the sorting room. Employee Q then took off the yellow gown, gloves, and mask, and went to the washer closest to the dryers that contained a finished load and emptied the wet linen into a small brown bin using her bare hands. Employee Q did not wash her hands between handling soiled linen and clean laundry. The clean linen carts Employee Q approached while wearing the yellow gown contained tablecloths, shower curtains, king sheets, and bed spreads. When asked about infection control in the laundry room, Employee Q stated to make sure to wash hands before touching dirty laundry and that "the stuff in red and yellow bags get washed separately." At the time of survey, a resident identified in the sample as Resident #122 had Methicillin-resistant staph aureus [MRSA] of the skin. According to the Centers for Disease Control and Prevention (CDC), MRSA is spread by contact with infected people or things such as towels which have touched infected skin. Also, a resident identified	F 880		

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F 880	Continued From page 356 in the sample as Resident #378 had neutropenia (which reduced his ability to resist microbes and increased his risk of being infected). On 06/20/2019 by the end of survey, the interim administrator had no further information to offer.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, pharmacy record review, and facility document review, the facility staff failed to maintain an active facility wide Antibiotic Stewardship Program. The findings included; The facility staff failed to maintain an active facility wide antibiotic stewardship, and Infection Prevention and Control Program (IPCP). On 6-14-19 at approximately 11:00 a.m.., the Administrator was asked who surveyors should speak with, in regard to the facility infection control program. The Administrator stated the Assistant Director of Nursing (ADON) was in charge of it, and she was an interim employee	F 881	1. Facility obtained correct Infection Control surveillance documents and Antibiotic Stewardship Report from pharmacy. 2. All residents may have potentially been impacted. Assistant Director of Nursing/designee completed an audit of June 2019 Infection Control log comparing Physician orders with the Antibiotic/Antimicrobial report and tracking and trending surveillance. This information will be reported to the QAPI Committee. 3. The DON at the time of the survey is no longer employed at the facility. The current Assistant Director of Nursing has	8/4/19

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F 881	Continued From page 357 from a sister facility. The Administrator stated the previous Director of Nursing (DON) had been responsible for it, however, she was no longer employed. On 6-14-19 at 12:00 p.m., the Registered Nurse (ADON) came into the conference room and stated she would be in charge of infection control. She brought in with her a 3 ring binder with "the infection control program" she stated, in it. The ADON was interviewed in the conference room by surveyors. The ADON was asked to show us her tracking and trending for the infection surveillance, and she began to read from the book. She was again asked to provide the documents for surveyor review. She handed the surveyor the binder and contained within were the infection control surveillance documents from a sister facility. She was asked where the documents were for this facility, and she stated that these were the documents, that the pharmacy had just made an error and printed the wrong facility name on the documents. The Pharmacy was called and the "Antibiotic Stewardship Report" for the last quarter was requested for this facility. The documents were received, and compared. The review revealed completely different numbers for both the new resident admissions, and for those residents receiving antimicrobials, from the sister facility numbers. Copies of the facility "Infection control logs" for April and May 2019 were received, and there was no log for June. The ADON was then asked for the physician's orders for the last quarter for all ordered antimicrobials/antibiotics, and it was received.	F 881	been educated by Divisional Director of Clinical Services on how to obtain, analyze and organize infection data for accurate monitoring of an infective control program and an Antibiotic Stewardship program to include antibiotic usage protocols. The current monthly report will carryover names of residents who initiated but continued on antibiotic therapy from the previous month. The monthly report and analysis of infections and use of antibiotics will be submitted to the QAPI program for further review / analysis 4. Director of Nursing/designee will conduct audits of antibiotic/antimicrobial therapy is documented on the Infection Control log, weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. If variances are found, the log will be corrected, and the responsible staff person will be re-educated. Findings from the audits will be submitted to the monthly QAPI Committee for additional review and oversight. 5. 8/4/2019.	

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F 881	Continued From page 358 The physicians orders were compared to the "Infection control logs." In April 2019 there were 10 Residents receiving physician ordered antimicrobial therapy that were not documented on the log, in May 2019 there were 10 residents receiving antimicrobial therapy that were not documented on the log, and after the ADON completed the log for June on 6-14-19 at 2:15 p.m., there were 6 residents receiving antimicrobial therapy that were not documented on the log. The facility policy was requested and reviewed. The standard for the facility infection control program and policy was the national standard from the Center's for Disease Control (CDC). The facility staff was asked to provide the following 5 documents, and it was stated they did not have them. 1. Corrective actions related to infections, tracking information about their antibiotic stewardship program. 2. The facility process for communicating with acute care institutions when transfers (to and from) occurred, involving, multi-drug resistant organisms (MDRO's), Labs, diagnoses, discharge summaries, organism colonization, and health care associated infections (HAI's). 3. Protocols for making adjustments to antibiotic therapy. 4. Identify and produce infection assessment tools or management algorithms used for infections. 5. Notes from the QAPI committee on data review, and follow up planning.	F 881		

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F 881	Continued From page 359 The ADON, DON, and Corporate RN were interviewed and stated that the infection control program, and antibiotic stewardship program, had not been active programs with the previous DON, and that oversight would be corrected immediately. For April, May, and June of 2019 (second quarter), nothing had been brought to the Facility Quality Assurance program committee from the Infection Control, nor the antibiotic stewardship programs. On 6-14-19 the Administrator was made aware of the findings. No further information was provided by the facility.	F 881		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, Resident interview, and staff interview, the facility failed to maintain a safe, functional, sanitary environment. The findings included; On 6-5-19 at 12:00 p.m. during the initial tour of the facility, and medication pour and pass observations, several surveyors noticed foul odors on all three units in the facility. The same foul odors were noted on 3 of 3 units during each day of the entire 3 week survey. Both the facility hallways and rooms were	F 921	1. The handrail in the hallway across from room 116 was fixed on 7/15/19. Ceiling tiles were replaced on 7/11/19. The toilet was cleaned and bathroom curtains in rooms were replaced, including room 105 on 7/10/19. Staff member educated about leaving soiled linens on the floor. Both mattresses in room 105 were replaced on 7/10/19. HVAC vendor fixed control fuse, economizer, washed a condenser, repaired leak on suction service port, and charged AC units on 6/27/19. Resident rooms in the facility and commons areas were emptied of contents. Contents packed in tubs and	8/4/19

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F 921	Continued From page 360 pervasive with the smell of feces and urine. The Residents also were noted to smell of strong body odors consistent with lack of bathing, and lack of hygiene product use such as antiperspirant, and tooth/oral care products. The hand railing in the hallway by room 116 was broken revealing a rectangular shaped hole in the face of the hard hollow plastic railing measuring approximately 5 inches long by 3 inches wide and 2 inches deep. The broken area edges were examined, and found to be very sharp and could easily cut skin. Ceiling areas were noted to be stained, and sagging in places. The floors were sticky with a substance that the surveyors shoes stuck to and pulled one shoe off as the surveyor was walking. The bathroom and bedroom in room 105 were observed during the medication pour and pass observation on 6-5-19. The observation revealed urine and feces soiled linens on the floor, the toilet was smeared with feces, and the bathroom doorway, which was a curtain had multiple, 12 inch by 12 inch stains on it. This was noted in other rooms on this hallway as well. Both beds in the 105 room were stripped of linens to reveal mattresses with cracked plastic coatings which could not be hygienically cleaned, as the soft inner portion was exposed. An interview was conducted with the Licensed Practical medication Nurse (LPN A), who stated there were many residents on the unit who were incontinent, and often refused to bathe or shower and that she thought that might be the smell. The nurse also stated that she was working on a six week contract, and that there were not enough	F 921	floors were stripped, top scrubbed and buffed. Persistent Noxious odors have resolved; residents are being provided with incontinent care. 2. All residents in the facility may have been impacted. Clinical staff being trained on ADL cares of residents and expectations. Contract environmental vendor provide daily cleaning and will maintain schedule for floor cleaning, deep cleaning schedule and tasks completed during cleaning of rooms and facility. Handrails have been inspected and repaired as needed to ensure they are firmly affixed and smooth. 3. Nursing staff were re-educated on appropriately and timely ADL care in a dignified manner. A skills fair on ADLs has been scheduled. Environmental contract vendor had a meeting with facility, Regional and Divisional leadership.to define expectations. Contract environmental vendor provide daily cleaning and will maintain schedule for floor cleaning, deep cleaning schedule and tasks completed during cleaning of rooms and facility. Housekeeping, laundry staff and CNAs will be re-educated on infection control practices. 4. Rounds will be conducted 5 days a week x 3 months by assigned leadership team members to observe for clean, safe, comfortable, home-like environment, resident dignity and if ADL care has been provided appropriately and timely; if variances are identified they will be	

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F 921	Continued From page 361 staff to manage all of the residents, and she would not be renewing her contract with the Administrator to return. The building was noted to be uncomfortably warm, and ventilation was poor. The Maintenance Director (employee F) was called to the unit and performed air temperature checks which resulted in multiple findings of 78, and 79 degrees Fahrenheit. He checked the thermostat on the wall and stated someone had turned off the air-conditioning. This happened on numerous days of the 3 week survey. The noxious odors, and elevated temperatures were not ventilated during the survey, and never dissipated. The Resident in room 109 was asked during medication administration if she was comfortable in her room. She stated "No, you could fry an egg on my head it is so hot in here. Can't you see I am wearing this gown to cool off." Residents, nursing staff, and the housekeeping staff were all noted to be visibly sweating. On 6-11-19 at approximately 10 AM, an interview was conducted with the Administrator who stated the Housekeeping and nursing staff had identified several rooms in the facility including rooms on the Liberty and Freedom Units for targeted cleaning to help diminish foul odors. She went on to say it did not feel hot in the facility to her, and the ventilation problems were because it was an old building. The Administrator stated she also noted the pungent odor on the Units and was aware of a "few" residents who often refused showers and baths. The Administrator stated the Housekeeping	F 921	corrected and/or reported to the Unit Managers for follow-up. Findings from the audits will be submitted to the DON / ADON for tracking / trending and a summary of observations and actions will be reported to QAPI. 5. 8/4/2019	

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F 921	Continued From page 362 Department utilized a schedule where rooms were cleaned regularly. During the survey 3 Housekeeping staff were noted in the hallways of the units, however, the odors never dissipated. The Administrator was made aware of the issues during her interview, and no further information was provided by the facility.	F 921		
F 923 SS=E	COMPLAINT DEFICIENCY. Ventilation CFR(s): 483.90(i)(2) §483.90(i)(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview, the facility staff failed to maintain adequate ventilation of outside air to provide good air circulation for residents. The findings included; On 6-5-19 at 12:00 p.m. during the initial tour of the facility, and medication pour and pass observations, several surveyors noticed foul odors on all three units in the facility. The same foul odors were noted on 3 of 3 units during each day of the entire 3 week survey. Both the facility hallways and rooms were pervasive with the smell of feces and urine. The Residents also were noted to smell of strong	F 923	1. Contract HVAC Vendor was contracted to inspect and repaired HVAC units / system on 6/27/19. The resident in room 105 is satisfied with room temperature. Persistent Noxious odors have resolved; residents are being provided with incontinent care 2. All residents may have potentially been affected. Clinical staffs being trained on ADL care of residents and expectations. Contract environmental vendor provide daily cleaning and will maintain schedule for floor cleaning, deep cleaning schedule and tasks completed during cleaning of rooms and facility. HVAC units / systems have been repaired.	8/4/19

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F 923	Continued From page 363 body odors consistent with lack of bathing, and lack of hygiene product use such as antiperspirant, and tooth/oral care products. An interview was conducted with the Licensed Practical medication Nurse (LPN A), who stated there were many residents on the unit who were incontinent, and often refused to bathe or shower and that she thought that might be the smell. The nurse also stated that she was working on a six week contract, and that there were not enough staff to manage all of the residents, and she would not be renewing her contract with the Administrator to return. The building was noted to be uncomfortably warm, and ventilation was poor. The Maintenance Director (Employee F) was called to the unit and performed air temperature checks which resulted in multiple findings of 78, and 79 degrees Fahrenheit. He checked the thermostat on the wall and stated someone had turned off the air-conditioning. This happened on numerous days of the 3 week survey. The noxious odors, and elevated temperatures were not ventilated during the survey, and never dissipated. The Resident in room 109 was asked during medication administration if she was comfortable in her room. She stated "No, you could fry an egg on my head it is so hot in here. Can't you see I am wearing this gown to cool off." Residents, nursing staff, and the housekeeping staff were all noted to be visibly sweating. On 6-11-19 at approximately 10 AM, an interview was conducted with the Administrator who stated the Housekeeping and nursing staff had identified	F 923	3. Clinical staff being trained on ADL care of residents and expectations. Contract environmental vendor provide daily cleaning and will maintain schedule for floor cleaning, deep cleaning schedule and tasks completed during cleaning of rooms and facility. HVAC units / systems have been repaired. Staffs have been educated on process of reporting to Maintenance HVAC units that do not appear to work, and a work order will be submitted for repair. 4. The Maintenance Director / designee will monitor room temperatures in 3 rooms on each unit 3 times weekly x 12 weeks to ensure that the HVAC units are functioning, and the room temperature is comfortable per resident choice. Any identified variances will be corrected. The Maintenance Director will submit a weekly report to the Executive Director and a summary of the weekly audits will be reported to the monthly QAPI Committee for oversight and further recommendation. Rounds will be conducted 5 days a week x 3 months by assigned leadership team members to observe for clean, safe, comfortable, home-like environment, resident dignity, if ADL care has been provided appropriately and timely; and if HVAC units are providing appropriate ventilator and temperatures that are comfortable. If variances are identified they will be corrected and/or reported to the Unit Managers for follow-up. Findings from the audits will be submitted to the	

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F 923	Continued From page 364	F 923		
	several rooms in the facility including rooms on the Liberty and Freedom Units for targeted cleaning to help diminish foul odors. She went on to say it did not feel hot in the facility to her, and the ventilation problems were because it was an old building. The Administrator stated she also noted the pungent odor on the Units and was aware of a "few" residents who often refused showers and baths. The Administrator stated the Housekeeping Department utilized a schedule where rooms were cleaned regularly. During the survey 3 Housekeeping staff were noted in the hallways of the units, however, the odors never dissipated. The Administrator was made aware of the issues during her interview, and no further information was provided by the facility.		DON / ADON for tracking / trending and a summary of observations and actions will be reported to QAPI. 5. 8/4/2019	
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to maintain a safe environment with secure handrails in good working condition for residents. The findings included; The hand railing in the hallway by room 116 was broken revealing a rectangular shaped hole in the face of the hard hollow plastic railing measuring	F 924	1. Handrail in the hallway by room 116 was repaired 7/16/19. 2. All residents at Envoy of Williamsburg may have potentially been affected. An inspection of all handrails was completed on 7/11/19 and repairs were made as appropriate to ensure that rails were secure and smooth.	8/4/19

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F 924	Continued From page 365 approximately 5 inches long by 3 inches wide and 2 inches deep. The broken area edges were examined, and found to be very sharp and could easily cut skin. On 6-11-19, the Administrator stated the rail would be repaired. The Administrator was interviewed, and made aware of the issue, and no further information was provided by the facility. It was not repaired by the time of exit on 6-20-19.	F 924	3. The Maintenance Director / designee will complete an inspection of handrails monthly and provide a report to the Executive Director. All staff have been educated on how to notify Maintenance and/or submit a work order for any rails that need repair. 4. Rounds will be conducted 5 days a week x 3 months by assigned leadership team members to observe for clean, safe, comfortable, home-like environment, including that handrails are secure and smooth. If variances are identified they will be corrected and/or reported to the Unit Managers for follow-up. Findings from the audits will be submitted to the DON / ADON for tracking / trending and a summary of observations and actions will be reported to QAPI. 5. 8/4/2019	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain an effective pest control program and provide pest-free living conditions. The findings included:	F 925	1. The facility has a current pest control contract. An inspection of pest control recommendations for a door sweep of the Emergency exit door on Liberty Unit and the "baseboard below wash table in the dish room has been completed. 2. All residents at Envy of Williamsburg	8/4/19

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F 925	Continued From page 366 On 06/10/2019 at 9:56 AM, this surveyor observed a fly at the nurse's station by room 144. On 06/17/2019 at 9:00 AM, a copy of pest control contract, work orders, and pest control policy were requested. On 06/17/2019 at 9:30 AM, Employee F from Maintenance provided pest work orders, sighting logs, and pest control policy. Employee F stated he was still looking for the pest control contract. The pest sightings logs were reviewed and revealed the following: For the Liberty unit: On 03/22/2019, roaches were seen at the Liberty's nurse's station. Under "Action taken" it was documented, "Monitor and bait." On 04/29/2019, ants were seen in room 136 and treated with insecticide. On 05/24/2019, there were oriental roaches seen at the nurse's station and treated with insecticide. On 06/03/2019, there were "bugs" seen at nurse's station and a work order request with a pest control company had been submitted. For the Freedom unit: On 03/22/2019, there were roaches sighted at the nurse's station. Under "Action taken" it was documented, "Monitor and bait." For the Colonial unit: On 03/29/2019, there were roaches seen at the nurse's station. Under "Action taken" it was documented, "Monitor and bait." On 05/24/2019, there were roaches seen at the nurse's station and treated with insecticide. On 06/07/2019, there were ants seen in room 178 by the window and a work request with a pest control company had been submitted.	F 925	may have been affected. The contract Pest Control vendor will complete a full-house inspection and provide recommendations to the Executive Director to minimize the presence of pests. 3. Staff will be re-educated on the importance and process for reporting observation of pests by Divisional Executive Director. The contract Pest Control vendor will complete a full-house inspection and provide recommendations to the Executive Director to minimize the presence of pests. Resident rooms have been deep cleaned. Pest control was discussed during Resident Council and the facility will provide bags and/or covered containers as needed to assist residents in securing snacks and food items. A copy of the current page of pest book will be brought to daily Stand Down meeting to review for pest activity and the exterminator will be contacted as appropriate for targeted treatment. 4. Rounds will be conducted 5 days a week x 3 months by assigned leadership team members to observe for clean, safe, comfortable, home-like environment, observation for pest. If variances are identified they will be corrected and/or reported to the Unit Managers for follow-up. Findings from the audits will be submitted to the DON / ADON for tracking / trending and a summary of observations and actions will be reported to QAPI. 5. 8/4/2019	

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F 925	Continued From page 367 The pest control work orders serviced by a pest control company were reviewed and revealed: A work order from a pest control company dated 10/24/2018 sighted fruit flies in the kitchen; german roaches in the soiled linen room, laundry room, records room, and on environmental carts in the basement. The company applied targeted treatment. A work order from a pest control company dated 11/28/2018 sighted german roaches in the kitchen; on a kitchen cart; by the A.C. unit in the Activities room. The company applied targeted treatment. A work order from a pest control company dated 12/26/2018 sighted fruit flies and mosquitoes in the dishroom; german roaches in the activity room and Liberty nurse's station.. The company applied targeted treatment. A work order from a pest control company dated 02/15/2019 sighted german roaches in room 112. The company applied targeted treatment. A work order from a pest control company dated 04/05/2019 sighted a roach in room 106. The company applied targeted treatment for roaches, flies, and fruit flies. A work order from a pest control company dated 04/12/2019 sighted roaches in the kitchen. A comment associated with that sighting documented, "Along back wall. However staff are stating there is activity everywhere." The company applied targeted treatment in the kitchen, dish room, activities room, records room, basement, housekeeping, laundry room, and soiled linen room. A work order from a pest control company dated 04/29/2019 did not document sightings but the company applied targeted treatment for roaches, ants, and flies.	F 925		

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F 925	Continued From page 368 A work order from a pest control company dated 05/24/2019 sighted roaches and applied targeted treatment at the nurse's stations and also treated activity room and community area. A work order from a pest control company dated 06/03/2019 documented, "Inspection room 126 for possible bed bug or spider bite. Supposedly resident went to hospital for bite earlier this week. Check those resident beds, curtains as well, and baseboards and found no evidence of bed bugs or spider activity in the room. Found no evidence of new roach activity in the room as well." Two recommendations from the company on every work order since 12/26/2018 documented, "Emergency exit door just before Liberty has a large door gap at the bottom. Please attach a door sweep." A second recommendation documented, "baseboard below wash table in dish room is falling apart. Heavy organic slime behind baseboard as well as fly breeding areas and mosquito activity." The facility staff provided a copy of their pest control contract with a pest control company. At the bottom of the form above "Commencement date" it documented, "Sept. to Dec. 2015 only." When Employee F was questioned about that, he provided a copy of an email correspondence dated 06/17/2019 at 10:28 AM addressed to Employee F from a pest control company. An excerpt of the letter documented, "I'm still working on the contract. It's a different system since [facility corporation name] was originally under the [company] brand and [other company] took over." I reached out and let them know the urgency of needing the contract now." The facility provided a copy of their pest control	F 925		

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F 925	Continued From page 369 policy entitled, "Pest Control." Section 1 stated, "A pest control contract will be maintained with a licensed exterminator." On 06/18/2019 at 9:30 AM, this surveyor observed a roach in the bathroom by the front lobby. On 06/20/2019 at approximately 5:30 PM, this surveyor observed a fly walking on the desk in the interim administrator's office. By the end of survey, the interim administrator had no further information to offer.	F 925		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review and in the course of a complaint investigation, the facility administration failed to maintain an effective	F 943	1. Current employees will be trained in abuse/neglect and misappropriation of resident property.	8/4/19

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F 943	Continued From page 370 training program. For 50 employees, the facility administration failed to provide training to their staff on abuse, neglect, exploitation and misappropriation of resident property. The findings included: On 6/18/19 a review of employee education files revealed the following: 28 clinical/nursing staff had not received any abuse/neglect and misappropriation of property training and education. 7 of the 28 clinical staff were working and/or scheduled to work on the day of the review, 6/18/19. For 3 of 12 dietary employees, the facility had no evidence that they have received any abuse/neglect and misappropriation of property training/education. For 7 of 12 dietary employees, the contracted company, nor the facility, had provided annual training on abuse/neglect and misappropriation of property policies/reporting within the past year. For 6 of 10 housekeeping/laundry employees, the facility has no evidence of abuse/neglect and misappropriation of property training/education. For 3 of 10 housekeeping/laundry employees, the contracted company, nor the facility, had provided annual training on abuse/neglect and misappropriation of property within the past year. As of 6/20/19 at the time of exit, there was no evidence provided to indicate that the three	F 943	2. All residents at Envoy of Williamsburg may have been affected. Current employees will be trained in abuse/neglect and misappropriation of resident property 3. All staff was given education on abuse during survey. Additional training on abuse / neglect will providing using multiple modalities including group training / discussion facilitated by an external long-term care consultant, small group and 1:1 review and discussion with staff; on-line training, etc. Abuse training will be provided to new employees during orientation. HR Coordinator will track 12-month Abuse Education and turn into ED weekly to assure staff has mandated education. A listing of employees who has not completed annual abuse training will be provided to the Executive Director and the staff will be removed from the schedule until the training is completed. 4. The Executive Director / designee will provide a summary of abuse training activities and any actions taken to the monthly QAPI Committee for additional review and recommendation. 5. 8/4/2019	

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F 943	Continued From page 371 therapy staff had received any abuse/neglect and misappropriation of property training. During the survey process of this facility, there was a preponderance of evidence that 10 residents were abused, neglected and/or had misappropriation of property by facility staff. Review of the facility assessment with a date of 3/1/19 revealed that on pages 11-12 that "every staff member has a knowledge competency in abuse, neglect, exploitation and misappropriation;" "Competencies are verified upon orientation, least annually [sic] and as needed." Review of the facility Policy and procedure titled "Resident Abuse" with a revision date of 2/1/17 read, "Employees of the company will receive education and training on resident rights, resident abuse and abuse reporting during orientation and annually thereafter." COMPLAINT DEFICIENCY.	F 943		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		8/4/19

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F 947	Continued From page 372 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review the facility staff failed to ensure 7 CNA's (certified nursing assistants) of 13 CNA's in the survey sample, received 12 hours of in-service training per year (CNA-A, CNA-B, CNA-D, CNA-F, CNA-H, CNA-I, and CNA-J). The findings included: 1. The facility staff failed to ensure that CNA-A received a minimum of 12 hours of in-service training per year to include, abuse training and dementia management. CNA-A was hired 7/13/16. Review of training records revealed that CNA-A received 2.75 hours of training in 2018. The training did not include abuse training or dementia management as required. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 2. The facility staff failed to ensure that CNA-B received a minimum of 12 hours of in-service	F 947	1. Review initiated during the survey. CNA□s A,B,D,F,H,I, and J will be educated by July 31,2019. 2. Current residents have the potential to be affected. CNAs will be scheduled to receive a minimum 12 hours per year of education. 3. The DON / designee will facilitate a “skills fair” for CNAs to include but not be limited to: Handwashing, Foley catheter care, incontinence care, turning/reposition; mech lift use; vital signs, ADL documentation, use of Stop/Watch/ pink skin sheet / isolation [donning/doffing PPE], etc. In addition, CNAs will be educated on abuse identification / reporting, and assisting residents with meals and Dementia Management. CNA’s will receive full twelve hours a year of education. The Human Resource Coordinator will be responsible to ensure that education training hours are appropriately entered in the computer system and will notify the DON when required training hours are not met for staff. Performance evaluations	

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F 947	Continued From page 373 training per year to include, dementia management. CNA-B was hired 9/21/15. Review of training records revealed that CNA-B received 2.75 hours of training in 2018. The training did not include dementia management as required. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 3. For CNA-D, the facility staff failed to ensure the CNA received 12 hours of education annually to include but not limited to abuse prevention. CNA-D was hired 2/4/16. Review of employee education records revealed that CNA-D received 11.5 hours of in-service education in 2018, none of which included abuse prevention. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 4. For CNA-F, the facility staff failed to ensure the CNA received 12 hours of education annually to include but not limited to abuse prevention. CNA-F was hired 4/12/17. Review of employee education records revealed that CNA-F received 11.75 hours of in-service education in 2018, none of which included abuse prevention. An interview was conducted with Employee H,	F 947	will be scheduled for each CNA annually. 4. The Director of Nursing/designee will audit the required education weekly x 3 months, and monthly thereafter. Variances will be investigated, and appropriate education and/or disciplinary action will be taken. The Director of nursing will audit the education calendar monthly for six months, Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. 8/4/2019	

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F 947	Continued From page 374 Regional Clinical Director, Employee H stated she had no further education documentation to provide. 5. For CNA-H, the facility staff failed to ensure the CNA received 12 hours of education annually to include but not limited to dementia management. CNA-H was hired 11/25/07. Review of employee education records revealed that CNA-H received 1.5 hours of in-service education in 2018, none of which included dementia management. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 6. For CNA-I, the facility staff failed to ensure the CNA received 12 hours of education annually to include but not limited to abuse prevention. CNA-I was hired 9/11/12. Review of employee education records revealed that CNA I received 11.5 hours of in-service education in 2018, none of which included abuse prevention. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide. 7. For CNA-J, the facility staff failed to ensure the CNA received 12 hours of education annually to include but not limited to abuse prevention and	F 947		

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F 947	Continued From page 375 dementia management. CNA-J was hired 10/24/17. Review of employee education records revealed that CNA-J received 1 hour of in-service education in 2018, none of which included abuse prevention or dementia management. An interview was conducted with Employee H, Regional Clinical Director, Employee H stated she had no further education documentation to provide.	F 947		