STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD** **FREDERICKSBURG, VA 22407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/23/19 through 07/26/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [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 every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency	E 026	E026 1. Address how corrective action will be accomplished for those residents affected	8/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/15/2019

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 026	Continued From page 1 preparedness plan. Facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 07/25/19 at approximately 6:00 p.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 2, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. OSM # 2 stated that the facility did not have it. On 07/25/19 at 6:22 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the findings. No further information was provided prior to exit.	E 026	by deficient practice; There was no negative outcome due to the deficient practice. The residents□ safety was maintained at all times and the Emergency Preparedness Plan contained appropriate response actions for emergency situations. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents of the facility potentially can be affected by the failure to have policies and procedures in the emergency plan that describe the facility□s role in providing care and treatment at altered care sites under an 1135 waiver. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; The facility will develop a section within the Emergency Preparedness Plan that addresses the facility□s role in providing care during a 1135 wavier situation. The facility has familiarized itself on the process and requisition requirement for the 1135 Waiver under the Social Security Act. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; The facility has included in it emergency preparedness plan the process and requisition requirement for the 1135 Waiver under the Social Security Act. On a quarterly basis, this requirement will be reviewed in the facility Quality Assurance meeting.	

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/23/19 through 7/26/19. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 177 certified bed facility was 114 at the time of the survey. The survey sample consisted of 48 current resident reviews and six closed record reviews.	F 000		
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	F 580		8/25/19

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F 580 Continued From page 3 F 580

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, 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a change in resident condition for one of 54 residents in the survey sample, Resident #71.
The facility staff failed to notify the physician and/or nurse practitioner of Resident #71's significant weight loss in June 2019.

The findings include:

Resident #71 was admitted to the facility on

F580
1. Address how corrective action will be accomplished for those residents affected by deficient practice; On 7/25/19 the physician/MD was made aware of change in condition.

2. Address how facility will identify other residents potentially affected by deficient practice; Any resident can be affected by failure of notifying physician in a timely manner regarding change of condition.

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F 580	Continued From page 4 1/22/19. Resident #71's diagnoses included but were not limited to heart failure and diabetes. Resident #71's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/16/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section K coded Resident #71 as having a feeding tube and as having a weight loss of five percent or more in the last month or ten percent or more in the last six months. Review of Resident #71's clinical record revealed the following weights: -5/6/19 202 lbs. (pounds). -6/10/19 184 lbs (an 8.91% weight loss from 5/6/19). Further review of Resident #71's clinical record (including nurses' notes, physician/nurse practitioner notes and dietary assessments) failed to reveal the physician and/or nurse practitioner was made aware of the significant weight loss. Resident #71's comprehensive care plan dated 2/18/19 failed to document information regarding the significant weight loss. On 7/25/19 at 11:15 a.m., an interview was conducted with OSM (other staff member) #5 (the diet tech). OSM #5 was asked the facility process for an addressing significant weight loss. OSM #5 stated, "When a person triggers for significant weight loss, I am the one who checks the weights. I check the weekly weights every week and put into the system and I check monthly weights monthly. I check and identify and refer to the dietician and the dietician does an assessment and makes recommendations and gives them to nurses and the dietary	F 580	3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Per facility's Nursing Policy and Procedure Reporting Change of Condition; resident changes of condition will be reported to physician/MD. Licensed nursing staff responsible for reporting changes of condition for residents will be re-in-serviced on company policy. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; Inter-Disciplinary-Team (IDT) will review change of condition for residents and notification of physicians in the Morning Meeting process 5x per week x 4 weeks. The DON/Designee will review the daily findings and corrective measures enacted for the previous week period. This monitoring will continue x 4 weeks, quarterly x 2 quarters. Negative findings/patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations x 2 quarters.	

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F 580	Continued From page 5 manager and it's followed from there." OSM #5 was asked if Resident #71 was evaluated and if the resident's significant weight loss was addressed in June 2019 to see if changes needed to be made to her plan of care. OSM #5 stated, "I know we talked about her at the weight meeting but I cannot say if a RD (registered dietician) or doctor assessed her." On 7/25/19 at 1:12 p.m., an interview was conducted with ASM (administrative staff member) #4 (the nurse practitioner). ASM #4 was asked if she was made aware of Resident #71's significant weight loss in June 2019. ASM #4 stated, "It's hard to say. They go over those in the QAPI (quality assurance and performance improvement) meetings. We may have known. I know we look for them on our own independently when we do re-certifications and note." ASM #4 stated Resident #71 had a feeding tube and she relies on the RD a lot for residents with tube feedings so she felt confident the RD followed Resident #71. ASM #4 confirmed she would document an evaluation of significant weight loss in her notes if she assessed a resident for this. ASM #4 reviewed her June 2019 notes and confirmed her notes did not contain any specific information regarding Resident #71's significant weight loss. ASM #4 stated the facility staff may have told her about the weight loss and she may have asked if they were doing weekly weights and then said, 'okay.' On 7/25/19 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked what should be done when a resident presents with a significant weight loss. LPN #3 stated, "We have our weight meetings weekly. We identify them there; the dietician then	F 580		

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F 580	Continued From page 6 gets involved, and notify the physician or nurse practitioner." When asked why the physician and/or nurse practitioner should be notified, LPN #3 stated, "Once we do the weekly weights, we want to identify what we need to do. Supplement, vitamins, you need an order for." When asked if nurses should document physician and/or nurse practitioner notification of a resident's significant weight loss, LPN #3 stated, "When we get the new order we document the dietician recommendation and reviewed with the nurse practitioner." On 7/25/19 at 6:22 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Weighing the Resident" documented, "10. The nurse will: a. Notify the physician and responsible party of any significant weight change..." No further information was presented prior to exit.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		8/25/19

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F 584 Continued From page 7
receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined that facility staff failed to maintain a homelike environment in one of 12 bathrooms on the West One Unit. On the West One Unit, facility staff failed to provide unstained ceiling tiles in the resident bathroom promoting a homelike environment in a shared bathroom between two resident rooms.

The findings include:

F 584

F584
1. Address how corrective action will be accomplished for those residents affected by deficient practice; The resident bathroom with the identified ceiling tile has been replaced.

2. Address how facility will identify other residents potentially affected by deficient practice; Resident bathrooms with ceiling

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F 584 Continued From page 8

On 7/23/19 at 2:28 p.m., an observation of the bathroom connecting Resident rooms # 81 and # 83 revealed two stained ceiling tiles. Observation of the ceiling tiles revealed they had two round stains on one tile near the center of the ceiling over the toilet and another stain on the tile surrounding the sprinkler head over the back of the toilet.

On 7/24/19 at 8:00 a.m., an observation of the bathroom connecting Resident rooms # 81 and # 83 revealed findings as described above.

On 7/25/19 at 3:25 p.m., an interview was conducted with OSM (other staff member) #2 (director of maintenance) regarding ceiling tiles. When asked how often ceiling tiles are inspected OSM #2 described that room inspections are done daily. OSM #2 stated that staff put badly stained tiles in the maintenance book or report them to him directly. OSM #2 stated there was an abundance of them last week due to the extremely high temperatures causing the air condition unit in the ceiling to sweat. OSM #2 stated, "A lot of the time we have to prioritize those to see if we have to move the resident to do the project." When asked why they replace stained tiles, OSM #2 stated "For cosmetic purposes and if damaged it could collapse." When asked if stained tiles promote a homelike environment, OSM #2 stated "not pretty." OSM #2 viewed the observed tiles in the shared bathroom between Resident rooms # 81 and # 83 and agreed that they needed to be addressed.

On 7/25/19 at 6:22 p.m., ASM (administrative staff member) #1 (administrator) and ASM #2 (director of nursing) were made aware of the

F 584

tiles are subject to staining and will need replacement when staining occurs.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Care Keeper Rounds (environmental rounds) have been annotated with specific inspection items on the checklist that include ceiling tile condition. Care Keeper Rounds are performed to identify needed areas of repair or replacement 5x per week, and communicated in the Morning Meeting process. Care Keeper Round finding are reviewed in the facility stand-down meeting 5x per week in the afternoons.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; On a weekly basis the Administrator/Designee will review the daily findings and corrective measures enacted for the previous week period. This monitoring will continue x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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F 584	Continued From page 9 above concern. No further information was provided prior to exit.	F 584		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §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 resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure four of 54 residents in the survey sample were from abuse; Residents #73, #29, #11, and #58. Residents #73, #29, and #11 were involved in a resident-to-resident altercation on 7/8/19, per a Facility Reported Incident (FRI) sent to the required state agency on 7/9/19. The facility failed to ensure that each resident was free from being abused by each other. Resident #11 a cognitively intact resident observed, Resident #73, a cognitively impaired resident, hitting Resident #29, a cognitively impaired resident. Resident #11 inserted herself into the	F 600	F600 1. Address how corrective action will be accomplished for those residents affected by deficient practice; There was no negative outcome due to the deficient practice. The resident safety was maintained at all times and the Care Plan missing documentation was flagged and noted. Responsible parties/families and physicians were notified. 2. Address how facility will identify other residents potentially affected by deficient practice; Any resident with an episodic event, involving an altercation which is	8/25/19

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F 600	Continued From page 10 situation to stop Resident #73 from hitting Resident #29. Resident #11 proceeded to hit Resident #73, who in turn hit Resident #11 back. Resident #58 was struck in the face by another resident during a meal. The findings include: 1. Resident #73 was admitted to the facility on 6/9/17 with the diagnoses including but not limited to: dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's disease, mood disorder, and depression. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as total care for bathing; extensive assistance for bathing, dressing, toileting, and hygiene; and supervision for eating. Resident #29 was admitted to the facility on 11/11/13. Diagnoses include, but are not limited to: dementia, dysphagia, glaucoma, cataracts, heart failure, schizophrenia, spondylosis, and diabetes. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/19 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, eating, toileting, and hygiene. Resident #11 was admitted to the facility on 4/12/19. Diagnoses include, but are not limited to: diabetes, high blood pressure, osteoarthritis, anxiety, and depression. The quarterly MDS (Minimum Data Set) with an ARD (Assessment	F 600	resident-to-resident has the potential to be affected. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; While maintaining the residents' freedom to access all areas of their facility, staff monitoring of resident to resident interactions involving behaviors that may lead to aggression will be reviewed in the Morning Meeting process which occurs 5x per week. Residents exhibiting aggressive behaviors that are not successfully re-directed will be referred to the psychiatric nurse practitioner for intervention recommendations. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; Results of behavioral investigations will be reported and reviewed in the Morning Meeting process. On a weekly basis the DON/Designee will review daily findings and corrective measures enacted for the previous week period. This monitoring will continue x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.	

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Reference Date) of 7/9/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, and supervision only for all other areas of activities of daily living.

A review of a FRI (facility reported incident) report dated 6/9/19 regarding an incident dated 6/8/19 (dated incorrectly, the actual incident occurred on 7/8/19 and was reported on 7/9/19), documented, "Per (Resident #11), (Resident #73) hit her and she slapped her back in return. Per (Resident #11), (Resident #73) hit (Resident #29). Residents were separated. County Sheriff was called. Investigation started."

The investigation revealed a statement by OSM #14 (Other Staff Member - dietary staff) which documented, "Employee reports seeing (Resident #11) standing and striking @ (at) (Resident #73). She reports that she observed (Resident #11) slap (Resident #73) 3 times in the face (with) the palm of her L (left) hand. Associate added that (Resident #73) was sitting in her w/c (wheelchair) and struggling to hit (Resident #11) back. She saw (Resident #73) slap (Resident #11) once in the face with the palm of her hand."

The investigation further revealed a statement by Resident #11, which documented, "Resident reports that she was defending (Resident #29) and herself when she was observed by dietary staff hitting (Resident #73). She added that (Resident #73) had been hitting (Resident #29) and her in the legs prior to this event. Further, that (Resident #73) had hit her in the left shoulder. (Resident #11) was sitting @ (at) the West 1 nurses station waiting for someone to get

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her ice @ this time."

The investigation revealed another statement by Resident #11, which documented, "I was going to get ice and I see this woman (Resident #73) beating on a woman (Resident #29) who was sitting there. I had no choice but to separate her. She hit her on the legs, her stomach, and her chest. The woman was afraid. I stucked {sic} my nose in it, I had to protect her." Per (Resident #11) she told (Resident #73) to stop and she said no. "She then hit me on my neck, face and my glasses knocked off. After that I hit her I think it was in the face."

A review of the clinical record for Resident #73 revealed notes that documented as follows:

A nurse's note dated 7/8/19 documented, "Resident was returned to West [number of unit] @ 5:45pm from West 1. West middle charge nurse reported that there had been a physical altercation between (Resident #73) and another female resident whom resides on West [number of unit]. This was a witnessed event by a dietary associate who responded immediately to separate the residents involved. It was reported that (Resident #73) had been hit in the face 3 times with the palm of the other residents hand. DNS (Director of Nursing Services), Unit manager, and daughter were notified of this event. (Name of county) Sheriff's department was called per policy and instructions of management. (Resident #73) was extremely anxious after this event. Fast pacing in her w/c and staff were unable to calm her or redirect her behaviors. Ativan (1) was administered with good effect. A skin check was performed by middle

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charge nurse. LUQ (left upper quadrant) with erythema and there is a petechial type rash on the LUE (left upper extremity) and right forearm which have been ongoing. BP (blood pressure) 143/98 - 98 (pulse) - 18 (respirations) - 97.6F (temperature) with a SPo2 (oxygen saturation) of 96% on RA (room air). Deputy (name) arrived and checked (Resident #73) twice. Once upon initially arriving and then a second time after speaking to the witness of this event. Deputy reported that there will be no further actions from the police and that he will file a report. Daughter/POA (Power of Attorney) was updated on police finding. Deputy did request that staff contact them for new areas of related injuries are observed."

A note by the social worker, dated 7/10/19 documented, "An interview was conducted with the resident r/t (related to) the incident noted on July 7, 2019 (incorrect date of incident). The resident denied having any knowledge of any such incident taking place. She maintains she does not feel threatened, fearful, or that she is in any danger. The resident further stated she is not scared and enjoys life...."

A review of the clinical record for Resident #29 revealed notes that documented as follows:

A nurses note dated 7/9/19 documented, "This writer was informed that there was a possibility that (Resident #29) had been hit in her legs by another female resident. This information was reported by a female who had been in a physical altercation which had been observed by staff. There were no witnesses to confirm this report. Skin check included broken blood vessels on the

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left upper shin which are surrounded by a faint green bruising. DNS (director of nursing services), NP (nurse practitioner), Unit manager, and POA (power of attorney) were notified of this allegation. A (county) Deputy was in to examine residents legs and to view her general well being. He reported that there would be no further investigation and that a report would be filed. He added that the staff should call if injuries develop R/T (related to) this event. A call was placed to update dtr (daughter)/POA but there was no answer and there had been no return call."

A second nurse's note dated 7/9/19 documented, "....She was mentioned in the altercation between (Resident #73 and Resident #11) but her skin assessment did not indicate any break in skin on any bruise."

A third nurse's note dated 7/9/19 documented, "Daughter in to visit and updated on events of previous evening. Resident displayed no signs of discomfort and no injury noted, from possibly being in this middle of confrontation between two other residents yesterday. Daughter without problems of explanation of events."

A review of the clinical record for Resident #11 revealed notes that documented as follows:

A nurses note dated 7/9/19 that documented, "Writer was notified that there was a physical altercation between this resident and a female resident from West [number of unit] @ 5:45pm. (Resident #11) was observed hitting other female in the face 3 times with an open hand. She was standing at the time and per dietary aide was very aggressive. (Resident #11) reported that the

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second female had been hitting her on the legs and later on her left shoulder before she hit her back. DNS, NP, Niece, and the West 2 unit manager were notified of this event. The (county) Sheriff's department was called per policy and instruction of management. A deputy was in to interview (Resident #11). He reported that no further action would be taken by the police and requested that the staff call if any injuries develop R/T this event. (Resident #11) has no signs of injury to her face on this day. Nurse has reiterated to this resident that calling the staff for assistance would be the appropriate measure if similar events occurred. Niece was called to update her on police findings."

Another nurses note dated 7/9/19 documented, "Resident had an altercation with (Resident #73) at about 5:45pm. She complained of pain and was given her prescribed medication. She is alert and oriented to time and took all her medication. Skin assessment did not indicate any scratches on her face or body."

Another nurse's note dated 7/9/19 documented, "Resident without injury from confrontation with another resident previous evening. Meds (medications) per order. No complaints of discomfort. Going about her normal daily routine this afternoon."

A social worker note dated 7/11/19 documented, "This writer spoke with the resident r/t the incident dated 7/9/19. Per the resident, she was defending another resident whom she felt was not capable of defending herself. The resident was educated on the steps to be taken when such an incident occurs, be it towards her or another resident. She acknowledged understanding

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F 600	Continued From page 16 further stating, that as a child, she was taught to defend herself and those who were unable to defend themselves. She also stated that the dietary aid did intervene but only witnessed her hitting the other roommate. The resident says she is not fearful of the other resident and does not plan to have any further altercations with her. Staff will observe the resident for aggressive behaviors, and any mood and behavior concerns. Please continue POC (plan of care)." On 7/24/19 at 9:13 AM, in an interview with Resident #11, she stated, that she was going to get ice. She stated that she "was halfway down the hall when I saw (Resident #73) take a fist and hit a woman (Resident #29) in a wheelchair that can't talk." She stated, "To me it was pathetic to see it. I yelled at her to stop it. She took a fist and hit the other lady in the legs, stomach and face. I told her to stop and she said no. I just knew I had to protect the lady who couldn't talk." When asked what the woman getting hit (Resident #29) did, she stated, "She just sat there, like a statue, she didn't seem to know what was going on and didn't try to protect herself. I yelled at her (Resident #73) to stop, she said no and continued to keep hitting her. I told her she has to stop and she hauled off and bopped me, I had a scratch on my face (touched chin area). When she hit me, my instinct was to protect me and the other lady, so I belted her back. She had power behind her when she belted me." When asked where she hit Resident #73, she stated, "I'm not sure where I hit her, I think the face. She kept coming at me. If it was not for kitchen staff, I don't know what would happen. Kitchen staff stopped it. I probably hit her a couple times. After staff stopped it, I went back to my room.	F 600		

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The nurse came in with me. All I wanted to do was protect the other lady. It is pathetic someone would hit someone in that state. They called the police. He told me I had defended myself and the other woman. They were gonna let staff here handle it. I can't tell you what they did." When asked if any staff told her to not to get involved when she sees incidents like that happen, she stated, "They told me to try to avoid these situations. I have never hit anyone here before. I am sorry it happened the way it did. I can fight to protect myself." When asked if prior to this incident had she gotten involved in another situation and hit someone, she stated, "No." When asked if she yelled for a nurse to help, she stated, "I didn't think to yell out for a nurse. I just screamed at her (Resident #73) to stop."

On 07/24/19 at approximately 11:00 a.m., a request was made to ASM (Administrative Staff Member) # 2, Director of Nursing, to speak with the kitchen staff who witnessed the incident with Residents #73, #11 and #29 (OSM #14). At approximately 11:30 AM, ASM #2 stated the staff was not working and was not available.

On 7/25/19 at 2:39PM, in an interview with RN #2 (Registered Nurse), she stated that if a resident is hitting another resident, it is abuse and should be reported immediately to management (Administration).

A review of the comprehensive care plan for Resident #29 failed to reveal any evidence of a history of behaviors or any provision to protect the resident from being the target of abuse or reflect any revision or update related to the 7/8/19 incident.

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A review of the comprehensive care plan for Resident #73 revealed one dated 6/10/17 for "I have the potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication, Anti-psychotic medications, Anti-anxiety medications. I am at risk for psychosocial wellbeing issues due to use of antidepressants; I am at risk of having s/s (signs and symptoms) of depressed mood...." This care plan included the following interventions:
Monitor for behaviors associated with depression including sad affect, crying. This intervention was dated 6/10/19.
Monitor for behaviors of anxiety including nervousness, restlessness, fearful. This intervention was dated 6/26/19.
Monitor for target behaviors of aggression and document including hitting, yelling or threating {sic} behavior. This intervention was dated 6/26/19.

Another care plan, dated 9/12/18 documented the focus of, "I sometimes have behaviors which include taking other residents items, hitting/grabbing other residents, hitting staff, refusing my medications, declining to eat, spitting out medications, throwing food and or drinks at staff, wandering." The interventions included:
Attempt interventions before my behavior begin. This intervention was dated 2/19/19.
Please do not invade my personal space when I am upset as I am likely to hit, pinch, or bite you. This intervention was dated 2/19/19.

The comprehensive care plan did not include any provision to protect the resident from being the

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target of abuse or reflect any revision or update related to the 7/8/19 incident.

A review of the comprehensive care plan for Resident #11 included one dated 6/6/19 that documented the focus area, "I sometimes have behaviors which include: refusing showers." This care plan included the interventions:
Attempt interventions before my behaviors begin, if I refuse care, please reapproach at a later time to offer shower/care again. This intervention was dated 6/6/19 and revised on 7/23/19.
Let my physician know if I my behaviors are interfering with my daily living. This intervention was dated 6/6/19.
Make sure I am not in pain or uncomfortable. This intervention was dated 6/6/19.
Please tell me what you are going to do before you begin. This intervention was dated 6/6/19.

The comprehensive care plan did not include any provision to protect the resident from being the target of abuse. The behavior care plan did not include anything denoting the resident having behaviors towards other residents. The comprehensive care plan did not reflect any revision or update related to the 7/8/19 incident.

On 7/25/19 at 1:30 PM ASM #1 (the Administrator) and ASM #2 were made aware of the findings. ASM #1 stated that Resident #11 was educated on getting assistance and not intervening in future situations like this. ASM #1 stated that there was no witnesses or evidence that Resident #29 was ever hit but that the resident was monitored under the presumption that she was and there were no previous

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incidents involving Resident #29. ASM #1 stated Resident #73 does have behaviors at times, and is monitored but that she has a right to move about her home and interact with other residents. ASM #1 stated, that the facility felt it had done all it could to allow Resident #73 the freedom to move about her home while minimizing the impact of her behavior on others.

A review of the facility policy, "Resident Abuse" documented, "Policy: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property....Resident Abuse-Resident to Resident....Residents must not be subjected to abuse by anyone, including but not limited to....other residents....Virginia State regulations: Nursing facility residents shall be free from abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of resident personal property...."

No further information was provided by completion of the survey.

(1) Ativan - is used to relieve anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

2. Resident #58 was struck in the face by another resident during a meal.

Resident #58 was admitted to the facility on 06/21/2017. His diagnoses included, but were not limited to, dementia, major depression, muscle weakness, and lack of coordination. Resident

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#58's most recent Minimum Data Set (MDS) assessment was an annual assessment with an Assessment Reference Date (ARD) of 06/05/2019. The Brief Interview for Mental Status (BIMS) scored Resident #58 at an 8, indicating severe impairment. Resident #58 was coded as requiring extensive assistance of 2 or more people for dressing and personal hygiene, and supervision of 1 person for other Activities of Daily Life (ADLs).

A review of Resident #58's record was conducted beginning on 07/23/2019. During review of the medical record, a Progress Note dated 07/19/2019 at 1:27p.m. read as follows: "Resident was grabbed by arm and slapped in face by another resident in dining room at breakfast time. No injuries noted. No c/o (complaint of) pain or discomfort. No acute distress. RP (responsible party) notified and aware."

The facility policy entitled "Facility Policies and Procedures, Subject: Resident Abuse" with an effective date of 02/17 states in part under "Policy":

"It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property."

The policy defines abuse, under "Definition of Abuse" as:

"A. An abusive act is any act of omission, which may cause or causes actual physical, psychological, or emotional harm or injury to a resident or any act which willfully deprives a

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F 600	Continued From page 22 resident of his rights by law or as stated herein." Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings on the morning of 07/25/2019. No further documentation was provided.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed follow federal regulations to review and revise their policies relating to abuse to address the mandatory reporting time frame of immediately or within 2 hours for any allegations of abuse for three of 54 residents in the survey sample; Residents #73, #29, and #11; and failed to implement abuse policies for one of 25 employee records reviewed. The findings include:	F 607	F607 1. Address how corrective action will be accomplished for those residents affected by deficient practice; The affected residents were and are in stable condition per baseline both physically and mentally. No subsequent negative outcomes have been identified due to the deficient practice. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents residing in the facility have the potential to be affected. The	8/25/19

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1. Residents #73, #29, and #11 were involved in a resident-to-resident altercation that included each of the 3 residents getting hit, on 7/8/19, per a Facility Reported Incident (FRI). The incident, which occurred at approximately 5:45 PM on 7/8/19, was not reported to the required state agency until 11:44 AM on 7/9/19, approximately 18 hours after the incident occurred.

A review of the facility policy, "Resident Abuse" dated 02/17 (February 2017) documented, "Policy: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse.....Procedures for Reporting Abuse: A. All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigations. B. The Abuse Coordinator of Facility will endeavor to protect the rights of residents and employees. The Administration recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened. Thus, while the Administration reserves the right

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required reporting of allegations and instances of abuse (in accordance with State law) to State Survey Agency and to Adult Protective Services will be in-serviced/re-educated to current employees.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Staff re-education on the current regulations (replacing the outdated 2014 guidance) with specific education on the time reporting requirement for ALL allegations of abuse will be performed for existing staff members; and with new employees during the corrected policy updated for the orientation process. This education will be performed annually and as needed. PRN staff will be re-in-serviced prior to working their first shift.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; The Director of Nursing/Social Services Director or Designee will do a random audit/testing of 5 employees weekly x 4 weeks for knowledge of reporting requirement by interviewing them to assess and ensure that alleged violations are promptly identified and investigated according to facility policy. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations x 2 quarters.

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to suspend a suspect pending an investigation, such suspension is not to be deemed as an assessment of guilt....See state specific guidelines for abuse reporting."

This reporting policy did not include any required time frame for reporting allegations of abuse to the required state agency.

The policy also included an out-dated document, dated 2014, from the required state agency, which documented, "This guideline has been developed to assist facilities in determining when an incident of misconduct, such as abuse, neglect, or misappropriation of resident personal property has occurred. This guideline, however, is not a replacement for adhering to the law and/or regulation regarding incidences of misconduct and cannot be used to avoid a citation of noncompliance....(name of required state agency) recommends that each facility review and revise, where appropriate, their policies, protocols, and practices annually to ensure compliance with state and federal laws and regulations regarding the investigation of misconduct towards residents....General Rules....C. Within 24 hours of learning of an incident the facility must report it to the (required state agency)...."

This document the facility utilized as part of its policy was out-dated with current regulations and the facility did not follow current regulations for the reporting of abuse.

A review of the facility policy, "Resident Abuse - Resident to Resident" documented, "Protocol:...9.

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The State Department of Health is to be notified by the Administrator, Director of Nursing, or their designee of the facility's knowledge of resident to resident altercations in which a resident is injured to the extent that physical intervention and/or transfer or discharge to a hospital is required per state specific protocols." This reporting policy did not include any required time frame for reporting to the required state agency.

This policy was specific to altercations with injury and did not address the timely reporting of all allegations of abuse.

Resident #73 was admitted to the facility on 6/9/17 with the diagnoses of but not limited to dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's Disease, mood disorder, depression, congestive heart failure, restless leg syndrome, cataracts, glaucoma, and sleep apnea. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as total care for bathing; extensive assistance for bathing, dressing, toileting, and hygiene; and supervision for eating.

Resident #29 was admitted to the facility on 11/11/13 with the diagnoses of but not limited to dementia, dysphagia, glaucoma, cataracts, skin cancer, heart failure, high blood pressure, schizophrenia, spondylosis, atrial fibrillation, scoliosis, and diabetes. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/19, coded the resident as

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F 607	Continued From page 26 being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, eating, toileting, and hygiene. Resident #11 was admitted to the facility on 4/12/19 with the diagnoses of but not limited to diabetes, high blood pressure, osteoarthritis, anxiety, depression, and atherosclerotic heart disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/9/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing; and supervision only for all other areas of activities of daily living. A review of a FRI report dated 6/9/19 regarding an incident dated 6/8/19 (dated incorrectly, the actual incident occurred on 7/8/19 and was reported on 7/9/19), documented, "Per (Resident #11), (Resident #73) hit her and she slapped her back in return. Per (Resident #11), (Resident #73) hit (Resident #29). Residents were separated. County Sheriff was called. Investigation started." The investigation revealed a statement by OSM #14 (Other Staff Member - dietary staff) which documented, "Employee reports seeing (Resident #11) standing and striking @ (at) (Resident #73). She reports that she observed (Resident #11) slap (Resident #73) 3 times in the face (with) the palm of her L (left) hand. Associate added that (Resident #73) was sitting in her w/c (wheelchair) and struggling to hit (Resident #11) back. She saw (Resident #73) slap (Resident #11) once in the face with the palm of her hand."	F 607		

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The investigation further revealed a statement by Resident #11 which documented, "Resident reports that she was defending (Resident #29) and herself when she was observed by dietary staff hitting (Resident #73). She added that (Resident #73) had been hitting (Resident #29) and her in the legs prior to this event. Further, that (Resident #73) had hit her in the left shoulder. (Resident #11) was sitting @ (at) the West 1 nurses station waiting for someone to get her ice @ this time."

The investigation revealed another statement by Resident #11 which documented, "I was going to get ice and I see this woman (Resident #73) beating on a woman (Resident #29) who was sitting there. I had no choice but to separate her. She hit her on the legs, her stomach, and her chest. The woman was afraid. I stucked {sic} my nose in it, I had to protect her." Per (Resident #11) she told (Resident #73) to stop and she said no. "She then hit me on my neck, face and my glasses knocked off. After that I hit her I think it was in the face."

A review of the clinical record for Resident #73 revealed notes that documented as follows:

A nurses note dated 7/8/19 documented, "Resident was returned to West 2 @ 5:45pm from West 1. West middle charge nurse reported that there had been a physical altercation between (Resident #73) and another female resident whom resides on West 1. This was a witnessed event by a dietary associate who responded immediately to separate the residents involved. It was reported that (Resident #73) had

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been hit in the face 3 times with the palm of the other residents hand. DNS (Director of Nursing Services), Unit manager, and daughter were notified of this event. (Name of county) Sheriff's department was called per policy and instructions of management. (Resident #73) was extremely anxious after this event. Fast pacing in her w/c and staff were unable to calm her or redirect her behaviors. Ativan (1) was administered with good effect. A skin check was performed by middle charge nurse. LUQ (left upper quadrant) with erythema and there is a petechial type rash on the LUE (left upper extremity) and right forearm which have been ongoing. BP (blood pressure) 143/98 - 98 (pulse) - 18 (respirations) - 97.6F (temperature) with an SPo2 (oxygen saturation) of 96% on RA (room air). Deputy (name) arrived and checked (Resident #73) twice. Once upon initially arriving and then a second time after speaking to the witness of this event. Deputy reported that there will be no further actions from the police and that he will file a report. Daughter/POA (Power of Attorney) was updated on police finding. Deputy did request that staff contact them for new areas of related injuries are observed."

A note by the social worker, dated 7/10/19 documented, "An interview was conducted with the resident r/t (related to) the incident noted on July 7, 2019 (incorrect date of incident). The resident denied having any knowledge of any such incident taking place. She maintains she does not feel threatened, fearful, or that she is in any danger. The resident further stated she is not scared and enjoys life...."

A review of the clinical record for Resident #29

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revealed notes that documented as follows:

A nurses note dated 7/9/19 documented, "This writer was informed that there was a possibility that (Resident #29) had been hit in her legs by another female resident. This information was reported by a female who had been in a physical altercation which had been observed by staff. There were no witnesses to confirm this report. Skin check included broken blood vessels on the left upper shin which are surrounded by a faint green bruising. DNS, NP (nurse practitioner), Unit manager, and POA were notified of this allegation. A (county) Deputy was in to examine residents legs and to view her general well being. He reported that there would be no further investigation and that a report would be filed. He added that the staff should call if injuries develop R/T this event. A call was placed to update dtr (daughter)/POA but there was no answer and there had been no return call.

A second nurses note dated 7/9/19 documented, "....She was mentioned in the altercation between (Resident #73 and Resident #11) but her skin assessment did not indicate any break in skin on any bruise."

A third nurses note dated 7/9/19 documented, "Daughter in to visit and updated on events of previous evening. Resident displayed no signs of discomfort and no injury noted, from possibly being in this middle of confrontation between two other residents yesterday. Daughter without problems of explanation of events."

A review of the clinical record for Resident #11 revealed notes that documented as follows:

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A nurses note dated 7/9/19 that documented, "Writer was notified that there was a physical altercation between this resident and a female resident from West 2 @ 5:45pm. (Resident #11) was observed hitting other female in the face 3 times with an open hand. She was standing at the time and per dietary aide was very aggressive. (Resident #11) reported that the second female had been hitting her on the legs and later on her left shoulder before she hit her back. DNS, NP, Niece, and the West 2 unit manager were notified of this event. The (county) Sheriff's department was called per policy and instruction of management. A deputy was in to interview (Resident #11). He reported that no further action would be taken by the police and requested that the staff call if any injuries develop R/T this event. (Resident #11) has no signs of injury to her face on this day. Nurse has reiterated to this resident that calling the staff for assistance would be the appropriate measure if similar events occurred. Niece was called to update her on police findings."

Another nurses note dated 7/9/19 documented, "Resident had an altercation with (Resident #73) at about 5:45pm. She complained of pain and was given her prescribed medication. She is alert and oriented to time and took all her medication. Skin assessment did not indicate any scratches on her face or body."

Another nurses note dated 7/9/19 documented, "Resident without injury from confrontation with another resident previous evening. Meds per order. No complaints of discomfort. Going about her normal daily routine this afternoon."

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F 607	Continued From page 31 A social worker note dated 7/11/19 documented, "This writer spoke with the resident r/t the incident dated 7/9/19. Per the resident, she was defending another resident whom she felt was not capable of defending herself. The resident was educated on the steps to be taken when such an incident occurs, be it towards her or another resident. She acknowledged understanding further stating, that as a child, she was taught to defend herself and those who were unable to defend themselves. She also stated that the dietary aid did intervene but only witnessed her hitting the other roommate. The resident says she is not fearful of the other resident and does not plan to have any further altercations with her. Staff will observe the resident for aggressive behaviors, and any mood and behavior concerns. Please continue POC (plan of care)." On 7/24/19 at 9:13 AM, in an interview with Resident #11, she stated, that she was going to get ice. She stated that she "was halfway down the hall when I saw (Resident #73) take a fist and hit a woman (Resident #29) in a wheelchair that can't talk." She stated, "To me it was pathetic to see it. I yelled at her to stop it. She took a fist and hit the other lady in the legs, stomach and face. I told her to stop and she said no. I just knew I had to protect the lady who couldn't talk." When asked what the woman getting hit (Resident #29) did, she stated, "She just sat there, like a statue, she didn't seem to know what was going on and didn't try to protect herself. I yelled at her (Resident #73) to stop, she said no and continued to keep hitting her. I told her she has to stop and she hauled off and bopped me, I had a scratch on my face (touched chin area). When she hit me my instinct was to protect me	F 607		

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and the other lady so I belted her back. She had power behind her when she belted me." When asked where did she hit Resident #73, she stated, "I'm not sure where I hit her, I think the face. She kept coming at me. If it was not for kitchen staff I don't know what would happen. Kitchen staff stopped it. I probably hit her a couple times. After staff stopped it, I went back to my room. The nurse came in with me. All I wanted to do was protect the other lady. It is pathetic someone would hit someone in that state. They called the police. He told me I had defended myself and the other woman. They were gonna let staff here handle it. I can't tell you what they did." When asked if any staff told her to not to get involved when she sees incidents like that happen, she stated, "They told me to try to avoid these situations. I have never hit anyone here before. I am sorry it happened the way it did. I can fight to protect myself." When asked if prior to this incident had she gotten involved in another situation and hit someone, she stated, "No." When asked if she yelled for a nurse to help, she stated, "I didn't think to yell out for a nurse. I just screamed at her (Resident #73) to stop."

On 07/24/19 at approximately 11:00 a.m., a request was made to ASM (Administrative Staff Member) # 2, Director of Nursing, to speak with the kitchen staff who witnessed the incident with Residents #73, #11 and #29 (OSM #14). At approximately 11:30 ASM #2 stated the staff was not working and was not available.

On 7/25/19 at 2:39PM, in an interview with RN #2 (Registered Nurse), she stated that if a resident is hitting another resident, it is abuse and should be reported immediately to management

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(Administration).

On 7/25/19 at 1:30 PM ASM #1 (the Administrator) and ASM #2 were made aware of the findings. When asked about reporting the incident within the required 2 hour time frame, he stated that there were no injuries.

(1) Ativan - is used to relieve anxiety.
Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

2. The facility staff failed to implement the abuse policy for employee screening requirements. The facility staff failed to evidence a criminal background check was completed for RN (registered nurse) #4.

The facility abuse policy documented, "II. Screening
Persons applying for employment with Facility will be screened for a history of abuse, neglect, or mistreating residents to include: A. References from previous or current employers (with applicant permission). B. Criminal Background check..."

Review of RN #4's employee record revealed RN #4 was hired on 6/17/19. Further review of RN #4's employee record failed to reveal evidence that a criminal background check was completed.

On 7/25/19 at 2:48 p.m., an interview was conducted with OSM (other staff member) #7 (the human resources generalist). OSM #7 was asked to describe the facility process for screening employees. OSM #7 stated the

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F 607	Continued From page 34 director of nursing conducts her interviews with nursing staff and if there is someone she decides she wants to pursue, then she forwards the application to OSM #7 and OSM #7 completes a criminal background check before orientation. OSM #7 was made aware of the above concern and was asked to provide any further information. On 7/25/19 at 6:22 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the concern. No further information was presented prior to exit.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §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.	F 609		8/25/19

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§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 resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to report an allegation of abuse immediately, but not later than 2 hours after the allegation, to the required state agency for three of 54 residents in the survey sample; Residents #73, #29, and #11.

The findings include:

Residents #73, #29, and #11 were involved in a resident-to-resident altercation on 7/8/19, per a Facility Reported Incident (FRI) sent to the required state agency on 7/9/19. Resident #11, a cognitively intact resident, observed Resident #73, a cognitively impaired resident, hitting Resident #29, a cognitively impaired resident. Resident #11 inserted herself into the situation to stop Resident #73 from hitting Resident #29. Resident #11 proceeded to hit Resident #73, who in turn hit Resident #11 back. The incident, which occurred at approximately 5:45 PM on 7/8/19, was not reported to the required state agency until 11:44 AM on 7/9/19, approximately 18 hours after the incident occurred.

Resident #73 was admitted to the facility on

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1. Address how corrective action will be accomplished for those residents affected by deficient practice; The affected residents were and are in stable condition per baseline both physically and mentally. No subsequent negative outcomes have been identified due to the deficient practice.

2. Address how facility will identify other residents potentially affected by deficient practice; Residents residing in the facility have the potential to be affected. The required reporting of allegations and instances of abuse (in accordance with State law) to State Survey Agency and to Adult Protective Services will be in-serviced/re-educated to current employees.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Staff re-education on the current regulations (replacing the outdated 2014 guidance) with specific education on the time reporting requirement for ALL allegations of abuse will be performed for existing staff

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F 609	Continued From page 36 6/9/17 with the diagnoses including but not limited to: dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's disease, mood disorder, and depression. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as total care for bathing; extensive assistance for bathing, dressing, toileting, and hygiene; and supervision for eating. Resident #29 was admitted to the facility on 11/11/13. Diagnoses include, but are not limited to: dementia, dysphagia, glaucoma, cataracts, heart failure, schizophrenia, spondylosis, and diabetes. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/19 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, extensive care for transfers, dressing, eating, toileting, and hygiene. Resident #11 was admitted to the facility on 4/12/19. Diagnoses include, but are not limited to: diabetes, high blood pressure, osteoarthritis, anxiety, and depression. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/9/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, and supervision only for all other areas of activities of daily living. A review of a FRI report dated 6/9/19 regarding an incident dated 6/8/19 (dated incorrectly, the	F 609	members; and with new employees during the corrected policy updated for the orientation process. This education will be performed annually and as needed. PRN staff will be re-in-serviced prior to working their first shift. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; The Director of Nursing/Social Services Director or Designee will do a random audit/testing of 5 employees weekly x 4 weeks for knowledge of reporting requirement by interviewing them to assess and ensure that alleged violations are promptly identified and investigated according to facility policy. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations x 2 quarters.	

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actual incident occurred on 7/8/19 and was reported on 7/9/19), documented, "Per (Resident #11), (Resident #73) hit her and she slapped her back in return. Per (Resident #11), (Resident #73) hit (Resident #29). Residents were separated. County Sheriff was called. Investigation started."

The investigation revealed a statement by OSM #14 (Other Staff Member - dietary staff) which documented, "Employee reports seeing (Resident #11) standing and striking @ (at) (Resident #73). She reports that she observed (Resident #11) slap (Resident #73) 3 times in the face (with) the palm of her L (left) hand. Associate added that (Resident #73) was sitting in her w/c (wheelchair) and struggling to hit (Resident #11) back. She saw (Resident #73) slap (Resident #11) once in the face with the palm of her hand."

The investigation further revealed a statement by Resident #11, which documented, "Resident reports that she was defending (Resident #29) and herself when she was observed by dietary staff hitting (Resident #73). She added that (Resident #73) had been hitting (Resident #29) and her in the legs prior to this event. Further, that (Resident #73) had hit her in the left shoulder. (Resident #11) was sitting @ (at) the West 1 nurses station waiting for someone to get her ice @ this time."

The investigation revealed another statement by Resident #11, which documented, "I was going to get ice and I see this woman (Resident #73) beating on a woman (Resident #29) who was sitting there. I had no choice but to separate her. She hit her on the legs, her stomach, and her chest. The woman was afraid. I stucked {sic} my

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F 609	Continued From page 38 nose in it, I had to protect her." Per (Resident #11) she told (Resident #73) to stop and she said no. "She then hit me on my neck, face and my glasses knocked off. After that I hit her I think it was in the face." A review of the facility policy, "Resident Abuse" dated 02/17 (February 2017) documented, "Policy: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse.....Procedures for Reporting Abuse: A. All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigations. B. The Abuse Coordinator of Facility will endeavor to protect the rights of residents and employees. The Administration recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened. Thus, while the Administration reserves the right to suspend a suspect pending an investigation, such suspension is not to be deemed as an assessment of guilt....See state specific guidelines for abuse reporting."	F 609		

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This reporting policy did not include any required time frame for reporting to the required state agency.

The policy also included an outdated document, dated 2014, from the required state agency, which documented, "This guideline has been developed to assist facilities in determining when an incident of misconduct, such as abuse, neglect, or misappropriation of resident personal property has occurred. This guideline, however, is not a replacement for adhering to the law and/or regulation regarding incidences of misconduct and cannot be used to avoid a citation of noncompliance.... (name of required state agency) recommends that each facility review and revise, where appropriate, their policies, protocols, and practices annually to ensure compliance with state and federal laws and regulations regarding the investigation of misconduct towards residents....General Rules....C. Within 24 hours of learning of an incident the facility must report it to the (required state agency)...."

This document the facility utilized as part of its policy was outdated with current regulations and the facility did not follow current regulations for the reporting of abuse.

A review of the facility policy, "Resident Abuse - Resident to Resident" documented, "Protocol: ...9. The State Department of Health is to be notified by the Administrator, Director of Nursing, or their designee of the facility's knowledge of resident to resident altercations in which a

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resident is injured to the extent that physical intervention and/or transfer or discharge to a hospital is required per state specific protocols." This reporting policy did not include any required time frame for reporting to the required state agency.

This policy was specific to altercations with injury and did not address the timely reporting of all allegations of abuse.

A review of the clinical record for Resident #73 revealed notes that documented as follows:

A nurse's note dated 7/8/19 documented, "Resident was returned to West [number of unit] @ 5:45pm from West 1. West middle charge nurse reported that there had been a physical altercation between (Resident #73) and another female resident whom resides on West [number of unit]. This was a witnessed event by a dietary associate who responded immediately to separate the residents involved. It was reported that (Resident #73) had been hit in the face 3 times with the palm of the other residents hand. DNS (Director of Nursing Services), Unit manager, and daughter were notified of this event. (Name of county) Sheriff's department was called per policy and instructions of management. (Resident #73) was extremely anxious after this event. Fast pacing in her w/c and staff were unable to calm her or redirect her behaviors. Ativan (1) was administered with good effect. A skin check was performed by middle charge nurse. LUQ (left upper quadrant) with erythema and there is a petechial type rash on the LUE (left upper extremity) and right forearm which have been ongoing. BP (blood pressure)

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143/98 - 98 (pulse) - 18 (respirations) - 97.6F (temperature) with a SPo2 (oxygen saturation) of 96% on RA (room air). Deputy (name) arrived and checked (Resident #73) twice. Once upon initially arriving and then a second time after speaking to the witness of this event. Deputy reported that there will be no further actions from the police and that he will file a report. Daughter/POA (Power of Attorney) was updated on police finding. Deputy did request that staff contact them for new areas of related injuries are observed."

A note by the social worker, dated 7/10/19 documented, "An interview was conducted with the resident r/t (related to) the incident noted on July 7, 2019 (incorrect date of incident). The resident denied having any knowledge of any such incident taking place. She maintains she does not feel threatened, fearful, or that she is in any danger. The resident further stated she is not scared and enjoys life...."

A review of the clinical record for Resident #29 revealed notes that documented as follows:

A nurses note dated 7/9/19 documented, "This writer was informed that there was a possibility that (Resident #29) had been hit in her legs by another female resident. This information was reported by a female who had been in a physical altercation which had been observed by staff. There were no witnesses to confirm this report. Skin check included broken blood vessels on the left upper shin which are surrounded by a faint green bruising. DNS (director of nursing services), NP (nurse practitioner), Unit manager, and POA (power of attorney) were notified of this

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allegation. A (county) Deputy was in to examine residents legs and to view her general well being (Sic.). He reported that there would be no further investigation and that a report would be filed. He added that the staff should call if injuries develop R/T (related to) this event. A call was placed to update dtr (daughter)/POA but there was no answer and there had been no return call."

A second nurse's note dated 7/9/19 documented, "....She was mentioned in the altercation between (Resident #73 and Resident #11) but her skin assessment did not indicate any break in skin on any bruise."

A third nurse's note dated 7/9/19 documented, "Daughter in to visit and updated on events of previous evening. Resident displayed no signs of discomfort and no injury noted, from possibly being in this middle of confrontation between two other residents yesterday. Daughter without problems of explanation of events."

A review of the clinical record for Resident #11 revealed notes that documented as follows:

A nurses note dated 7/9/19 that documented, "Writer was notified that there was a physical altercation between this resident and a female resident from West [number of unit] @ 5:45pm. (Resident #11) was observed hitting other female in the face 3 times with an open hand. She was standing at the time and per dietary aide was very aggressive. (Resident #11) reported that the second female had been hitting her on the legs and later on her left shoulder before she hit her back. DNS (director of nursing), NP (nurse practitioner), Niece, and the West 2 unit manager

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were notified of this event. The (county) Sheriff's department was called per policy and instruction of management. A deputy was in to interview (Resident #11). He reported that no further action would be taken by the police and requested that the staff call if any injuries develop R/T this event. (Resident #11) has no signs of injury to her face on this day. Nurse has reiterated to this resident that calling the staff for assistance would be the appropriate measure if similar events occurred. Niece was called to update her on police findings."

Another nurses note dated 7/9/19 documented, "Resident had an altercation with (Resident #73) at about 5:45pm. She complained of pain and was given her prescribed medication. She is alert and oriented to time and took all her medication. Skin assessment did not indicate any scratches on her face or body."

Another nurse's note dated 7/9/19 documented, "Resident without injury from confrontation with another resident previous evening. Meds (medications) per order. No complaints of discomfort. Going about her normal daily routine this afternoon."

A social worker note dated 7/11/19 documented, "This writer spoke with the resident r/t the incident dated 7/9/19. Per the resident, she was defending another resident whom she felt was not capable of defending herself. The resident was educated on the steps to be taken when such an incident occurs, be it towards her or another resident. She acknowledged understanding further stating, that as a child, she was taught to defend herself and those who were unable to defend themselves. She also stated that the

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dietary aid did intervene but only witnessed her hitting the other roommate. The resident says she is not fearful of the other resident and does not plan to have any further altercations with her. Staff will observe the resident for aggressive behaviors, and any mood and behavior concerns. Please continue POC (plan of care)."

On 7/24/19 at 9:13 AM, in an interview with Resident #11, she stated, that she was going to get ice. She stated that she "was halfway down the hall when I saw (Resident #73) take a fist and hit a woman (Resident #29) in a wheelchair that can't talk." She stated, "To me it was pathetic to see it. I yelled at her to stop it. She took a fist and hit the other lady in the legs, stomach and face. I told her to stop and she said no. I just knew I had to protect the lady who couldn't talk." When asked what the woman getting hit (Resident #29) did, she stated, "She just sat there, like a statue, she didn't seem to know what was going on and didn't try to protect herself. I yelled at her (Resident #73) to stop, she said no and continued to keep hitting her. I told her she has to stop and she hauled off and bopped me, I had a scratch on my face (touched chin area). When she hit me, my instinct was to protect me and the other lady, so I belted her back. She had power behind her when she belted me." When asked where did she hit Resident #73, she stated, "I'm not sure where I hit her, I think the face. She kept coming at me. If it was not for kitchen staff, I don't know what would happen. Kitchen staff stopped it. I probably hit her a couple times. After staff stopped it, I went back to my room. The nurse came in with me. All I wanted to do was protect the other lady. It is pathetic someone would hit someone in that state. They called the police. He told me I had

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defended myself and the other woman. They were gonna let staff here handle it. I can't tell you what they did." When asked if any staff told her to not to get involved when she sees incidents like that happen, she stated, "They told me to try to avoid these situations. I have never hit anyone here before. I am sorry it happened the way it did. I can fight to protect myself." When asked if prior to this incident had she gotten involved in another situation and hit someone, she stated, "No." When asked if she yelled for a nurse to help, she stated, "I didn't think to yell out for a nurse. I just screamed at her (Resident #73) to stop."

On 07/24/19 at approximately 11:00 a.m., a request was made to ASM (Administrative Staff Member) # 2, Director of Nursing, to speak with the kitchen staff who witnessed the incident with Residents #73, #11 and #29 (OSM #14). At approximately 11:30 AM, ASM #2 stated the staff was not working and was not available.

On 7/25/19 at 2:39PM, in an interview with RN #2 (Registered Nurse), she stated that if a resident is hitting another resident, it is abuse and should be reported immediately to management (Administration).

A review of the comprehensive care plan for Resident #29 failed to reveal any evidence of a history of behaviors or any provision to protect the resident from being the target of abuse or reflect any revision or update related to the 7/8/19 incident.

A review of the comprehensive care plan for

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Resident #73 revealed one dated 6/10/17 for "I have the potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication, Anti-psychotic medications, Anti-anxiety medications. I am at risk for psychosocial well being (Sic.) issues due to use of antidepressants; I am at risk of having s/s (signs and symptoms) of depressed mood...." This care plan included the following interventions:
Monitor for behaviors associated with depression including sad affect, crying. This intervention was dated 6/10/19.
Monitor for behaviors of anxiety including nervousness, restlessness, fearful. This intervention was dated 6/26/19.
Monitor for target behaviors of aggression and document including hitting, yelling or threating {sic} behavior. This intervention was dated 6/26/19.

Another care plan, dated 9/12/18 documented the focus of, "I sometimes have behaviors which include taking other residents items, hitting/grabbing other residents, hitting staff, refusing my medications, declining to eat, spitting out medications, throwing food and or drinks at staff, wandering." The interventions included:
Attempt interventions before my behavior begin. This intervention was dated 2/19/19.
Please do not invade my personal space when I am upset as I am likely to hit, pinch, or bite you. This intervention was dated 2/19/19.

The comprehensive care plan did not include any provision to protect the resident from being the target of abuse or reflect any revision or update related to the 7/8/19 incident.

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A review of the comprehensive care plan for Resident #11 included one dated 6/6/19 that documented the focus area, "I sometimes have behaviors which include: refusing showers." This care plan included the interventions:
Attempt interventions before my behaviors begin, if I refuse care, please reapproach at a later time to offer shower/care again. This intervention was dated 6/6/19 and revised on 7/23/19.
Let my physician know if I my behaviors are interfering with my daily living. This intervention was dated 6/6/19.
Make sure I am not in pain or uncomfortable. This intervention was dated 6/6/19.
Please tell me what you are going to do before you begin. This intervention was dated 6/6/19.

The comprehensive care plan did not include any provision to protect the resident from being the target of abuse. The behavior care plan did not include anything denoting the resident having behaviors towards other residents. The comprehensive care plan did not reflect any revision or update related to the 7/8/19 incident.

On 7/25/19 at 1:30 PM ASM #1 (the Administrator) and ASM #2 were made aware of the findings. ASM #1 stated that Resident #11 was educated on getting assistance and not intervening in future situations like this. ASM #1 stated that there was no witnesses or evidence that Resident #29 was ever hit but that the resident was monitored under the presumption that she was and there were no previous incidents involving Resident #29. ASM #1 stated Resident #73 does have behaviors at times, and is monitored but she has a right to move about

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F 609	Continued From page 48 her home and interact with other residents. ASM #1 stated the facility felt it had done all it could to allow Resident #73 the freedom to move about her home while minimizing the impact of her behavior on others. When asked about reporting the incident within the required 2-hour time frame, he stated that there were no injuries. No further information was provided by completion of the survey. (1) Ativan - is used to relieve anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html	F 609		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (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	F 622		8/25/19

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F 622	Continued From page 49 under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(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	F 622		

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F 622	Continued From page 50 needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure the required documentation was provided to the receiving facility, upon transfer to the hospital for eleven of 15 residents in the survey sample of 54, who were investigated for hospitalizations, (Residents #14, #71, #85, 73, #32, #96, #9, #26, #41, #58 and #36). The findings include: 1. The facility staff failed to provide evidence that	F 622	F622 1. Address how corrective action will be accomplished for those residents affected by deficient practice; Nursing and administrative staff have received education on INTERACT procedures and reporting requirements for facility-initiated transfers. This training addresses all required documentation and information to be provided to the receiving provider for a facility-initiated transfer.	

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all required information was provided to the hospital staff when Resident #14 was transferred to the hospital on 4/9/19.

Resident #14 was admitted to the facility on 4/20/17. Resident #14's diagnoses included but were not limited to urinary tract infection and diabetes. Resident #14's most recent MDS (minimum data set) (prior to a recent discharge), an annual assessment with an ARD (assessment reference date) of 4/23/19, coded the resident as being cognitively intact.

Review of Resident #14's clinical record revealed the resident was transferred to the hospital on 4/9/19 for behaviors and shortness of breath. A nurse's note dated 4/9/19 documented a report was called to the hospital and Resident #14's history, medications, allergies and reason for transfer was provided. Further review of Resident #14's clinical record failed to reveal documentation to evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med [medication] list, depending on what sending for, may send copies of labs [laboratory tests], progress notes, whatever information that helps

F 622

2. Address how facility will identify other residents potentially affected by deficient practice; Residents currently residing in the facility are at risk.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; INTERACT training will be completed for existing nursing staff tasked with communicating and reporting facility-initiated transfer/discharges. INTERACT 4.0 Nursing Home to Hospital Transfer Form is utilized for this communication to the acute care facility. As part of the transfer process the required, the transferred resident's Comprehensive Care Plan Goals will be sent to the acute care facility.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; 5x per week in the Morning Meeting process, facility-initiated discharges to acute care faculties will be reviewed as part of the Census Review portion of the meeting process. Each discharge will be audited for compliance. On a weekly basis the Administrator/Designee will audit the previous 7 days' discharges and review for compliance to INTERACT communication requirement. This monitoring will continue x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided to the receiving hospital, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the interact (form) in the front of the chart."

Further review of Resident #14's clinical record failed to reveal evidence of an "interact" form for the resident's 4/9/19 hospital transfer.

On 7/24/19 at 6:45 p.m., evidence of the information provided to hospital staff when Resident #14 was transferred to the hospital on 4/9/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) presented interact forms for other hospital transfers but did not provide an "interact" form for Resident #14's hospital transfer on 4/9/19. ASM #2 stated this was all the information she could provide regarding the list of requested items.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2

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were made aware of the above concern.

The facility document titled, "DISCHARGE AND TRANSFER" documented, "What is needed upon discharge? (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 483.219(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care..."

No further information was presented prior to exit.

2. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #71 was transferred to the hospital on 3/26/19, 4/24/19 and 5/13/19.

Resident #71 was admitted to the facility on 1/22/19. Resident #71's diagnoses included but were not limited to heart failure and diabetes. Resident #71's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/16/19, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #71's clinical record revealed the resident was transferred to the hospital on the following dates:
-3/26/19 for rapid shallow breathing and

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wheezing.
-4/24/19 for evaluation and treatment of an undocumented condition.
-5/13/19 for a low oxygen level.

Further review of Resident #71's clinical record failed to reveal documentation to evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff for the above dates of transfer.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med list, depending on what sending for, may send copies of labs, progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the "interact" in the front of the chart."

Further review of Resident #71's clinical record failed to reveal an "interact" form for the resident's above hospital transfers.

On 7/24/19 at 6:45 p.m., evidence of the information provided to hospital staff when

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Resident #71 was transferred to the hospital on 3/26/19, 4/24/19 and 5/13/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) presented interact forms for other hospital transfers but did not provide an "interact" form for Resident #71's 3/26/19, 4/24/19 and 5/13/19 hospital transfers. ASM #2 stated this was all the information she could provide regarding the list of requested items.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #85 was transferred to the hospital on 3/26/19 and 5/6/19.

Resident #85 was admitted to the facility on 8/30/17. Resident #85's diagnoses included but were not limited to seizures and heart failure. Resident #85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/5/19, coded the

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resident's cognitive skills for daily decision making as independent.

Review of Resident #85's clinical record revealed the resident was transferred to the hospital on the following dates:
-3/26/19 for shortness of breath and an elevated heart rate.
-5/6/19 for nausea and vomiting.

Further review of Resident #85's clinical record failed to reveal documentation to evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff for the above dates of transfer.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med list, depending on what sending for, may send copies of labs, progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the "interact" in the front of the chart."

Further review of Resident #85's clinical record

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failed to reveal an "interact" form for the resident's above hospital transfers.

On 7/24/19 at 6:45 p.m., evidence of the information provided to hospital staff when Resident #85 was transferred to the hospital on 3/26/19 and 5/6/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) presented interact forms for other resident hospital transfers but did not provide an "interact" form for Resident #85's hospital transfers. ASM #2 stated this was all the information she could provide regarding the list of requested items.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

4. The facility staff failed to evidence what, if any, required documentation was provided to the receiving facility upon Resident #73's transfer to the hospital on 4/20/19 and 5/9/19.

Resident #73 was admitted to the facility on

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6/9/17. Diagnoses include, but are not limited to dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's disease, mood disorder, depression, congestive heart failure, and sleep apnea. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as total care for bathing, extensive assistance for dressing, toileting, and hygiene and as supervision for eating.

A review of the clinical record revealed a nurses note dated 4/21/19 at 12:23 AM that documented, "Patient went to ER (emergency room) at 8:30 this evening. She was found unconscious by CNA (certified nursing assistant) around 8 pm. Patient came around a few times with vitals of 120 Hr (heart rate) 85 O2 (oxygen saturation) and Bp 97/58 (blood pressure). NP (nurse practitioner) (NP name)/unit manager were notified. Daughter notified and went to ER."

A review of the clinical record revealed a nurse's note dated 5/9/19 at 1:04 PM, that documented, "continues to have little PO (oral) intake, NP made aware new orders for IV (intravenous) fluids .... NP (nurse practitioner) in facility reassessed resident, complaint of right upper quad (quadrant) pain upon palpitation, NP called ER directly explained resident has been sent multiple times but keeps being sent back, NP explain her assessment of resident, new order obtained to send to ER (emergency room)."

Further review of the clinical record failed to reveal what, if any, required documentation was

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sent to the hospital with the resident for either transfer on the dates above.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med (medication list) list, depending on what sending for, may send copies of labs (laboratory tests), progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the interact in the front of the chart."

On 7/24/19 at 6:45 p.m., evidence of the information provided to hospital staff when Resident #73 was transferred to the hospital on 4/21/19 and 5/9/19 was requested via a list provided to ASM (administrative staff member) #1 (the Administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the Director of Nursing) presented interact forms for other hospital transfers but did not provide an interact form for Resident #73's hospital transfers on 4/21/19 and 5/9/19. ASM #2 stated this was all the information she could provide regarding the list of requested items.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the

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facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

5. The facility staff failed to evidence what, if any, required documentation was provided to the receiving facility upon Resident #32's hospital transfer on 4/12/19 and failed to ensure that the comprehensive care plan goals were sent to the receiving facility upon Resident #32's transfer to the hospital on 7/3/19.

Resident #32 was admitted to the facility on 3/6/16. Diagnoses include but are not limited to, peripheral vascular disease, depression, left and right hip contractures, right above knee amputation, dysphagia, psychosis, mood disorder, epilepsy, high blood pressure, dementia, and chronic obstructive pulmonary disease. The 30-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/13/19 coded the resident as moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurses note dated 4/12/19 that documented, "resident witnessed with SOB (shortness of breath), neb (nebulizer) treatment given as ordered, effective, respirations unlabored and his lung fields clear,

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abdomen is distended, firm to touch, non painful, positive for bowel sounds, last BM (bowel movement) 4/11/19 per record, resident has been on two courses of ABT (antibiotic therapy) therapies, with negative chest xrays, NP (Nurse Practitioner) aware and after assessment gave verbal order to send to (name of hospital) for further evaluation, unable to contact daughter."

Further review of the clinical record failed to reveal what, if any, required documentation was sent to the hospital with the resident for this transfer.

A review of the clinical record revealed a nurse's note dated 7/3/19 that documented in part, "Resident with worsening cough and congestion. ... Transferred to ER by stretcher unit at 8:00pm. A (Sic.) f/u (follow up) call to ER (emergency room) @ (at) 2230 (10:30 PM) and resident has been admitted into (room number) with diagnoses of acute renal failure, acute respiratory failure and sepsis."

Further review of the clinical record revealed a nurses note dated 7/3/19 that documented, "interact reported copied and sent to ER with patient, report called to (name of hospital) ER."

Further review of the clinical record failed to reveal any evidence that Resident #32's comprehensive care plan goals were sent to the hospital for this transfer.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information

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provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med (medication list) list, depending on what sending for, may send copies of labs (laboratory tests), progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the interact in the front of the chart."

On 7/24/19 at 6:45 p.m., evidence of the information provided to hospital staff when Resident #32 was transferred to the hospital on 4/12/19 and 7/3/19 was requested via a list provided to ASM (administrative staff member) #1 (the Administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the Director of Nursing) presented interact forms for the 7/3/19 hospital transfer but did not provide an "interact" form for the 4/12/19 hospital transfers or evidence that the comprehensive care plan goals were sent to the on the 7/3/19 hospital transfer. ASM #2 stated this was all the information she could provide regarding the list of requested items.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send

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the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.
6. The facility staff failed to send the required documents to the hospital for a facility initiated transfer of Resident #96 on 3/30/19 and 4/22/19.

Resident #96 was admitted to the facility on 3/18/19 with diagnoses that included but were not limited to: high blood pressure, seizure disorder, stroke and chronic kidney disease requiring hemodialysis [a procedure used in toxic conditions and renal (kidney) failure, in which wastes and impurities are removed from the blood by a special machine] (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/11/19, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions.

The nurse's note dated, 3/30/19 at 2:40 p.m., documented in part, "Called (sic) received from lab (laboratory) of critical H&H (hemoglobin and hematocrit)...NP (nurse practitioner) notified of labs, new order obtained to send to (initials of hospital) ER (emergency room), RP (responsible party) and resident notified. (Name of ambulance service) called for transport...Significant other states she will meet the resident at the hospital.

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Resident stable."

Physician order dated, 3/30/19 at 2:34 p.m. documented, "May sent to (initials of hospital) ER for critical H&H."

The nurse's note dated, 4/22/19 at 3:03 p.m. documented in part, "Resident being sent to (name of hospital) ER related to purulent drainage from left shoulder wound. NP has examine and ordered resident to be sent out."

The physician order dated, 4/22/19 at 5:00 p.m. documented, "Send to hospital for wound abscess."

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med list, depending on what sending for, may send copies of labs, progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the interact in the front of the chart."

Further review of Resident #96's clinical record failed to reveal an "interact" form for the resident's 3/30/19 and 4/22/19 hospital transfers.

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A request was made on 7/24/19 at approximately 6:00 p.m. for the evidence that the required documentation was sent to the hospital for Resident #96's transfers to the hospital on 3/30/19 and 4/22/19.

ASM #2, the director of nursing, stated on 7/25/19 at 10:00 a.m., that she did not have any documentation for Resident #96 regarding his transfers to the hospital.

Administrative staff member (ASM) #1, the administrator, and ASM #2 the director of nursing, were made aware of the above concern on 7/25/19 at 1:25 p.m.

No further information was provided prior to exit.
7. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer of Resident # 9 to the hospital on 04/09/2019.

Resident # 9 was admitted to the facility on 10/02/2018, with a readmission on 04/10/2019 with diagnoses that included but were not limited to breast cancer, low iron, and high blood pressure. Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/16/19, coded Resident # 9 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions.

The facility's "Progress Notes" for Resident # 9 dated 04/09/2019 documented, "Resident still complaining of discomfort to g-tube (Gastrostomy feeding tube) (1). NP (nurse practitioner)

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informed and orders received to transport to (Name of Hospital) ER (emergency room) for g-tube placement. Family informed. Transported via (by) (Name of Transport Company), report given to ER."

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med [medication] list, depending on what sending for, may send copies of labs [laboratory tests], progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the Interact in the front of the chart."

Review of the clinical record and the EHR (electronic health record) for Resident # 9 failed to evidence that documentation and information was provided to the receiving provider for a facility-initiated transfer on 04/09/2019 for Resident # 9.

On 7/24/19 at 6:45 p.m., a request was made via a list provided to ASM (administrative staff member) #1 (the administrator) for evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 04/09/2019 for Resident # 9.

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On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) presented several packets including Interact forms for particular residents requested. ASM #2 stated, "These are all that we have." No evidence was provided for the facility-initiated transfer on 04/09/2019 for Resident # 9.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website:
https://medlineplus.gov/ency/article/002937.htm

8. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer of Resident #26 to the hospital on 05/11/2019.

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Resident # 26 was admitted to the facility on 05/02/1015 with diagnoses that included but were not limited to high blood pressure, high cholesterol and seizure disorder. Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/02/19, coded Resident # 26 as scoring a six on the staff assessment for mental status (BIMS) of a score of 0 - 15, six- being severely impaired of cognition for making daily decisions.

The facility's "Progress Notes" for Resident # 26 dated 05/11/19 documented in part, "Around 4:30 p.m., writer observed resident having a seizure that lasted approx (approximately) 5 (five) mins (minutes. Resident [sic] have another seizure that lasted for 8 (eight) mins after v/s (vital signs) obtained. Res (resident) son (Name of Son) notified and requested to send his father to (Name of Hospital) for further evaluation. Resident transferred by (Name of Transportation Company) medical team via (by) stretcher around 5:30 pm (p.m.)."

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med [medication] list, depending on what sending for, may send copies of labs [laboratory tests], progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurses evidence this information is provided, LPN #2 stated, "The

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nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the Interact in the front of the chart."

Review of the clinical record and the EHR (electronic health record) for Resident # 26 failed to evidence that documentation and information was provided to the receiving provider for a facility-initiated transfer on 05/11/19 for Resident # 26.

On 7/24/19 at 6:45 p.m., a request was made via a list provided to ASM (administrative staff member) #1 (the administrator) for evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 05/11/19 for Resident # 26.

On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) presented several packets including Interact forms for particular residents requested. ASM #2 stated, "These are all that we have." No evidence was provided for the facility-initiated transfer on 05/11/19 for Resident # 26.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 (administrator)

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and ASM #2 (director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

9. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer of Resident #41 to the hospital on 05/07/2019.

Resident # 41 was admitted to the facility on 09/10/1009 with and a readmission on 03/17/2017 with diagnoses that included but were not limited to depression, low iron and bipolar disorder (1). Resident # 41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/24/19, coded Resident # 41 as scoring a three on the staff assessment for mental status (BIMS) of a score of 0 - 15, three- being severely impaired of cognition for making daily decisions.

The facility's "Progress Notes" for Resident # 41 dated 05/07/19 documented in part, "16:03 (4:03 p.m.) Transferred via (by) stretcher/ambulance to (Name of Hospital) @ (at) 11 A (11:00 a.m.) to have new g-tube (Gastrostomy feeding tube) (2) placement. Returned prior to lunch with new g-tube in place and patent."

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care

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instructions), care plan, bed hold policy, med [medication] list, depending on what sending for, may send copies of labs [laboratory tests], progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the Interact in the front of the chart."

Review of the clinical record and the EHR (electronic health record) for Resident # 41 failed to evidence that documentation and information was provided to the receiving provider for a facility-initiated transfer on 05/07/19 for Resident # 41.

On 7/24/19 at 6:45 p.m., a request was made via a list provided to ASM (administrative staff member) #1 (the administrator) for evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 05/07/19 for Resident # 41.

On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) presented several packets including Interact forms for particular residents requested. ASM #2 stated, "These are all that we have." No evidence was provided for the facility-initiated transfer on 05/07/19 for Resident # 41.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred

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to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

References:
(1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website:
https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website:
https://medlineplus.gov/ency/article/002937.htm

10. The facility staff failed evidence that Resident #58's comprehensive care plan goals were provided to the hospital for the resident's transfer on 5/21/19.

Resident #58 was admitted to the facility on 06/21/2017. His diagnoses included, but were not limited to, dementia, major depression, muscle weakness, and lack of coordination. Resident #58's most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of

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06/05/2019. The Brief Interview for Mental Status (BIMS) scored Resident #58 at an 8, indicating severe impairment.

A review of Resident #58's record was conducted beginning on 07/23/2019.

A progress note dated 05/21/2019 at 2:29p.m., documented: "Resident combative to staff. Appetite remains very poor. Refused all medications including supplement. Refused VS (vital signs). NP (Nurse Practitioner) in to visit and examined N.O. (new orders) noted to send to [HOSPITAL] ER (emergency room). RP [RP NAME] made aware. Resident transported via [TRANSPORT] on stretcher with 3 attendants to [HOSPITAL] around 12:15p.m."

No documentation was noted describing what, if any, documents were sent with the resident to the hospital.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med list, depending on what sending for, may send copies of labs, progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the interact in the front of the

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chart."

Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings on the morning of 07/25/2019. No further documentation was provided.

11. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 4/24/2019 for resident #36.

Resident # 36 was admitted to the facility on 05/21/2013 with a readmission on 05/01/2019 with diagnoses that included but were not limited to encephalopathy (1), unspecified convulsions (2), and unspecified dementia (3). Resident # 36's most recent MDS (minimum data set), a 14 day assessment with an ARD (assessment reference date) of 05/15/19, coded Resident # 36 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions.

The nurse's "Progress Notes," dated 04/24/2019 08:51 (8:51 a.m.) for Resident # 36 documented, "At 6:17am call place to 911. 911 arrive in the facility at approximately 6:27am and left with resident at 6:38am."

The nurse's "Progress Notes," dated 04/24/2019 09:36 (9:36 a.m.) for Resident # 36 documented, "NP (nurse practitioner) notified at 9:30am and order to send patient out in place."

The POS (physician order summary) dated

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04/24/2019 09:32 (9:32 a.m.) for Resident #36 documented, "Transfer PT (patient) to [name of hospital] to evaluate and treat d/t (due to) seizure."

The nurse's "Progress Notes," dated 04/24/2019 16:15 (4:15 p.m.) for Resident # 36 documented, "Phoned [name of hospital] and resident admitted with DX (diagnosis) of Seizures."

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated, "Interact (a form containing information including but not limited to contact information and care instructions), care plan, bed hold policy, med list, depending on what sending for, may send copies of labs, progress notes, whatever information that helps them understand the situation better to be able to treat them." When asked how nurse's evidence this information is provided, LPN #2 stated, "The nurses will send a copy to the hospital with the patient and will also call the hospital to give report. Sometimes fax over, and then put a copy of the Interact in the front of the chart."

Review of the clinical record and the EHR (electronic health record) for Resident # 36 failed to evidence that documentation and information was provided to the receiving provider for a facility-initiated transfer on 4/24/2019 for Resident #36.

On 7/24/19 at 6:45 p.m., a request was made via a list provided to ASM (administrative staff

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member) #1 (the administrator) for evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 04/24/2019 for Resident #36.

On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) presented several packets including Interact forms for particular residents requested. ASM #2 stated, "These are all that we have." No evidence was provided for the facility-initiated transfer on 04/24/2019 for Resident #36.

On 7/25/19 at 1:58 p.m., an interview was conducted with ASM #2. ASM #2 stated the facility has a packet and a checklist for nurses to pick up and send when a resident is transferred to the hospital. ASM #2 stated the nurses send the information but do not always make a copy of the information sent. ASM #2 stated the nurses do document a note and this process was implemented in June 2019.

On 7/25/19 at 6:22 p.m., ASM (administrative staff member) #1 (administrator) and ASM #2 (director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

References:

1. Encephalopathy- A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website:
http://www.ninds.nih.gov/disorders/encephalopath

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F 622	Continued From page 77 y/encephalopathy.htm. 2. Convulsions- The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. 3. Dementia- A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		8/25/19

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F 623	Continued From page 78 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to provide written notification of transfer to residents and/or their representatives for thirteen

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1. Address how corrective action will be accomplished for those residents affected by deficient practice; 30-Day Involuntary

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of 15 residents in the survey sample of 54, investigated for hospitalizations, Residents #14, #71, #85, #73, #32, #83, #96, #20, #9, #26, #41, #58 and #36.

The findings include:

1. Resident #14 was transferred to the hospital on 4/9/19. The facility staff failed to evidence that written notification regarding the transfer was provided to the resident and/or representative.

Resident #14 was admitted to the facility on 4/20/17. Resident #14's diagnoses included but were not limited to urinary tract infection and diabetes. Resident #14's most recent MDS (minimum data set) (prior to a recent discharge), an annual assessment with an ARD (assessment reference date) of 4/23/19, coded the resident as being cognitively intact.

Review of Resident #14's clinical record revealed the resident was transferred to the hospital on 4/9/19 for behaviors and shortness of breath. Further review of Resident #14's clinical record failed to reveal documentation to evidence the resident and/or representative was provided written notification regarding the transfer.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

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Discharge Notice could not be retro-actively given for the previous resident discharges.

2. Address how facility will identify other residents potentially affected by deficient practice; Residents currently residing in the facility are at risk.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; All transfers and discharges will be discussed as part of the Morning Meeting process. During the morning meeting, a licensed nurse will provide the social worker with a copy of all transfer and discharge (INTERACT) forms. The social worker will provide written confirmation to the RP and will enter the resident□s and the RP□s name on a tracking form. Prior to mailing the INTERACT and Facility-Initiated Discharge Notice (30-Day Involuntary Discharge Notice), a copy of the addressed and stamped envelope as proof of compliance will be initialed by the Social Services. The tracking will be reported to the facility QAPI committee for six months for review and recommendation. A copy of the notice will be forwarded to a representative of the Office of the State Long-Term Care Ombudsman.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; 5x per week in the Morning Meeting process, all facility-initiated

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On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

On 7/24/19 at 6:45 p.m., evidence that written notification of hospital transfer was provided to Resident #14 and/or the resident's representative was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

The facility document titled, "DISCHARGE AND TRANSFER" documented, "DISCHARGES:
PREVIOUS PROCESS
- 30 DAY DISCHARGE NOTICE
-Non-payment
-Cannot provide care or needs
-Danger to themselves or others
-Improved and no longer qualifies for LTC (long-term care) level
CURRENT PROCESS
Must also go to ombudsman and family or POA (power of attorney). If they are at hospital you must give a copy to the family and or POA at the same time you send a copy to the ombudsman."

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discharges to acute care faculties will be reviewed as part of the Census Review portion of the meeting process. Each discharge will be audited for compliance. On a weekly basis the Administrator/Designee will audit the previous 7 days' discharges and review for compliance to INTERACT communication requirement. This monitoring will continue x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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No further information was presented prior to exit.

2. Resident #71 was transferred to the hospital on 3/26/19, 4/24/19 and 5/13/19. The facility staff failed to evidence that written notification regarding the transfers was provided to the resident and/or representative.

Resident #71 was admitted to the facility on 1/22/19. Resident #71's diagnoses included but were not limited to heart failure and diabetes. Resident #71's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/16/19, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #71's clinical record revealed the resident was transferred to the hospital on the following dates:
-3/26/19 for rapid shallow breathing and wheezing.
-4/24/19 for evaluation and treatment of an undocumented condition.
-5/13/19 for a low oxygen level.

Further review of Resident #71's clinical record failed to reveal documentation to evidence the resident and/or representative was provided written notification regarding the transfers.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or

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discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

On 7/24/19 at 6:45 p.m., evidence that written notification of hospital transfers was provided to Resident #71 and/or the resident's representative was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested items.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

3. Resident #85 was transferred to the hospital on 3/26/19 and 5/6/19. The facility staff failed to evidence that written notification regarding the transfers was provided to the resident and/or representative.

Resident #85 was admitted to the facility on 8/30/17. Resident #85's diagnoses included but were not limited to seizures and heart failure.

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Resident #85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/5/19, coded the resident's cognitive skills for daily decision making as independent.

Review of Resident #85's clinical record revealed the resident was transferred to the hospital on the following dates:
-3/26/19 for shortness of breath and an elevated heart rate.
-5/6/19 for nausea and vomiting.

Further review of Resident #85's clinical record failed to reveal documentation to evidence the resident and/or representative was provided written notification regarding the transfers.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

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On 7/24/19 at 6:45 p.m., evidence that written notification of hospital transfers was provided to Resident #85 and/or the resident's representative was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested items.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

4. The facility staff failed to evidence that written notification was provided to the resident representative upon a hospital transfer on 4/20/19 and 5/9/19 for Resident #73.

Resident #73 was admitted to the facility on 6/9/17 with the diagnoses of but not limited to dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's Disease, mood disorder, depression, congestive heart failure, restless leg syndrome, cataracts, glaucoma, and sleep apnea. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurses note dated 4/21/19 at 12:23 AM, which documented, "Patient went to ER (emergency room) at 8:30 this evening. She was found unconscious by CNA (certified nursing assistant)

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around 8 pm. Patient came around a few times with vitals of 120 Hr (heart rate) 85 O2 (oxygen saturation) and Bp 97/58 (blood pressure). NP (nurse practitioner) (NP name)/unit manager were notified. Daughter notified and went to ER."

A review of the clinical record revealed a nurse's note dated 5/9/19 at 1:04 PM, that documented, "continues to have little PO (oral) intake, NP made aware new orders for IV (intravenous) fluids....NP in facility reassessed resident, complaint of right upper quad pain upon palpitation, NP called ER directly explained resident has been sent multiple times but keeps being sent back, NP explain her assessment of resident, new order obtained to send to ER."

Further review of the clinical record failed to reveal any evidence that written notification was provided to the resident representative regarding these hospital transfers.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call

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residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

On 7/24/19 at 6:45 p.m., evidence that written notification of hospital transfer was provided to Resident #73 and/or the resident's representative was requested via a list provided to ASM (administrative staff member) #1 (the Administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the Director of Nursing) confirmed she could not provide the above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

5. The facility staff failed to evidence that written notification was provided to the resident representative upon a hospital transfer on 4/12/19 for Resident #32.

Resident #32 was admitted to the facility on 3/6/16 with the diagnoses of but not limited to peripheral vascular disease, depression, left and right hip contractures, right above knee amputation, dysphagia, psychosis, mood disorder, epilepsy, high blood pressure, dementia, and chronic obstructive pulmonary disease. The 30-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/13/19 coded the resident as moderately impaired in ability to make daily life decisions.

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A review of the clinical record revealed a nurses note dated 4/12/19 that documented, "resident witnessed with SOB (shortness of breath), neb [nebulizer] treatment given as ordered, effective, respirations unlabored and his lung fields clear, abdomen is distended, firm to touch, non painful, positive for bowel sounds, last BM (bowel movement) 4/11/19 per record, resident has been on two courses of ABT (antibiotic therapy) therapies, with negative chest xrays, NP (Nurse Practitioner) aware and after assessment gave verbal order to send to (name of hospital) for further evaluation, unable to contact daughter."

Further review of the clinical record failed to reveal any evidence that written notification was provided to the resident representative regarding this hospital transfer.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

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On 7/24/19 at 6:45 p.m., evidence that written notification of hospital transfer was provided to Resident #32 and/or the resident's representative was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the Director of Nursing) confirmed she could not provide the above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

6. The facility staff failed to evidence that written notification was provided to the resident representative upon a hospital transfer on 6/15/19 for Resident #83.

Resident #83 was admitted to the facility on 1/1/16 with the diagnoses of but not limited to dementia with behaviors, left clavicle fracture, multiple rib fractures, right shoulder fracture, seizures, anxiety disorder, depression, affective disorder, hypothyroidism, anoxic brain injury. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions.

A review of the clinical record revealed the Interact form dated 6/15/19 that documented the resident was sent to the hospital for edema.

Further review of the clinical record failed to reveal any evidence that written notification was

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provided to the resident representative regarding this hospital transfer.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

On 7/24/19 at 6:45 p.m., evidence that written notification of hospital transfer was provided to Resident #83 and/or the resident's representative was requested via a list provided to ASM (administrative staff member) #1 (the Administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the Director of Nursing) confirmed she could not provide the above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.
7. The facility staff failed to provide written notification to the resident and/or resident

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representative for a facility initiated transfer for Resident #96 on 3/30/19 and 4/22/19.

Resident #96 was admitted to the facility on 3/18/19 with diagnoses that included but were not limited to: high blood pressure, seizure disorder, stroke and chronic kidney disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/11/19, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions.

The nurse's note dated, 3/30/19 at 2:40 p.m., documented in part, "Called (sic) received from lab (laboratory) of critical H&H (hemoglobin and hematocrit)...NP (nurse practitioner) notified of labs, new order obtained to send to (initials of hospital) ER (emergency room), RP (responsible party) and resident notified. (Name of ambulance service) called for transport...Significant other states she will meet the resident at the hospital. Resident stable."

Physician order dated, 3/30/19 at 2:34 p.m. documented, "May sent to (initials of hospital) ER for critical H&H."

The nurse's note dated, 4/22/19 at 3:03 p.m. documented in part, "Resident being sent to (name of hospital) ER related to purulent drainage from left shoulder wound. NP has examine and ordered resident to be sent out."

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The physician order dated, 4/22/19 at 5:00 p.m. documented, "Send to hospital for wound abscess."

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

A request was made on 7/24/19 at approximately 6:00 p.m. for the evidence that a written notification was provided to the resident and/or resident representative for Resident #96's transfers to the hospital on 3/30/19 and 4/22/19.

ASM #2, the director of nursing, stated on 7/25/19 at 10:00 a.m. she did not have any documentation for Resident #96 regarding his transfers to the hospital.

Administrative staff member (ASM) #1, the administrator, and ASM #2 the director of nursing, were made aware of the above concern on

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7/25/19 at 1:25 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.

8. The facility staff failed to provide Resident #20 and/or the resident representative with written notification of the reason for the transfer to the hospital on 7/13/19.

Resident #20 was admitted to the facility on 7/1/18 with a recent readmission on 7/15/19, with diagnoses that included but were not limited to: frequent falls, diabetes, high blood pressure and Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/18/19, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions.

The nurse's note dated, 7/13/19 at 9:00 p.m. documented in part, "Resident yelled out for help, staff responded to bistro seeing resident lying on stomach in front of wheelchair. Holding glasses with right hand and left hand straight down by side. Shoes on. Resident log rolled to bed with assist of three staff. Assessed with laceration

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noted above left eye, bleeding...Resident alert and about to follow directions and answer questions, no change noted to LOC (level of consciousness)/ Rescue squad transported to (initials of hospital) ER for evaluation. Daughter aware. NP (nurse practitioner) aware with no new orders."

The physician order dated, 7/13/19 at 9:00 p.m. documented, "Send to hospital for forehead laceration."

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

A request was made on 7/24/19 at approximately 6:00 p.m. for the evidence that the written notification of transfer was given to the resident and/or resident representative upon her transfer to the hospital on 7/13/19.

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ASM #2, the director of nursing, stated on 7/25/19 at 10:00 a.m. she did not have any evidence of a written notification provided to Resident #20 and/or her representative regarding her transfer to the hospital.

Administrative staff member (ASM) #1, the administrator, and ASM #2 the director of nursing, were made aware of the above concern on 7/25/19 at 1:25 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
9. The facility staff failed to evidence that written notification was provided to the resident representative upon a hospital transfer on 04/09/2019 for Resident # 9.

Resident # 9 was admitted to the facility on 10/02/2018, with a readmission on 04/10/2019 with diagnoses that included but were not limited to breast cancer, low iron, and high blood pressure. Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/16/19, coded Resident # 9 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions.

The facility's "Progress Notes" for Resident # 9 dated 04/09/2019 documented, "Resident still complaining of discomfort to g-tube (Gastrostomy feeding tube) (1). NP (nurse practitioner) informed and orders received to transport to (Name of Hospital) ER (emergency room) for

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g-tube placement. Family informed. Transported via (by) (Name of Transport Company), report given to ER."

Review of the clinical record and the EHR (electronic health record) for Resident # 9 failed to evidence that written notification of discharge was provided to the resident and resident's representative for the facility-initiated transfer on 4/09/19 for Resident # 9.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (director of social services) regarding resident transfers. When asked if the staff provide written notification of transfer to the resident and resident's representative for facility-initiated transfers OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

On 7/24/19 at 6:45 p.m., a request was made via list of residents to ASM (administrative staff member) #1 (administrator) for evidence that written notification was provided to the resident and resident's representative for a facility-initiated transfer on 04/09/2019 for Resident #9.

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On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) confirmed she could not provide the above requested item.

On 07/25/19 at 6:22 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the findings.

No further information was provided prior to exit.

(1) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website:
https://medlineplus.gov/ency/article/002937.htm

10. The facility staff failed to evidence that written notification was provided to the resident representative upon a hospital transfer on 05/11/2019 for Resident # 26.

Resident # 26 was admitted to the facility on 05/02/1015 with diagnoses that included but were not limited to high blood pressure, high cholesterol and seizure disorder. Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/02/19, coded Resident # 26 as scoring a six on the staff assessment for mental status (BIMS) of a score of 0 - 15, six- being severely impaired of cognition for making daily decisions.

The facility's "Progress Notes" for Resident # 26 dated 05/11/19 documented in part, "Around 4:30 p.m., writer observed resident having a seizure that lasted approx (approximately) 5 (five) mins

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(minutes. Resident [sic] have another seizure that lasted for 8 (eight) mins after v/s (vital signs) obtained. Res (resident) son (Name of Son) notified and requested to send his father to (Name of Hospital) for further evaluation. Resident transferred by (Name of Transportation Company) medical team via (by) stretcher around 5:30 pm (p.m.)."

Review of the clinical record and the EHR (electronic health record) for Resident # 26 failed to evidence that written notification of discharge was provided to the resident and resident's representative for the facility-initiated transfer on 05/11/19 for Resident # 26.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (director of social services) regarding resident transfers. When asked if the staff provide written notification of transfer to the resident and resident's representative for facility-initiated transfers OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

On 7/24/19 at 6:45 p.m., a request was made via list of residents to ASM (administrative staff

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member) #1 (administrator) for evidence that written notification was provided to the resident and resident's representative for a facility-initiated transfer on 05/11/2019 for Resident # 26.

On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) confirmed she could not provide the above requested item.

On 07/25/19 at 6:22 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the findings.

No further information was provided prior to exit.

11. The facility staff failed to evidence that written notification was provided to the resident representative upon a hospital transfer on 05/07/2019 for Resident # 41.

Resident # 41 was admitted to the facility on 09/10/1009 with and a readmission on 03/17/2017 with diagnoses that included but were not limited to depression, low iron and bipolar disorder (1). Resident # 41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/24/19, coded Resident # 41 as scoring a three on the staff assessment for mental status (BIMS) of a score of 0 - 15, three- being severely impaired of cognition for making daily decisions.

The facility's "Progress Notes" for Resident # 41 dated 05/07/19 documented in part, "16:03 (4:03 p.m.) Transferred via (by) stretcher/ambulance to (Name of Hospital) @ (at) 11 A (11:00 a.m.) to have new g-tube (Gastrostomy feeding tube) placement. Returned prior to lunch with new g-tube in place and patent."

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Review of the clinical record and the EHR (electronic health record) for Resident # 41 failed to evidence that written notification of discharge was provided to the resident and resident's representative for the facility-initiated transfer on 05/07/19 for resident # 41.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (director of social services) regarding resident transfers. When asked if the staff provide written notification of transfer to the resident and resident's representative for facility-initiated transfers OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

On 7/24/19 at 6:45 p.m., a request was made via list of residents to ASM (administrative staff member) #1 (administrator) for evidence that written notification was provided to the resident and resident's representative for a facility-initiated transfer on 05/07/2019 for Resident # 41.

On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) confirmed she could not provide the above requested item.

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On 07/25/19 at 6:22 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.
12. The facility staff failed evidence that they provided the resident or their RP with a written notice of transfer to the hospital on 5/21/19 for Resident #58.

Resident #58 was admitted to the facility on 06/21/2017. His diagnoses included, but were not limited to, dementia, major depression, muscle weakness, and lack of coordination. Resident #58's most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 06/05/2019. The Brief Interview for Mental Status (BIMS) scored Resident #58 at an 8, indicating severe impairment. Resident #58 was coded as requiring extensive assistance of two or more people for dressing and personal hygiene, and supervision of one person for other Activities of Daily Life (ADLs).

A review of Resident #58's record was conducted beginning on 07/23/2019.

A progress note dated 05/21/2019 at 2:29p.m., documented: "Resident combative to staff.

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Appetite remains very poor. Refused all medications including supplement. Refused VS (vital signs). NP (Nurse Practitioner) in to visit and examined N.O. (new orders) noted to send to [HOSPITAL] ER (emergency room). RP [RP NAME] made aware. Resident transported via [TRANSPORT] on stretcher with 3 attendants to [HOSPITAL] around 12:15p.m."

No documentation was noted describing what, if any, documents were sent with the resident to the hospital.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if residents and/or their representatives are provided written notification of transfer when residents are transferred to the hospital. OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice.

Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings on the morning of 07/25/2019. No further documentation was provided.

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13. The facility staff failed to provide Resident # 36 and Resident # 36's representative written notification of a facility-initiated transfer on 04/24/19 for Resident #36.

Resident # 36 was admitted to the facility on 05/21/2013 with a readmission on 05/01/2019 with diagnoses that included but were not limited to encephalopathy (1), unspecified convulsions (2), and unspecified dementia (3).
Resident # 36's most recent MDS (minimum data set), a 14 day reentry assessment with an ARD (assessment reference date) of 05/15/19, coded Resident # 36 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions.

The nurse's "Progress Notes," dated 04/24/2019 08:51 (8:51 a.m.) for Resident # 36 documented, "At 6:17am call place to 911. 911 arrive in the facility at approximately 6:27am and left with resident at 6:38am."

The POS (physician order summary) dated 04/24/2019 09:32 (9:32 a.m.) for Resident #36 documented, "Transfer PT (patient) to [name of hospital] to evaluate and treat d/t (due to) seizure."

The nurse's "Progress Notes," dated 04/24/2019 16:15 (4:15 p.m.) for Resident # 36 documented, "Phoned [name of hospital] and resident admitted with DX (diagnosis) of Seizures."

Review of the clinical record and the EHR (electronic health record) for Resident # 36 failed to evidence that written notification of transfer

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F 623	Continued From page 104 was provided to the resident and resident's representative for the facility-initiated transfer on 4/24/19 for Resident #36. On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (director of social services) regarding resident transfers. When asked if the staff provide written notification of transfer to the resident and resident's representative for facility-initiated transfers OSM #3 stated a notice of involuntary transfer or discharge is supposed to be presented to residents upon discharge to the hospital and the nurses are responsible for providing this form. On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if nurses provide written notification of transfer to residents and/or their representatives when residents are transferred to the hospital. LPN #2 stated the nurses call residents' families but she would have to check to see if written notification is provided because she has not had to provide this notice. On 7/24/19 at 6:45 p.m., a request was made via list of residents to ASM (administrative staff member) #1 (administrator) for evidence that written notification was provided to the resident and resident's representative for a facility-initiated transfer on 04/24/2019 for Resident #36. On 7/25/19 at approximately 10:00 a.m., ASM #2 (director of nursing) confirmed she could not provide the above requested item. On 07/25/19 at 6:22 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the findings.	F 623		

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F 623	Continued From page 105 No further information was provided prior to exit. References: 1. Encephalopathy- A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopath y/encephalopathy.htm. 2. Convulsions- The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. 3. Dementia- A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		8/25/19

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return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a written bed hold notice for a facility-initiated transfer for 9 of 15 residents in the survey sample of 54, investigated for hospitalizations, Residents #14, #71, #85, #73, #32. #96, #20, #58 and #36.

The findings include:

1. The facility staff failed to provide Resident #14 and/or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 4/9/19.

Resident #14 was admitted to the facility on 4/20/17. Resident #14's diagnoses included but were not limited to urinary tract infection and diabetes. Resident #14's most recent MDS

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1. Address how corrective action will be accomplished for those residents affected by deficient practice; A timely corrective action for the absence of the identified bed-hold notices to resident representatives is unavailable.

2. Address how facility will identify other residents potentially affected by deficient practice; Residents currently residing in the facility are at risk.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; In the event of an emergency transfer, the resident representative will be notified within 24 hours. Such

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(minimum data set) (prior to a recent discharge), an annual assessment with an ARD (assessment reference date) of 4/23/19, coded the resident as being cognitively intact.

Review of Resident #14's clinical record revealed the resident was transferred to the hospital on 4/9/19 for behaviors and shortness of breath. Further review of Resident #14's clinical record failed to reveal evidence that written notification of the bed hold policy was provided to the resident and/or the resident representative.

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of the interact form (a form containing information including but not limited to contact information and care instructions) is placed in residents' charts. Note- Resident #14's clinical record did

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notification will be noted in the resident□s chart. The resident will also receive (by hand) a copy of the notice.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; On a weekly basis the Administrator/Designee will review the daily findings and corrective measures enacted for the previous week period. This monitoring will continue x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations, quarterly x 2 quarters.

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not contain an interact form regarding the resident's 4/9/19 hospital transfer; furthermore, review of a blank interact form failed to reveal documentation regarding the bed hold policy.

On 7/24/19 at 6:45 p.m., evidence that the bed hold policy was provided to Resident #14 and/or the resident's representative when the resident was transferred to the hospital on 4/9/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

The facility document titled, "DISCHARGE AND TRANSFER" documented, "What is needed upon discharge? Bed hold policy..."

No further information was presented prior to exit.

2. The facility staff failed to provide Resident #71 and/or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 3/26/19, 4/24/19 and 5/13/19.

Resident #71 was admitted to the facility on 1/22/19. Resident #71's diagnoses included but were not limited to heart failure and diabetes. Resident #71's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/16/19, coded the resident's cognitive skills for daily

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decision-making as severely impaired.

Review of Resident #71's clinical record revealed the resident was transferred to the hospital on the following dates:
-3/26/19 for rapid shallow breathing and wheezing.
-4/24/19 for evaluation and treatment of an undocumented condition.
-5/13/19 for a low oxygen level.

Further review of Resident #71's clinical record failed to reveal evidence that written notification of the bed hold policy was provided to the resident and/or the resident representative for the above transfers.

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of

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the interact form (a form containing information including but not limited to contact information and care instructions) is placed in residents' charts. Note- Resident #71's clinical record did not contain an interact form regarding the resident's above hospital transfers; furthermore, review of a blank interact form failed to reveal documentation regarding the bed hold policy.

On 7/24/19 at 6:45 p.m., evidence that the bed hold policy was provided to Resident #71 and/or the resident's representative when the resident was transferred to the hospital on 3/26/19, 4/24/19 and 5/13/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested items.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to provide Resident #85 and/or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 3/26/19 and 5/6/19.

Resident #85 was admitted to the facility on 8/30/17. Resident #85's diagnoses included but were not limited to seizures and heart failure. Resident #85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/5/19, coded the resident's cognitive skills for daily decision

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making as independent.

Review of Resident #85's clinical record revealed the resident was transferred to the hospital on the following dates:
-3/26/19 for shortness of breath and an elevated heart rate.
-5/6/19 for nausea and vomiting.

Further review of Resident #85's clinical record failed to reveal evidence that written notification of the bed hold policy was provided to the resident and/or the resident representative for the above transfers.

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of the interact form (a form containing information including but not limited to contact information

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and care instructions) is placed in residents' charts. Note- Resident #85's clinical record did not contain an interact form regarding the resident's hospital transfers; furthermore, review of a blank interact form failed to reveal documentation regarding the bed hold policy.

On 7/24/19 at 6:45 p.m., evidence that the bed hold policy was provided to Resident #85 and/or the resident's representative when the resident was transferred to the hospital on 3/26/19 and 5/6/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested items.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

4. The facility staff failed to evidence that a written bed hold notice was provided to the resident representative for a hospital transfer on 4/20/19 and 5/9/19 for Resident #73.

Resident #73 was admitted to the facility on 6/9/17 with the diagnoses of but not limited to dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's Disease, mood disorder, depression, congestive heart failure, restless leg syndrome, cataracts, glaucoma, and sleep apnea. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded

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the resident as being severely impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurses note dated 4/21/19 at 12:23 AM, which documented, "Patient went to ER (emergency room) at 8:30 this evening. She was found unconscious by CNA (certified nursing assistant) around 8 pm. Patient came around a few times with vitals of 120 Hr (heart rate) 85 O2 (oxygen saturation) and Bp 97/58 (blood pressure). NP (nurse practitioner) (NP name)/unit manager were notified. Daughter notified and went to ER."

A review of the clinical record revealed a nurse's note dated 5/9/19 at 1:04 PM, that documented, "continues to have little PO (oral) intake, NP made aware new orders for IV fluids....NP in facility reassessed resident, complaint of right upper quad pain upon palpitation, NP called ER directly explained resident has been sent multiple times but keeps being sent back, NP explain her assessment of resident, new order obtained to send to ER."

Further review of the clinical record failed to reveal that a written bed hold notice was provided to the resident representative for either hospitalization.

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff

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and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of the interact form (a form containing information including but not limited to contact information and care instructions) is placed in residents' charts. A review of a blank interact form failed to reveal documentation regarding the bed hold policy. The facility had no evidence that an Interact form was even completed for either hospitalization.

On 7/24/19 at 6:45 p.m., evidence that the bed hold policy was provided to Resident #73 and/or the resident's representative when the resident was transferred to the hospital on 4/20/19 and 5/9/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

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5. The facility staff failed to evidence that a written bed hold notice was provided to the resident representative upon a hospital transfer on 4/12/19 and 7/3/19 for Resident #32.

Resident #32 was admitted to the facility on 3/6/16 with the diagnoses of but not limited to peripheral vascular disease, depression, left and right hip contractures, right above knee amputation, dysphagia, psychosis, mood disorder, epilepsy, high blood pressure, dementia, and chronic obstructive pulmonary disease. The 30-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/13/19 coded the resident as moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurses note dated 4/12/19 that documented, "resident witnessed with SOB (shortness of breath), neb treatment given as ordered, effective, respirations unlabored and his lung fields clear, abdomen is distended, firm to touch, non painful, positive for bowel sounds, last BM (bowel movement) 4/11/19 per record, resident has been on two courses of ABT (antibiotic therapy) therapies, with negative chest xrays, NP (Nurse Practitioner) aware and after assessment gave verbal order to send to (name of hospital) for further evaluation, unable to contact daughter."

A review of the clinical record revealed a nurse's note dated 7/3/19 that documented, "Resident with worsening cough and congestion. Facial edema and grey in color. NP in to see resident and it was ordered that he be sent to ER (emergency room) for eval/tx (evaluation and

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treatment). (Name of transport company) was arranged, report was called to (name of hospital) ER charge nurse and a message was left for his dtr/RP (daughter/responsible party) in regards to this order and residents clinical status. There has been no return call on this shift. Transferred to ER by stretcher unit at 8:00pm. A f/u (follow up) call to ER @ (at) 2230 (10:30 PM) and resident has been admitted into (room number) with diagnoses of acute renal failure, acute respiratory failure and sepsis."

Further review of the clinical record revealed a nurses note dated 7/3/19 that documented, "interact reported copied and sent to ER with patient, report called to (name of hospital) ER."

Further review of the clinical record failed to reveal any evidence that a written bed hold notice was provided to the resident representative for either hospital transfer.

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is

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transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of the interact form (a form containing information including but not limited to contact information and care instructions) is placed in residents' charts. A review of a blank interact form failed to reveal documentation regarding the bed hold policy.

On 7/24/19 at 6:45 p.m., evidence that the bed hold policy was provided to Resident #32 and/or the resident's representative when the resident was transferred to the hospital on 4/12/19 and 7/3/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

6. The facility staff failed to provide a notice of a bed hold to the resident and/or resident representative for a facility initiated transfer for Resident #96 on 3/30/19 and 4/22/19.

Resident #96 was admitted to the facility on 3/18/19 with diagnoses that included but were not limited to: high blood pressure, seizure disorder, stroke and chronic kidney disease requiring hemodialysis (a procedure used in toxic

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conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/11/19, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions.

The nurse's note dated, 3/30/19 at 2:40 p.m., documented in part, "Called (sic) received from lab (laboratory) of critical H&H (hemoglobin and hematocrit)...NP (nurse practitioner) notified of labs, new order obtained to send to (initials of hospital) ER (emergency room), RP (responsible party) and resident notified. (Name of ambulance service) called for transport...Significant other states she will meet the resident at the hospital. Resident stable."

Physician order dated, 3/30/19 at 2:34 p.m. documented, "May sent to (initials of hospital) ER for critical H&H."

The nurse's note dated, 4/22/19 at 3:03 p.m. documented in part, "Resident being sent to (name of hospital) ER related to purulent drainage from left shoulder wound. NP has examine and ordered resident to be sent out."

The physician order dated, 4/22/19 at 5:00 p.m. documented, "Send to hospital for wound abscess."

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents

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and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of the interact form (a form containing information including but not limited to contact information and care instructions) is placed in residents' charts. Note- Resident #96's clinical record did not contain an interact form regarding the resident's 4/9/19 hospital transfer; furthermore, review of a blank interact form failed to reveal documentation regarding the bed hold policy

A request was made on 7/24/19 at approximately 6:00 p.m. for the evidence that the bed hold policy was given to the resident and/or resident representative upon his transfers to the hospital on 3/30/19 and 4/22/19.

ASM #2, the director of nursing, stated on 7/25/19 at 10:00 a.m. she did not have any documentation for Resident #96 regarding his transfers to the hospital.

Administrative staff member (ASM) #1, the

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administrator, and ASM #2 the director of nursing, were made aware of the above concern on 7/25/19 at 1:25 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.

7. The facility staff failed to provide a written bed hold notice to Resident #20 and/or the resident representative upon transfer to the hospital on 7/13/19.

Resident #20 was admitted to the facility on 7/1/18 with a recent readmission on 7/15/19, with diagnoses that included but were not limited to: frequent falls, diabetes, high blood pressure and Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/18/19, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions.

The nurse's note dated, 7/13/19 at 9:00 p.m. documented in part, "Resident yelled out for help, staff responded to bistro seeing resident lying on stomach in front of wheelchair. Holding glasses with right hand and left hand straight down by

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side. Shoes on. Resident log rolled to bed with assist of three staff. Assessed with laceration noted above left eye, bleeding...Resident alert and about to follow directions and answer questions, no change noted to LOC (level of consciousness)/ Rescue squad transported to (initials of hospital) ER for evaluation. Daughter aware. NP (nurse practitioner) aware with no new orders."

The physician order dated, 7/13/19 at 9:00 p.m. documented, "Send to hospital for forehead laceration."

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred.

A request was made on 7/24/19 at approximately 6:00 p.m. that the bed hold notice was provided to the resident and/or resident representative upon her transfer to the hospital on 7/13/19.

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ASM #2, the director of nursing, stated on 7/25/19 at 10:00 a.m. she did not have any documentation that the bed hold notice was given to the resident and/or resident representative upon transfer to the hospital on 7/13/19.

Administrative staff member (ASM) #1, the administrator, and ASM #2 the director of nursing, were made aware of the above concern on 7/25/19 at 1:25 p.m.

No further information was provided prior to exit.
8. The facility staff failed to provide a notice of a bed hold to the resident and/or resident representative for a facility initiated transfer to the hospital for Resident #58 on 5/21/19.

Resident #58 was admitted to the facility on 06/21/2017. His diagnoses included, but were not limited to, dementia, major depression, muscle weakness, and lack of coordination. Resident #58's most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 06/05/2019. The Brief Interview for Mental Status (BIMS) scored Resident #58 at an 8, indicating severe impairment.

A review of Resident #58's record was conducted beginning on 07/23/2019. A progress note dated 05/21/2019 at 2:29p.m., documented: "Resident combative to staff. Appetite remains very poor. Refused all medications including supplement. Refused VS (vital signs). NP (Nurse Practitioner) in to visit and examined N.O. (new orders) noted to send to [HOSPITAL] ER (emergency room). RP [RP NAME] made aware. Resident transported via [TRANSPORT] on stretcher with 3

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attendants to [HOSPITAL] around 12:15p.m."

Further review of the clinical record failed to reveal that a written bed hold notice was provided to the resident representative for the 5/21/19 transfer to the hospital.

On 7/24/19 at 2:26 p.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 was asked if the written bed hold policy is provided to residents and/or their representatives when residents are transferred to the hospital. OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of the interact form (a form containing information including but not limited to contact information and care instructions) is placed in residents' charts. Note- Resident #85's clinical record did not contain an interact form regarding the resident's hospital transfers; furthermore, review of a blank interact form failed to reveal documentation regarding the bed hold policy.

Administrative Staff Member (ASM) #1, the

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Administrator, and ASM #2, the Director of Nursing, were informed of the findings on the morning of 07/25/2019. No further documentation was provided.

9. The facility staff failed to provide Resident # 36 and Resident # 36's representative written notification of the bed hold policy for a facility-initiated transfer on 04/24/19 for Resident #36.

Resident # 36 was admitted to the facility on 05/21/2013 with a readmission on 05/01/2019 with diagnoses that included but were not limited to encephalopathy (1), unspecified convulsions (2), and unspecified dementia (3).

Resident # 36's most recent MDS (minimum data set), a 14 day reentry assessment with an ARD (assessment reference date) of 05/15/19, coded Resident # 36 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions.

The nurse's "Progress Notes," dated 04/24/2019 08:51 (8:51 a.m.) for Resident # 36 documented, "At 6:17am call place to 911. 911 arrive in the facility at approximately 6:27am and left with resident at 6:38am."

The nurse's "Progress Notes," dated 04/24/2019 16:15 (4:15 p.m.) for Resident # 36 documented, "Phoned [name of hospital] and resident admitted with DX (diagnosis) of Seizures."

Review of the clinical record and the EHR (electronic health record) for Resident # 36 failed to evidence that written notification of the bed hold policy was provided to the resident and resident's representative for the facility-initiated

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transfer on 4/24/19 for resident #36.

On 7/24/19 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3 (director of social services) regarding facility-initiated transfers. When asked about the process for bed hold notification OSM #3 stated the bed hold policy is given to residents who are alert and oriented when they are transferred to the hospital. OSM #3 stated the social services staff and/or admissions staff calls residents' representatives if the bed hold policy is not provided to residents when they are transferred.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #2 stated the bed hold policy in addition to other documents is sent with residents when they are transferred. When asked how nurses evidence this information is provided, LPN #2 stated a copy of the interact form (a form containing information including but not limited to contact information and care instructions) is placed in residents' charts. A review of Resident #36's clinical record did not contain an interact form regarding the resident's 4/24/19 hospital transfer.

On 7/24/19 at 6:45 p.m., evidence that the bed hold policy was provided to Resident #36 and/or the resident's representative for the facility-initiated transfer on 4/24/19 was requested via a list provided to ASM (administrative staff member) #1 (the administrator).

On 7/25/19 at 10:00 a.m., ASM #2 (the director of nursing) confirmed she could not provide the

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above requested item.

On 7/25/19 at 6:22 p.m., ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

References:

1. Encephalopathy- A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

2. Convulsions- The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

3. Dementia- A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) | F 656 | | 8/25/19

§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

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F 656	Continued From page 127 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the	F 656	F656 1. Address how corrective action will be accomplished for those residents affected	

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comprehensive care plan for two of 54 residents in the survey sample, Residents #86 and #28.

The findings include:

1. The facility staff failed to implement Resident #86's comprehensive care plan for the monitoring of a wanderguard (a device used to prevent at-risk residents from exiting the facility) on 4/17/19 and 4/18/19.

The facility staff followed the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual regarding care plans. The manual documented, "Federal statute and regulations requiring nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."

Resident #86 was admitted to the facility on 7/29/16. Resident #86's diagnoses included but were not limited to Alzheimer's disease (1) and muscle weakness. Resident #86's most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 6/23/19, coded the resident's cognition as severely impaired. Section G coded Resident #86 as requiring supervision with walking.

Resident #86's comprehensive care plan revised on 7/18/17 documented, "I am at risk for Elopement R/T (related to) wandering at times...Personal wander gard prevention device-check for placement each shift and

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by deficient practice; There was no negative outcome due to the deficient practice. The res safety was maintained at all times and the missing documentation was flagged and noted with family and physician notified.

2. Address how facility will identify other residents potentially affected by deficient practice; Any resident requiring a Wanderguard may be affected.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Re-education of nursing staff on proper documentation of resident TAR to be completed. In-services to specify the signing of TAR as task is completed, or as order is carried out. Residents with Wanderguards TAR will be audited 5x per week for compliance and where incomplete documentation is evident, resident safety will be ensured, then correction to TAR will be made by the shift nurse responsible as appropriate with one-on-one education with DON/ADON or designee.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; On a weekly basis the Director of Nursing/Designee will review the daily TARs of Wanderguarded residents x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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function daily..."

Review of Resident #86's clinical record revealed an elopement risk assessment dated 4/15/19 that documented Resident #86 was at risk for elopement. Further review of Resident #86's clinical record revealed a physician's order dated 4/15/19 that documented, "Wanderguard. Check for Placement and Functioning every shift for High Risk for Elopement."

Resident #86's April 2019 TAR (treatment administration record) documented, "Wanderguard. Check for Placement and Functioning (sic,) every shift for High Risk for Elopement." Further review of the April 2019 TAR failed to reveal evidence that the resident's wanderguard was checked for placement and function during the night shift on 4/17/19 and 4/18/19 (as evidenced by a blank space with no nurse's initials signed off to indicate this was done). A nurse's note dated 4/19/19 documented, "wanderguard check for placement and function not done 4/17/19 and 4/18/19, MD (medical doctor) RP (responsible party) aware."

Note- Resident #86 resided on the locked memory care unit.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked why a resident on the locked memory care unit would have a wanderguard. LPN #2 stated, "Some residents are faster, if someone walks out of the unit door, some residents have a history of attempting to exit, so a wanderguard is placed on them to prevent exit from the facility doors (to the outside) if they get off the unit." LPN #2 was asked what the risk is if

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a resident's wanderguard is not checked per physician's order. LPN #2 stated, "There's the potential that it's not working correctly." When asked if a wanderguard should be checked every shift if there is a physician's order to do so, LPN #2 stated, "Yes."

On 7/24/19 at 5:32 p.m., an interview was conducted with LPN #1. LPN #1 was asked the purpose of a care plan. LPN #1 stated, "To share the information so that it's available for everyone. The care that is specific for that resident." LPN #1 was asked how staff ensures a resident's care plan for a wanderguard is implemented. LPN #1 stated, 'There is an order for things that we need to routinely do and then we have our kardexs for the CNAs (certified nursing assistants)."

On 7/24/19 at 6:41 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Elopement Risk" documented, "2. If the resident is identified as an elopement risk based on the assessment, the care plan will reflect the interventions (i.e. Wander Guard) or Code Alert) and desired outcomes...3. Residents identified as at risk for elopement may require nursing to check resident regularly and document on the Safety Check's..."

No further information was presented prior to exit.

(1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. AD begins slowly. It first involves the parts of the

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brain that control thought, memory and language. People with AD may have trouble remembering things that happened recently or names of people they know." This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+disease&_ga=2.135332914.2089506196.1564224503-1667741437.1550160688
2. The facility staff failed to implement Resident #28's comprehensive care plan for wound care.

Resident #28 was admitted to the facility on 2/18/16 with the diagnoses of but not limited to peripheral vascular disease, major depressive disorder, pressure ulcer of sacral region - Unstageable (1), type 2 diabetes mellitus, and high blood pressure. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 5/8/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making.

On 7/23/19 at 3:23 PM, an interview was conducted with Resident #28. When asked about her pressure injury wound care, Resident #28 stated, "It is all cleared up."

On 7/25/19 at 8:29 AM, an interview with RN (registered nurse) #7 was conducted. When RN #7 was asked about wound care for Resident #28, she stated, "She does not receive wound care at this time. No orders."

On 7/25/19 at 8:35 AM, an observation of Resident #28's sacrum pressure injury was

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conducted with RN #7. The observation of Resident #28's sacrum pressure injury revealed an open wound, with no dressing in place, no drainage, and no odor. Measurements obtained by RN #7 were documented as 4 cm X 3 cm X 0.5 cm.

On 7/25/19 at 8:47 AM, a follow up interview was conducted with RN #7. When asked if she was aware, the wound was open, RN #7 stated, "Yes, it is the same since I began working here in March." When asked if wound care physicians were following Resident #28, RN #7 stated, "Let me check her chart." After RN #7 reviewed the chart, she stated, "She has an order to see wound care physicians." When RN #7 reviewed the wound care physician's consult notes, dated 7/14/19, she stated, "She has Stage 4 wound on her sacrum. There are measurements. Leptospermum honey applied once a day for 18 days, alginate calcium once a day for 18 days, plastic surgeon consult," When asked if those are the wound care physician's recommendations should there be an order, RN #7 stated, "It was on 7/14/19, right? She has order for plastics consult that is discontinued. All of her wound care is discontinued." When asked about the process staff follows to obtain an order, when the wound care physician recommends a treatment, RN #7 stated, "We inform the physician of the recommendations and he makes the decision to order them or change them." When asked if the staff followed up with the physician for the wound care physician's recommendations from the 7/14/19 wound care visit, RN #7 stated, "I have no idea what happened with that day."

A review of the clinical record revealed a physician's note dated 6/18/19, which

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documented in part, "...She has a stage 4 pressure wound sacrum for at least 484 days duration. There is moderate serous exudate ...Stage 4 pressure wound sacrum: 3.2 X 2.4 X 1.1 cm ...10% thick adherent devitalized necrotic tissue ...90% granulation tissue ...Wound progress: No change ...Dressing treatment plan: Leptospermum honey (2) apply once daily for 9 days; Alginate calcium (3) apply once daily for 9 days ...foam with boarder apply once daily for 9 days ...Surgical excisional debridement procedure ...a clean dressing was applied ...."

A review of the "Treatment Administration Record" (TAR), dated June 2019, for Resident #28 documented in part the following, " ...Cleanse sacrum with normal saline, pat dry, apply aquacel AG (4), packed gently into wound and cover with 6X6 foam boarder dressing, change 3 times a week and PRN (as needed), every night shift, every Monday, Wednesday, and Friday, Order date 4/25/19 at 3:44 PM, Discontinued date 6/20/19 at 2:36 PM ..." Dressing changes were documented with a check mark and initials on 6/3/19, 6/5/19, 6/7/19, 6/10/19, 6/12/19, 6/14/19, 6/17/19, and 6/19/19.

A physician's order dated 6/20/19 at 2:36 PM, documented in part, "Cleanse sacrum with normal saline, pat dry, apply medi honey topically, packed gently into wound and cover with 6 X 6 foam boarder dressing for 9 days every night shift for 9 days." On 6/20/19, the order was discontinued at 2:36 PM, and then was re-entered.

Further review of the "Treatment Administration Record" dated June 2019, revealed in part the following: "...Cleanse sacrum with normal saline,

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pat dry, apply medi honey topically, packed gently into wound and cover with 6X6 foam boarder dressing, daily for 9 days, every night shift for 9 days, Order date 6/20/19 at 2:36 PM..." Dressing changes were documented with a check mark and initials on 6/20/19, 6/21/19, 6/23/19, 6/24/19, 6/25/19, 6/26/19, 6/27/19, and 6/28/19. There was no documentation wound care was provided as ordered on 6/22/19. There was also no documentation of wound care on 6/29 and 6/30/19.

A physician's note dated 7/2/19, documented in part, "...She has a stage 4 pressure wound sacrum for at least 484 days duration. There is moderate serous exudate ...Stage 4 pressure wound sacrum: 3 X 2.4 X 1.2 cm ...5% thick adherent devitalized necrotic tissue ...95% granulation tissue ...Wound progress: Improved ...Dressing treatment plan: Leptospermum honey apply once daily for 30 days; Alginate calcium apply once daily for 9 days ...foam with boarder apply once daily for 30 days ...Surgical excisional debridement procedure ...a clean dressing was applied ...."

A physician's note dated 7/14/19, documented in part, " ...She has a stage 4 pressure wound sacrum for at least 496 days duration. There is moderate serous exudate ...Stage 4 pressure wound sacrum: 2.8 X 2.2 X 1.1 cm ...5% thick adherent devitalized necrotic tissue ...95% granulation tissue ...Wound progress: Improved ...Dressing treatment plan: Leptospermum honey apply once daily for 18 days; Alginate calcium apply once daily for 9 days ...foam with boarder apply once daily for 18 days ...Surgical excisional debridement procedure ...a clean dressing was

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F 656	Continued From page 135 applied ...." Review of the "Treatment Administration Record" for July 2019, documented in part: "...Cleanse sacrum with normal saline, pat dry, apply medi honey topically, packed gently into wound and cover with 6X6 foam boarder dressing, daily for 9 days, every night shift for 9 days, Order date 7/3/19 at 4:11PM..." Dressing changes were documented as provided with a check mark and initials on 7/3/19 thru 7/11/19. There was no further documentation of wound care being provided for 7/12/19 thru 7/25/19, and no documentation of wound care being provided to Resident #28's pressure injury on 7/1 and 7/2/19. A review of the clinical record revealed the following physician's order dated, 7/25/19 at 9:08 AM, which, in part documented: "Cleanse sacrum with normal saline, pat dry, skin prep to the periwound skin, apply medi honey (3) to wound base, packed gently into wound and cover with calcium alginate (4) and boarded foam dressing for 18 days every night shift for 18 days." (*Note this order was written during or after the observation of Resident #28's pressure wound without a dressing, was conducted as written above.) The "Comprehensive Care Plan" documented in part the following: "I am at risk for further skin break down due to I had a pressure ulcer present on admission, incontinence, and I require assistance with bed mobility ...I often decline position changes, showers, and assistance with hygiene which increases my risk for further breakdown: Date initiated 3/18/18, ...Interventions: treatment per orders: Date initiated 7/3/19..."	F 656		

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On 7/24/19 at 5:32 PM, an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of a care plan. LPN #1 stated, "To share the information so that it's available for everyone. The care that is specific for that resident." LPN #1 was asked how staff ensures a resident's care plan is implemented. LPN #1 stated, "There is an order for things that we need to routinely do and then we have our kardexs for the CNAs (certified nursing assistants)."

On 7/25/19 at 9:20 AM, an interview with LPN #2, the Unit Manager, was conducted. LPN #2 was asked about Resident #28's wound care. LPN #2 stated, "She was going to get a flap done, but don't want to go out of the facility. The wound care physician comes in-house to see her. She was last seen on July 14th." When asked if Resident #28 received daily wound care, LPN #2 stated, "Yes. She should be." When asked if there is an order for wound care, LPN #2 stated, "She does now. I am going thru the wound care meeting preparation for Thursday. We have wound care meetings every Thursday, and I noticed she didn't have one (an order for wound care), and I put the order in today for daily wound care." When asked if Resident #28 is receiving wound care, LPN #2 stated, "I am sure the nurses would be doing it cause she has had that wound and it would have been done."

A review of the facility policy "Care Plan Completion" documented in part, "...Review of the CAA(s) (Care Area Assessment) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the

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continuance or revision of the existing care plan ...Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan ..."

On 7/24/19 at 6:35 PM, ASM (Administrative Staff Member) # 1, the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings.

No further information was provided by the end of the survey.

(1) Pressure ulcer of sacral region - Unstageable: A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non-Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

Unstageable pressure ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent,

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intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(2) MEDIHONEY® Gel Wound & Burn Dressing contains 100% active Leptospermum honey in a hydrocolloidal suspension. Supports the removal of necrotic tissue and aids in wound healing. Thicker consistency than MEDIHONEY® paste provides more stability. This information obtained from the following website: https://www.woundsource.com/product/medihoney-gel-wound-burn-dressing

(3) ALGISITE* M Calcium Alginate Dressing | Wound Care Product is a fast-gelling calcium alginate dressing that forms a hydrophilic gel when in contact with exudate. Helps create and maintain a moist wound environment. This information was obtained from the following website: https://www.woundsource.com/product/algisite-m-calcium-alginate-dressing

(4) AQUACEL® Ag Ribbon Dressing with Strengthening Fibers and Ionic Silver features Hydrofiber® Technology - a unique gelling technology exclusive to ConvaTec. Soft, non-woven ribbon dressing can be used on acute and chronic wounds. This information was obtained from the following website: https://www.woundsource.com/product/aquacel-ag-ribbon-dressing-strengthening-fibers-and-ionic-silver

F 657 Care Plan Timing and Revision F 657 8/25/19

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F 657 SS=E	Continued From page 139 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to review and revise the comprehensive care plan for four of 54 residents in the survey sample; Residents #73, #29, #11, and #71.	F 657	F657 1. Address how corrective action will be accomplished for those residents affected by deficient practice; An update of the Care Plan by charge nurse prior to end of shift when episodic events occur. Review during nursing 24-hour report meeting and updated by unit managers to ensure	

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The findings include:

1. Residents #73, #29, and #11 were involved in a resident-to-resident altercation on 7/8/19, per a Facility Reported Incident (FRI) sent to the required state agency on 7/9/19. The facility staff failed to review and revise the comprehensive care plan to address the incident that occurred and potential for continued abuse and/or potential abuse to other residents, for each of these residents after this incident.

Resident #73 was admitted to the facility on 6/9/17 with the diagnoses including but not limited to: dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's disease, mood disorder, and depression. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as total care for bathing; extensive assistance for bathing, dressing, toileting, and hygiene; and supervision for eating.

Resident #29 was admitted to the facility on 11/11/13. Diagnoses include, but are not limited to: dementia, dysphagia, glaucoma, cataracts, heart failure, schizophrenia, spondylosis, and diabetes. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/19 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, extensive care for transfers, dressing, eating, toileting, and hygiene.

Resident #11 was admitted to the facility on

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appropriate updates and ensure implementation of interventions.

2. Address how facility will identify other residents potentially affected by deficient practice; Residents with an episodic event, altercations which is resident-to-resident, can be affected by this practice.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; In the event of a resident-to-resident altercation, Care Plans will be reviewed in the Morning Meeting process where incidents will be reviewed to ensure appropriate interventions have been implemented. Interventions will be reviewed within 7 days to determine effectiveness.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; On a weekly basis the Director of Nursing/Designee will review the incidents as reported in the Morning Meeting process for any resident altercations/behaviors x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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4/12/19. Diagnoses include, but are not limited to: diabetes, high blood pressure, osteoarthritis, anxiety, and depression. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/9/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, and supervision only for all other areas of activities of daily living.

A review of a FRI report dated 6/9/19 regarding an incident dated 6/8/19 (dated incorrectly, the actual incident occurred on 7/8/19 and was reported on 7/9/19), documented, "Per (Resident #11), (Resident #73) hit her and she slapped her back in return. Per (Resident #11), (Resident #73) hit (Resident #29). Residents were separated. County Sheriff was called. Investigation started."

The investigation revealed a statement by OSM #14 (Other Staff Member - dietary staff) which documented, "Employee reports seeing (Resident #11) standing and striking @ (at) (Resident #73). She reports that she observed (Resident #11) slap (Resident #73) 3 times in the face (with) the palm of her L (left) hand. Associate added that (Resident #73) was sitting in her w/c (wheelchair) and struggling to hit (Resident #11) back. She saw (Resident #73) slap (Resident #11) once in the face with the palm of her hand."

The investigation further revealed a statement by Resident #11, which documented, "Resident reports that she was defending (Resident #29) and herself when she was observed by dietary staff hitting (Resident #73). She added that (Resident #73) had been hitting (Resident #29) and her in the legs prior to this event. Further,

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that (Resident #73) had hit her in the left shoulder. (Resident #11) was sitting @ (at) the West 1 nurses station waiting for someone to get her ice @ this time."

The investigation revealed another statement by Resident #11, which documented, "I was going to get ice and I see this woman (Resident #73) beating on a woman (Resident #29) who was sitting there. I had no choice but to separate her. She hit her on the legs, her stomach, and her chest. The woman was afraid. I stucked {sic} my nose in it, I had to protect her." Per (Resident #11) she told (Resident #73) to stop and she said no. "She then hit me on my neck, face and my glasses knocked off. After that I hit her I think it was in the face."

A review of the clinical record for Resident #73 revealed notes that documented in part the following:

A nurse's note dated 7/8/19 documented, "Resident was returned to [name and number of unit] @ 5:45pm from [name and number of unit]. [Name of unit] middle charge nurse reported that there had been a physical altercation between (Resident #73) and another female resident whom resides on [name and number of unit]. This was a witnessed event by a dietary associate who responded immediately to separate the residents involved. It was reported that (Resident #73) had been hit in the face 3 times with the palm of the other residents hand. DNS (Director of Nursing Services), Unit manager, and daughter were notified of this event. (Name of county) Sheriff's department was called per policy and instructions of

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management. (Resident #73) was extremely anxious after this event. Fast pacing in her w/c (wheelchair) and staff were unable to calm her or redirect her behaviors. Ativan (1) was administered with good effect. A skin check was performed by middle charge nurse. LUQ (left upper quadrant) with erythema and there is a petechial type rash on the LUE (left upper extremity) and right forearm which have been ongoing. BP (blood pressure) 143/98 - 98 (pulse) - 18 (respirations) - 97.6F (temperature) with an SPo2 (oxygen saturation) of 96% on RA (room air). Deputy (name) arrived and checked (Resident #73) twice. Once upon initially arriving and then a second time after speaking to the witness of this event. Deputy reported that there will be no further actions from the police and that he will file a report. Daughter/POA (Power of Attorney) was updated on police finding. Deputy did request that staff contact them for new areas of related injuries are observed."

A note by the social worker, dated 7/10/19 documented, "An interview was conducted with the resident r/t (related to) the incident noted on July 7, 2019 (incorrect date of incident). The resident denied having any knowledge of any such incident taking place. She maintains she does not feel threatened, fearful, or that she is in any danger. The resident further stated she is not scared and enjoys life...."

A review of the comprehensive care plan for Resident #73 revealed one dated 6/10/17 for "I have the potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication, Anti-psychotic medications, Anti-anxiety medications. I am at risk for psychosocial well

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being (sic.) issues due to use of antidepressants; I am at risk of having s/s (signs and symptoms) of depressed mood...." This care plan included the following interventions:
Monitor for behaviors associated with depression including sad affect, crying. This intervention was dated 6/10/19.
Monitor for behaviors of anxiety including nervousness, restlessness, fearful. This intervention was dated 6/26/19.
Monitor for target behaviors of aggression and document including hitting, yelling or threating {sic} behavior. This intervention was dated 6/26/19.

Another care plan, dated 9/12/18 documented the focus of, "I sometimes have behaviors which include taking other residents items, hitting/grabbing other residents, hitting staff, refusing my medications, declining to eat, spitting out medications, throwing food and or drinks at staff, wandering." The interventions included:
Attempt interventions before my behavior begin. This intervention was dated 2/19/19.
Please do not invade my personal space when I am upset as I am likely to hit, pinch, or bite you. This intervention was dated 2/19/19.

The comprehensive care plan did not include any provision to protect the resident from being the target of abuse or reflect any revision or update related to the 7/8/19 incident.

A review of the clinical record for Resident #29 revealed notes that documented in part the following:

A nurses note dated 7/9/19 documented, "This

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F 657	Continued From page 145 writer was informed that there was a possibility that (Resident #29) had been hit in her legs by another female resident. This information was reported by a female who had been in a physical altercation which had been observed by staff. There were no witnesses to confirm this report. Skin check included broken blood vessels on the left upper shin which are surrounded by a faint green bruising. DNS (director of nursing services), NP (nurse practitioner), Unit manager, and POA (power of attorney) were notified of this allegation. A (county) Deputy was in to examine residents legs and to view her general well being. He reported that there would be no further investigation and that a report would be filed. He added that the staff should call if injuries develop R/T this event. A call was placed to update dtr (daughter)/POA but there was no answer and there had been no return call. A second nurse's note dated 7/9/19 documented, "...She was mentioned in the altercation between (Resident #73 and Resident #11) but her skin assessment did not indicate any break in skin on any bruise." A third nurse's note dated 7/9/19 documented, "Daughter in to visit and updated on events of previous evening. Resident displayed no signs of discomfort and no injury noted, from possibly being in this middle of confrontation between two other residents yesterday. Daughter without problems of explanation of events." A review of the comprehensive care plan for Resident #29 failed to reveal any evidence of a history of behaviors or any provision to protect the resident from being the target of abuse or reflect any revision or update related to the 7/8/19	F 657		

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F 657	Continued From page 146 incident. A review of the clinical record for Resident #11 revealed notes that documented in part the following: A nurses note dated 7/9/19 that documented, "Writer was notified that there was a physical altercation between this resident and a female resident from [name and number of unit] @ (at) 5:45pm. (Resident #11) was observed hitting other female in the face 3 times with an open hand. She was standing at the time and per dietary aide was very aggressive. (Resident #11) reported that the second female had been hitting her on the legs and later on her left shoulder before she hit her back. DNS, NP, Niece, and the [name and number of unit] manager were notified of this event. The (county) Sheriff's department was called per policy and instruction of management. A deputy was in to interview (Resident #11). He reported that no further action would be taken by the police and requested that the staff call if any injuries develop R/T (related to) this event. (Resident #11) has no signs of injury to her face on this day. Nurse has reiterated to this resident that calling the staff for assistance would be the appropriate measure if similar events occurred. Niece was called to update her on police findings." Another nurse's note dated 7/9/19 documented, "Resident had an altercation with (Resident #73) at about 5:45pm. She complained of pain and was given her prescribed medication. She is alert and oriented to time and took all her medication. Skin assessment did not indicate any scratches on her face or body."	F 657		

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Another nurse's note dated 7/9/19 documented, "Resident without injury from confrontation with another resident previous evening. Meds [medications] per order. No complaints of discomfort. Going about her normal daily routine this afternoon."

A social worker note dated 7/11/19 documented, "This writer spoke with the resident r/t the incident dated 7/9/19. Per the resident, she was defending another resident whom she felt was not capable of defending herself. The resident was educated on the steps to be taken when such an incident occurs, be it towards her or another resident. She acknowledged understanding further stating, that as a child, she was taught to defend herself and those who were unable to defend themselves. She also stated that the dietary aid did intervene but only witnessed her hitting the other roommate. The resident says she is not fearful of the other resident and does not plan to have any further altercations with her. Staff will observe the resident for aggressive behaviors, and any mood and behavior concerns. Please continue POC (plan of care)."

A review of the comprehensive care plan for Resident #11 included one dated 6/6/19 that documented the focus area, "I sometimes have behaviors which include: refusing showers." This care plan included the interventions:
Attempt interventions before my behaviors begin, if I refuse care, (Sic.) please reapproach at a later time to offer shower/care again. This intervention was dated 6/6/19 and revised on 7/23/19.
Let my physician know if I my behaviors are interfering with my daily living. This intervention

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was dated 6/6/19.
Make sure I am not in pain or uncomfortable. This intervention was dated 6/6/19.
Please tell me what you are going to do before you begin. This intervention was dated 6/6/19.

The comprehensive care plan did not include any provision to protect the resident from being the target of abuse. The behavior care plan did not include anything denoting the resident as having behaviors towards other residents. The comprehensive care plan did not reflect any revision or update related to the 7/8/19 incident.

On 7/24/19 at 9:13 AM, in an interview with Resident #11, she stated, that she was going to get ice. She stated that she "was halfway down the hall when I saw (Resident #73) take a fist and hit a woman (Resident #29) in a wheelchair that can't talk." She stated, "To me it was pathetic to see it. I yelled at her to stop it. She took a fist and hit the other lady in the legs, stomach and face. I told her to stop and she said no. I just knew I had to protect the lady who couldn't talk." When asked what the woman getting hit (Resident #29) did, she stated, "She just sat there, like a statue, she didn't seem to know what was going on and didn't try to protect herself. I yelled at her (Resident #73) to stop, she said no and continued to keep hitting her. I told her she has to stop and she hauled off and bopped me, I had a scratch on my face (touched chin area). When she hit me, my instinct was to protect me and the other lady so I belted her back. She had power behind her when she belted me." When asked where she hit Resident #73, Resident #11 stated, "I'm not sure where I hit her, I think the face. She kept coming at me. If it was not for

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kitchen staff, I don't know what would happen. Kitchen staff stopped it. I probably hit her a couple times. After staff stopped it, I went back to my room. The nurse came in with me. All I wanted to do was protect the other lady. It is pathetic someone would hit someone in that state. They called the police. He told me I had defended myself and the other woman. They were gonna let staff here handle it. I can't tell you what they did." When asked if any staff told her to not to get involved when she sees incidents like that happen, Resident #11 stated, "They told me to try to avoid these situations. I have never hit anyone here before. I am sorry it happened the way it did. I can fight to protect myself." When asked if prior to this incident, if she had gotten involved in another situation and hit someone, Resident #11 stated, "No." When asked if she yelled for a nurse to help, she stated, "I didn't think to yell out for a nurse. I just screamed at her (Resident #73) to stop."

On 7/25/19 at 4:28PM, ASM #2 (Administrative Staff Member, the Director of Nursing) was asked who updates care plans after an incident. ASM #2 stated "nursing." When asked which nurses, ASM #2 stated, "Management." ASM #2 was asked about the care plans being reviewed and revised for Residents #73, #29, and #11 regarding behaviors of abuse and/or being a target for abuse. ASM #2 stated that the care plan should be updated and that she would look into it. No further information was provided.

(1) Ativan - is used to relieve anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

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2. The facility staff failed to review and revise Resident #71's comprehensive care plan after the resident presented with a significant weight loss in June 2019.

Resident #71 was admitted to the facility on 1/22/19. Resident #71's diagnoses included but were not limited to heart failure and diabetes. Resident #71's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/16/19, coded the resident's cognitive skills for daily decision making as severely impaired. Section K coded Resident #71 as having a feeding tube and as having a weight loss of five percent or more in the last month or ten percent or more in the last six months.

Review of Resident #71's clinical record revealed the following weights:
-5/6/19 202 lbs (pounds)
-6/10/19 184 lbs (an 8.91% weight loss from 5/6/19).

Resident #71's comprehensive care plan dated 2/18/19 documented, "I am dependent on TUBE FEEDINGS and am at risk for inadequate food and beverage intake due to: Alzheimer's, Dysphagia (difficulty swallowing)...Refer to RD (registered dietitian) assessment as needed..." The care plan failed to document information regarding the June 2019 significant weight loss.

On 7/25/19 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the purpose of the care plan. LPN #3 stated, "To identify any problems and interventions that we need to put in place and let us know the person, getting to know them."

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F 657	Continued From page 151 When asked if a resident's care plan should be reviewed revised, when the resident presents with a significant weight loss, LPN #3 stated it should. When asked why, LPN #3 stated, "Because of the weight loss." On 7/25/19 at 6:22 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Weighing the Resident" documented, "9. Record weight and alert nurse to any significant change...c. Update the plan of care..." No further information was presented prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for the administration of medications for one of 54 residents in the survey sample, Resident #513. The facility staff failed to clarify physician's orders for two as needed pain medications, Tramadol (2) and Tylenol (3) to determine which, as needed pain medication should be administered to Resident #513 based on pain level parameters.	F 658	F658 1. Address how corrective action will be accomplished for those residents affected by deficient practice; On 7/25/19 the deficient practice was corrected by adding pain parameters to the administration of PRN pain medications. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents with orders for two differing pain medications can be affected.	8/25/19

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The findings include:

Resident #513 was admitted to the facility on 7/19/19 with diagnoses that included but were not limited to: status post Left Knee Replacement, nausea with vomiting, anxiety disorder, gastro-esophageal reflux disease [GERD - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], and high blood pressure.

The MDS (minimum data set) assessment had not been completed at time of survey. The admission data-collection form completed 7/19/19, documented the resident as: drowsy, understanding verbal content, ability to express ideas and wants. Pain was rated level 5- located in left knee. Current pain treat of Tramadol and Tylenol was rated as effective.

The physician orders dated, 7/19/19, documented:
1. Acetaminophen Tablet [used to treat fever and mild to moderate pain. (2)] 325 MG (milligrams), give 2 tablets by mouth every 6 hours as needed for pain.
2. Tramadol HCL (hydrochloride) [used to treat moderate to severe pain. (3)] 50 mg give 1 tablet by mouth every 6 hours as needed for pain related to unilateral primary osteoarthritis, left knee.

The July 2019 MAR (medication administration record) documented the above two medication orders and documented:
- Acetaminophen was administered on 7/20/19 at

F 658

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Licensed nursing staff who dispense medications to residents will receive re-education on proper usage of pain scales and parameters. Auditing of resident orders, with more than 1 PRN pain medication, has been performed. Resident orders now contain parameters to be compliant. Licensed Nursing staff instructed on following pain medication parameters as listed on MAR.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; DON/designee will observe the appropriate administration of PRN pain medications during a random med pass observation, 2 times per week for 4 weeks. These observations will be recorded on the Med Pass Observation form and reviewed in the Monthly Quality Assurance meeting. On a weekly basis x 4 weeks, a random med pass observation on two nurses will be conducted by nurse management to ensure the proper administration of prn pain medications and implementation of pain scale. These observations will be recorded on the Med Pass Observation form and reviewed in the Monthly Quality Assurance meeting. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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5:57am for a pain level of "0" for c/o (complaint of) left knee pain.
- Acetaminophen was administered on 7/21/19 at 12:15pm for a pain level of "5" for c/o left knee pain.
- Tramadol was administered on 7/20/19 4:12 pm for a pain level of "0" for c/o left knee pain.
- Tramadol was administered on 7/21/19 at 4:44 pm for a pain level of "5" for c/o left knee pain.

The comprehensive care plan dated 7/19/19, documented in part, "Focus: (Resident #513) needs pain management and monitoring related to: surgical procedure, abdominal pain, GERD, osteoarthritis." The "Interventions / Tasks" documented in part, "Administer pain medications as ordered."

An interview was conducted on 7/25/19 at 10:15am with LPN (licensed practical nurse) #4. When asked how nursing staff treated pain, LPN #4 stated that non-pharmacological interventions were used first then medication. LPN # 4 was shown the two medication orders, and was asked how nursing staff would determine which pain medication to administer. LPN #4 stated there were no guidelines for administration. LPN # 4 was shown the medication administration records for 7/20/19 & 7/21/19, which showed administration of Acetaminophen and Tramadol for pain levels of 0 and 5. LPN # 4 stated there were no guidelines for administration. LPN # 4 was asked if it was within her scope of practice to determine which medication to administer. LPN #4 stated "No". When asked about these medication orders, LPN #4 stated they (orders) needed to be clarified with the physician. When asked about the practice guidelines for nursing staff to follow regarding pain medications, LPN #4

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F 658	Continued From page 154 stated the nursing policies were their guidelines. Review of the facility, pain assessment policy and procedure did not include clarification of orders. Review of the facility policy, pain assessment and procedure did not include clarification of orders. According to Lippincott's "Fundamentals of Nursing, 5th edition, page 553, "Always clarify with the prescriber any medication order that is unclear or seems in appropriate." Administrative staff members (ASM) # 1, the administrator and (ASM) # 2, the director of nursing, were made aware of the above concerns on 7/25/19 at 1:28pm. On 7/25/19 at 12:15 p.m., the policy on clarifying physician orders was requested from ASM #1. At 3:07p.m. ASM #1 brought policies regarding clarification of dietary orders to the team with no other policy specific to medication orders provided. No further information was provided prior to exit.	F 658		
F 686 SS=E	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	F 686		8/25/19

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F 686	Continued From page 155 (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 observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for the treatment of pressure injuries and failed to provide care in a manner to promote healing and prevent infection for two of 54 residents in the survey sample, Resident #28 and Resident #92. The findings include: 1. The facility staff failed to obtain wound care orders and failed to evidence treatment to Resident #28's pressure injury was provided to promote healing and prevent infection on 6/29, 6/30, 7/1, 7/2 and 7/12-7/25/2019. On 7/25/19, Resident #28's pressure injury was observed without a dressing. During this observation, CNA (certified nurse assistant) #13 was observed providing incontinence care for a soft bowel movement and wiped from front to back with wet wipes passing over the top of Resident #28's open pressure injury wound. Resident #28 was admitted to the facility on 2/18/16 with the diagnoses of but not limited to peripheral vascular disease, major depressive disorder, pressure ulcer of sacral region - Unstageable (1), type 2 diabetes mellitus, and high blood pressure. The most recent MDS (Minimum Data Set), a quarterly assessment,	F 686	F686 1. Address how corrective action will be accomplished for those residents affected by deficient practice; A physician ordered treatment for the affected area was initiated. At time of survey, facility wound physician assessed and noted condition and ordered treatment. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents with wounds in the facility could potentially be affected. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Weekly skin assessments for residents with wounds/skin-integrity issues have been conducted, with treatments applied as ordered. Residents with wounds/skin-integrity issues will be monitored weekly for assessment of skin issues. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; DON/designee will randomly audit 3 residents weekly for 4 weeks to ensure that proper documentation and treatments are completed per physician's orders 2 times	

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F 686	Continued From page 156 with an ARD (Assessment reference date) of 5/8/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance for hygiene; total care for toileting and bathing; and was always incontinent of bladder and bowel. On 7/23/19 at 3:23 PM, an interview with Resident #28 was conducted. When Resident #28 was asked about her pressure injury wound care, she stated, "It is all cleared up." On 7/25/19 at 8:29 AM, an interview with RN (registered nurse) #7 was conducted. When RN #7 was asked about wound care for Resident #28, she stated, "She does not receive wound care at this time. No orders." On 7/25/19 at 8:35 AM, an observation of Resident #28's sacrum pressure injury was conducted with RN #7. The observation Resident #28's sacrum pressure injury revealed an open wound, without a dressing in place. There was no drainage, and no odor. Measurements obtained by RN #7 were documented as 4 cm X 3 cm X 0.5 cm. During this observation, CNA #13 was observed providing incontinence care to Resident #28 after the resident had a soft bowel movement. CNA #13 was observed wiping from front to back with wet wipes and passing over the top of Resident #28's open pressure injury wound with each wipe, possibly introducing bacteria such as E. coli (2) into the residents wound. On 7/25/19 at 8:47 AM, a follow up interview was conducted with RN #7. When asked if she was	F 686	per week for 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.	

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aware, the wound was open, RN #7 stated, "Yes, it is the same since I began working here in March." When asked if wound care physicians were following Resident #28, RN #7 stated, "Let me check her chart." After RN #7 reviewed the chart, she stated, "She has an order to see wound care physicians." When RN #7 reviewed the wound care physician's consult notes, dated 7/14/19, she stated, "She has Stage 4 wound on her sacrum. There are measurements. Leptospermum honey applied once a day for 18 days, alginate calcium once a day for 18 days, plastic surgeon consult," When asked if those are the wound care physician's recommendations should there be an order, RN #7 stated, "It was on 7/14/19, right? She has order for plastics consult that is discontinued. All of her wound care is discontinued." When asked about the process staff follows to obtain an order, when the wound care physician recommends a treatment, RN #7 stated, "We inform the physician of the recommendations and he makes the decision to order them or change them." When asked if the staff followed up with the physician for the wound care physician's recommendations from the 7/14/19 wound care visit, RN #7 stated, "I have no idea what happened with that day."

A review of the clinical record revealed a physician's note dated 6/18/19, which documented in part, "...She has a stage 4 pressure wound sacrum for at least 484 days duration. There is moderate serous exudate ...Stage 4 pressure wound sacrum: 3.2 X 2.4 X 1.1 cm ...10% thick adherent devitalized necrotic tissue ...90% granulation tissue ...Wound progress: No change ...Dressing treatment plan: Leptospermum honey (3) apply once daily for 9 days; Alginate calcium (4) apply once daily for 9

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days ...foam with boarder apply once daily for 9 days ...Surgical excisional debridement procedure ...a clean dressing was applied ...."

A review of the "Treatment Administration Record" (TAR), dated June 2019, documented in part the following: " ...Cleanse sacrum with normal saline, pat dry, apply aquacel AG (5), packed gently into wound and cover with 6X6 foam boarder dressing, change 3 times a week and PRN (as needed), every night shift, every Monday, Wednesday, and Friday, Order date 4/25/19 at 3:44 PM, Discontinued date 6/20/19 at 2:36 PM ..." Dressing changes were documented with a check mark and initials on 6/3/19, 6/5/19, 6/7/19, 6/10/19, 6/12/19, 6/14/19, 6/17/19, and 6/19/19.

A physician's order dated 6/20/19 at 2:36 PM, documented in part, "Cleanse sacrum with normal saline, pat dry, apply medi honey topically, packed gently into wound and cover with 6 X 6 foam boarder dressing for 9 days every night shift for 9 days." On 6/20/19, the order was discontinued at 2:36 PM, and then was re-entered.

Further review of the "Treatment Administration Record" dated June 2019, revealed in part the following: "...Cleanse sacrum with normal saline, pat dry, apply medi honey topically, packed gently into wound and cover with 6X6 foam boarder dressing, daily for 9 days, every night shift for 9 days, Order date 6/20/19 at 2:36 PM..." Dressing changes were documented with a check mark and initials on 6/20/19, 6/21/19, 6/23/19, 6/24/19, 6/25/19, 6/26/19, 6/27/19, and 6/28/19. There was no documentation wound care was provided as ordered on 6/22/19. There was also no

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documentation of wound care on 6/29 and 6/30/19.

A physician's note dated 7/2/19, documented in part, "...She has a stage 4 pressure wound sacrum for at least 484 days duration. There is moderate serous exudate ...Stage 4 pressure wound sacrum: 3 X 2.4 X 1.2 cm ...5% thick adherent devitalized necrotic tissue ...95% granulation tissue ...Wound progress: Improved ...Dressing treatment plan: Leptospermum honey apply once daily for 30 days; Alginate calcium apply once daily for 9 days ...foam with boarder apply once daily for 30 days ...Surgical excisional debridement procedure ...a clean dressing was applied ...."

A physician's note dated 7/14/19, documented in part, " ...She has a stage 4 pressure wound sacrum for at least 496 days duration. There is moderate serous exudate ...Stage 4 pressure wound sacrum: 2.8 X 2.2 X 1.1 cm ...5% thick adherent devitalized necrotic tissue ...95% granulation tissue ...Wound progress: Improved ...Dressing treatment plan: Leptospermum honey apply once daily for 18 days; Alginate calcium apply once daily for 9 days ...foam with boarder apply once daily for 18 days ...Surgical excisional debridement procedure ...a clean dressing was applied ...."

Review of the "Treatment Administration Record" for July 2019, documented in part: "...Cleanse sacrum with normal saline, pat dry, apply medi honey topically, packed gently into wound and cover with 6X6 foam boarder dressing, daily for 9 days, every night shift for 9 days, Order date 7/3/19 at 4:11PM..." There was no documentation of wound care provided on 7/1

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and 7/2/19. There were dressing changes documented as provided with a check mark and initials on 7/3/19 thru 7/11/19. Further review of the July 2019 TAR revealed there was no further documentation of wound care provided from 7/12/19 thru 7/25/19.

A review of the clinical record revealed the following physician's order dated, 7/25/19 at 9:08 AM, which, in part documented: "Cleanse sacrum with normal saline, pat dry, skin prep to the periwound skin, apply medi honey (3) to wound base, packed gently into wound and cover with calcium alginate (4) and boarded foam dressing for 18 days every night shift for 18 days." (*Note this order was written during or after the observation of Resident #28's pressure wound without a dressing, was conducted as written above.)

A review of the facility record of "Weekly Wound Care Meetings" revealed in part the following documentation on the following dates:

- 6/6/19 and 6/13/19 documented in part: " ... (Name of) Resident #28; Room # (number); Size: 3.4 X 2.4 X 1.1; Stage: stage 4; Acquired date: 12/26/17; No change; Interventions: incontinent care, turn, repositioning program, supplements, treatment (dressing, meds [medications]); Treatment: Honey ..."
- 6/27/19, documented in part, " ... (Name of) Resident #28; Room # (number); Size: 3.2 X 2.4 X 1.1; Stage: stage 4; Acquired date: 12/26/17; No change; Interventions: incontinent care, turn, repositioning program, supplements, treatment (dressing, meds); Treatment: Honey ..."

- 7/4/19, documented in part, " ... (Name of)

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Resident #28; Room # (number); Size: 3.0 X 2.4 X 1.2; Stage: stage 4; Acquired date: 12/26/17; No change; Interventions: incontinent care, turn, repositioning program, supplements, treatment (dressing, meds); Treatment: Honey ..."

- 7/11/19, documented in part, " ... (Name of) Resident #28; Room # (number); Size: 2.8 X 2.2 X 1.1; Stage: stage 4; Acquired date: 12/26/17; No change; Interventions: turn, repositioning program, supplements, pressure relieving mattress, treatment (dressing, meds); Treatment: Honey ..."

A review of the clinical record revealed a "Quarterly Data Collection Tool" dated 1/3/19 at 4:48 PM, which documented in part, " ...E. Risk for Pressure Ulcers: Sensory Perception: Completely limited; Moister: Constantly Moist; Activity: Bedfast; Mobility: Very limited; Nutrition: Adequate; Friction and Sheer: Potential Problem; Add together scores: Total score of 10 ..."

Resident #28's "Comprehensive Care Plan" documented in part the following: "I am at risk for further skin break down due to I had a pressure ulcer present on admission, incontinence, and I require assistance with bed mobility... I often decline position changes, showers, and assistance with hygiene which increases my risk for further breakdown: Date initiated: 3/18/18 ...Interventions: treatment per orders: Date initiated 7/3/19 ..."

On 7/25/19 at 9:20 AM, an interview was conducted with LPN (Licensed Practical Nurse) #2, the Unit Manager. When asked about Resident #28's wound care, LPN #2 stated, "She was going to get a flap done, but don't want to go

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out of the facility. The wound care physician comes in-house to see her. She was last seen on July 14th." When asked if Resident #28 received daily wound care, LPN #2 stated, "Yes. She should be." When asked if there is an order for wound care, LPN #2 stated, "She does now. I am going thru the wound care meeting preparation for Thursday. We have wound care meetings every Thursday, and I noticed she didn't have one (an order for wound care), and I put the order in today for daily wound care." When asked if Resident #28 is receiving wound care, LPN #2 stated, "I am sure the nurses would be doing it cause she has had that wound and it would have been done. We have a nurse that goes with the wound physician on rounds. I go to their website (wound care physician) and get the recommendations and then I go to the facility physician for orders."

On 7/25/19 at 1:18 PM, an interview was conducted with ASM (Administrative Staff Member) #1, the Administrator, and ASM #2, the Director of Nursing. ASM #1 and ASM #2 were informed of the concern wound care orders were not obtained from the 7/2/19 wound care physician's recommendations until 7/3/19. They were informed that there was no evidence orders were obtained from the 7/14/19 wound care physician's recommendations note until today (7/25/19). ASM #1 and ASM #2 were informed that there was no documented evidence that wound care had been provided to Resident #28's pressure injury on 6/29, 6/30, 7/1/19 and 7/2/19, and from 7/12 through 7/25/19. ASM #1 and ASM #2 were informed the residents wound was observed without a dressing (as documented above) during the observation conducted today at 8:35 a.m. ASM #1 and ASM #2 were informed

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that the 7/21/19 wound measurements on "Weekly Wound Care" meeting" document were identical to the 7/14/19 wound care physician's measurements. ASM #1 and ASM #2 were informed of the measurements obtained by RN #7 today, 7/25/19, indicating Resident #28's wound size was now larger. ASM #1 stated, "We'll find out." ASM #2 stated, "The 7/21/19 wound care measurements for the "Weekly Wound Care" meetings would have come from the 7/21/19 wound care physician's note for the pressure injury, the nurses use his measurements."

On 7/25/19 at 2:15 PM, a follow up interview with LPN #2 was conducted. LPN #2 was asked about the concern that weekly skin checks were being done for Resident #28, yet no one noticed that there was no documented evidence of wound care being provided on 6/29, 6/30, 7/1- 7/21/19, and from 7/12 through 7/25/19. LPN #2 stated, "That is what I am trying to figure out." When asked who completes the Pressure Injury checks, LPN #2 stated, "That would be me. I did the measurements. Nothing drew my attention, because I took off the dressing. There was writing on it but I do not recall what it said." When asked if she had called and spoken with the doctor about the fact that there was no order for treatment and dressing changes being done, LPN #2 stated, "I texted him." When asked how she could evidence 'He [the wound doctor] was aware', LPN #2 stated, "I don't know." When Resident #28's TAR for June and July 2019 for documented wound care was reviewed with LPN #2, she requested to take a break from the interview.

On 7/25/19 at 2:30 PM, LPN #2 returned and

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stated, "Wound care meetings are scheduled for Thursday's at 1:00 PM, unless something comes up to change them. We go over what the treatment is, the measurements, if the wound has improved or declined." When asked where the measurement information was obtained from for the Weekly Wound Care meetings, LPN #2 stated, "The majority of the patients are seen by the wound care physician, and he sees them on a weekly basis. Me and the other unit managers go into the wound care physician's system and get his measurements and treatment plan to bring to the meeting." When asked how the lack of wound care orders and wound care was not identified prior to today, LPN #2 stated, "I wish I knew. We would not be here right now."

On 7/25/19 at 1:48 PM, a phone interview was conducted with ASM #3, the wound care physician. When informed that there were no orders for wound care documented from 7/12 through today when an order was entered for Resident #28, ASM #3 stated, "There is no order?" ASM #3 then stated, "My system inputs how many of the original 30 days are left when the number of days are written. So when I saw her last on 7/14/19, it calculated the remaining days of the 30 days left from the 7/2/19 recommendations." When informed that there was no documentation of wound care for Resident #28, since 7/12/19 and the wound was observed without a dressing today (7/25/19), ASM #3 stated, "No dressing changes were done?" ASM #3 then stated, "I don't understand. Wow."

On 7/26/19 at 8:17 AM, a follow up interview was conducted with ASM #3. ASM #3 stated, "You have to be consistent with measuring wounds. I

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measured it this morning."

On 7/26/19 at 8:38 AM, ASM #3 measured Resident #28's sacrum wound at 2.5 X 1.1 X 1 cm. This surveyor and another surveyor observed the measurement. ASM #3 stated, "It's all about technique and I think the staff needs education."

A review of the facility policy, "Medication Orders: Non-controlled Medication Orders" documented in part the following: "Policy: Medications are administered only upon the receipt of a clear and complete, and signed order by a person lawfully authorized to prescribe ...or prescribing protocols that have been provided to the nursing care center by the responsible physician ..."

On 7/26/19 at 9:34 AM, ASM #1 stated, "The policy is for following physician's orders for medications and treatments." However, the policy did not include any criteria for treatments.

On 7/26/19 at 8:42 AM, ASM #1 and ASM #2 were notified of the findings.

No further information was provided by the end of the survey.

(1) Pressure ulcer of sacral region - Unstageable: A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of

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skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non-Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

Unstageable pressure ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(2) Escherichia coli: are bacteria found in the environment, foods, and intestines of people and animals. E. coli are a large and diverse group of bacteria. Although most strains of E. coli are harmless, others can make you sick. Some kinds of E. coli can cause diarrhea, while others cause urinary tract infections, respiratory illness and pneumonia, and other illnesses. The information was obtained from the following website: https://www.cdc.gov/ecoli/index.html

(3) Medihoney- medical-grade honey (Medihoney, for example) is irradiated to inactivate the bacterial spores. Medical-grade honey is also standardized to have consistent germ-fighting activity. Some experts also suggest that medical-grade honey should be collected from hives that are free from germs and not treated

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with antibiotics, and that the nectar should be from plants that have not been treated with pesticides. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/738.html.

(4) ALGISITE* M Calcium Alginate Dressing | Wound Care Product is a fast-gelling calcium alginate dressing that forms a hydrophilic gel when in contact with exudate. Helps create and maintain a moist wound environment. This information was obtained from the following website: https://www.woundsource.com/product/algisite-m-calcium-alginate-dressing

(5) AQUACEL® Ag Ribbon Dressing with Strengthening Fibers and Ionic Silver features Hydrofiber® Technology - a unique gelling technology exclusive to ConvaTec. Soft, non-woven ribbon dressing can be used on acute and chronic wounds. This information was obtained from the following website: https://www.woundsource.com/product/aquacel-ag-ribbon-dressing-strengthening-fibers-and-ionic-silver

2. The facility staff failed to perform wound care for Resident #92 in a manner to prevent infection and to promote healing and failed to apply the appropriate dressing to Resident #92's sacral pressure injury. LPN #3 was observed cleaning Resident #92's sacral pressure sore using a gauze pad. LPN #3 moved from the center of the wound to the outside, then back to the center of the wound with the same gauze. LPN #3 applying Medihoney directly to the pressure wound with her gloved index finger and applied a Dermafilm thin dressing to the sacral pressure wound instead of the foam dressing ordered by the

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F 686	Continued From page 168 physician. While cleaning Resident #92's elbow wounds, LPN #3 cleansed wound #2 located at the lower outer portion of the elbow first and then proceeded to clean wound #1 located at the top portion of the left elbow. The saline used to clean wound #1 drained down onto wound #2 that had just been cleaned. Resident # 92 was admitted to the facility on 6/29/19 with diagnoses that included but were not limited to Parkinson's disease (1), non-Alzheimer's dementia (2) and cerebral infarction (3). Resident # 92's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/07/19, coded Resident # 92 on the brief interview for mental status (BIMS) with a score of 99, 99-being unable to complete the interview. The staff assessment for mental status was conducted, Resident #92 was coded a three under cognitive skills for daily decision making. Resident # 92 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M "Skin Conditions)" coded Resident # 92 as having a "Stage 2- Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister." and a "Stage 3 - Full thickness tissue loss. Subcutaneous (4) fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling." Under "M1200 Skin and Ulcer/Injury Treatment" it documented, "Applications of ointments/medications other than to feet and Pressure ulcer/injury (5) care."	F 686		

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On 7/24/19 at approximately 9:10 a.m., an observation was conducted of LPN (licensed practical nurse) #3 performing a dressing change to the pressure ulcer on Resident #92's sacrum and on the left elbow. LPN #3 washed her hands and set up a clean barrier pad over Resident #92's bedside table after disinfecting it. LPN #3 then placed the clean dressings and treatments on the over-the-bed table. Resident #92 was lying on his back in the bed. LPN #3 explained the procedure to Resident #92. CNA (certified nursing assistant) #1 and LPN #3 positioned the resident on his left side and placed a disposable pad underneath Resident #92's lower back and buttocks. LPN #3 washed her hands and applied gloves, she then removed the dressing dated 7/23/19, 7-3 and placed it on the disposable pad on the resident's mattress. When LPN #3 opened gauze pads to place on bedside table, the gauze pads fell to the floor. LPN #3 removed her gloves, sanitized hands and left the room. LPN #3 returned to room with more gauze and a measuring tape. LPN #3 measured the wound as 1cm (centimeter) by 1 cm, described the wound as "tissue pink, no drainage with little abrasion to coccyx (4)." LPN #3 removed her gloves, washed her hands and left the room.

LPN #3 returned to the room, washed her hands and applied gloves. LPN #3 had a medicine cup containing a brown substance, which she placed on the bedside table. LPN #3 removed scissors, a black marker and a pill packet from her scrub pocket. LPN #3 identified the pill packet as "Flagyl" and the medicine cup contents as "medihoney". LPN #3 cleaned the scissors with an alcohol wipe prior to placing them on the bedside table. LPN #3 cut strips of tape and

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F 686	Continued From page 170 dated them with the marker. LPN #3 opened the package labeled hydrocolloid dressing with the scissors. LPN #3 used a vial of saline to clean the wound, cleansed the center of the wound to the outside, then back to middle of the wound, and then back to the outside of the wound again. LPN #3 then placed a gauze on the wound, blotted the wound at the top proceeding to the bottom of the wound, and then repeated the process placing the same gauze on the open wound a second time. LPN #3 placed her gloved index finger in the medicine cup, to retrieve the contents and then applied the medicine cup contents identified as "medihoney" directly to the pressure ulcer using her gloved index finger. LPN #3 then opened and placed the crushed pill package directly onto the wound to apply the medication. Observation revealed LPN #3 pressed pill packaging into the wound three times, first in the center of the pressure ulcer, then the lower outside of the pressure ulcer and then back in the center of the pressure ulcer. LPN #3 then used a gauze pad to blot the wound several times, medication was observed on the gauze after the blotting. LPN #3 then attempted to unwrap the hydrocolloid dressing but it was observed stuck to her gloves and itself. LPN #3 removed her gloves, sanitized her hands and left the room. LPN #3 returned to the room, sanitized her hands, applied gloves and stated, "I got a bigger dressing." LPN #3 opened packaging for Dermafilm thin 6"x7" split sacral hydrocolloid dressing. LPN #3 placed the dressing on the sacral area pressure ulcer; it was observed that the clear split area in the center of the "heart" shaped dressing was placed over the pressure ulcer itself with the tan dressing noted on both	F 686		

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sides of the pressure ulcer. LPN #3 removed her gloves picked up the removed dressing with bare hands and placed it into the red biohazard bag for disposal. LPN #3 sanitized her hands and left the room.

LPN #3 returned to the room, washed her hands, applied new gloves and placed supplies on the bedside table. LPN #3 and CNA #1 positioned Resident #92 for the dressing change to left elbow. LPN #3 removed the dressing dated 7/22/19 11-7 on the left elbow. Observation revealed two wounds to the left elbow, wound #1 located on the top of the left elbow and wound #2 to on the left lower outer elbow. LPN #3 removed gloves, sanitized her hands and applied new gloves. LPN #3 measured the left elbow wound #1 as 2.5cm x 1cm, and described the wound as "dry scab, circular, with new pink granulation and clean." LPN #3 then measured wound #2 as 2.5 cm x 0.7 cm, and described the wound as "a little bit of granulation, larger amount covers the scab distal aspect." LPN #3 then cleaned the wounds with a saline vial and was observed cleaning wound #2 located at the lower outer portion of the elbow first and then proceeded to clean wound #1 located at the top portion of the left elbow. The saline used to clean wound #1 was observed draining down onto wound #2 that was previously cleaned. LPN #3 used a gauze pad to blot the wound moving from the inside of the wound to the outside of the wound and then back to the center of the wound. LPN #3 then placed a hydrocolloid dressing over wound #1 and a second dressing over wound #2 on the residents elbow. LPN #3 removed her gloves, picked up the removed dressings with her bare hands, and placed the dressings into the biohazard bag. LPN #3 then used hand sanitizer and left the room with the

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biohazard bag.

Review of Resident #92's electronic medical record revealed an "Initial Pressure Injury Record" dated 6/29/19 13:08 (1:08 p.m.). The record documented of a stage 3 (three) pressure ulcer to the coccyx (6) measuring 4 cm (centimeter) (length) x 3.6 cm (width) x 0.2 cm (depth).

The nurses general progress notes dated 7/10/19 19:08 (7:08 p.m.) documented in part, "Continues with pressure ulcer to sacrum (7). Area with improvements noted measure 2x1x0.3."

A nurse's general progress notes dated 7/9/19 17:26 (5:26 p.m.) documented, "Resident noted with blanchable redness to left elbow. Small abrasion observed at left outer elbow ...N/O (new order) for hydrocolloid (8) see order ..."

A nurses note dated 7/17/19 17:36 (5:36 p.m.) documented, "Clarification abrasion continues to left elbow."

The POS (physician order summary) dated 7/24/19 8:34 a.m. documented the following, "Wound care: Cleanse sacral wound with n/s (normal saline) pat dry, apply medihoney (9), Flagyl (10), cover with foam dressing daily." An order dated 7/1/19 documented, "Wound care: Cleanse left elbow with n/s (normal saline) pat dry, apply hydrocolloid every 3 days until resolved."

The comprehensive care plan for Resident # 92 dated 06/29/2019 documented, "I have a pressure ulcer actual or at risk due to : Pressure Ulcer Present on my coccyx, right hip- resolved,

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R (right) Buttock PU (pressure ulcer), L (left) posterior thigh excoriation." Under "Interventions" it documented, "Treatments as ordered." Date Initiated: 06/29/2019, Revision on 07/24/2019.

On 7/25/19 at 8:08 a.m., an interview was conducted with LPN #3. When asked about the above observation of cleaning the wound inside out then back to the middle of the wound and outside again with the same gauze, LPN #3 stated "if the order says to clean with saline I do, blot dry, I like to go side to side." When asked why LPN #3 stated to clean it. When asked what is done after cleaning, LPN #3 stated, "Then I apply the dressing. If there is medication, I do that and then the dressing itself. I am already gloved first." When asked about the process for completing treatments to multiple wounds, LPN #3 stated, "do one at a time, do top one first." When informed of the observation made above where she had cleaned the lower wound to the elbow prior to the upper wound and the saline from the top wound was observed running down into the bottom ulcer, LPN #3 stated that she though she did the top one first. When asked the purpose of cleaning the top one first, LPN #3 stated, "So it does not contaminate."

When asked about the process for application of medications during dressing changes, LPN #3 stated, "I would have liked to have had a stick, technically if I could have set up the way I wanted, I would have not had extra-large gloves. I rubbed it because I wanted the Flagyl to stick to it." When asked what standard process is followed for applying medications to wounds, LPN #3 stated, "I should have used a stick." When asked about the placement of hydrocolloid dressings, LPN #3 stated, "I position it with the point down, a

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little bit of slant in the middle should cover the pressure ulcer. The middle has the medication in it." LPN #3 confirmed that her understanding of the split sacral hydrocolloid dressing was that the hydrocolloid portion was in the clear middle portion of the dressing between the two tan padded portions.

When asked for the product insert for the hydrocolloid dressing, LPN #3 stated that she did not know how to get the product insert for the hydrocolloid dressing used during the observation and that ASM (administrative staff member) #2 (director of nursing) would be able to obtain that. LPN #3 agreed that if hydrocolloid dressing is ordered and is not applied to affected area then the wound is not being treated as ordered.

When asked what standard of practice is used at facility for wound care LPN #3 stated that she was not sure, stated that she has an information packet that she was given regarding wound care and that she referred to it prior to the dressing change during observation. LPN #3 stated to ask ASM #2 about the standard of practice specifically.

On 7/25/19 at 9:35 a.m., an interview was conducted with ASM #2 regarding wound care. When asked what standard of practice is used for wound care ASM #2 stated, "We use our policy for stages, 1, 2, 3 wounds or follow the physician orders." When asked about the process for placement of hydrocolloid dressing, ASM #2 stated, "The sticky part to the skin, if heart shaped it is for sacral area, we place it in the center." When asked about placement of a split dressing on pressure ulcer in the center of the buttocks, ASM #2 stated, "If it is a split dressing I

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am not sure of the placement of the dressing." A request was made to ASM #2 for the product insert for the DermaFilm thin hydrocolloid split sacral dressing applied above, all wound care documentation for Resident #92 and for the facilities wound care policy.

On 7/25/19 at 1:40 p.m., a telephone interview was conducted with ASM #3 (wound physician). When asked about proper placement of the split sacral hydrocolloid dressing in relation to the pressure ulcer, ASM #3 stated, "If it is a heart-shaped dressing, picturing the person standing upright, the dressing should be placed like a heart." When asked if there is medication in the split section in the middle of the dressing, ASM #3 stated, "I am not too familiar specifically with this type of dressing, I don't know for sure. There are different types of dressings, foams, hydrocolloids and other types. The whole thing should be hydrocolloid." When asked if the tan padded looking portion on the two sides of the dressing are hydrocolloid, ASM #3 stated "Yes, it should be." ASM #3 stated that if the pressure ulcer is not covered with the hydrocolloid dressing "it is probably not enhancing wound healing."

7/25/19 at 2:10 p.m., an interview was conducted with LPN #3 regarding information received from ASM #3. When asked if a dressing is not placed to ensure pressure ulcer is covered with hydrocolloid area are facility staff following orders? LPN #3 stated "no." LPN #3 agreed that if prescribed medication was not on the wound it would not promote wound healing. LPN #3 stated, "if not on it at all, I think some of it was over it." LPN #3 stated that if she would have used the first dressing she had gotten it would have covered the wound but it became damaged

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during the dressing change and someone gave her the split dressing to use. Stated that she learned something about the split dressing, that she always thought the hydrocolloid portion was in the clear middle section of the split.

The product insert titled "DermaFilm Thin- Thin bordered hydrocolloid wound dressing" notes under "Description- DermaFilm Thin is a thin bordered hydrocolloid wound dressing for shallow non-infected wounds and shallow pressure ulcers. DermaFilm provides thermal insulation and protection, maintains a moist wound environment and aids in autolytic debridement (8)."

The facility policy "Wound Prevention Program" provided by ASM #2 did not document information on placement of wound dressing or the process for cleaning a wound.
"Techniques for aseptic dressing and procedures" (12) published by the US National Library of Medicine National Institutes of Health documents under "Cleaning and dressing the wound- Start from the dirty area and then move out to the clean area. Be very careful when doing this as the tissue or skin may be tender and there may also be sutures in place. Clean the area without causing further damage or distress to the patient. Make sure you do not re-introduce dirt or ooze by ensuring that cleaning materials (i.e. gauze, cotton balls) are not over-used. Change them regularly (use once only if possible) and never re-introduce them to a clean area once they have been contaminated. Make sure that you have selected the correct dressing type and materials needed to provide full and appropriate coverage for the type, size and location of the wound, according to the care plan or the physician's or

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senior charge nurse's recommendations."
On 7/24/19 at approximately 6:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Parkinson's disease
A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

2. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. Cerebrovascular disease, infarction or accident
A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

4. Subcutaneous
The term "cutaneous" refers to the skin. Subcutaneous means beneath, or under, all the layers of the skin. For example, a subcutaneous cyst is under the skin. This information was

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obtained from the website:
https://medlineplus.gov/ency/article/002297.htm

5. Pressure Ulcer
Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website:
https://medlineplus.gov/ency/patientinstructions/000147.htm.

6. Coccyx
The tailbone (coccyx) is the small bone at the lower tip of the spine. The most common cause of injury to the tailbone is a backward fall onto a hard surface, such as a slippery floor or ice. This information was obtained from the website:
https://medlineplus.gov/ency/imagepages/9757.htm

7. Sacrum
The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis. Joined at the very end of the sacrum are two to four tiny, partially fused vertebrae known as the coccyx or "tail bone". The coccyx provides slight support for the pelvic organs but actually is a bone of little use. This information was obtained from the website:
https://medlineplus.gov/ency/imagepages/19464.htm

8. Hydrocolloid

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A hydrocolloid dressing is a bandage made of a gel. It molds to the pressure sore and promotes healing and skin growth. These dressings can stay on for several days at a time. https://familydoctor.org/condition/pressure-sores/?adfree=true

9. Medihoney
Honey can become contaminated with germs from plants, bees, and dust during production, collection, and processing. Fortunately, there are characteristics of honey that prevent these germs from remaining alive or reproducing. However, some bacteria that reproduce using spores, such as the type that causes botulism, can remain. This explains why botulism has been reported in infants given honey by mouth. To solve this problem, medical-grade honey (Medihoney, for example) is irradiated to inactivate the bacterial spores. Medical-grade honey is also standardized to have consistent germ-fighting activity. Some experts also suggest that medical-grade honey should be collected from hives that are free from germs and not treated with antibiotics, and that the nectar should be from plants that have not been treated with pesticides. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/738.html.

10. Flagyl
Metronidazole capsules and tablets are used to treat infections of the reproductive system, gastrointestinal (GI) tract, skin, heart, bone, joint, lung, blood, nervous system, and other areas of the body. Metronidazole capsules and tablets are also used to treat sexually transmitted diseases (STDs). Metronidazole extended-release (long-acting) tablets are used to treat bacterial vaginosis (an infection caused by too much of

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F 686	Continued From page 180 certain types of harmful bacteria in the vagina) in women. Metronidazole is in a class of medications called nitroimidazole antimicrobials. It works by stopping the growth of bacteria. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a689011.html 11. Zinc Zinc is a mineral. It is called an "essential trace element" because very small amounts of zinc are necessary for human health. Since the human body does not store excess zinc, it must be consumed regularly as part of the diet. Common dietary sources of zinc include red meat, poultry, and fish. Zinc deficiency can cause short stature, reduced ability to taste food, and the inability of testes and ovaries to function properly. Bed sores. Applying zinc paste appears to help improve the healing of bed sores in elderly people. Also, increasing zinc intake in the diet seems to improve bed sore healing in hospitalized patients with bed sore. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/982.html 12. Pickering, D., & Marsden, J. (2015). Techniques for aseptic dressing and procedures. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4579997/	F 686		
F 689 SS=D	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	F 689		8/25/19

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F 689	Continued From page 181 §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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to adequately monitor a supervision device for one of 54 residents in the survey sample, Resident #86. The facility staff failed to check Resident #86's wanderguard (a device used to prevent at-risk residents from exiting the facility) for placement and function per physician's order on 4/17/19 and 4/18/19. The findings include: Resident #86 was admitted to the facility on 7/29/16. Resident #86's diagnoses included but were not limited to Alzheimer's disease (1) and muscle weakness. Resident #86's most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 6/23/19, coded the resident's cognition as severely impaired. Section G coded Resident #86 as requiring supervision with walking. Review of Resident #86's clinical record revealed an elopement risk assessment dated 4/15/19 that documented Resident #86 was at risk for elopement. Further review of Resident #86's clinical record revealed a physician's order dated 4/15/19 that documented, "Wanderguard. Check for Placement and Functioning every shift for High Risk for Elopement." Resident #86's comprehensive care plan revised on 7/18/17 documented, "I am at risk for Elopement R/T (related to) wandering at times...Personal wander	F 689	F689 1. Address how corrective action will be accomplished for those residents affected by deficient practice; There was no negative outcome due to the deficient practice. The res safety was maintained at all times and the missing documentation was flagged and noted with family and physician notified. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents of the facility requiring a Wanderguard may be affected. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Education of nursing staff on proper documentation of resident TAR to be completed. In-servicing to specify the signing of TAR as task is completed, or as order is carried out. Residents with Wanderguards TAR will be audited 5x per week for compliance and where incomplete documentation is evident, resident safety will be ensured, then correction to TAR will be made by the shift nurse responsible as appropriate with one-on-one education with DON/ADON or designee. 4. Indicate how the facility will monitor its	

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F 689

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guard prevention device-check for placement each shift and function daily..."

Resident #86's April 2019 TAR (treatment administration record) documented, "Wanderguard. Check for Placement and Functioning every shift for High Risk for Elopement." Further review of the April 2019 TAR failed to reveal evidence that the resident's wanderguard was checked for placement and function during the night shift on 4/17/19 and 4/18/19 (as evidenced by a blank space with no nurse's initials signed off to indicate this was done). A nurse's note dated 4/19/19 documented, "wanderguard check for placement and function not done 4/17/19 and 4/18/19, MD (medical doctor) RP (responsible party) aware."

Note- Resident #86 resided on the locked memory care unit.

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked why a resident on the locked memory care unit would have a wanderguard. LPN #2 stated, "Some residents are faster, if someone walks out of the unit door, some residents have a history of attempting to exit, so a wanderguard is placed on them to prevent exit from the facility doors (to the outside) if they get off the unit." LPN #2 was asked what the risk is if a resident's wanderguard is not checked per physician's order. LPN #2 stated, "There's the potential that it's not working correctly." When asked if a wanderguard should be checked every shift if there is a physician's order to do so, LPN #2 stated, "Yes."

On 7/24/19 at 6:41 p.m., ASM (administrative

F 689

performance to make sure that solutions are sustained; On a weekly basis the Director of Nursing/Designee will review the daily TARs of Wanderguarded residents x 4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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F 689	Continued From page 183 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Elopement Risk" documented, "2. If the resident is identified as an elopement risk based on the assessment, the care plan will reflect the interventions (i.e. Wander Guard) or Code Alert) and desired outcomes...3. Residents identified as at risk for elopement may require nursing to check resident regularly and document on the Safety Check's..." No further information was presented prior to exit. (1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. AD begins slowly. It first involves the parts of the brain that control thought, memory and language. People with AD may have trouble remembering things that happened recently or names of people they know." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+disease&_ga=2.135332914.2089506196.1564224503-1667741437.1550160688	F 689		
F 692 SS=D	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	F 692		8/25/19

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F 692	Continued From page 184 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to address a significant weight loss in a timely manner for one of 54 sampled residents, (Resident #71), and failed to provide a physician ordered therapeutic diet to one of 54 sampled residents, (Resident #513). The facility staff failed to address Resident #71's significant weight loss in June 2019 and failed to provide Resident #513 with a gluten free diet as ordered by the physician. The findings include: 1. The facility staff failed to address Resident #71's significant weight loss in June 2019. Resident #71 was admitted to the facility on 1/22/19. Resident #71's diagnoses included but were not limited to heart failure and diabetes. Resident #71's most recent MDS (minimum data	F 692	F692 1. Address how corrective action will be accomplished for those residents affected by deficient practice; An updated nutritional assessment was completed for resident #71. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents who experience weight loss or weight gain are potential affected by this practice. Residents who require special diets are potentially affected by this practice. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; An audit was conducted of current facility residents for significant weight loss and interventions provided.	

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set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/16/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section K coded Resident #71 as having a feeding tube and as having a weight loss of five percent or more in the last month or ten percent or more in the last six months.

Review of Resident #71's clinical record revealed the following weights:
-5/4/19 199.8 lbs (pounds)
-5/5/19 201.6 lbs
-5/6/19 202 lbs
-5/21/19 222.1 lbs
-5/22/19 224 lbs
-5/23/19 220 lbs

A registered dietician assessment dated 5/23/19 documented Resident #71 was re-admitted from the hospital with diagnoses including shortness of breath, low potassium, urinary tract infection and a pressure wound. The assessment further documented a weight gain was noted on re-admission, the resident had a history of lower extremity edema (swelling) and a diuretic (medication used to treat edema) was prescribed so weight fluctuations were anticipated related to fluid.

-6/1/19 181.4 lbs
-6/3/19- 181.4 lbs
-6/10/19 184 lbs (an 8.91% weight loss from 5/6/19).

Further review of Resident #71's clinical record (including nurses' notes, physician/nurse practitioner notes and dietary assessments) failed to reveal Resident #71's significant weight loss

F 692

Additionally, a diet order audit was conducted of current facility residents for accuracy in special physician ordered diets. Residents with weight loss reviewed weekly in the clinical meeting. Registered Dietician/Designee will audit residents with significant weight loss to ensure that significant weight changes have been addressed with the appropriate recommendations implemented weekly x 4 weeks.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; The District Manager of Food and Nutrition Services or designee to conduct a diet audit weekly x5 weeks to ensure accurate diets are being provided. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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F 692	Continued From page 186 from 5/6/19 to 6/10/19 was addressed until a RD (registered dietician) assessment on 7/13/19 (note- Resident #71 was discharged to the hospital on 7/2/19 and returned on 7/11/19). Resident #71's comprehensive care plan dated 2/18/19 documented, "I am dependent on TUBE FEEDINGS and am at risk for inadequate food and beverage intake due to: Alzheimer's, Dysphagia (difficulty swallowing)...Refer to RD assessment as needed..." The care plan failed to document information regarding the significant weight loss. On 7/25/19 at 10:51 a.m., an interview was conducted with OSM (other staff member) #4 (the registered dietician). OSM #4 was asked the facility process for addressing significant weight losses. OSM #4 stated she is in the facility once a week. OSM #4 stated on the days she is there, she reviews the reports and sees who has been admitted and she reviews section K of the MDS assessments that are in progress. OSM #4 stated she began working at the facility the first week of June 2019 and the very first couple of weeks she missed the review of a couple of newly admitted residents because they were re-admissions and they did not have a MDS assessment scheduled. OSM #4 was made aware of the above concern regarding Resident #71's significant weight loss in June 2019. OSM #4 stated she would have to investigate. OSM #4 was asked if she should be notified of residents who present with a significant weight loss and address the issue. OSM #4 stated the diet tech (technician) goes to the weight meetings every week and makes her aware of the residents who need to be evaluated. OSM #4 was asked if she could recall anyone notifying her of Resident #71's significant weight loss in June 2019. She	F 692		

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stated she did not know why this did not trigger.

On 7/25/19 at 11:15 a.m., an interview was conducted with OSM #5 (the diet tech). OSM #5 was asked about the facility process for addressing significant weight losses. OSM #5 stated, "When a person triggers for significant weight loss, I am the one who checks the weights. I check the weekly weights every week and put them into the system and I check monthly weights monthly. I check and identify and refer to the dietician and the dietician does an assessment and makes recommendations and gives them to nurses and the dietary manager and it's followed from there." OSM #5 was made aware of the above concern that Resident #71 presented with a significant weight loss per the 6/16/19 MDS assessment and the resident was not assessed until 7/13/19. OSM #5 stated Resident #71's weight was addressed in May when she gained approximately 20 pounds. OSM #5 stated Resident #71 gained weight in May because she went to the hospital and returned with edema and a prescription for a diuretic medication and then the resident returned to her "normal" weight. OSM #5 was asked if Resident #71 was evaluated and if the significant weight loss was addressed in June 2019 to see if changes needed to be made to her plan of care. OSM #5 stated, "I know we talked about her at the weight meeting but I cannot say if a RD (registered dietician) or doctor assessed her."

On 7/25/19 at 1:12 p.m., an interview was conducted with ASM (administrative staff member) #4 (the nurse practitioner). ASM #4 was asked if she was made aware of Resident #71's significant weight loss in June 2019. ASM #4 stated, "It's hard to say whether. They go over

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those in the QAPI (quality assurance and performance improvement) meetings. We may have known. I know we look for them on our own independently when we do re-certifications and a note." ASM #4 stated Resident #71 had a feeding tube and she relies on the RD a lot for residents with tube feedings so she felt confident the RD followed Resident #71. ASM #4 confirmed she would document an evaluation of significant weight loss in her notes if she assessed a resident for this. ASM #4 reviewed her June 2019 notes and confirmed her notes did not contain any specific information regarding Resident #71's significant weight loss. ASM #4 stated the facility staff may have told her about the weight loss and she may have asked if they were doing weekly weights and then said, 'okay.'

On 7/25/19 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked what should be done when a resident presents with a significant weight loss. LPN #3 stated, "We have our weight meetings weekly. We identify them there; the dietician then gets involved, and notify the physician or nurse practitioner." LPN #3 was made aware of the above concern, and was asked to present any further information.

On 7/25/19 at 6:22 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Weighing the Resident" documented, "9. Record weight and alert nurse to any significant change. 10. The nurse will: a. Notify the physician and responsible party of any significant weight change. b. Consult with the Director of Dietary Services and/or dietician. c.

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Update the plan of care. 11. The weight committee will review residents with a significant difference in weight..."

No further information was presented prior to exit.

2. The facility staff failed to provide a therapeutic gluten free diet to Resident # 513 per the physician orders.

Resident #513 was admitted to the facility on 7/19/19 with diagnoses that included but were not limited to: status post Left Knee Replacement, nausea with vomiting, gastro-esophageal reflux disease (GERD - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (1), and high blood pressure.

The MDS (minimum data set) assessment had not been completed. The admission data collection form; completed on 7/19/19; documented: drowsy, understanding verbal content, ability to express ideas and wants. Gastrointestinal: bowels continent and nutrition: adequate.

An interview was conducted with Resident #513 interview 7/23/19 1:25 PM "I am unable to eat this food, I'm to be on a gluten free meals and told this to them when I came in." Asked what happens if she eats gluten, patient stated that her stomach hurts and she has diarrhea. Reviewed her dietary orders and meal trays; found diet was lacto-ovo vegetarian and included products with gluten (macaroni, roll and bread).

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Observation was made of Resident # 513 meal trays on the following dates and meals. The diet slip on each of these trays documented, "Lacto-ovo vegetarian diet." The following was observed on the resident's meal trays:
7/24/19 supper: non-gluten free macaroni & cheese and roll
7/25/19 breakfast: non-gluten free toast
7/25/19 lunch: non-gluten free bread
7/25/19 supper: non-gluten free bread

Kitchen observation was completed on 7/24/19 at 1:25 pm: one cup gluten free macaroni, one (10 ounce) unopened box of gluten free lasagna. There are no other gluten free products.

The physician orders dated, 7/19/19, documented:
1.7/19/19 5:03 PM regular diet, regular texture
2. 7/22/19 2:10 PM NPO diet, regular texture
3. 7/23/19 2:38 PM Gluten free diet, regular texture, per patient she does not eat gluten

The nurse's note of 7/23/19 at 2:48 pm documented, "New order for diet change entered and followed through. C/o (complained of) diarrhea this afternoon, but when assessed, pt (patient) had no loose or water stool this shift. Denies nausea at this time."

Review of the bowel elimination and bowel consistency record documented the following:
7/20/19 one loose stool
7/22/19 two loose stools

The Comprehensive Care Plan dated 7/20/19, documented in part, "Focus: (Resident #513) Gastrointestinal distress due to gastro

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esophageal reflux disease." The "Interventions / Tasks" documented in part, "administer medications as ordered, observe labs and response to medication and treatment. Observe for presence of nausea/vomiting, intake or weight changes, difficulty chewing."

An interview with OSM (other staff member) #6, on 7/24/19 at 5:40 pm. When asked what a gluten free diet includes, OSM #6 stated, "Gluten free bread, macaroni, pasta, fruit, and vegetables." When asked if they had these items in the kitchen, OSM # 6 stated "We have one box of lasagna noodles, no bread or other pasta".

An interview was conducted with Resident # 513, on 7/25/19 at 5:00pm regarding her supper tray. When asked about her supper tray, Resident #513 stated, "The nurse took the bread off.

An interviewed was conducted with LPN (licensed practical nurse) # 5, on 7/25/19 at 5:10 pm. When asked to describe Resident #513's supper tray this evening, LPN #5 stated, "She had a bun I removed because she said she couldn't eat gluten."

A review of Resident #513 dietary tray slips found it labeled as "Lacto-ovo vegetarian diet". The tray items were confirmed with the facility diet guide sheets for those meals as "lacto-ovo vegetarian diet". Gluten free diets were listed on diet guide sheets although none were provided for the four meals after the gluten free diet order.

As per the facility Diet Orders policy, "Therapeutic diet as a diet ordered by a physician as part of the treatment for a disease or clinical condition, to eliminate or decrease specific nutrients in the diet

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F 692	Continued From page 192 (e.g. sodium), or to increase specific nutrients in the diet (e.g. potassium) or to provide food that a resident is able to eat (e.g. mechanically altered diet)." As per the facility therapeutic diets policy, "It is the center policy to provide therapeutic diets in accordance with physician orders." This policy lists the action steps to be taken and includes the diet requisition form. Administrative staff members (ASM) # 1, the administrator was made aware of the above concern on 7/24/19 at 5:28pm. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure pain management was provided consistent with professional standards of practice for one of 45 residents in the survey sample, Resident # 11. The facility staff failed implement	F 697	F697 1. Address how corrective action will be accomplished for those residents affected by deficient practice; The resident affected by this practice received PRN pain medication without non-pharmacological interventions.	8/25/19

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non-pharmacological interventions prior to the administration of a prn (as needed) pain medication to Resident #11.

The findings include:

Resident # 11 was admitted to the facility on 04/12/2019 with diagnoses that included but were not limited to: osteoarthritis (1), high blood pressure and muscle weakness. Resident # 11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/09/19, coded Resident # 11 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0400 Pain Frequency" coded Resident # 11 as "Occasionally" having pain and section "J0600 Pain Intensity coded the resident's level of pain as "2 (two) Moderate."

The POS (physician's order sheet) dated "July 2019" for Resident # 11 documented, "Acetaminophen Tablet. Give 650 mg (milligrams) by mouth every 4 (four) hours as needed for pain/fever. Order Date: 4/12/19."

The eMAR (electronic administration record) for Resident # 11 dated "May June and July 2019" documented the above physician's order. The eMAR dated May 2019 documented the administration of Acetaminophen 650 mg on 05/25/19 at 1:46 a.m. with a pain level of one, 05/27/19 at 2:58 a.m. with pain level of seven, 05/29/19 at 5:36 p.m. with pain level of six, and on 05/31/19 at 9:27 a.m. with pain level of ten.

The eMAR dated June 2019 documented the physician's order as stated above. Further review

F 697

2. Address how facility will identify other residents potentially affected by deficient practice; Resident with pain medication orders can potentially be affected by this practice.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Licensed nursing staff who dispense medications to residents will receive education on nonpharmacological interventions as options to PRN pain medications, prior to administering PRN pain medications.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; On a weekly basis x 4 weeks, a random med pass observation on two nurses will be conducted by nurse management to ensure the proper administration of prn pain medications and implementation of nonpharmacological interventions. These observations will be recorded on the Med Pass Observation form and reviewed in the Monthly Quality Assurance meeting. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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F 697	Continued From page 194 of the eMAR revealed administration of Acetaminophen 650 mg on 06/02/19 at 9:00 a.m. with pain level of four, 06/04/19 at 10:21 a.m. with pain level of eight, and 06/07/19 at 6:35 p.m. with pain level of five. On 06/08/19 at 9:28 a.m. with pain level of eight, 06/09/19 at 9:28 a.m. with pain level of eight, 06/22/19 at 12:46 p.m. with pain level of six and on 06/28/19 at 10:12 a.m. with pain level of eight. The eMAR dated July 2019 documented the administration of Acetaminophen 650 mg on 07/08/19 at 1:24 a.m. with pain level of eight and on 07/14/19 at 6:55 p.m. with pain level of six. The comprehensive care plan for Resident # 11 dated 04/13/19 documented, "Problem/Need. I require pain management and monitoring related to Osteoarthritis, Depression, Diabetic Neuropathy. Date Initiated: 04/13/19."Under "Approaches" it documented in part, "Administer Pain medication as ordered." On 07/24/19 at 10:50 a.m., an interview was conducted with Resident # 11. When asked if she is offered alternate interventions to alleviate her pain prior to receiving prn (as needed) pain medication Resident # 11 stated, "No." On 07/25/19 at 2:15 p.m., an interview was conducted with LPN (licensed practical nurse) # 4, nurse manager. When asked to describe the process for administering as needed pain medication LPN # 4 stated, "I would try to alleviate the pain using non-pharmacological approaches such as repositioning, cold/hot compresses, try to alleviate the pain without medication. If it isn't working I would get the pain level zero to ten, with ten being the worse pain,	F 697		

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check what prn (as needed) medication was prescribed and if the resident could receive it at that time. If the medication is administered, I would reevaluate the resident after about 30 minutes." When asked where the non-pharmacological interventions would be documented, LPN # 4 stated, "On eMAR and/or in the nurse's notes and if it's not documented I can't say it was done." LPN # 4 was then asked to review the nurse's notes dated 05/01/19 through 07/22/19 and eMARs dated MAY, June and July 2019 for documentation of non-pharmacological interventions.

On 07/25/19 at 3:58 p.m., LPN # 4 stated that non-pharmacological interventions were not attempted for the dates listed above.

The facility's policy "Pain Assessment" documented, "A Pain Flow Record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they have pain. Record the following: a. Date and time, b. Site / location, c. Type of pain, d. Intensity, e. Precipitating / aggravating, f. Interventions - non-med [medication] / medication, g. Intensity of pain after intervention, h. Side effects, i. Initials."

On 07/25/19 at approximately 6:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints.

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F 697	Continued From page 196 It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for two of 54 residents in the survey sample, Residents #314 and #20. The facility staff failed to evidence that Resident #314 and Resident #20 were assessed	F 700	F700 1. Address how corrective action will be accomplished for those residents affected by deficient practice; On July 25, 2019 during the survey, #314 and #20 resident beds were audited for bed/side-rail attachments.	8/25/19

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F 700	Continued From page 197 for the use of bed rails, and failed to review risks and benefits and obtain informed consent for both resident's use of bed rails. The findings include: 1. The facility staff failed to evidence that Resident #314 was assessed for the use of bed rails, and failed to review risks and benefits and obtain informed consent for the resident's use of bed rails. Resident #314 was admitted to the facility on 4/6/16. Resident #314's diagnoses included but were not limited to pain and abnormal posture. Resident #314's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/19, coded the resident as being cognitively intact. Section G coded Resident #314 as being independent with bed mobility. On 7/23/19 at 3:10 p.m., an observation of Resident #314 was conducted. The resident was lying in bed. Bilateral assist-bar bed rails were observed in the up position on the resident's bed. Resident #314 was observed holding one of the assist bar bed rails to sit up in bed. Review of Resident #314's clinical record failed to reveal a physician's order for the assist bar bed rails, failed to reveal the resident was assessed for the use of the bed rails, failed to reveal risks and benefits were reviewed with Resident #314 and failed to reveal informed consent was obtained. Resident #314's comprehensive care plan dated 3/23/18 documented, "I currently use Halo	F 700	2. Address how facility will identify other residents potentially affected by deficient practice; Residents that are identified by an assessment for the need of a bedrail are at risk. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Residents will be assessed upon admission, quarterly, and upon sig change of condition for side-rails or enabling devices. Residents identified with the need will have an initial assessment completed to determine if device is an enabler or a restraint. Once a device is utilized a quarterly assessment will be completed to determine if a reduction and/or alternative to the device can be initiated. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; Devices and enabler/restraints will be audited weekly to ensure that initial assessment, quarterly assessment, consent, and orders are completed. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.	

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(another type of bed rail) on my bed to aid with increased bed mobility..."

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked the facility process for residents who have bed rails. LPN #2 stated, "We have assessments that needs to be done and after completed, they are put in the chart and they have to be signed by the patient or rp (responsible party)." LPN #2 was asked if this process was completed for residents who use halo or assist bar bed rails. LPN #2 stated, "Not the assessment or consent because it's a smaller device."

On 7/24/19 at 5:41 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated during the previous year, side rails (bed rails longer than halos or assist bars) were discontinued for most patients and at that time, it was determined who needed additional assistance like a halo or an assist bar. ASM #2 stated there was no documentation to evidence this. ASM #2 also confirmed that assessments were not documented and consents were not obtained for residents with halos or assist bar bed rails.

On 7/24/19 at 6:41 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Side Rail Screening" documented, "1. A side rail screening tool will be performed on admission and quarterly by nursing. 2. If the side rail is deemed as a restraint, the Interdisciplinary Team will review. 3. A consent

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form will be signed per restraint policy..." The policy did not document information regarding halo or assist bar bed rails.

No further information was presented prior to exit.
2. The facility staff failed to evidence that Resident #20 was assessed for the use of bed rails, and failed to review risks and benefits and obtain consent for the resident's use of bed rails.

Resident #20 was admitted to the facility on 7/1/18 with a recent readmission on 7/15/19, with diagnoses that included but were not limited to: frequent falls, diabetes, high blood pressure and Parkinson's disease. [Parkinson's disease is a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability] (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/18/19, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of two staff members for bed mobility.

Observations were made of Resident #20's bed on 7/23/19 at 1:10 p.m. and on 7/25/19 at 9:52 a.m. The resident was not in the bed at that time. In place on the bed was bilateral halo (another type of bed rail) rings.

Review of Resident #20's clinical record failed to

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evidence a physician order for the halo rings.

The comprehensive care plan dated, 7/12/18 and revised on 7/15/19, documented in part, "Focus: I have physical functioning deficits." The "Interventions" documented in part, "Assistive devices: Grab bars for bed mobility."

On 7/24/19 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked the facility process for residents who have bed rails. LPN #2 stated, "We have assessments that needs to be done and after completed, they are put in the chart and they have to be signed by the patient or rp (responsible party)." LPN #2 was asked if this process was completed for residents who use halo or assist bar bed rails. LPN #2 stated, "Not the assessment or consent because it's a smaller device."

On 7/24/19 at 5:41 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated during the previous year, side rails (bed rails longer than halos or assist bars) were discontinued for most patients and at that time, it was determined who needed additional assistance like a halo or an assist bar. ASM #2 stated there was no documentation to evidence this. ASM #2 also confirmed that assessments were not documented and consents were not obtained for residents with halos or assist bar bed rails.

An interview was conducted with RN (registered nurse) # 8, on 7/25/19 at 9:52 a.m. When asked if Resident #20 can use the halo rails, RN #8 stated, "I believe so as she has good range of

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F 700	Continued From page 201 motion." ASM #1, the administrator and ASM #2 were made aware of the above concern on 7/25/19 at 1:25 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.	F 700		
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 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	F 758		8/25/19

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F 758	Continued From page 202 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 staff interview, clinical record review, and facility document review, the facility staff failed to ensure that PRN (as needed) orders, for psychotropic drugs are limited to 14 days, or that orders are reviewed by the attending physician, to address the appropriateness for the PRN order to be extended beyond 14 days in the medical record, for two of 54 sampled residents, (Residents #73 and #60). The findings include: 1. Resident #73 had orders for PRN (as needed) Psychotropic medications in place for greater	F 758	F758 1. Address how corrective action will be accomplished for those residents affected by deficient practice; For resident #73, physician assessed resident for appropriate usage and diagnosis and it was determined by physician that the med remain a PRN medication until the physician□s next review. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents who have physician orders for PRN psychotropic medications are affected by this practice.	

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than 14 days, with no set end date, no review, renewal by the physician or documentation for why the medications should extended beyond 14 days.

Resident #73 was admitted to the facility on 6/9/17 with the diagnoses of but not limited to dementia, anxiety disorder, chronic kidney disease, high blood pressure, seizures, diabetes, left pubis fracture, dysphagia, Alzheimer's Disease, mood disorder, depression, congestive heart failure, restless leg syndrome, cataracts, glaucoma, and sleep apnea. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as total care for bathing; extensive assistance for bathing, dressing, toileting, and hygiene; and supervision for eating.

A review of the clinical record revealed a nurse's note dated 6/21/19 that documented, "....Hospice medications were rec'd (received) to include prn Haldol (1), Lorazepam (2)...."

A review of the physician's orders revealed an order dated 6/21/19 for "Lorazepam 0.5 mg (milligrams), give 1 tablet by mouth every 6 hours as needed for anxiety." This order did not contain a 14-day end date.

Further review of the clinical record revealed this order was renewed on 7/8/19, which was 17 days later, 3 days after the required time frame expired.

A nurse's note by the Director of Nursing dated 7/9/19 documented, "Per hospice, resident to

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3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Per facility Medication Management Policy regarding time limitation on PRN psychotropic medications, licensed nursing staff and medical director will receive re-education on this policy, to include renewal process extended beyond 14 days.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; The DON/designee will review any new orders for psychotropic medications, 5x per week by 4 weeks, in the Morning Meeting process to ensure that PRNs are limited to 14 day. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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continue Lorazepam PRN."

In addition, review of the clinical record revealed an order dated 6/21/19 for "Haloperidol tablet, 2 mg, give 0.5 mg by mouth every 6 hours as needed for agitation...." This order did not contain a 14-day end date. As of the survey, on 7/25/19, this order continued consecutively, without review and renewal. A review of the MAR (Medication Administration Record) for June 2019 and July 2019 revealed that the Haldol had not been administered, but continued to be available for use.

On 7/25/19 at 4:28PM an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that when she wrote the note on 7/8/19 regarding the Lorazepam, that it was to include the Haldol as well. She stated that there were no other notes documenting the Haldol may be continued without a 14 day renewal.

A review of the facility policy, Medication Management" documented, "PRN Orders for Psychotropic and Antipsychotic Medications....(in a table format was documented the following) PRN orders for Psychotropic medications excluding antipsychotics...Time Limitation: 14 days. Exception: Order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order. Required Actions: Attending physician or prescribing practitioner should document the rationale for the extended time period in the medical record and indicate a specific duration. PRN orders for antipsychotic medications only: Time Limitation 14 days. Exception: none. Required Actions: If the attending physician or

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prescribing practitioner wishes to write a new order for the prn antipsychotic, the attending physician or prescribing practitioner must evaluate the resident (through direct examination) to determine if the new order for the prn antipsychotic is appropriate....The required evaluation of a resident before writing a new PRN order for an antipsychotic entails the attending physician or prescribing practitioner directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed. As part of the evaluation, the attending physician or prescribing practitioner should, at a minimum, determine and document the following in the resident's medical record: Is the antipsychotic medication still needed on a PRN basis? What is the benefit of the medication to the resident? Have the resident's expressions or indications of distress improved as a result of the PRN medication?...."

No further information was provided.

(1) Haldol - is used to treat psychotic disorders. Information obtained from https://medlineplus.gov/druginfo/meds/a682180.html

(2) Lorazepam - is used to relieve anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

2. Resident #60 had an order for PRN (as needed) Psychotropic medications in place for greater than 14 days and with no set end date.

Resident #60 was admitted to the facility on

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04/03/2017. Her diagnoses included but were not limited to major depression, muscle weakness, mood disorder, and dementia. Resident #60's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 06/07/2019. The Brief Interview for Mental Status (BIMS) scored Resident #60 at a 9, indicating major impairment.

The Physician Order Sheet dated 07/25/2019, the following order was noted: "Lorazepam(1) Tablet 0.5MG Give 0.5 tablet by mouth every 12 hours as needed for Agitation, Anxiety related to ANXIETY DISORDER, UNSPECIFIED". The order status was listed as "active". The order start date was listed as "07/10/2019". The order end-date, field was blank.

Review of the July MAR revealed Resident #60 received the PRN (as needed) Ativan 3 times in July: 07/10/2019, 07/18/2019, and 07/23/2019.

Review of the progress notes for the month of July, up to 07/23/19 at the time of survey, failed to reveal any documentation by the physician regarding the Ativan.

A review of the facility policy entitled "Medication Monitoring/Medication Management" dated 11/17 reveals the following:

"PRN (as needed) orders for psychotropic drugs are limited to 14 days. Exception: 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 patient's medical record and indicate the duration for the PRN order."

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F 758	Continued From page 207 Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings on the morning of 07/25/2019. No further documentation was provided.	F 758		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide food required to meet special special dietary needs for one of 54 residents in the survey sample, Resident #513. The physician prescribed a gluten free diet on 7/23/19 for Resident #513 and during multiple observations meals served to the resident revealed food products that contained gluten. The findings include: Resident #513 was admitted to the facility on 7/19/19 with diagnoses that included but were not limited to: status post Left Knee Replacement, nausea with vomiting, gastro-esophageal reflux disease [GERD - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the	F 800	F800 1. Address how corrective action will be accomplished for those residents affected by deficient practice; The resident□s diet was changed to Gluten-free during the survey period. Food preferences for resident #513 were updated on 7/24/19. A diet order audit was conducted of current facility residents for accuracy in special physician ordered diets in PCC and Mealtracker. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents who require special diets are potentially affected by this practice. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will	8/25/19

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esophagus, commonly known as heartburn]. (1)

The MDS (minimum data set) assessment had not been completed. The admission data collection form; completed on 7/19/19; documented: drowsy, understanding verbal content, ability to express ideas and wants. Gastrointestinal: bowels continent and nutrition: adequate.

A kitchen observation was conducted on 7/23/18 at approximately 12:45 p.m. The following items were observed: one cup of gluten free elbow macaroni and one 10-ounce box of gluten free lasagna. There were no other gluten free food items in the kitchen's storage area, refrigerators or freezers.

An interview was conducted with Resident #513 on 7/23/19 at 1:25 p.m. Resident #513 stated, "I am unable to eat this food, I'm to be on a gluten free meals diet and told this to them when I came in." When asked what happens if she eats gluten, Resident #513 stated that her stomach hurts and she has diarrhea.

Review of the physician orders for Resident #513 dated, 7/19/19, documented:
1.7/19/19 5:03 PM regular diet, regular texture
2. 7/22/19 2:10 PM NPO (nothing by mouth) diet, regular texture
3. 7/23/19 2:38 PM Gluten free diet, regular texture, per patient she does not eat gluten.

Observation was made of the meals trays served to Resident # 513. The diet slip on each of the trays documented, "Lacto-ovo vegetarian diet," The following was observed on the resident's meal trays during on the following meals and

F 800

not recur; The dietary manager will complete food preferences of each newly admitted resident within 24 hours. Physician ordered diets will be entered into PCC by nutritional staff or completed by the dietary manager. New admissions will be reviewed and documented in the resident record as part of the Morning Meeting process, 5x per week by 4 weeks, by Dietary manager or designee.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; The dietary district manager will audit food preferences once weekly and findings recorded once weekly x4 weeks. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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dates:
7/24/19 supper: non-gluten free macaroni & cheese and roll
7/25/19 breakfast: non-gluten free toast, oatmeal.
7/25/19 lunch: non-gluten free bread
7/25/19 supper: non-gluten free bread.

An interview was conducted with Resident # 513, on 7/25/19 at 5:00pm regarding her supper tray. When asked about her supper tray, Resident #513 stated, "The nurse took the bread off."

An interviewed was conducted with LPN (licensed practical nurse) # 5, on 7/25/19 at 5:10 pm. When asked to describe Resident #513's supper tray this evening, LPN #5 stated, "She had a bun I removed because she said she couldn't eat gluten."

An interview was conducted with OSM (other staff member) #6 on 7/24/19 at 5:40 pm. When asked what gluten free diet includes, OSM #6 stated, "Gluten free bread, macaroni, pasta, fruit, and vegetables." When asked if they had these items in the kitchen, OSM # 6 stated, "We have one box of lasagna noodles, no bread or other pasta."

The facility policy, "Dining Services Operations-Diet Order and Tray Card Accuracy" documented in part,
1. The account manager will obtain from the nursing staff, via the electronic medical record or other reporting method, a current listing of each resident and their current diet order as recorded in the physician orders of the medical record."

Administrative staff members (ASM) # 1, the

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F 800	Continued From page 210 administrator, was made aware of the above concern on 7/24/19 at 5:28pm. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.	F 800		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, it was determined the facility staff failed to ensure food was served at palatable taste and temperature during the lunch meal on one of five units, (West 2 Unit). The findings include: An interview was conducted with Resident #513 on 7/23/19 at 1:25 PM. Resident #513 was alert and oriented. An MDS (minimum data set) had not been completed. The admission data collection form; completed on 7/19/19; documented: drowsy, understanding verbal	F 804	F804 1. Address how corrective action will be accomplished for those residents affected by deficient practice; Management instituted dining area management coverage to oversee and monitor compliance for food temperatures, dining cart delivery, and meal item palatability. 2. Address how facility will identify other residents potentially affected by deficient practice; Residents who dine at facility are subject to be affected by this practice. 3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES	8/25/19

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content, ability to express ideas and wants. Resident #513 stated the food tastes like vomit. She also stated she was not receiving a gluten free diet.

An interview was conducted with Resident # 101 on 7/23/19 at 2:56 p.m. When asked how the food was, Resident # 101 stated it tasted terrible and was cold when he got it. Resident #101 had a BIMS of 13, indicating he was capable of making daily cognitive decisions.

On 07/24/19 at approximately 1:00 p.m., a test tray consisting of chicken breast, mashed potatoes, and egg noodles with mushrooms, peas, chopped chicken breast, pureed chicken breast and pureed mixed vegetables was placed in the food cart and was sent to the West 2 Unit. The food cart was followed by 2 surveyors and OSM (other staff member) # 6, dietary manager from a sister facility. At approximately 1:15 p.m., the last lunch tray was served to a resident on the West 2 Unit. At this time, OSM # 6 was asked to remove the test tray from the food cart. OSM #6 removed the tray, placed it on top of a rolling table, and proceeded to take the temperatures of the food. OSM # 6 was observed obtaining the test tray, food temperatures using a facility thermometer. The chicken breast was 138 degrees F (Fahrenheit), mashed potatoes were 143 degrees F, egg noodles with mushrooms were 193 degrees F, peas were 130 degrees F, chopped chicken breast was 131 degrees F, pureed chicken breast was 149 degrees F and the pureed mixed vegetables were 144 degrees F. Two surveyors and OSM #6 sampled the test tray for appropriate holding temperatures and palatable taste. When asked to describe the taste of the pureed chicken breast, OSM # 6

F 804

made to ensure the deficient practice will not recur; Tray line temperatures are monitored and recorded to ensure that the food items are served at a safe/appropriate temperatures. Resident test trays will be conducted weekly x2. Resulting temperatures will meet guideline of 135 degrees tray temperature. Dietary manager or designee will conduct pre-meal tray-line meetings to ensure the cook and staff are knowledgeable and able to prepare and plate for optimum temperature, presentation, and palatability. Dietary Manager or kitchen staff will offer to reheat resident meals upon request, and residents are also offered alternate meal.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; On a weekly basis the Administrator/Designee will review the daily findings and corrective measures enacted for the previous week period. This monitoring will continue x 4 weeks, Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations quarterly x 2 quarters.

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stated, "It's a pasty taste." When asked about the holding temperatures of the peas and chopped chicken breast, OSM # 6 stated, "It's not warm enough."

On 07/24/19 at 4:13 p.m., an interview was conducted with OSM # 6. OSM # 6 was asked about the procedure for ensuring appropriate temperatures and palatability for the resident's food. OSM # 6 stated, "The cook is to taste all the food after preparing it and ask a manager or coworker to also taste the food because it may taste fine for one person but not another. If not palatable, you would adjust it by adding more food product to enhance the flavor. It couldn't be fixed or adjusted they would make another batch.

Mid way through the line service line, you would retemp (retake temperatures) the food because the food may stay in the hallway for a period before the food is served. When asked if these processes followed for the meal observed OSM # 6 stated, "No."

The facility policy, "Food: Quality and Palatability"" documented in part, "Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature."

On 07/24/19 at approximately 6:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

Complaint deficiency

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store and prepare food in a sanitary manner in the facility kitchen. 1. The facility staff failed to store dry goods available for use, in a manner that maintains the integrity of the product and ensure items were not held beyond their use by date. 2. The facility staff failed to ensure proper disposal of gloves in the dry storage area. 3. The facility staff failed to ensure that available for use cooking utensils were stored in a clean location.	F 812	F812 1. Address how corrective action will be accomplished for those residents affected by deficient practice; Kitchen operations will utilize the Opening Checklist which identifies sanitation needs, storage area condition, and sanitation of service areas including surfaces, cookware, glassware, and utensils. 2. Address how facility will identify other residents potentially affected by deficient practice; The deficient practice cited potentially affects residents of the facility. 3. Address what MEASURES will be put	8/25/19

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4. The facility staff failed to ensure that cookware was arranged properly when drying and juice glasses were properly dried prior to storage.

5. The facility staff failed to store refrigerated foods available for use, in a manner that maintains the integrity of the product and ensure items were not held beyond their use by date in the walk-in refrigerator in the kitchen.

The findings include:

1. The facility staff failed to store dry goods available for use in a manner that maintains the integrity of the product and ensure items were not held beyond their use by date.

On 07/23/19 at approximately 12:50 p.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 6, dietary manager. OSM #6 stated that she was filling in for the dietary manager assigned to the facility for the week.

An observation of the kitchen area revealed a six-quart plastic container of cookies covered with plastic wrap, available for use, sitting on top of a food prep table. Further observation of the container failed to evidence a date when the cookies were placed in the container. Further investigation in the kitchen area revealed three covered five-gallon buckets on the shelf underneath a food prep table, available for use. Bucket #1 was identified as flour by OSM #6. The product scoop was inside of the bucket touching the flour. When asked about the scoop, OSM #6 stated, "It should not be in the bucket,

F 812

in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Kitchen staff will be re-in-serviced on proper labelling and storage of dry goods when delivered, and/or opened applying an open-date, use-by-date. Kitchen staff will be in-serviced on how to properly reseal products that have been opened and still available for reuse. The dietary manager will conduct a dining services checklist/audit 5x per week on kitchen morning rounds form x 4 weeks.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; On a weekly basis the Administrator/Designee will review the daily findings and corrective measures enacted for the previous week period. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations, quarterly x 2 quarters.

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touching the product." OSM #6 immediately removed the scoop from the bucket. On the same food, preparation table a 16-ounce container labeled "beef base" was noted without a lid leaving the product open to air. OSM #6 confirmed it was not being used, was about three quarters full and should have a lid or be covered to protect it from contaminants. OSM #6 immediately removed the product.

Observation of the dry storage area in the kitchen revealed one 16 ounce box of Bisquick with one half of the box remaining and one 12 ounce gluten free box of elbow pasta with one half of the box remaining on the second shelf to the right side of the room. The Bisquick box was observed opened with the bag containing the mix open to air, the elbow pasta box was opened with the top pushed inside of the box leaving the box open to air, the pasta was observed not in a bag. When asked about the boxes, OSM #6 stated, "Anything opened should be dated, covered." Also on the second shelf were three 25-pound bags of dry pasta. Bag #1, was identified as spiral pasta, and was observed with approximately three quarters of pasta left the bag; bag #2 was identified as spiral pasta and had approximately two cups of pasta left in the bag. Bag #3 was identified as elbow noodles and had approximately one-half the noodles left in the bag. Further observation failed to evidence an open date on any of the bags of pasta. OSM #6 confirmed the bags were opened, and stated, "They (staff) should date them (bags of pasta) when they open them." On the third shelf, a five-pound bag of dry milk available for use with approximately one-third left in the bag was dated as opened on 3/26/2019, with a use by date of 6/26/2019. OSM #6 stated it should have been

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F 812	Continued From page 216 discarded. Further observation of the dry storage area revealed a tray containing ten covered four-ounce bowls of dry cereal sitting on a tray on the top shelf on the left side of room. Five of the bowls were dated 7/21/19 and five of the bowls did not have a date. A two-gallon zip-closure plastic bag was located on top of the bowls with approximately one third of the bag filled with cereal. OSM #6 confirmed that the five bowls and the two-gallon bag of cereal did not have a date. OSM #6 stated, "They should have a date." 2. The facility staff failed to ensure proper disposal of gloves in the dry storage area. An observation of the dry good storage area in the kitchen revealed two gloves on the second rack from the top of storage rack beside two boxes of tea bags. The gloves were turned inside out. When asked about the gloves OSM #6 stated, "They should not be there." OSM #6 agreed they appeared to be used gloves and removed them immediately. 3. The facility staff failed to ensure that cooking utensils available for use were stored in a clean location. An observation of the kitchen area revealed three 32-ounce plastic containers with plastic lid. Food debris and a glove were observed inside of one container and food debris were in the other two containers along with clean serving utensils. OSM #6 agreed that the containers holding clean serving utensils should not have food debris or gloves in them. OSM #6 immediately removed them from the area.	F 812		

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4. The facility staff failed to ensure that cookware was arranged properly when drying and juice glasses were properly dried prior to storage.

An observation of the kitchen area revealed two 32-ounce plastic containers stacked inside of each other, on the second shelf of a cart with four shelves. OSM #6 confirmed that they were on the drying rack. OSM #6 confirmed there was water on the inside of the bottom container. When asked about the containers, OSM #6 stated, "They have to be dried apart." Further observation revealed four large silver bowls stored inside of each other wet nesting, on the fourth shelf. OSM #6 confirmed that there was water on the first three bowls removed from inside each other. OSM #6 stated, "They should be air dried completely before being stored inside of each other." OSM #6 immediately removed the bowls from the area.

Further observation in the kitchen revealed three silver sheet pans stacked inside of each other on top of the food preparation table. On the sheet pans, were four-ounce clear plastic cups stacked upon each other with two to three cups in each stack. Observation revealed that 39 (thirty-nine) of the cups had moisture inside of the cups. OSM #6 confirmed the presence of water inside the cups and stated, "They should not be stacked like that until they are dry."

5. The facility staff failed to store refrigerated foods available for use, in a manner that maintains the integrity of the product and ensure items were not held beyond their use by date in the walk-in refrigerator in the kitchen.

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F 812	Continued From page 218 An observation in the walk in refrigerator of the facility's kitchen revealed a one gallon bottle of Italian dressing approximately one-third left full, a one gallon bottle of sweet relish with approximately four cups left in the bottle, a one gallon bottle of mayonnaise approximately half full, and a half full one gallon bottle of honey mustard dressing. All items were on the top shelf in the walk-in refrigerator and available for use. There were no opened dates observed on these bottles. OSM #6 confirmed that there were no open dates on the bottles and stated, "They should have been dated when opened." A four and one-half pound bottle of salsa available for use with approximately two cups left in the bottle was observed on the same shelf with a use by date of 7/3/2019. When asked about the salsa, OSM #6 stated, "It should have been thrown out" and discarded the salsa immediately. A three-pound box of cream cheese with approximately 16 ounces left was observed available for use on the second shelf uncovered. OSM #6 stated the cream cheese should be covered once opened and discarded the cheese immediately. Further observation of the walk in refrigerator revealed a ladder rack holding prepared covered four-ounce bowls without dates. OSM #6 confirmed the tray on the bottom shelf of the ladder rack consisted of two salad bowls, one apple crisp, one pureed apple crisp, one peach cup and five fruit cups and stated, "They should have been dated." Further observation of the walk in refrigerator revealed two covered four-ounce prepared bowls on the second shelf without dates. OSM #6 identified the bowls as chocolate pudding and	F 812		

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stated that they should be dated. The bottom shelf revealed a one-gallon plastic zip-closure bag with 21 hot dogs inside. OSM #6 confirmed they were hot dogs and stated, "They should have dated the bag."

On 7/23/19 at 5:07 p.m., an interview was conducted with OSM # 6, dietary manager regarding the finding in the kitchen. When asked the process for drying cookware OSM #6 stated, "After they wash them the clean dishes go there stacked to dry. The purpose of stacking them one by one is so they are not wet nesting (1)." When asked why it is important to ensure cookware is not wet nesting, OSM #6 stated, "It is a cross contamination risk, infection control. This is why we have to air dry before stacking." When asked about the process for storing dry goods, OSM #6 stated, "When we open up dry goods it has the date that it comes in on it, you are supposed to date it three months from the date that you open it so that everybody knows the time you opened it. If it is not dated, you know when you received it, but not when it expires. It is very important to put the date that you open it and the three months out." When asked about the placement of the scoop for dry goods, OSM #6 stated, "The scoops are supposed to be in a Ziploc bag clean and dry not in containers. They should not be in contact with the product only if you are using it." When asked about glove use in the dry storage area, OSM #6 stated, "No, the used gloves on the shelf are an infection control issue, they should be thrown in the trash." When asked about storage of cooking utensils after cleaning, OSM #6 stated, "Storage bins should be cleaned on a daily basis, they go through the dishwasher with the utensils, and the tops should

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be secure on them."

The facility policy "Glove Usage" notes "How to properly remove gloves. Take glove by the cuff and pull up over your hand (should be turned inside-out when done). Discard first glove. Remove and discard the second glove in the same manner. Wash hands."

The facility policy "Manual Warewashing" notes "3. All serviceware and cookware will be air dried prior to storage."

The facility policy "Food Storage: Dry Goods" notes "Storage areas will be neat, arranged for easy identification, and date marked as appropriate."

The facility policy "Food Storage: Cold Foods" notes "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination."

On 7/24/19 at approximately 6:30 p.m., ASM # 1 (administrative staff member), administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. The Food Code requires that items must be allowed to air dry before being stacked or stored. Stacking wet items, such as pans and dishes, prevents them from drying and might allow an environment where microorganisms can begin to

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F 812	Continued From page 221 grow. Stacking dishes before they are dried is called wet-nesting. This information was obtained from the website: http://www.foodsafetysite.com/consumers/faq/index.html?m_knowledgebase_article=650	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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;	F 880		8/25/19

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F 880	Continued From page 222 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement infection control practices for one of	F 880	F880 1. Address how corrective action will be accomplished for those residents affected by deficient practice; The unprotected O2	

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54 sampled residents, (Residents #20); in one of three dining rooms, (Bistro); and in three of 12 bathrooms on the West one unit, (the shared bathrooms, between resident rooms 81 and 83, 85 and 87 and 64 to 66). During separate observations Resident #20's oxygen tubing and mask were observed uncovered and hanging over the handle of the oxygen tank. The facility staff touched plates on the food contact surfaces and handled food with their bare hands in the Bistro dining room during observation of the dinner meal. Bedpans were observed stored uncovered and nested inside of each other and directly on the floor in the shared bathrooms between resident rooms 81 and 83, 85 and 87 and 64 to 66, on the West one unit.

The findings include:

1. The facility staff failed to store oxygen equipment that was available for use, in a sanitary manner for Resident #20.

Resident #20 was admitted to the facility on 7/1/18 with a recent readmission on 7/15/19, with diagnoses that included but were not limited to: frequent falls, diabetes, high blood pressure and Parkinson's disease [a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability] (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/18/19,coded the resident as scoring a "6" on the BIMS (brief

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mask and cannula were removed from the resident area. Upon receipt (knowledge) of this incident, staff serving meals and food items to resident were inserviced and directed to appropriate food and food containers handling. The bedpans located in the bathroom were removed.

2. Address how facility will identify other residents potentially affected by deficient practice; Resident utilizing oxygen in the faculty could potentially be affected by this practice. Any resident that is served their meals in the dining areas are potentially affected by the improper handling of plated meals. Any resident who relies on bedpan usage and staff handling of soiled bedpans are potentially affected. The unsafe, unsanitary, storage/disposal of bedpans would potentially affect these and other residents.

3. Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; Nursing staff was re-educated on proper storage of oxygen, re-educated on proper storage of bedpans and infection control practices. Oxygen storage will be monitored during Care Keeper Rounds 5x per week by 4 weeks. Dietary staff was re-educated on infection control practice re handling of plated food.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained; Care Keepers will monitor storage of oxygen, sanitary conditions of resident bathrooms, and infection control

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interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was not coded in Section O - Special Treatments, Procedures and Programs for the use of oxygen.

On 7/23/19 at 1:06 p.m., observation was made or Resident #20's room. An oxygen tank, in the stand, was located against the wall near the resident's bed. There was tubing and an oxygen mask hanging over the handle of the tank. The tubing and mask were not covered.

On 724/9 at 8:36 a.m., a second observation was made of Resident #20's room. The oxygen tank remained in the room, with the tubing and oxygen mask uncovered.

On 7/24/19 at 4:57 p.m., LPN (licensed practical nurse) #1, was shown the tank and tubing. When asked if the oxygen mask was stored properly, LPN #1 stated, "It should be in a bag." When asked if it was available for use, LPN #1 stated, "Yes."

On 7/25/19 at 6:45 p.m., a policy on the storage of respiratory equipment was requested from the administrator, Administrative staff member (ASM) #1. On 7/26/19 at 8:57 a.m., ASM #1 confirmed the facility does not have a policy, but storage of oxygen equipment is monitored every day during care keeper rounds conducted by ten key personnel.

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing were made aware of the above finding on 7/24/19 at 6:32 p.m.

practices 5x per week, and report in the Morning Meeting process. Admin/dietary manager audit 3 meals per week to ensure proper staff handling/serving of food items. Negative patterns will be presented and discussed at the QAPI monthly/quarterly meeting for reviews/recommendations x 2 quarters.

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.

2. The facility staff failed to serve food to residents in a sanitary manner during a dinner dining room observation of the Bistro Dining Room.

On 7/23/19 between 5:02 PM and 5:45 PM, an observation was conducted of the Bistro Dining Room. CNA (Certified Nursing Assistant) #5, CNA #6, and CNA #7 were observed touching the food -contact surface area, of the rim of the plates with their bare hands as each retrieved resident food trays from the warmer cart and placed the plates on the table. CNA #7 was observed removing a straw from the wrapper with his bare hands and place the straw in a resident's cup. CNA #7 was observed placing butter on a resident's biscuit by holding the biscuit with his bare hand.

On 7/26/19 at 9:01 AM, an interview with CNA #3 was conducted. CNA #3 was asked about the process for serving residents in the dining room. CNA #3 stated, "We wash our hands or sanitize our hands and take the tray to table and set it up." When asked about the process for removing plates from the tray, CNA #3 stated, "I put my hands under the plate so I don't touch the food. Then I remove the drinks and silverware." When asked what happens when a server touches the food contact area, CNA #3 stated, "It would be contaminated and we would need to get another one."

On 7/26/19 at 9:05 AM, an interview with CNA #11 was conducted. When asked about the process for serving residents in the dining room,

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CNA #11 was she stated, "You are supposed to go by tables and each tray you pass you are to sanitize your hands. After three trays, you wash your hands. Then leave the assistance resident's food on the cart until staff is free to feed them." When CNA #11 was asked about the process for removing the plates from the tray, CNA # 11 stated, "We take everything off the tray and check it by the ticket. We set it up, the sugar, the salt, and butter for the biscuits." CNA #11 was asked what happens if a server touched the food-surface contact area. CNA #11 stated, "That would be infection control. They need to get a new plate." When asked if a server should butter a biscuit with their bare hands, open a straw by touching it with their bare hands and then place it into a resident's cup, CNA #11 stated, "No, it is infection control. They need to get a new cup and plate of food."

A review of the facility policy "Diet Manual" documented in part, "Policy Statement: It is the center policy to use an approved diet manual ..." The policy did not include any criteria for serving food to the residents in a sanitary manner.

On 7/24/19 at 6:35 PM, ASM # 1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings.

No further information was provided by the end of the survey.
3. The facility staff failed to store bedpans in a sanitary manner in three of 12 bathrooms on the West One Unit.

On 7/23/19 at 2:28 p.m., an observation of the shared bathroom between resident rooms 81 and 83 revealed two plastic bedpans sitting on the

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floor to the left of the toilet facing the door to room 81. The bedpans were uncovered and nested inside of each other. Additional observations on 7/23/19 at 4:30 p.m., 7/24/19 at 8:00 a.m. and 7/24/19 at 2:05 p.m. revealed the findings above.

On 7/23/19 at 2:47 p.m., an observation of the shared bathroom between resident rooms 85 and 87 revealed two plastic bedpans sitting on the floor to the left of the toilet facing the door to room 85. The bedpans were uncovered and stacked one of top of the other. Additional observations on 7/23/19 at 4:32 p.m., 7/24/19 at 7:55 a.m. and 7/24/19 at 2:03 p.m. revealed the findings above.

On 7/24/19 at 5:00 p.m., an observation of the shared bathroom between resident rooms 64 to 66 revealed two plastic bedpans sitting on the floor to the left of the toilet with a wash basin inside of the top bedpan. The bedpans were uncovered and nested inside of each other. Additional observations on 7/24/19 at 6:05 p.m. revealed the findings above.

On 7/24/19 at 11:24 a.m., an interview was conducted with CNA (certified nursing assistant) #2 regarding bedpans. When asked why bedpans are used, CNA #2 stated that bedpans are used for residents to go to the bathroom so they do not go on themselves when they cannot get to the toilet. When asked how bedpans are stored, CNA #2 stated that they are stored in a plastic bag in a drawer, usually a drawer in the room like in their closet. When asked why they are stored that way, CNA #2 stated, "Contamination issues, we write the room number and bed on the bag. They could contaminate

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	495240	A. BUILDING ______ B. WING ______	C 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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clothes, laundry, sheets or dresser."

On 7/24/19 at 2:00 p.m., an interview was conducted with CNA #3 regarding bedpans. When asked why bedpans are used CNA #3 stated, "a few residents use them, some for urine and some for bowel movements." When asked how bedpans are stored, CNA #3 stated that they are stored in bathrooms in plastic bag with names on the bags. When asked why they are stored that way, CNA #3 stated, "To keep clean, keep germs off." CNA #3 agreed that if bedpans are not stored that way there is a risk of cross contamination and infection control risk. CNA #3 was asked observe the bed pans in the shared bathrooms for rooms 81 to 83 and 85 to 87. Observation of the bathrooms revealed the bedpans remained on the floor as documented above. CNA #3 stated, "I saw those, I don't use them. I get residents up in the wheelchair to go to the bathroom, I meant to throw them away but keep forgetting. I go to do something else and forget. They should be thrown away."

On 7/24/19 at 2:10 p.m., an interview was conducted with LPN (licensed practical nurse) #3 regarding bedpans. When asked why bedpans are used, LPN #3 stated for residents to go to the bathroom. When asked how bedpans are stored, LPN #3 stated that they are stored in bathrooms in plastic with a number on them. When asked why they are stored that way, LPN #3 stated, "To keep clean, sanitary reasons." LPN #3 agreed that if bedpans are not stored that way there is a risk of cross contamination and infection control risk. LPN #3 was asked observe the bed pans in the shared bathrooms for rooms 81 to 83 and 85 to 87. Observation of the bathrooms revealed the bedpans remained on the floor as documented

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	495240	A. BUILDING ______ B. WING ______	C 07/26/2019

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above. LPN #3 stated, "Nothing should be on the floor ever. Somebody should have checked it, we will get it taken care of." LPN #3 asked CNA #3 to throw the bedpans away.

The facility policy "Guidelines for Disposable Resident Care Items" notes under Procedure "1A. Examples of multiple-use disposable items include rigid plastic items; such as, bed pans, basins, urinals and water pitchers. 3. Multiple use disposable items should also be easily identified as belonging to the specific resident using the item either by labeling or geographic locations where the item is stored. The item must be easily identified by the facility staff or the item is disposed of and a new one is issued with proper resident information labeling the object."