STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	C 08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/20/19 through 08/22/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/20/19 through 8/22/19. Four complaints were investigated during 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 60 certified bed facility was 51 at the time of the survey. The standard survey sample consisted of 32 current resident reviews and 6 closed record reviews.	F 000		
F 580 SS=E	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);	F 580		10/5/19

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

Electronically Signed | 09/13/2019

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, 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 a complaint investigation, staff interview, facility documentation review, and clinical record review, the facility staff failed notify	F 580	F580 Resident #202 was discharged from the facility on 03/21/2019.	

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F 580	Continued From page 2 1 of 38 residents in the survey sample, Resident #202, Responsible Party of changes in condition. The findings included: The facility staff failed to notify Resident #202's Responsible Party (RP) of facility acquired pressure ulcers. Resident #202 was originally admitted to the facility on 06/08/14. Resident #202 was discharged to the hospital on 03/21/19. Diagnoses for Resident #202 include but not limited to Disruption of wound and Vascular dementia without behavioral disturbance. Resident #202's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 01/30/19 coded Resident #202's Brief Interview for Mental Status (BIMS) a 99 indicating short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. In addition, the MDS coded Resident #202 total dependence of one with bathing, personal hygiene and dressing, extensive assistance of two with bed mobility, extensive assistance of one with eating and toilet use for Activities of Daily Living care. The MDS was also coded under section M-skin condition for having one (1) stage two (2) pressure ulcer. The MDS also included the use of a pressure-reducing device of bed and pressure ulcer treatment care. Resident #202's person-center comprehensive care plan with a revision date of 02/14/19 documented the resident with actual alternation in skin integrity, pressure ulcer stage II to left buttocks (proximal) and left buttocks stage II (distal). The goal: pressure ulcer will show signs of improvement by the next review (03/03/19).	F 580	All residents with pressure injuries and/or experiencing unplanned significant weight loss have the potential to be impacted. Facility wide audits are being conducted by the Director of Nursing (“DON”) and Assistant Director of Nursing (“ADON”) to identify current residents who have experienced unplanned significant weight loss over the past 90 days as well as current residents with pressure injuries that developed or worsened over the past 90 days; confirming timely notification of the resident and/or responsible party (RP) as well as the physician. The findings will be promptly addressed and forwarded to QAA for processing. The facility has reviewed its’ “Physician Notification” and “Changes to Resident’s Condition” (both of which address notification of the resident, responsible party and physician) policies; ensuring clarity. No revisions are needed. All licensed nurses (which include full time, part time and active per diem nurses) will be re-educated by the DON or ADON to the above noted policies which address communication with above parties when changes in a resident’s condition occurs inclusive of pressure injuries and unplanned, significant weight loss by 10-5-19. The facility will review unplanned, significant weight loss and pressure injuries weekly during its weekly “Resident at Risk” meetings; which will include verification that Resident, RP and/or Physician notification has occurred in accordance with aforementioned policies. Findings will be promptly addressed, documented and forwarded to	

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F 580	Continued From page 3 Some of the intervention/approaches to manage goal included: please do all my treatments the way my MD/NP has ordered on the TAR (treatment administration record), please help me avoid positions that places pressure on existing ulcers as much as possible and please check my dressings and if soiled or falling off-replace as needed. Review of Resident #202's Treatment Administration Record (TAR) for March 2019 included the following order: -01/02/18 - Check and Ensure Functioning of low air loss pressure relieving specialty mattress every shift. Review of the clinical record revealed the following pressure ulcers: -Weekly Skin Integrity Review Form dated 01/29/19 indicated the following: Left buttock pressure ulcer (distal) measuring 1 cm x 3 cm x 0.1 cm - stage II. -Clinical note dated: 02/06/19 - during care noted a 4 cm x 2 cm open area to upper left buttock (proximal), treatment done as per standing order: cleaned with soap and water, rinsed and dried, applied Z-Guard paste and dry dressing - area with no infection or drainage noted from area; on call physician notified. -Clinical note dated 02/07/19: measurements for left buttocks (proximal) measuring 3 cm x 2.2 cm, wound bed beefy red with peri-area white, non-painful when doing treatment. Physician notified with new order: clean with dermal wound cleanser (DWC), pat dry, apply calcium alginate to wound bed and cover with dry dressing every shift.	F 580	QAA for processing. The Licensed Nursing Home Administrator (“LNHA”) is responsible for the Plan of Correction (“POC”) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) Monday through Friday clinical dashboard and 24 hour report review by the DON and/or ADON specific to unplanned, significant, weight loss and pressure injuries development or worsened; confirming documented resident, RP and physician notification of resident changes. b) Weekly “Resident at Risk” meetings will include a review of residents with unplanned, significant weight loss and pressure injuries; confirming documented notification of the resident, RP and/or physician of the same. Findings will be addressed promptly and forwarded to the QAA team for processing and review. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	

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Review of the clinical record revealed the following pressure ulcers:
-Weekly Skin Integrity Review Form dated 02/12/19 indicated the following: sacrum pressure ulcer measuring
3 cm x 2 cm x 0.1 cm - stage II.

Review of Resident #202's clinical note dated 03/01/19 at approximately 10:36 p.m., revealed the following documentation. A pressure ulcer noted to back of upper left shoulder measuring 1 cm x 2 cm open area and a 1 cm x 2 cm open area to the top of the left shoulder, areas cleaned with wound cleanser, covered with dressing; areas with no s/s of infection to either area.

Review of Resident #202's clinical note dated 03/12/19 at approximately 10:20 p.m., revealed the following documentation. The left shoulder open areas are healed; will continue treatment x 3 days to assure areas stay closed.

During the review of Resident #202's clinical record did not show evidence that Resident #202's Responsible Party (RP) was notified of the following pressure ulcers: left buttocks (distal and proximal), sacrum and upper shoulder and the upper back of the left shoulder.

The Administrator, Regional Nurse and Director of Nursing was informed of the finding during a briefing on 08/22/19 at approximately 5:00 p.m. The facility staff did not present any further information about the findings.

The facility's policy titled Change in a Resident's Condition or Status (Revision date 2015. Vero Health and Rehab 2017).

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-Policy statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (spouse) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.).
4. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when:
-The resident is involved in any accident or incident that results in an injury including injuries of an unknown source.
-There is a significant change in the resident's physical, mental, or psychosocial status.
5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/condition or status.

The facility staff also failed to notify Resident # 202's RP of significant weight loss. Resident #202's comprehensive person centered care plan revised on 01/3/19 documented Resident #202 with significant weight loss due to imbalanced nutrition related to disease process/dementia as evidence by cognitive loss. The goal: supplements as ordered, weight per protocol, Registered Dietitian (RD) to evaluate and make diet change recommendations as needed, provide diet at ordered (pureed/regular), provide food in bowls per order, monitor intake-record meal percentage, monitor and report to physician-significant weight changes and assist with feeding as needed.

Review of the clinical record revealed the following dietary note dated: 1/31/19-Late entry note: January weight triggered for significant loss

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of 8.51% in one month and 13.42% in 6 months. She receives 120 ml by mouth three times daily (TID) for nutritional support. She needs to be fed by staff. Multivitamin with minerals in place. Recommend Prostat 30 ml by mouth TID to aid in healing and provide additional calories/protein.

Review of Resident #202's Physician Order Sheet (POS) for August 2019 included but not limited to the following:
-Dietary diet - Fortified foods -pureed texture, thin liquids consistency -starting on 06/22/18.
-Dietary supplements - MedPass - three times a day for supplement 120 ml - starting on 10/08/18.
-Push fluids - 240 cc every 4 hours for hydration starting on 04/14/18.
-Prostat 30 ml by mouth three times daily for supplement starting on 02/01/19.
-Weekly weights every day shift related to feeding difficulties starting on 02/01/19.

Review of the Nutrition Evaluation Initial and Annual Assessment was completed on 02/22/19 revealed the following information:
-Current weight @ 118.2.
-Medications: Multivitamin with minerals, Metoprolol, Iron, Vitamin C.
-Diet Order: Puree/regular
-Usual intake - 50%
-Eats in restorative.
-At risk for: nutritional decline r/t dementia and advance age (98).
Summary: 98 year old female, significant change. February weight triggered for significant weight loss of 11.53% in 3 months, and 15.69% in 6 months. She has needed fluids due to abnormal labs. She was started on prostate due to wound. She receives MedPass for nutrition support. Current diet, pureed regular. Oral

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intake has been poor and need to be fed by staff. Oral intake and weight loss may be unavoidable due to dementia and disease trajectory.

Review of the physician progress note dated 03/14/19 included the following documentation: dietitian consult for poor oral intake. Patient does have current noted weight loss, patient weight on 02/20/19 @118.2 and weight on 03/08/19 @ 118. The staff to feed Resident #202, resident has poor intake of fluids as well as nutrition. The patient's dementia has continued to advance of which it is expected to do so as the patient advances in age.

Review of the physician progress note dated 03/19/19 included the following documentation: the patient is currently refusing fluids as well as meals, the resident responsible party made aware of patients change in condition.

The review of Resident #202's clinical record revealed that the Responsible Party (RP) was not notified of the resident significant weight loss that initially started on 12/17/18. Her weight on 12/17/18 was 127.2 lbs., and her weight on 3/20/19 was @ 102 lbs., that indicated:
-10% change (comparison weight) 09/28/18, 133.6 lbs., 23.7%, -31.6 lbs.
-7.5% change (comparison weight) 12/20/18, 124.8 lbs., 18.3%, -22.8 lbs.

An interview was conducted with the DON and Regional Nurse on 08/22/19 at approximately 10:35 a.m. The surveyor asked if Resident #202's RP was made of aware of Resident #202's significant weight loss that was first identified on 12/17/18 and continued to lose weight until discharged to the hospital on 03/21/19. The

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F 580	Continued From page 8 Regional Nurse replied, "I am unable to provide written documentation/evidence that the RP was made aware of Resident #202's weight loss. Complaint deficiency.	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 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	F 584		10/5/19

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F 584	Continued From page 9 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, staff interview, clinical record review and facility document review, it was determined that facility staff failed to ensure a clean, comfortable and homelike environment for two of 38 residents in the survey sample, Resident #5 and #11. The findings included: 1. Facility staff failed to ensure Resident #5's reclining chair was free from a large rip located directly where his head rests, prior to placing him in the chair. Resident #5 was admitted to the facility on 8/24/04 and readmitted on 9/17/18 with diagnoses that included but were not limited to cerebral palsy, severe intellectual disability, and high blood pressure. Resident #5's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 8/7/19. Resident #5 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status exam. On 8/20/19 at 11:16 a.m., Resident #5's reclining chair was out in the hallway with his name on the chair. The middle of the chair, just below the head rest had a large rip in it exposing the white cushion underneath. At 11:35 a.m., Resident #5's	F 584	F584 Resident #5's chair will be repaired and/or replaced. A clean cubicle curtain has been hung in Resident #11's room. All residents have the potential to be impacted. The facility Housekeeping Manager conducted environmental rounds of all cubicle curtains; confirming them to be clean. The facility Maintenance Director conducted an audit of all resident recliner chairs; confirming all to be in good condition and free of disrepair. Findings will be addressed, repaired, and /or replaced and forwarded to the QAA committee for processing. A review of the facility's policy "Homelike Environment" was conducted; ensuring clarity. No revisions are needed. The LNHA re-educated the housekeeping and maintenance directors to the policy. In turn, the housekeeping and maintenance director swill educate their department staff to the policy and expectations. Room rounds conducted Monday through Friday have been enhanced to include a	

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F 584	Continued From page 10 assigned nursing aide was observed pulling the chair into Resident #5's room. The nursing aide shut the door to his room. On 8/20/19 at 11:52 a.m., Resident #5 was observed sitting up in the ripped chair. Resident #5 head was sitting right in the center of the large tear. Resident #5's nursing aide then proceeded to push the Resident down the hallway in the chair. On 8/20/19 at approximately 2:30 p.m., Resident #5 was observed in the same ripped reclining chair. On 8/21/19 at 11:15 a.m., Resident #5 was observed to have a new reclining chair. Review of the facility's maintenance logs failed to evidence a work order request for an new reclining chair. On 8/21/19 at 4:42 p.m., an interview was conducted with CNA (certified nursing assistant) #2. When asked the process if he were to see large rips in a resident's reclining chair, CNA #2 stated that he would let maintenance know about the chair and request a new one. CNA #2 stated that the nursing aides are responsible for cleaning the chairs and that a ripped up chair would be hard to clean. CNA #2 stated that a ripped up chair was not clean or homelike. CNA #2 stated that he did not work with Resident #5 on a regular basis. CNA #2 stated that he had never seen Resident #5's chair but that he overheard staff talking about his chair last Saturday (8/17/19). On 8/21/19 at 4:52 p.m., an interview was conducted with OSM (other staff member) #4, the Director of Maintenance. OSM #4 stated that he is usually made aware by floor staff if a new reclining chair is needed for a resident. OSM #4 stated that a work order is usually submitted.	F 584	review of cubicle curtains and recliner chairs. Findings are reported promptly to the LNHA and/or DON during the morning stand up meeting. Findings will be addressed promptly and forwarded to the QAA committee for processing. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the on-going monitoring of this process as follows: a) Monday through Friday documented room rounds performed by the housekeeping staff weekly x 2 then monthly x 2 will be conducted which will include a review of cubicle curtains and recliner chairs. b) The Housekeeping Director will conduct weekly documented environmental rounds with a focus on cubicle curtains weekly x 4 then monthly x 2. c) At least quarterly, the LNHA will conduct environmental rounds; ensuring cubicle curtains and reclining chairs are clean and in good repair. Findings will be promptly addressed and forwarded to the QAA committee. The QAA committee will determine the frequency of continued ongoing monitoring thereafter. Date of Compliance: 10/05/2019	

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OSM #4 stated that he was not made aware that Resident #5 needed a new reclining chair until that morning of 8/21/19. OSM #4 stated that he took care of the problem right away and replaced his chair. OSM #4 stated that the scheduler (OSM #5) made him aware that Resident #5 needed a new chair.

On 8/21/19 at 4:57 p.m., an interview was conducted with OSM #5, the facility scheduler. OSM #5 stated that she had noticed the large tear in Resident #5's recliner and then she made the administrator aware that morning. When asked if a rip of that size was something that could have just happened over night, OSM #5 stated, "It could have just happened over night." When asked if it was clean, comfortable or homelike for the resident's head to be lying directly on the large tear, OSM #5 stated, "No. That is why I didn't like that."

On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. No further information was presented prior to exit.

2. Facility staff failed to ensure that Resident #11's bedroom/cubicle curtain, remained free of excessive soiling.

Resident #11 was admitted to the facility on 9/11/2015. The latest diagnoses included, but not limited to, peripheral vascular disease, (unspecified), gastro-esophageal reflux disease without esophagitis, acquired absence of left leg above knee, acquired absence of right leg below knee type 2 diabetes mellitus with diabetic

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chronic kidney disease, peripheral vascular disease, Alzheimer's disease, major depressive disorder, recurrent.

Resident #11's most recent MDS (minimum data set) assessment was a quarterly review assessment with an ARD (assessment reference date) of 5/28/2019. Resident #11 was coded as being intact in cognitive function scoring 10 out of possible 15 on the BIMS (brief interview for mental status) exam.

A resident room initial screening activity on 8/20/2019 at approximately 12:27 p.m. yielded observations that the privacy curtain around the bed of resident #11 as heavily soiled with brown spots and splotching throughout the bed curtain. On 8/21/2019 at approximately 11:30 a.m., an interview was conducted with Resident #11. When asked about the condition of his bed curtain, he responded, "it bothers me."

During an interview conducted on August 22, 2019 at approximately 11:02 a.m. with Other Administrative Staff #7, Housekeeping Director, when asked about facility policy regarding maintaining cleanliness of bed curtains, his response was, "Conduct daily checks, utilize replacement curtains and document daily."

Facility policy regarding Cleaning Cubicle Curtains included:

"1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and wen these surfaces are visibly soiled.

2. Environmental surfaces will be disinfected (or

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F 584	Continued From page 13 cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 11. Clean curtains, window blinds, and walls when they are visibly soiled or dusty." Facility Housekeeping policy included: "Examine curtains while doing QCI or at discharge. If curtain is stained, remove immediately, If Curtain is torn-replace If curtains are off hooks, repair ... Wash cubicle curtains annually. The facility Executive Director was made aware of the soiled bed curtain observation during a briefing conducted on 8/22/2010 at approximately 2:05 p.m. No further information was provided."	F 584		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622		10/5/19

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(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)

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F 622	Continued From page 15 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Facility staff failed to ensure the required documentation was sent upon transfer to the hospital for seven of 38 residents in the survey sample, Resident #12, #20, #48, #40, #34, #200 & #11. The findings included:	F 622	F622 Residents #12, #20, #48, #40, #34 and #11 have returned to the facility following the identified hospital transfers and remain at baseline. Resident #200 no longer resides in the facility. All licensed nurses (which includes full time, part time	

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F 622	Continued From page 16 1. Resident #12 was admitted to the facility on 10/21/15 and readmitted on 6/4/19 with diagnoses that included but were not limited to heart failure, high blood pressure, and dementia. Resident #12's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 8/12/19. Resident #12 was coded as being severely impaired in cognitive function scoring 99 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #12's nursing notes revealed that Resident #12 had been sent out to the hospital on 8/2/19. The following note in part was documented, "...Resident exited facility apprx (approximately) 830am. Son, (Name of son) contacted and aware of patient change of condition. Resident was admitted to (Name of hospital) r/t (related) CHF (congestive heart failure) and pneumonia." Further review of Resident #12's clinical record revealed that he returned to the facility on 8/6/19. There was no evidence in the clinical record that Resident #12's care plan or care plan goals were sent with Resident #12 at the time of transfer to the hospital. On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked what documents were sent with residents when they are transferred to the emergency room, RN #1 stated that nurses will send the resident's face sheet, transfer summary sheet, a list of current medications, bed hold notice, and any pertinent tests, orders. When asked if care plan goals or the care plan was sent with	F 622	and active per diem) will be re-educated to the facility's policy on "Transfer or Discharge, Emergency" and the expectation of documenting the provision of a transfer form, face sheet, advance directives, care plans and/or care plan goals with the resident at the time of unplanned, emergent transfers and/or discharges. All residents who have been emergently transferred or discharged from the facility have the potential to be impacted. The facility will conduct a review of all residents who emergently transferred and/or discharged from the facility in the past thirty (30) days; ensuring the documentation specific to the provision of a transfer form, face sheet, advance directives, care plans and/or care plan goals with the resident at the time of this transfer/discharge. Findings will be recorded and forwarded to QAA for processing. The facility has reviewed its' "Transfer or Discharge, Emergency" policy; ensuring clarity. The facility will enhance the above noted policy to more clearly denote documents that should accompany the resident at the time of the emergent transfer as well as the documentation of said provision of documents. All licensed nurses (which include full time, part time and active per diem nurses) will be re in-serviced on the above policy by the DON or ADON before 10/05/2019. The facility will review all emergency transfers and discharges during the next business	

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F 622	Continued From page 17 residents upon transfer to the hospital, RN #1 stated that she would have to get back to this writer on that one. When asked if she (RN #1) has ever sent care plan goals with a resident upon transfer to the hospital, RN #1 stated, "I have not done that." On 8/21/19 at 2:24 p.m., an interview was conducted with OSM (other staff member) #6, the MDS nurse. OSM #6 stated that she could not find evidence that care plan goals were sent for Resident #12 at the time of transfer. OSM #6 stated, "We have not been implementing that." On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. No further information was presented prior to exit. 2. Resident #20 was re-admitted to the facility on 6/28/19 with diagnoses that included but were not limited to Alzheimer's disease, fractured femur, and muscle weakness. Resident #20's most recent MDS (minimum data set assessment) was a significant change assessment with an ARD (assessment reference date) of 7/4/19. Resident #20 was coded as being severely impaired in cognitive function scoring 05 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #20's clinical record revealed that she had gone out to the hospital on 6/25/19. The following note in part was documented, "...Resident sent out to ER (emergency room), RP (responsible party) made aware. Resident admitted...with dx (diagnosis) of fracture right	F 622	day during stand up; confirming the documented provision of the above documents at the time of emergency transfer/discharge. The facility will review its' licensed nurse general orientation process confirming the inclusion of the "Transfer or Discharge, Emergency" policy and the expectations. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The DON and ADON will review the clinical dashboard and 24-hour report Monday through Friday which includes a review of emergency transfers and discharges. This review will confirm the documentation of the provision of a transfer form, face sheet, advance directives, care plans/care plan goals with the resident at the time of the transfer/discharge per policy. b) Weekly during "Resident at Risk" meetings, the DON and/or ADON will review emergent resident transfers or discharges; ensuring the documentation of the provision of a transfer form, face sheet, advance directives, care plans/care plan goals with the resident at the time of the transfer/discharge. c) The DON and/or ADON will report emergent transfers and discharges monthly to the QAA team for a minimum of three (3) months and then quarterly thereafter; confirming compliance with the facility's policy and process and responsive action.	

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F 622	Continued From page 18 hip." There was no evidence in the clinical record that Resident #20's care plan or care plan goals were sent with Resident #20 at the time of transfer to the hospital. There was also no evidence that a transfer summary sheet or face sheet that contains all other required information (Contact information of the practitioner responsible for the care of the resident, Resident representative information including contact information, Advance Directive information, All special instructions or precautions for ongoing care, as appropriate) was sent with the resident at the time of transfer. On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked what documents were sent with residents when they are transferred to the emergency room, RN #1 stated that nurses will send the resident's face sheet, transfer summary sheet, a list of current medications, bed hold notice, and any pertinent tests, orders. When asked if care plan goals or the care plan was sent with residents upon transfer to the hospital, RN #1 stated that she would have to get back to this writer on that one. When asked if she (RN #1) has ever sent care plan goals with a resident upon transfer to the hospital, RN #1 stated, "I have not done that." On 8/21/19 at 2:24 p.m., an interview was conducted with OSM (other staff member) #6, the MDS nurse. OSM #6 stated that she could not find evidence that care plan goals were sent for Resident #12 at the time of transfer. OSM #6 stated, "We have not been implementing that."	F 622	After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	

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On 8/22/19 at 1:38 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When asked how it would be determined that a transfer summary sheet or face sheet was sent with a resident at the time of a transfer to the hospital, LPN #2 stated that nurses should document in a nursing note that "all the proper paper work was given to the EMT (emergency medical technician)."

On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. No further information was presented prior to exit.

3. Resident #48 was admitted to the facility on 7/10/19 and readmitted on 7/25/19 with diagnoses that included but were not limited to pneumonia, Alzheimer's disease, high blood pressure and atrial fibrillation. Resident #48's most recent MDS (minimum data set assessment) was a 14 day scheduled assessment with an ARD (assessment reference date) of 8/8/19. Resident #48 was coded as being moderately impaired in cognitive function scoring 10 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #48's clinical record revealed that he had gone out to the hospital on 7/22/19. The following note in part, was documented: "...Spoke with NP (nurse practitioner) (Name of NP) was told to send out resident Resident sent out via 911 family was at residents bedside when transported to hospital." Further Review of Resident #48's clinical record revealed that he had returned on 7/25/19 with a diagnosis of

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pneumonia.

There was no evidence in the clinical record that Resident #48's care plan or care plan goals were sent with the Resident at the time of transfer to the hospital. There was also no evidence that a transfer summary sheet or face sheet that contains all other required information (Contact information of the practitioner responsible for the care of the resident, Resident representative information including contact information, Advance Directive information, All special instructions or precautions for ongoing care, as appropriate) was sent with the resident at the time of transfer.

On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked what documents were sent with residents when they are transferred to the emergency room, RN #1 stated that nurses will send the resident's face sheet, transfer summary sheet, a list of current medications, bed hold notice, and any pertinent tests, orders. When asked if care plan goals or the care plan was sent with residents upon transfer to the hospital, RN #1 stated that she would have to get back to this writer on that one. When asked if she (RN #1) has ever sent care plan goals with a resident upon transfer to the hospital, RN #1 stated, "I have not done that."

On 8/21/19 at 2:24 p.m., an interview was conducted with OSM (other staff member) #6, the MDS nurse. The MDS nurse was assisting with making copies for this writer. OSM #6 stated that she could not find evidence that care plan goals were sent for Resident #12 at the time of transfer. OSM #6 stated, "We have not been implementing

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that."

On 8/22/19 at 1:38 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When asked how it would be determined that a transfer summary sheet or face sheet was sent with a resident at the time of a transfer to the hospital, LPN #2 stated that nurses should document in a nursing note that "all the proper paper work was given to the EMT (emergency medical technician)."

On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. No further information was presented prior to exit.

4. Resident #40 was originally admitted to the facility on 11/23/18 and was re-admitted to the facility on 04/11/19. Diagnoses for Resident #40 included but not limited to Chronic Respiratory Failure.

Resident #40's Minimum Data Set (MDS-an assessment protocol), a quarterly with an Assessment Reference Date of 07/22/19 coded the resident with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The Discharge MDS assessments was dated for 04/02/19-discharge return anticipated.

On 04/02/19 at approximately 1:35 a.m., according to the facility's documentation, Resident #40's bilateral lung fields with inspiratory and expiratory rhonchi throughout and the on-call doctor's office was notified and gave new orders to send out to local Hospital (ER).

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On 08/22/19 at approximately 4:23 p.m., an interview was conducted with the MDS Coordinator. The surveyor asked if Resident #40's care plan to included his goals were sent to the hospital when Resident #40 was discharged to the hospital on 04/02/19. She stated, "This has never been implemented here, the care plan is not being sent with the resident's upon discharged to the hospital."

The Administrator, Regional Nurse and Director of Nursing was informed of the finding during a briefing on 08/22/19 at approximately 5:00 p.m. The facility staff did not present any further information about the findings.

5. Resident #34 was admitted to the facility on 11/21/18 and readmitted to the facility on 07/05/19. Diagnoses for Resident #34 included but not limited to Major Depressive Disorder and Muscle Weakness.

The current Minimum Data Set (MDS), a discharge assessment with an Assessment Reference Date (ARD) of 07/12/19 coded the resident with a 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments was dated for 07/02/19-discharge return anticipated; re-admitted to the facility on 07/05/19.

A review of the progress notes showed no documentation that the care plan goals were sent with the resident to the hospital.

On 08/22/19, at approximately 1:31 PM an interview was conducted with Other Staff #6

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concerning the above. She stated that care plan goals were not sent.

6. Resident #200 was admitted to the facility on 10/31/18 and readmitted to the facility on 05/16/2019. Diagnoses for Resident #200 included but not limited to Major Depressive Disorder and Muscle Weakness.

The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 05/11/19 coded the resident with 99 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The Discharge MDS assessment was dated for 05/11/19-discharge return anticipated; re-admitted to the facility on 05/16/19.

A review of the progress notes showed no documentation that care plan goals were sent with the resident to the hospital.

On 08/22/19 at approximately 4:50 PM a pre-exit interview was conducted with the Administrator, Director of Nursing and The Director of Clinical Services they were informed of the above findings; no comments were made.

7. Resident #11 was admitted to the facility on 9/11/2015. The latest diagnoses included, but not limited to, peripheral vascular disease, (unspecified), gastro-esophageal reflux disease without esophagitis, acquired absence of left leg above knee, acquired absence of right leg below knee type 2 diabetes mellitus with diabetic chronic kidney disease, peripheral vascular disease, Alzheimer's disease, major depressive

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disorder, recurrent.

Resident #11's most recent MDS (Minimum Data Set) assessment was a quarterly review assessment with an ARD (assessment reference date) of 5/28/2019. Resident #11 was coded as being moderately impaired in cognitive function scoring 10 out of possible 15 on the BIMS (brief interview for mental status) exam.

Review of Resident #11's clinical record revealed that he was transferred to the hospital on 8/17/19. The following nursing note was documented: "Received care of the client, called to the resident. Resident left eye is swollen, observed and appear with hemorrhage noted, blurred vision and some pain noted."

Further review of the clinical record revealed Resident #11 was sent back to the facility on the same day (8/17/19) with a diagnosis of an eye infection.

There was no evidence that the required documentation; physician contact information, responsible party contact information, advanced directives and, any special instructions for ongoing care were sent with the resident at the time of transfer on 8/17/2019.

On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked what documents were sent with residents when they are transferred to the emergency room, RN #1 stated that nurses will send the resident's face sheet, transfer summary sheet, a list of current medications, bed hold notice, and any pertinent tests, orders. When asked if care plan goals or the care plan was sent with

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F 622	Continued From page 25 residents upon transfer to the hospital, RN #1 stated that she would have to get back to this writer on that one. When asked if she (RN #1) has ever sent care plan goals with a resident upon transfer to the hospital, RN #1 stated, "I have not done that." Facility policy regarding Transfer or Discharge Emergency states: 1. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer d. Prepare a transfer form to send with the resident; e. Notify the representative (sponsor) or other family member; f. Assist in obtaining transportation; and g. Others as appropriate or as necessary	F 622		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility staff failed to encode a quarterly Minimum Data Set (MDS) assessment prior to 92 days after the previous Omnibus Budget Reconciliation Act (OBRA) MDS	F 638	F638 Resident #25 remains at his baseline. The resident's Omnibus Reconciliation Act (OBRA) quarterly assessment was	10/5/19

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F 638	Continued From page 26 assessment for 1 of 38 residents (Resident #25), in the survey sample. The findings included: Resident #25 was originally admitted to the facility 4/4/19 and he had never been discharged from the facility. The current diagnoses included; Huntington's disease, a seizure disorder and dysphagia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/11/19 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired abilities for daily decision making. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two with bed mobility, transfers and eating, total care of one with locomotion, dressing, toileting, personal hygiene and bathing. On 8/21/19 a review of Resident #25's MDS assessment revealed only the 4/11/19 OBRA admission assessment. There were also multiple Prospective Payment System (PPS) assessments but no OBRA quarterly assessment which was due to be conductive on or before 7/12/19. A quarterly non-comprehensive MDS assessment is due as follows; ARD of previous OBRA assessment of any type + 92 calendar days. (CMS RAI Manual October 2018; page 2-17).	F 638	completed, submitted and accepted on 8/23/2019. The Minimum Data Set (MDS) nurse and DON will be reeducated to the OBRA requirements in accordance with the RAI manual by the Regional Director of Clinical Reimbursement by 10/5/2019. All residents in the facility have the potential to be impacted. The MDS Nurse will review an Assessment History Report for the past six (6) months for current residents; confirming that OBRA MDS' have been performed in accordance with the required Resident Assessment Instrument (RAI) manual schedule. Findings will result in completion, submission and acceptance of these MDS' in accordance with the RAI manual and forwarded to the QAA for processing. The MDS nurse and DON have refamiliarized themselves with the CMS RAI Manual Guidelines specific to OBRA quarterly assessments. The DON and MDS Nurse will be in-serviced CMS guidelines. The Minimum Data Set (MDS) nurse and DON will be reeducated to the OBRA requirements in accordance with the RAI manual by the Regional Director of Clinical Reimbursement by 10/5/2019. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a)The MDS Nurse will run an Assessment History Report bi	

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F 638	Continued From page 27 An interview was conducted with the MDS Coordinator on 8/22/19, at approximately 4:30 p.m. The MDS Coordinator stated she thought the 90 day PPS assessment met the requirements for the quarterly OBRA assessment but she had learned an OBRA assessment must be completed for it drives resident care. On 8/22/19, at approximately 5:00 p.m., the above findings were shared with the Administrator, the Director of Nursing and the Corporate consultant. The Corporate consultant stated a quarterly MDS assessment should have been completed on or before the 92nd day after the previous OBRA MDS assessment.	F 638	weekly x 4 then monthly thereafter; presenting it to the DON for review and validation that all required assessments have been performed, submitted and accepted. Findings will be addressed promptly reported to the QAA team. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing Date of Compliance: 10/05/2019	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		10/5/19

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F 655	Continued From page 28 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, and staff interviews, the facility staff failed to ensure the baseline care plan included preferences for activities of daily living which included showers and shampoos for 1 of 38 residents in the survey sample, Resident #149. The findings included: Resident #149 was originally admitted to the facility 8/16/19 and had never been discharged from the facility. The current diagnoses included; transient ischemia attack, generalized weakness, underweight and history of falling.	F 655	F655 Residents #149 remains at baseline. Her comprehensive care plan is in place; addressing her ADL needs specific to bathing needs and preferences. All facility nurses and nursing assistants will be reeducated on honoring a resident's preferences specific to bathing needs which shall be reflected in the resident's care plan. All residents admitted to the facility have the potential to be impacted. The facility will conduct a review of 48-hour care	

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F 655	Continued From page 29 The admission Minimum Data Set (MDS) assessment had not been completed therefore information was obtained from the nursing admission assessment dated 8/16/19. The assessment stated the resident was alert and oriented to three spheres, she could understand written and spoken information and make her needs known. It also revealed the resident required assistance with activities of daily living and she was incontinent of bowel and bladder. An interview was conducted with the resident on 8/21/19, at approximately 3:15 p.m. The resident stated before admission to the facility she lived in a private home with her husband who was her primary caregiver. Resident #149 also stated her husband provided all care including transfers, bathing, dressing, toileting and meal preparation and he did a fine job. The resident further stated she had been at the facility since Friday 8/16/19, and she had not had a shower and her hair especially needed washing. Resident #149 then stated my husband who has dementia does a much better job that the facility's staff. Observation of the resident on 8/21/19 at approximately 3:15 p.m., revealed stringy and greasy hair, very dry skin and the resident wearing the same clothing she wore the previous day. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 8/22/19 at approximately 2:10 p.m. LPN #2 stated Resident #149 room is scheduled for showers on the 3 p.m.-11:00 p.m. shift on Wednesdays and Saturdays but there was no documentation she received them or refused them. LPN #2 also stated a staff member had interviewed the	F 655	plans for all residents admitted within the past thirty (30) days; confirming the completion of the same in a timely and comprehensive manner. The facility will also meet with current residents to confirm his/her bathing schedule is congruent with one's preference and that those bathing preferences are noted in one's care plan specific to ADL support. Findings will be addressed and forwarded to the QAA team for processing. The facility has reviewed its' a "48 Hour Baseline Care Plan "and "Shower-Tub Bath" policies and process. No revisions are needed at this time. The DON or ADON will reeducate nurses responsible for care plan development to the 48 hour care plan process, assignment and expectation as well as shower-tub bath policies and expectations of a) completing the care plan in a timely manner and b) ensuring that a resident's bathing preference is identified, scheduled and completed in accordance with the resident's preference. The DON or ADON will reeducate all licensed nurses (which include full time, part time and active per diem nurses) shower-tub bath policy and expectations of a) ensuring that a resident's bathing preference is identified, scheduled and completed in accordance with the resident's needs and preference. The Nursing assistants (which includes full time, part time and active per diem nursing assistants) will be reeducated to the shower-tub bath policies and expectations ensuring a resident's bathing needs and preferences are identified,	

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F 655	Continued From page 30 resident regarding shower preferences that afternoon and the resident stated her preference was showers in the morning therefore she will begin receiving a shower 8/23/19, on the 7 a.m.-3:00 p.m. shift. On 8/22/19, at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate consultant. The Corporate consultant stated on the day of admissions the interview should have been conducted regarding activities of daily living preferences and the resident should have had showers and shampoos scheduled and provided based on the information received. The Corporate Consultant also stated the information should have been added to the baseline care plan.	F 655	scheduled and completed in accordance with the resident's preference. The LHNA is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) Monday through Friday, the DON or ADON will review the developing 48 hour care plan during Monday through Friday morning meetings with the interdisciplinary team (IDT); ensuring the thorough completion of the same inclusive of ADL support (which includes bathing). b) The weekend charge nurse(s) will review the 48-hour care plan on Saturdays and Sundays; ensuring the timely activation and completion of one's 48-hour baseline care plan and the inclusion of ADL support (which includes bathing). c) Weekly during Resident at Risk, the MDS nurse will report the completion of the resident's 48-hour care plan which addresses the resident's preferences for ADL support (inclusive of bathing). Findings will be addressed and forwarded to the QAA team for processing. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing. Date of Compliance: 10/05/2019	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		10/5/19

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F 656	Continued From page 31 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate 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	F 656		

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F 656	Continued From page 32 section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow the comprehensive care plan for one of 38 residents in the survey sample, and improperly transferred Resident #12, which resulted in a fall with no injury. The findings included: Resident #12 was admitted to the facility on 10/21/15 and readmitted on 6/4/19 with diagnoses that included but were not limited to heart failure, high blood pressure, and dementia. Resident #12's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 8/12/19. Resident #12 was coded as being severely impaired in cognitive function scoring 99 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #12's nursing notes revealed that Resident #12 had fallen on 5/11/19. The following was documented: "Called to resident's room and noted resident sitting on floor beside bed. CNA (certified nursing assistant) stated she was transferring resident from wheel chair to bed when resident's legs gave way and CNA lowered him to the floor. no (sic) redness, bruising or abrasions noted via body audit. resident (sic) denies any pain. Name of NP (Nurse practitioner) and (Name of RP (responsible party) notified..." Review of the facility incident report dated 5/11/19	F 656	F656 Resident #12 remains at baseline. CNA #7, who was assigned to assist Resident #12, was re-educated to the care plan interventions designed with and for her specific to safe transfers. Resident #12 continues to benefit from a mechanical lift which requires the presence and assistance of two (2) persons at all times per policy. Care Plans and ADL needs are available to all care givers in the electronic medical record. All residents have the potential to be impacted. The facility will conduct a review of all current resident's transfer needs; ensuring the same is care planned and that Point of Care reflects the same. Findings will be addressed and forwarded to the QAA team for processing. The facility has reviewed its' policies on "Comprehensive Care Plans", "Safe Lifting and Movement of Residents" and "Mechanical Lift"; ensuring clarity. No revisions are needed at this time. The facility has reviewed its general orientation process for newly hired certified nursing assistants ("CNAs") and nurses ensuring the policies "Safe Lifting and Movement of Residents" and "Mechanical Lift" is discussed during orientation. All nursing assistants (which includes full time, part time and active per diem nursing assistants) will be reeducated to the Point of Care, "Safe Lifting and Movement of Residents", and "Mechanical Lift" policies; ensuring an understanding. All licensed	

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F 656	Continued From page 33 documented the following: "called to resident's room. noted (sic) resident sitting on floor beside bed. cna (certified nursing assistant) reported during transfer resident's legs gave way and she lowered him to the floor. no injuries noted. resident denies pain." Review of Resident #12's quarterly MDS (minimum data set) assessment dated 4/16/19 (prior to fall) coded Resident #12 in Section G (Functional Status), as requiring 2 plus persons for all transfers. Review of Resident #12's comprehensive care plan for ADLs (activities of daily living) documented the following intervention dated 1/3/19: "I depend on 2 staff to use the mechanical lift to move me from bed to chair and back." This intervention was still current as of 8/20/19. The nurse who was working on 5/11/19 at the time of the fall is no longer employed with the facility and could not be reached for an interview. On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked the purpose of the care plan, RN #1 stated that the purpose of the care plan was for staff to get a decent picture of the residents needs and how to properly care for the residents. When asked it was important for the care plan to be accurate for each resident, RN #1 stated that it was. When asked who had access to the care plan, RN #1 stated that all nurses had access. When asked if nursing aides (CNA's) had access to the care plans, RN #1 stated that she believed nursing aides had their own Kardex in the computer. RN #1 stated that she would have to verify that. When asked if the Kardex has	F 656	nurses responsible for care plans (which includes full time, part time and active per diem nurses) will be re educated to the “Comprehensive care plan” policy. The Quality Assessment and Assurance (“QAA”) team and its members will be responsible for the ongoing monitoring of this process through the a) The DON and ADON will observe up to 30% of resident transfers performed by different nursing assistants and review the Point of Care documentation monthly x 2 then quarterly x 2; ensuring compliance with the resident’s care plan, policies and Point of Care. b) The DON and/or ADON will conduct a weekly review x 4 weeks then monthly x 2 of up to 30% of current residents who require assistance with transfers; confirming care plan interventions specific to safe transfer. All findings will be addressed and forwarded to the QAA committee for processing. Following the completion of the above monitoring, the QAA team will determine the frequency of ongoing audits however the audits. Date of Compliance: 10/05/2019	

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information on how the resident is transferred, RN #1 stated that she would have to ask because she only works as needed. RN #1 was not sure who updated the kardex for the nursing aides. RN #1 stated that she had not worked with Resident #12 in awhile or in May of 2019.

Review of Resident #12's nursing kardex failed to evidence any information on how to properly transfer the resident in and out of bed to his wheelchair.

On 8/21/19 at 4:42 p.m., an interview was conducted with CNA #2. When asked how he was made aware on a resident's transfer status; CNA #2 stated that he looked at a Kardex on the computer for each resident. CNA #2 stated that he could also look in the resident's chart or ask someone on the floor who is familiar with the resident. When asked if he had ever worked with Resident #12, CNA #2 stated that he had. When asked how many assist Resident #12 required for transfers, CNA #2 stated that Resident #12 required a hoyer lift.

On 8/21/19 at approximately 5 p.m., administration was asked to find out who the nursing aide was working with Resident #12 at the time of the fall on 5/11/19.

On 8/22/19 at approximately 8:30 a.m., OSM (other staff member) #5, the scheduler stated she was still trying to figure out the nursing aide working that day and shift (3 PM-11 PM).

On 8/22/19 at 10:53 a.m., an interview was conducted with CNA #1, a nursing assistant who worked 5/11/19 7 AM-3 PM shift. CNA #1 stated that nursing aides can use a chart (kardex) or

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look at the resident's care plan to determine the transfer status of a resident. When asked how many staff was required to transfer Resident #12, CNA #1 stated that Resident #12 was a hoyer lift with two staff members. CNA #1 stated that she was not present during his fall on 5/11/19, but stated that he was a hoyer lift back in May as well. CNA #1 stated that Resident #12 was too heavy to be transferring without a lift.

On 8/22/19 at 3:13 p.m., an interview was conducted with CNA #7, the aide assigned to Resident #12 on 5/11/19 (3-11 shift). CNA #7 stated that she was assigned to Resident #12 when he had fallen, but that she was not the aide in the room at the time of the fall. CNA #7 stated that she could not recall the nursing aide that was helping her that day. When asked how she would know the transfer status of a resident, CNA #7 stated, "We should have a care plan or access to the chart, but we were never given a care plan to look at." When asked about the Kardex, CNA #7 stated, "What is that?" When asked how many staff members was required to transfer Resident #12, CNA #7 stated, "We lift him personally." When asked if Resident #12 required a lift, CNA #7 stated that she wasn't aware he required a hoyer lift, that she just did what she saw other aides doing. CNA #7 stated that she started working at the facility in January of 2019 and would always transfer the resident by herself or with another aide.

Review of Resident #12's May 2019 ADL transfer log revealed that there were several times in May where staff documented "4/2" for transfers; indicating Resident #12 was totally dependent on one staff member for transfers. This log did not indicate if a mechanical lift was used. Nothing

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F 656	Continued From page 36 was documented for 3-11 shift on 5/11/19. On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. A policy could not be provided regarding the above concerns. When asked if the care plan was followed for Resident #12, ASM #3 stated that at the time of the fall and on the several occasions in May of 2019, it was clear that staff were not following the care plan for transfers. Facility policy titled, "Care Plan-Comprehensive," documents in part, the following: " An individualized comprehensive care plan that includes measurable objectives and timetables to meet the needs of the resident's medical, nursing, mental, and psychological needs is developed for each resident...Each resident's comprehensive care plan is designed to ...aid in preventing or reducing declines in the resident's functional status and or functional levels." This policy did not address following the care plan. No further information was presented prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		10/5/19

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F 657	Continued From page 37 (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 observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to review and revise the care plan for 3 of 38 residents in the survey sample, Residents #12, #39 & #22. The findings include: 1. For Resident #12, facility staff failed to revise the comprehensive care plan to reflect his use for prn (as needed) oxygen. Resident #12 was admitted to the facility on 10/21/15 and readmitted on 6/4/19 with diagnoses that included but were not limited to heart failure, high blood pressure, and dementia. Resident #12's most recent MDS (minimum data set assessment) was a quarterly assessment with	F 657	F657 Residents #12, #39 and #22 remain at baseline. Resident #12's care plan was enhanced to reflect the use of PRN (as needed) oxygen. Residents #39 and #22 care plans were amended to reflect the use of bed rails. All residents benefiting from oxygen or bed rails have the potential to be impacted. The MDS nurse will conduct a facility wide review of all current residents using oxygen and/or bed rails; ensuring a) current residents with orders for PRN oxygen use have responsive care plans; and b) current residents with bed rails have responsive care plans. Findings will be addressed and forwarded to the QAA team for processing.	

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F 657	Continued From page 38 an ARD (assessment reference date) of 8/12/19. Resident #12 was coded as being severely impaired in cognitive function scoring 99 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #12's nursing notes revealed that Resident #12 had been sent out to the hospital on 8/2/19. The following note was documented in part, "...Resident was admitted to (Name of hospital) r/t (related) CHF (congestive heart failure) and pneumonia." The next nursing note dated 8/6/19 documented the following: "Resident returned for hospital at 2345 (11:45) pm. orders verified with NP (nurse practitioner). resident was on ABT (antibiotics) at the hospital and will remain for 5 days on ABT for pneumonia. resident is on oxygen 2L (liters) PRN (as needed). 02 (oxygen) 97% no shortness of breath. skin intact. call bell within reach. will continue to monitor. Review of Resident #12's August 2019 POS (physician order summary) revealed the following active order: "Respiratory: Oxygen as needed." Further review of Resident #12's clinical record revealed that his pneumonia had resolved on 8/12/19. Resident #12's respiratory care plan was resolved on 8/12/19. His comprehensive care plan did not reflect his current order for prn (as needed) oxygen. On 8/20/19 at 12:21 p.m., an observation was made of Resident #12. He was sleeping in his bed with his nasal cannula in place. The oxygen concentrator was set to 2 liters. The end of his	F 657	The facility has reviewed its' policy on "Comprehensive Care Plans" and "Bed/Side Rails" for accuracy and clarity. No revisions are needed at this time. The DON, ADON, and MDS nurse will be reeducated by the LNHA to the above noted policy as well and expectation of maintaining resident specific care plans in accordance with one's needs. The LHNA is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) MDS nurse will observe all residents using oxygen as well as those requiring assistance with transfers prior to the care plan meeting; confirming the presence of comprehensive care plans specific to oxygen and/or use of transfer assistance specifics. b) The DON and ADON will review up to 30% of completed Care Plans for residents requiring oxygen as well as those requiring transfer assistance; confirming care plan accuracy monthly for three (3) months. Findings will be promptly addressed and forwarded to the QAA team for processing. Following the conclusion of the above monitoring, the QAA team will determine the frequency of ongoing audits. Date of Compliance: 10/05/2019	

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oxygen tubing was not hooked up to the concentrator. The end of oxygen tubing was on the floor. A nursing aide in the room at this time (CNA #3) stated that Resident #12 wore his oxygen as needed and usually at night.

On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked the purpose of the care plan, RN #1 stated that the purpose of the care plan was for staff to get a decent picture of the residents' needs and how to properly care for the residents. When asked it was important for the care plan to be accurate for each resident, RN #1 stated that it was.

On 8/22/19 at 10:09 a.m., an interview was conducted with OSM (other staff member) #6, the MDS nurse. OSM #6 stated that MDS revised care plans and not the floor nurses. When asked if a resident was receiving oxygen if it should be reflected on the care plan, OSM #6 stated if a resident was receiving oxygen continuously that it would be on the care plan. When asked if a resident had a prn (as needed) order for oxygen if that would be on the care plan, OSM #6 stated that it would not be on the care plan because prn oxygen was a standing order for every resident. OSM #6 then stated that his prn oxygen used to be on his care plan when he had pneumonia. OSM #6 stated that his pneumonia had resolved on 8/12/19 so she resolved the care plan. OSM #6 again stated that because the order is prn, it does not have to be on the care plan. OSM #6 stated that if the resident actually used the oxygen, she would then add it to the care plan. This writer made OSM #6 aware of the above observations and the aide saying he wore it at night. OSM #6 stated that she was not aware the

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resident was actually using his oxygen.

On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. ASM #3 stated that an order for prn (as needed) oxygen should be on the care plan.

2. The facility staff failed to revise the Comprehensive Resident-Centered Plan of Care for Resident #39 for the implementation of bilateral half side rails.

Resident #39 was admitted to the facility on 10/20/15 and a re-admission on 7/21/18 with diagnoses to include but not limited to, legal blindness, Alzheimer's disease and unsteadiness on feet. The current MDS (Minimum Data Set) a quarterly with an Assessment Reference Date of 7/22/19 coded the resident as having long and short term memory deficits with severely impaired daily decision making skills. The resident required extensive assistance of one person for bed mobility and transfers, the resident was wheelchair bound.

During each of the survey days on 8/20/19, 8/21/19 and 8/22/19 the resident was observed in bed with half-side rails attached to both sides of the head of the bed.

Record review revealed on 11/5/18 the facility had obtained signed consent from Resident #39's Representative Party for the use of the bed rails. The form titled Bed Rail Usage Consent read, in part: Efforts to Promote Bed Safety-In an effort to promote a safe environment and deter falls and related injuries for (Resident #39's name) while

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resting in bed, the interdisciplinary team has trialed and/ or offered the use of the following strategies: bed in lowest position/mattress on the floor, table and toiletries in reach, rehabilitation session, minimized room clutter, individual bed side activities, adaptive equipment, complementary snacks and hydration. Regrettably, these efforts were unsuccessful in assisting or declined by (Resident#39's name) with optimum bed safety. The interdisciplinary team has conducted a safety/bed rail assessment with (Resident #39's name) (resident/representative) to further explore additional strategies for bed safety including the use of bed rails.

The Comprehensive Resident-Centered Plan of Care dated 4/1/18 identified the resident had the potential for falls related to decline in cognition, poor safety awareness and blindness. The goal was that the resident would not experience fall related injury and to keep safe from fall injuries through the next review target date 10/22/19. The care plan was not revised to include the use of the bilateral side rails to promote bed safety and deter falls.

The above findings was shared during the pre-exit meeting with the Administrator, the Director of Nursing and the Regional Nurse. They were asked if the care plan should have been revised to include the bed rails for safety. The Regional Nurse stated, "Yes." When asked who was responsible for revising care plans, the Regional Nurse stated, "The MDS nurse."

No additional information was provided prior to exit.

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3. The facility staff failed to revise the Comprehensive Resident-Centered Plan of Care for Resident #22 for the implementation of bilateral half side rails.

Resident #22 was admitted to the facility on 4/19/18 and a re-admission on 6/22/19 with diagnoses to include but not limited to, dementia with behavioral disturbances, generalized muscle weakness, unsteadiness on feet and repeated falls. The current MDS (Minimum Data Set) a significant change with an Assessment Reference Date of 7/2/19 coded the resident as having long and short term memory deficits with moderately impaired daily decision making skills. The resident required extensive assistance of one person for bed mobility and extensive assistance of two staff for transfers, the resident utilized a Geri-chair recliner when out of bed.

During each of the survey days on 8/20/19, 8/21/19 and 8/22/19 the resident was observed in bed with one half-side rail attached to right side of the head of the bed. The resident's bed was placed against the wall.

Record review revealed on 12/1/18 the facility had obtained a telephone consent from Resident #22's Representative Party for the use of the bed rails. The form titled Bed Rail Usage Consent read, in part: Efforts to Promote Bed Safety-In an effort to promote a safe environment and deter falls and related injuries for (Resident #22's name) while resting in bed, the interdisciplinary team has trialed and/or offered the use of the following strategies: bed in lowest position/mattress on the floor, table and toiletries in reach, rehabilitation session, minimized room clutter, minimized noise distraction, use of TV or

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videos, complementary snacks and hydration. Regrettably, these efforts were unsuccessful in assisting or declined by (Resident#22's name) with optimum bed safety. The interdisciplinary team has conducted a safety/bed rail assessment with (Resident #22's name) (resident/representative) to further explore additional strategies for bed safety including the use of bed rails.

The Comprehensive Resident-Centered Plan of Care dated 5/16/18 identified the resident was at risk secondary to short term memory loss and history of falls and psychotropic drug use. The focus listed approximately 36 dates of actual falls from 5/16/18 through 8/18/19. The goal was to keep the resident safe from fall related injuries and help reduce falls through the next review target date 9/1/19. The care plan was not revised to include the use of the bilateral side rails to promote bed safety and deter falls.

The above findings was shared during the pre-exit meeting with the Administrator, the Director of Nursing and the Regional Nurse. They were asked if the care plan should have been revised to include the bed rails for safety. The Regional Nurse stated, "Yes." When asked who was responsible for revising care plans, the Regional Nurse stated, "The MDS nurse."

No additional information was provided prior to exit.

The facility policy titled Care Plans-Comprehensive with a revision date of 2017 read, in part:
Policy Statement-An individualized comprehensive care plan that includes

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F 657	Continued From page 44 measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation: 9. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident	F 660		10/5/19

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representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the

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F 660	Continued From page 46 evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interview, facility documentation review, and clinical record review, the facility staff failed adequately develop and implement a discharge plan for 1 of 38 residents (Resident #202) in the survey sample. The findings included: The facility staff failed assist Resident #202's Responsible Party with a requested discharge plan to home with home health care services. Resident #202 was originally admitted to the facility on 06/08/14 and discharged to the hospital on 3/21/19. Diagnoses for Resident #202 include but not limited to Disruption of wound, Vascular dementia without behavioral disturbance and Cerebrovascular Disease (stroke.) Resident #202's Minimum Data Set (MDS-an assessment protocol), a quarterly assessment with an Assessment Reference Date (ARD) of 01/30/19 coded Resident #202's Brief Interview for Mental Status (BIMS) a 99 indicating short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. In addition, the MDS coded Resident #202 with total dependence of one with bathing, personal hygiene and dressing, extensive assistance of two with bed mobility, extensive assistance of one with eating and toilet use for	F 660	F660 Resident #202 was discharged from the facility on 03/21/2019. The facility Social Worker (“SW”) who is responsible facilitating discharge planning (inclusive of home health services) will be re-educated to the facility’s policy on “Discharge Summary and Plan” as well as the importance of prompt follow through by the LNHA. All residents who desire discharge from the facility have the potential to be impacted. The Social Worker will conduct a review of all discharges in the past thirty (30) days; ensuring evidence of a timely, comprehensive discharge plan. The Social Worker will also review social service notes for all residents over the past thirty (30) days to identify discharge discussions; ensuing prompt follow up. Findings will be addressed promptly and reported to the QAA committee for processing. The facility has reviewed its’ policy on “Discharge Summary and Plan”; ensuring clarity. No revisions are needed. The facility Social Worker (“SW”) will be in-serviced to the above policy by 10/05/2019 by the LNHA. Residents	

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F 660	Continued From page 47 activities of daily living care. Review of Resident #202's clinical record revealed the following documentation entered by the Social Worker (SW) dated 02/20/19 at 4:26 p.m., "Resident's daughter spoke with the SW regarding a family request discharge. The resident's daughter felt that she and her family, along with home health would be able to provide the needed care for Resident #202. The resident's daughter was provided a list of home health agency/options and she settled on one of the local home health agencies. SW will initiate contact the home health agency and begin the discharge process, per family's request." On 8/21/19 at approximately 8:52 a.m., an interview was conducted with the SW. She said Resident #202's Responsible Party (RP) spoke to her about taking her mother home with home health care. The SW said she called the local home health agency that was requested by the resident's RP. She said the home health agency only needed a Uniform Assessment Instrument (UAI) to get the process started. She said the UAI was faxed on 02/22/19 but no one from the home health agency every emailed or called her back. The surveyor asked, "Did you call the home health agency, she replied, "Yes but I never could reach anyone." The surveyor asked, "Did you document anywhere in the resident's medical record that you reached out to the home health agency to see if the UAI was every received." The SW reviewed Resident #202's medical record the stated, "I do not see documentation of my attempts to reach the home health agency." The SW said she informed Resident #202's RP that the home health agency of her choice had not responded back to her. She said the	F 660	discharges are reviewed weekly Resident at Risk (“RAR”) meetings in an effort to ensure a safe, timely, comprehensive discharge plan. The Licensed Nursing Home Administrator (“LNHA”) is responsible for the Plan of Correction (“POC”) implementation. The Quality Assessment and Assurance (“QAA”) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process through a) Monday through Friday during the morning meeting, the Social Worker will discuss residents desiring discharge; ensuring prompt follow through and discharge planning. B) Weekly during “Resident at Risk” residents discharging from the facility will be discussed by the Social Worker, DON or ADON; ensuring timely and thorough discharge planning. Findings will be promptly addressed and forwarded to the QAA team. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	

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opportunity was given to the RP to choose another agency but the resident's RP chose to stay with the first agency of choice. The surveyor asked, what is the process for discharging a resident home with home health care per the family's request; she stated the following:
-A UAI is faxed to the agency then they will send someone out to do an assessment.
-The Physician/Nurse Practitioner (NP) is made aware of the request for discharge to home.
-The Physician/NP will do a discharge assessment.
-The Physician/NP will write a script for medications, medical equipment to include a hospital bed and what every equipment that may be needed.
-The Physician/NP will write a script for home health therapy to include, PT/PT, ST and nursing.

The SW presented a cover sheet that was faxed to the local home health agency (of choice) on 02/22/19 at approximately 10:17 a.m. The paperwork attached to the cover sheet was a completed UAI.

A phone interview was conducted with Staffing Coordinator at the home health agency of choice on 08/22/19 at approximately 10:00 a.m. She said, no one has ever contacted her related to Resident #202 receiving home health services. She said I am the only one here that receives and takes calls. She stated "I'm on call even after hours so I would have received any message that was left on the answering machine or faxes that would have come through; I check the fax machine every couple of hours throughout the day." She said a UAI would have been needed before we could start the process but one was never received. The surveyor reviewed the

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confirmation cover fax sheet which revealed a completed UAI that was faxed to the local home health agency (of choice) on 02/22/19 at approximately 10:17 a.m. The staffing coordinator stated, "That is the correct fax number but I never received a UAI."

An interview was conducted with the Regional Nurse on 08/22/19 at approximately 10:35 a.m. The surveyor asked, "Who should have followed up with the home health agency to ensure the UAI was received?" She said the SW should have called a couple of times if the home health agency did not respond that the UAI was ever received. The Regional Nurse said the SW should have continued to contact the home health agency; if no response from the agency then the SW should have alerted the company. The Regional Nurse said the Medial Director and the Interdisciplinary (IDT) team should have been notified as well maintaining on going communication with the RP. The Regional Nurse said all communication should have documented in the resident's clinical record. On the same day approximately 3:00 p.m., an interview was conducted with the SW with the Regional Nurse and Director of Nursing (DON) present. The SW stated, "I should have made several attempts to contact to the home health agency and documented the follow up in the resident's clinical record."

An interview was conducted with the Nurse Practitioner on 08/22/19 at approximately 5:03 p.m. She stated, "I do remember something about a possible discharge but I was never contacted by the SW or nursing to do a discharge assessment on Resident #202."

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F 660	Continued From page 50 Complaint deficiency.	F 660		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to ensure residents received necessary activities of daily care to include; showers, shampoos, and finger nail care for 4 of 38 residents (Resident #149, #44, #5 and #48), in the survey sample. The findings included: 1. The facility's staff failed to ensure Resident #149 preferences for showers and shampoos were performed. Resident #149 was originally admitted to the facility 8/16/19 and had never been discharged from the facility. The current diagnoses included transient ischemia attack, generalized weakness, underweight and history of falling. The admission Minimum Data Set (MDS) assessment had not been completed therefore information was obtained from the nursing admission assessment dated 8/16/19. The assessment stated the resident was alert and oriented to three spheres, she could understand written and spoken information and make her needs known. It also revealed the resident	F 677	F677 Residents #149, #44, #5 and #48 remain at baseline. Resident #149's care plan specific to ADL support has been enhanced to address one's bathing preferences for showers and shampoos. Residents #44, #5 and #48 care plans have been enhanced to reflect the provision of fingernail care. All residents have the potential to be impacted. The facility will review the facility's current resident shower/bathing schedule; ensuring through discussions with the residents that the schedule is congruent with his/her need, preference and that documentation and the care plan confirms compliance with the same. The facility will also conduct a 100% fingernail review with all current residents; confirming nail grooming is congruent with the resident's need, preference, that fingernail care is being performed in accordance with the resident's needs and preference and in accordance with one's care plan. Findings will be promptly addressed and forwarded to QAA	10/5/19

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F 677	Continued From page 51 required assistance with activities of daily living and she was incontinent of bowels and bladder. An interview was conducted with the resident on 8/21/19, at approximately 3:15 p.m. The resident stated before admission to the facility she lived in a private home with her husband who was her primary caregiver. Resident #149 also stated her husband provided all care including transfers, bathing, dressing, toileting and meal preparation and he did a fine job. The resident further stated she had been at the facility since Friday 8/16/19, and she had not had a shower and her hair especially needed washing. Resident #149 then stated my husband who has dementia does a much better job that the facility's staff. Observation of the resident on 8/21/19 at approximately 3:15 p.m., revealed stringy and greasy hair, very dry skin and the resident wearing the same clothing she wore the previous day. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 8/22/19 at approximately 2:10 p.m. LPN #2 stated Resident #149 room is scheduled for showers on the 3 p.m.-11:00 p.m. shift on Wednesdays and Saturdays but there was no documentation she received them or refused them. LPN #2 also stated a staff member had interviewed the resident regarding shower preferences that afternoon and the resident stated her preference was showers in the morning therefore she will begin receiving showers 8/23/19, on the 7 a.m.-3:00 p.m. shift. On 8/22/19, at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate	F 677	committee for processing. The facility has reviewed its' policies related to "Comprehensive Care Plans" and "Nail Care" for clarity. No revisions are needed. All licensed nurses (which includes full time, part time and active per diem) will be educated to the comprehensive care plan and nail care policies; ensuring one's understanding and facility expectation. All nursing assistants (which includes full time, part time and active per diem nursing assistants) will be re-educated to the nail care policy and expectation. The Licensed Nursing Home Administrator ("LHNA") is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The DON or ADON will review resident skin checks performed by both the nursing assistants and nurses; confirming documentation of performed nail care weekly x 4, then monthly x 2. b) The DON or ADON will review Point of Care documentation reflective of resident bathing; confirming the documentation of the same in accordance with the resident's care plan and bathing schedule. c) The DON or ADON will conduct resident observations for up to 30% of residents monthly x 2 then quarterly x 1; ensuring nail care and bathing is occurring in accordance to the resident preference with reflective documentation. Findings will be	

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F 677	Continued From page 52 consultant. The Corporate consultant stated on the day of admissions the interview should have been conducted regarding activities of daily living preferences and the resident should have had showers and shampoos scheduled and provided based on the information received. 2. The facility staff failed to provide fingernail care for Resident #44. Resident #44 was admitted to the facility on 04/01/19. Diagnoses for Resident #44 included but not limited to Alzheimer's disease. The recent Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 07/28/19 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 10 out of a possible score of 15, which indicated moderate cognitive impairment for daily decision-making. The resident was not coded for rejection of care to include Activities of Daily Living (ADL). Resident #44 was coded to require extensive assistance of one with bathing and toilet use and limited assistance of one with personal hygiene. Resident #44's person centered care plan with a revision date 07/17/19 had a problem which read: I am at risk for ADL decline related to the need for assistance at times. The goal: any decline in my ability to do my ADL's will quickly be noted. My abilities will be maximized. I will keep myself clean and free of body odor. I will be well groomed and well nourished through the next review (10/15/19). The interventions include but not limited to: please monitor me for the need for assistance. I am independent with grooming myself at times.	F 677	addressed promptly reported to the QAA team. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	

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During the initial tour on 08/20/19 at approximately 11:22 a.m., Resident #44 was lying in bed on his back, with his hands placed on his stomach. The resident's fingernails were long, curved with jagged edges and a brown substance under his nails. Resident #44 said he would really like to have his fingernails cut; they are really too long. The resident said look at this, he used his fingernails to remove the brown substance from underneath his fingernails. On the same day at approximately 4:05 p.m., Resident #44's fingernails were observed and remained unchanged.

On 08/21/19 at approximately 9:30 a.m., the resident's fingernails remained unchanged. On the same day at 9:35 a.m., Registered Nurse (RN) #1 and this surveyor went to inspect the fingernails of Resident #44. After the RN inspected his fingernails she replied, "They need to be cut and trimmed." The RN asked Resident #44 if he would like to have his fingernails cut and trimmed, he replied "Yes." The surveyor asked, "Who cuts and trims the resident fingernails, she replied, "We all do, but Resident #44's fingernails should have been checked daily with care; cleaned and trimmed as needed. She told Resident #44, "I will come back to trim and cut your fingernails and get rid of the jagged ends."

An interview was conducted with Director of Nursing (DON) on 08/22/19 at approximately 11:03 a.m., who stated, "The Certified Nursing Assistant (CNA) should be observing for nail care on a daily basis doing ADL care. The fingernails should be cut and trimmed as needed."

On 08/22/19 at approximately 2:40 p.m., Resident #44's fingernails were cut and trimmed

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The Administrator, Regional Nurse and Director of Nursing was informed of the finding during a briefing on 08/22/19 at approximately 5:00 p.m. The facility staff did not present any further information about the findings.

The facility's policy titled Care of Fingernails/Toenails - MED-PASS, (Revision date: 2017).
-Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.

-General Guidelines includes but not limited to:
-Nail care includes daily cleaning and regular trimming.
-Proper nail care can aid in the prevention of skin problems around the nail bed.
-Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.
3. The facility staff failed to provide fingernail care for Resident #5.

Resident #5 was admitted to the facility on 8/24/04 and readmitted on 9/17/18 with diagnoses that included but were not limited to cerebral palsy, severe intellectual disability, and high blood pressure. Resident #5's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 8/7/19. Resident #5 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status exam.

On 8/20/19 at 11:35 a.m., an observation was made of Resident #5. His bilateral hands were contracted outward. All of his finger nails were

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also observed to be about 1/2 inch long.

On 8/21/19 at 9:11 a.m., an observation was made of Resident #5. His fingernails were still observed to be about 1/2 inch long.

Review of Resident #5's comprehensive care plan dated 3/11/19 documents in part, the following:
I am dependent of staff to provide my ADLs (activities of daily living) r/t (related to) CP (cerebral palsy), and intellectual disabilities. I am unable to perform my own ADLs...I am dependent on 1 staff to provide me with grooming. Date initiated: 3/11/19"

On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked when finger nails were checked for cleanliness and length, RN #1 stated that during morning care, nails should be checked by the nursing aides and cleaned. When asked who was responsible for cutting fingernails, RN #1 stated that the nurses can cut finger nails. RN #1 followed this writer to Resident #5. RN #1 agreed that his nails were very long. RN #1 could not say when his nails were cut last. When asked if Resident #5 was able to cut his nails himself, RN #1 stated that he was not.

On 8/21/19 at 11:53 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated that both nurses and CNAs (certified nursing assistants) should be checking the residents nails when they first see the resident or when they first go into their rooms. LPN #2 stated that CNAs will often report to the nurses when a resident's fingernails need to be trimmed. LPN #2 stated that the nurses then cut

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the resident's fingernails.

On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. No further information was presented prior to exit.

4. The facility staff failed to provide fingernail care for Resident #48.

Resident #48 was admitted to the facility on 7/10/19 and readmitted on 7/25/19 with diagnoses that included but were not limited to pneumonia, Alzheimer's disease, high blood pressure and atrial fibrillation. Resident #48's most recent MDS (minimum data set assessment) was a 14 day scheduled assessment with an ARD (assessment reference date) of 8/8/19. Resident #48 was coded as being moderately impaired in cognitive function scoring 10 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 8/20/19 at 11:30 a.m., an interview was conducted with Resident #48. During the interview it was observed that his finger nails were about 2-3 centimeters long and some were jagged. When asked the last time his nails were cut, Resident #48 stated that he was not sure how long ago but that it had been awhile. Resident #48 stated that he would like his nails cut. When asked if he had ever asked the staff to cut his nails, Resident #48 stated that he was not sure if they knew or not.

Review of Resident #48's comprehensive care plan dated 11/14/18 documented in part, the

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following: "I need assistance with my ADL's (activities of daily living) due to right sided hemiparesis (paralysis) and secondary to my decreased cognition...I need you to assist me with grooming."

On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked when finger nails were checked for cleanliness and length, RN #1 stated that during morning care, nails should be checked by the nursing aides and cleaned. When asked who was responsible for cutting fingernails, RN #1 stated that the nurses can cut finger nails.

On 8/21/19 at 11:53 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated that both nurses and CNAs (certified nursing assistants) should be checking the residents nails when they first see the resident or when they first go into their rooms. LPN #2 stated that CNAs will often report to the nurses when a resident's fingernails need to be trimmed. LPN #2 stated that the nurses then cut the resident's fingernails. When told about the observation of Resident #48's nails and how he'd like them cut the nurse stated "Oh he will let us do it now?" When asked if the resident had refused for his nails to be cut recently, LPN #2 stated that he had. When asked if this was documented anywhere of the nursing staff's recent attempt to cut his nails and his refusal, LPN #2 stated that she was not sure. LPN #2 stated that she had already seen Resident #48 that day but that she did not look at his nails.

Further review of Resident #48's clinical record failed to evidence any occasion where he had recently refused finger nail care.

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F 677	Continued From page 58 On 8/21/19 at 12:58 p.m. LPN #2 confirmed that she had made an observation of Resident #48 and that some of his nails needed to be cut. LPN #2 stated that she had cut Resident #48's nails after he had given permission. On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. Facility policy titled, "Nail Care," documents in part, the following: "Nail care included daily cleaning and regular trimming. 2. Proper nail care and aid in the prevention of skin problems around the nail bed...Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name of the individuals who administered nail care. 3. The condition of the resident's nails and nail bed...If the resident refused the treatment, the reason(s) why and the interventions taken." No further information was presented prior to exit.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's	F 687		10/5/19

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F 687	Continued From page 59 medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 38 residents (Resident #7) in the survey sample who were unable to carry out activities of daily living, received the necessary services to maintain toenail care. The findings included: The facility staff failed to ensure that podiatry services was provided to Resident #7. Resident #7 was admitted to the facility on 05/24/19. Diagnoses for Resident #7 included but not limited to Type II Diabetes Mellitus. The most recent Minimum Data Set (MDS) was an admission assessment (14-day) with an Assessment Reference Date (ARD) of 05/31/19. The MDS coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15, which indicated no cognitive impairment for daily decision-making. Resident #7 was coded extensive assistance of one with bed mobility, toilet use, transfer, dressing, personal hygiene and bathing for Activities of Daily Living (ADL). Resident #7's person-centered comprehensive care plan with a revision date of 05/25/19 documented Resident #7 with the need for assistance with ADL's. The goal: my abilities will be maximized will remain clean and free of body	F 687	F687 Residents #7 remains at baseline. a Resident #7's care plan has been enhanced to reflect toenail care interventions. All residents have the potential to be impacted. The facility will also conduct a 100% toenail observation with all current residents; confirming nail grooming is congruent with the resident's needs, preference and care plan and that the same is completed in accordance with the same. Findings will be promptly addressed and forwarded to QAA committee for processing and ongoing monitoring. The facility has reviewed its' policies related to "Comprehensive Care Plans" and "Nail Care" for clarity. No revisions are needed. All licensed nurses (which includes full time, part time and active per diem nurses) will be educated to the comprehensive care plan and nail care policies; ensuring one's understanding and facility expectation. All nursing assistants (which includes full time, part time and active per diem nursing assistants) will be re-educated to the nail care policy and expectation.	

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F 687	Continued From page 60 odor, well groomed and well nourished with your assistance through the next review (09/11/19). One of the intervention/approaches to manage goal include to please assist me with grooming myself; I need 1 staff to assist me. During the initial tour on 08/20/19 at approximately 11:33 a.m., an interview was conducted with Resident #7. The resident said her toenails were long, thick and her shoes hurt whenever she put her shoes on. She stated, "I had asked several times to get my toenails cut and trimmed but it never happen." She said "The nurses kept saying they were going to put me on the list to see the foot doctor, but apparently they never did because my toenails was never cut." The resident removed her slipper. The surveyor observed Resident #7 toenails on both feet. On the left foot, the 2nd, 3rd and 4th digits were long, thick and had curved over the toe making direct contact with the resident's skin. On the right foot, the 2nd, 3rd and 4th digits were long, thick and had curved over the toe coming in direct contact with the resident's skin. The resident stated, "I only have one pair of slippers and shoes that I can wear." She said "When I put my shoes on, my toes go to the top of the shoe and because my toenails are so long, my toes hurt." On the same day at approximately 4:15 p.m., the resident stated her toenails still have not been cut. On 08/21/19 at approximately 9:53 a.m., the resident's toenails remained unchanged. On the same day at 10:00 a.m., Registered Nurse (RN) #1 and this surveyor went to inspect Resident #7's toenails. After the RN inspected her toenails she replied, "They need to be cut." The surveyor asked if Resident #7 had ever requested to be	F 687	The Licensed Nursing Home Administrator (“LHNA”) is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The DON or ADON will review resident skin checks performed by both the nursing assistants and nurses; confirming documentation of performed nail care weekly x 4, then monthly x 2. b) The DON or ADON will review Point of Care documentation reflective of resident bathing; confirming the documentation of the same in accordance with the resident’s care plan and bathing schedule. c) The DON or ADON will conduct resident observations for up to 30% of residents monthly x 2 then quarterly x 1; ensuring nail care and bathing is occurring in accordance to the resident preference with reflective documentation. Findings will be addressed promptly reported to the QAA team. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance:10/05/2019	

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put on the list to be seen by the podiatrist. The RN said she does remember Resident #7 requesting to be seen by the podiatry and thought that she was placed on the list to be seen. The surveyor and RN reviewed the podiatry list since May 2019 and Resident #7's name was not listed. The RN added Resident #7's name to the August 2019 podiatry list.

An interview was conducted with the Director of Nursing (DON) on 08/22/19 at approximately 9:55 a.m., who stated, "Resident's toenails should be assessed on admission, daily during ADL care and will doing the skin assessment." She said the Certified Nursing Assistants (CNA) are to report to the nurses and the nurses are to give the names to me and I will put them on the list to be seen by the podiatrist.

Review of the resident's medical record on 8/22/19 revealed the following note written by RN #1 on 08/21/19 at approximately 12:00 p.m. Podiatry called regarding resident's request for toenails to be cut. Podiatry aware of request awaiting arrival.

The Administrator, Regional Nurse and Director of Nursing was informed of the finding during a briefing on 08/22/19 at approximately 5:00 p.m. The facility staff did not present any further information about the findings.

The facility's policy titled Care of Fingernails/Toenails-MED-PASS, (Revision date: 2017).
-Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.

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F 687	Continued From page 62 General Guidelines: -Nail care includes daily cleaning and regular trimming. -Proper nail care can aid in the prevention of skin problems around the nail bed. -Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. -Watch for and report any changes in the color of the skin round the nail bed, blueness of the nails, and signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. -Stop and report to the nurse supervisor if there is evidence of ingrown nails infections, pain, or if nails are too hard or thick to cut with ease. Consultant Podiatrist -The facility may elect to engage the services of a Podiatrist to assist in the management of resident foot and toenail care. -Should a Podiatrist be contracted to provide services, the facility will schedule a routine visit schedule by the Podiatrist. -The facility shall maintain a podiatry list for those resident's who foot/toenail care is non urgent.	F 687		
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		10/5/19

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F 689	Continued From page 63 by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure an environment free from accidents and/or hazards for two of 38 residents in the survey sample, Resident #12 and #39. For Resident #12, facility staff conducted an improper transfer resulting in a fall with no injury and the facility staff failed to ensure the call light was in reach to promote safety and prevent avoidable accidents for Resident #39. The findings included: 1. Resident #12 was admitted to the facility on 10/21/15 and readmitted on 6/4/19 with diagnoses that included but were not limited to heart failure, high blood pressure, and dementia. Resident #12's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 8/12/19. Resident #12 was coded as being severely impaired in cognitive function scoring 99 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #12's nursing notes revealed that Resident #12 had fallen on 5/11/19. The following was documented: "Called to resident's room and noted resident sitting on floor beside bed. CNA (certified nursing assistant) stated she was transferring resident from wheel chair to bed when resident's legs gave way and CNA lowered him to the floor. no redness, bruising or abrasions noted via body audit. resident denies any pain. Name of NP (Nurse Practitioner) and (Name of RP (responsible party) notified..."	F 689	F689 Residents #12 and #39 remain at baseline. Resident #12 remains at baseline. CNA #7, who was assigned to assist Resident #12, was re-educated to the care plan interventions designed with and for her specific to safe transfers. Resident #12 continues to benefit from a mechanical lift which requires the presence and assistance of two (2) persons at all times per policy. Care Plans and ADL needs are available to all care givers in the electronic medical record. CNA #6, who was assigned to Resident #39, was re-educated to the facility's processes and expectations of ensuring the call light is within reach of the resident to promote safety and prevent avoidable accidents on 8/22/2019. All residents have the potential to be impacted. The facility will conduct a review of all current resident's transfer needs; ensuring the same is care planned and that Point of Care reflects the same. Findings will be addressed and forwarded to the QAA team for processing. The facility will also conduct resident room rounds; confirming all current residents have call lights in reach to promote resident safety and deter accidents and in accordance with one's care plan. Findings will be promptly addressed and forwarded to the QAA tam for processing. The facility has reviewed its' policies on "Comprehensive care plans", "Safe lifting and movement of residents", and call bell usage; ensuring clarity. No revisions are	

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F 689	Continued From page 64 Review of the facility incident report dated 5/11/19 documented the following: "called to resident's room. noted resident sitting on floor beside bed. cna (certified nursing assistant) reported during transfer resident's legs gave way and she lowered him to the floor. no injuries noted. resident denies pain." Review of Resident #12's quarterly MDS (minimum data set) assessment dated 4/16/19 (prior to fall) coded Resident #12 in Section G (Functional Status), as requiring 2 plus persons for all transfers. Review of Resident #12's comprehensive care plan for ADLs (activities of daily living) documented the following intervention dated 1/3/19: "I depend on 2 staff to use the mechanical lift to move me from bed to chair and back." This intervention was still current as of 8/20/19. The nurse who was working on 5/11/19 at the time of the fall is no longer employed with the facility and could not be reached for an interview. On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked the purpose of the care plan, RN #1 stated that the purpose of the care plan was for staff to get a decent picture of the residents' needs and how to properly care for the residents. When asked it was important for the care plan to be accurate for each resident, RN #1 stated that it was. When asked who had access to the care plan, RN #1 stated that all nurses had access. When asked if nursing aides had access to the care plans, RN #1 stated that she believed nursing aides had their own Kardex in the computer. RN #1 stated that she would have to	F 689	needed at this time. All licensed nurses (which includes full time, part time and active per diem nurses) and nursing assistants (which includes full time, part time and active per diem nursing assistants) will be reeducated to above policies and facility expectation that a) care plans accurately reflect the needs and preferences of the residents and followed by staff providing care, b) residents are to be transferred between surfaces in accordance with one's assessed needs and care plan, and c) residents are to have access to one's call bell/light and as noted in one's care plan. The Quality Assessment and Assurance ("QAA") team and its members will be responsible for the ongoing monitoring of this process through the a The DON or ADON will review resident skin checks performed by both the nursing assistants and nurses; confirming documentation of performed nail care weekly x 4, then monthly x 2. b) The DON or ADON will conduct resident observations for up to 30% of residents monthly x 2 then quarterly x 1; ensuring toenail care is occurring in accordance to resident need and preference with reflective documentation. All findings will be addressed promptly and forwarded to the QAA team for processing. Following the completion of the above monitoring, the QAA team will determine the frequency of ongoing audits however the audits. Date of Compliance: 10/05/2019	

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verify that. When asked if the Kardex has information on how the resident is transferred, RN #1 stated that she would have to ask because she only works as needed. RN #1 was not sure who updated the kardex for the nursing aides. RN #1 stated that she had not worked with Resident #12 in a while or in May of 2019.

Review of Resident #12's nursing kardex failed to evidence any information on how to properly transfer the resident in and out of bed to his wheelchair.

On 8/21/19 at 4:42 p.m., an interview was conducted with CNA #2. When asked how he was made aware of a resident's transfer status, CNA #2 stated that he looked at a Kardex on the computer for each resident. CNA #2 stated that he could also look in the resident's chart or ask someone on the floor who is familiar with the resident. When asked if he had ever worked with Resident #12, CNA #2 stated that he had. When asked how many assist Resident #12 required for transfers, CNA #2 stated that Resident #12 required a hoyer lift.

On 8/21/19 at approximately 5 p.m., it was requested by administration to find out who the nursing aide was working with Resident #12 at the time of the fall on 5/11/19.

On 8/22/19 at approximately 8:30 a.m., OSM (other staff member) #5, the scheduler stated she was still trying to figure out the nursing aide working that day and shift (3 PM-11 PM).

On 8/22/19 at 10:53 a.m., an interview was conducted with CNA #1, a nursing aide who worked 5/11/19 7 AM-3 PM shift. CNA #1 stated

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that nursing aides can use a chart (kardex) or look at the resident's care plan to determine the transfer status of a resident. When asked how many staff was required to transfer Resident #12, CNA #1 stated that Resident #12 was a hoyer lift with two staff members. CNA #1 stated that she was not present during his fall on 5/11/19, but stated that he was a hoyer lift back in May as well. CNA #1 stated that Resident #12 was too heavy to be transferring without a lift.

On 8/22/19 at 3:13 p.m., an interview was conducted with CNA #7, the aide assigned to Resident #12 on 5/11/19 (3-11 shift). CNA #7 stated that she was assigned to Resident #12 when he had fallen, but that she was not the aide in the room at the time of the fall. CNA #7 stated that she could not recall the nursing aide that was helping her that day. When asked how she would know the transfer status of a resident, CNA #7 stated, "We should have a care plan or access to the chart, but we were never given a care plan to look at." When asked about the Kardex, CNA #7 stated, "What is that?" When asked how many staff members was required to transfer Resident #12, CNA #7 stated, "We lift him personally." When asked if Resident #12 required a lift, CNA #7 stated that she wasn't aware he required a hoyer lift, that she just did what she saw other aides doing. CNA #7 stated that she started working at the facility in January of 2019 and would always transfer the resident by herself or with another aide.

Review of Resident #12's May 2019 ADL transfer log revealed that there were several times in May where staff documented "4/2" for transfers; indicating Resident #12 was totally dependent on one staff member for transfers. This log did not

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indicate if a mechanical lift was used. Nothing was documented for 3-11 shift on 5/11/19.

On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. A policy could not be provided regarding the above concerns. No further information was presented prior to exit.
2. The facility staff failed to ensure the call light was in reach to promote safety and prevent avoidable accidents for Resident #39.

Resident #39 was admitted to the facility on 10/20/15 with a re-admission on 7/21/18. Diagnoses to include but not limited to, legal blindness, Alzheimer's disease and unsteadiness on feet. The current MDS (Minimum Data Set) a quarterly with an Assessment Reference Date of 7/22/19 coded the resident as having long and short term memory deficits with severely impaired daily decision making skills. The resident required extensive assistance of one person for bed mobility and transfers, the resident was wheelchair bound.

On 8/20/19 at 1:37 p.m., during the initial tour the resident was observed sitting by the window in a wheelchair, near the foot of the bed on the left side. The call bell was observed on the opposite side of the bed and not within reach. At 1:41 p.m., the resident was observed in bed, eyes closed, the call light was observed dangling on the right side of the bed making contact with the floor.

On 8/21/19 at 11:06 a.m., observed the resident in bed, the call light was laying underneath the bed.

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F 689	Continued From page 68	F 689		

The Comprehensive Resident-Centered Plan of Care dated 4/1/18 identified the resident had the potential for falls related to decline in cognition, poor safety awareness and blindness. The goal was that the resident would not experience fall related injury and to keep safe from fall injuries through the next review target date 10/22/19. Interventions listed to maintain the goal included: "Please encourage me to use the call light or ask for assistance, keep my call light close to me because I am blind."

On 8/22/19 at 10:34 a.m., the Certified Nursing Assistant (CNA #6) who was assigned to care for Resident #39 was interviewed. She stated she had been assigned to care for the resident for the last two days. When asked about the resident's safety needs, the CNA stated the resident was blind, they assist her up to sit in the wheel chair three times a week and the resident prefers to stay in bed, as the bed is a comfort for her. When asked about fall risk she stated, "Yes, because she is blind, the side rails are for falls, she can use the call bell, we usually put it in her hands." The CNA was asked to escort this surveyor to the resident's room. The resident was asleep in bed, the call light cord was wrapped around the right side rail, the call light was behind the residents head wedged between the rails. When asked if the resident would be able to reach the call light, the CNA stated, "No" and proceeded to unwrap the call light cord and placed the call light in the resident's hands.

The above findings was shared during the pre-exit meeting with the Administrator, the Director of Nursing and the Regional Nurse. No additional information was provided prior to exit.

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F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review the facility staff failed to investigate the cause and implement interventions to prevent dislodgement of a nephrostomy tube for of 1 of 38 residents in the survey sample (Resident #33). A nephrostomy tube is a catheter that's inserted through your skin and into your kidney. The tube helps to drain urine from your body. The drained urine is collected in a small bag located outside of your body (www.healthline.com) The findings included: Resident #33 was originally admitted to the facility 8/26/16 and readmitted 7/8/19 after an acute care hospital stay. The current diagnoses included; Obesity, Parkinson's disease and use of a nephrostomy tube. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/15/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #33's cognitive abilities for daily decision making were intact. In section "G"	F 691	F691 Resident #33 remains at baseline. His care plan has been enhanced to reflect nephrostomy tube care and interventions to deter dislodgement of the nephrostomy tubes during care. The DON, ADON and MDS nurse will be re-educated to the expectation of identifying the cause for nephrostomy tube dislodgement as well as care plan enhancements following a dislodgement in an effort to minimize undesired outcomes. All residents with nephrostomy tubes have the potential to be impacted. The facility will conduct an audit of all residents with nephrostomy tubes; confirming the presence of nephrostomy tube care plans inclusive of interventions to deter the dislodging of the same. Findings will be addressed promptly and forwarded to QAA for processing. The facility has reviewed its' policies and processes on “Physician Orders”, “Care plan development” and “Nephrostomy tubes”; ensuring clarity. The DON, ADON and MDS nurse will be re-educated to up the expectation of identifying the cause for	10/5/19

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F 691	Continued From page 70 (Physical functioning) the resident was coded as requiring extensive assistance of 2 people with transfers, extensive assistance of 1 person with bed mobility, locomotion, dressing, toileting, and personal hygiene and he required total care with bathing. In section "H0100" the resident was coded for use of a nephrostomy tube. An interview was conducted with Resident #33 on 8/21/19 at approximately 12:40 p.m. Resident #33 stated he had been to the hospital at least twice in recent months for his nephrostomy tube coming out during care. He further stated he felt the certified nursing assistants (CNA) needed help when giving him care but most of the time they work alone and often the nephrostomy tubing is pulled tugged on. Review of the clinical record revealed a nurse's note dated 4/18/19, which read: "this nurse was called into the resident's room and by the CNA due to the left side nephrostomy tube coming out during care. The Nurse Practitioner (NP) was in the building assessed the resident. She gave an order to transport the resident non-emergent to a local hospital." The clinical record also revealed a nurse's note dated 7/2/19, which included the resident being sent to the emergency room non-emergent transport for a displaced nephrostomy tube. An interview was conducted with on 8/22/19, with Licensed Practical Nurse (LPN) #1. LPN #1 stated she makes sure the nephrostomy tube dressing is in place. The active care plan dated 12/17/18, had a problem which read; I have bilateral nephrostomy	F 691	nephrostomy tube dislodgement and the necessary care plan enhancements following the same in an effort to minimize undesired outcomes. All licensed nurses (which includes full time, part time and active per diem nurses) will be reeducated to the Physician's Orders and Nephrostomy tubes policies; ensuring understanding. All nursing assistants (which includes full time, part time and active per diem nursing assistants) will be reeducated on caring for a resident with nephrostomy tubes; ensuring understanding and interventions necessary to deter tube dislodgement. The Licensed Nursing Home Administrator ("LHNA") is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The DON, ADON and/or MDS nurse will observe nursing assistant care for resident's with nephrostomy tubes weekly x 2 then monthly (with different care givers) and following any tube dislodgement; ensuring that care is/was delivered in accordance with the resident's care plan and policy-using interventions to deter tube dislodgement. Findings will be addressed and forwarded to the QAA team for processing. Following the completion of the above monitoring, the QAA team will determine the frequency of ongoing audits however the audits. Date of Compliance: 10/05/2019	

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F 691	Continued From page 71 tubes in place. The goal read; I will not present with complications from my nephrostomy tubes thru the next review 10/7/19. The interventions included; Please cover my nephrostomy tubes. Please empty my tubes each shift. Please irrigate my nephrostomy tubes for decreased drainage/blockage. Please keep my nephrostomy tubes close to me. There was no identification of why the nephrostomy tube was being dislodged during care, no interventions added after the 4/18/19 or 7/2/19 dislodgements which resulted in hospital transfers, and no education of staff. On 8/22/19, the above findings were shared with the Administrator, Director of Nursing and Corporate consultant. An opportunity was given for the facility to present additional information but none was provided.	F 691		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined that facility staff failed to transcribe a complete order for oxygen for one of 38 residents	F 695	F695 Resident #12 remains at baseline. His care plan was enhanced to reflect the use	10/5/19

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F 695	Continued From page 72 in the survey sample, Resident #12. The findings included: Resident #12 was admitted to the facility on 10/21/15 and readmitted on 6/4/19 with diagnoses that included but were not limited to heart failure, high blood pressure, and dementia. Resident #12's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (assessment reference date) of 8/12/19. Resident #12 was coded as being severely impaired in cognitive function scoring 99 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #12's nursing notes revealed that Resident #12 had been sent out to the hospital on 8/2/19 and returned to the facility on 8/6/19 with a diagnosis of pneumonia. The following nursing note was documented: "Resident returned for hospital at 2345 (11:45) pm. orders verified with NP (nurse practitioner). resident was on ABT (antibiotics) at the hospital and will remain for 5 days on ABT for pneumonia. resident is on oxygen 2L (liters) PRN (as needed). 02 (oxygen) 97% no shortness of breath. skin intact. call bell within reach. will continue to monitor. Review of Resident #12's August 2019 POS (physician order summary) revealed the following active order: "Respiratory: Oxygen as needed." There were no liters per minute or other directives included in oxygen order. A current care plan could not be found regarding the use of Resident #12's prn (as needed) oxygen.	F 695	of oxygen and his oxygen order was amended on 9/12/2019 to reflect oxygen at 2 liters per minute (LPM) via nasal cannula (NC) PRN. The DON will reeducate the nurse who entered the order; ensuring she/he understands the need for a complete oxygen order. The MDS nurse was reeducated to care planning for residents using oxygen by the DON. All residents with who use oxygen and/or have orders for the same have the potential to be impacted. The facility will review all current residents using oxygen ensuring a) the presence of complete physician orders for oxygen; and b) the presence of a comprehensive care plan for oxygen use in accordance with one's diagnoses and orders. Findings will be promptly addressed and forwarded to QAA for processing. The facility has reviewed its' policies on "Physician's orders" and "Oxygen therapy"; ensuring clarity. No revisions are needed. All licensed nurses (which includes full time, part time and active per diem nurses) will be re in-serviced on the above policies and expectation by the DON or ADON before 10/05/2019. The Licensed Nursing Home Administrator ("LHNA") is responsible for the Plan of Correction ("POC") implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The DON or	

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F 695	Continued From page 73 On 8/20/19 at 12:21 p.m., an observation was made of Resident #12. He was sleeping in his bed with his nasal cannula in place. The oxygen concentrator was set to 2 liters, however the end of his tubing was not hooked up to the concentrator and it was observed on the floor. On 8/22/19 at 9:54 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, Resident #12's nurse. When asked how many liters of oxygen Resident #12 was supposed to be receiving, LPN #3 went to the orders in Resident #12's chart and stated his oxygen was prn but that the liter amount was not attached to the order. LPN #3 stated that the order needed to be clarified. LPN #3 stated that Resident #12 was probably on 2 liters of oxygen because the physician had standing orders for oxygen at 2 liters. LPN #3 showed this writer the list of standing orders for Resident #12's physician. Oxygen at 2 liters prn was a standing order. When asked if this order should have been transcribed completely on the physician order sheet, LPN #2 stated that it should have. On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. Facility policy titled, "Oxygen Therapy," did not address the above concerns.	F 695	ADON will conduct resident rounds weekly x 4 then monthly x 3 with residents using oxygen; ensuring oxygen therapy is being administered in accordance with one's orders and care plan. b) The DON or ADON will conduct a resident record review for those using oxygen; confirming the presence of a complete oxygen order and a care plan addressing one's oxygen need weekly x 4 then monthly x 3. Findings will be addressed promptly and forwarded to the QAA team for processing. Following the ongoing monitoring as outlined above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		10/5/19

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F 755	Continued From page 74 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to provide pharmaceutical services to ensure insulin was available to meet the diabetic needs of 1 of 38 residents in the survey sample, Resident #24. The findings included:	F 755	F755 Resident #24 remains at baseline. Resident #24's physician was notified of the medication variance. LPN #5 was re-educated to the facility's policies and expectations of administering insulin in	

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F 755	Continued From page 75 Resident #24 was admitted to the facility on 3/27/19 with diagnoses to include, but not limited to, type 2 diabetes. The current MDS a quarterly coded the resident as scoring a 15 out of a possible 15, indicating the resident's cognition was intact. The resident was coded as having received an insulin injection for 7 days of the 7 day look back assessment window. The Comprehensive Person-Centered Plan of Care dated 3/28/19 identified the resident was a diabetic. The goal was that the resident would maintain with adequate glucose levels and experience no signs and symptoms of low or high blood sugars through the next review date of 9/25/19. Two of the interventions listed to achieve the goals were to do finger sticks to check blood glucose levels, and administer medications as ordered. Review of the physician orders dated 3/27/19 was to administer sliding scale insulin subcutaneous before meals and at bedtime with Lispro (a short acting insulin) as follows: if 201-250=1 unit; 251-300=2 units; 301-350=3 units; 351-400=4 units; 401-450=5 units; 451-500= 6 units; blood sugar over 500 call the physician and an order for Lispro (Novolog) administer 6 units subcutaneous before meals also dated 3/27/19. Per the pharmacist telephone interview on 8/21/19 at 3:49 p.m., a therapeutic interchange request was made on 7/3/19 due to the insurance company's request. The interchange was to change the Lispro (Novolog) to Humalog. A vial labeled Novolog administer 6 units before meals was sent to the facility on 8/1/19. The order for the 6 units of Lispro (Novolog) was discontinued	F 755	accordance with physician's orders by the DON and ADON. All insulin dependent residents have the potential to be impacted. The facility will review an audit of all residents with orders for insulin and conduct a "chart to cart" check; confirming the presence of insulin for each resident in accordance with one's orders. Findings will be addressed promptly and forwarded to QAA for processing. The facility has reviewed its' policies on "Physician's orders", "Physician notification", "Insulin administration" and "Medication Storage"; ensuring clarity. No revisions are needed. All licensed nurses (which includes full time, part time and active per diem nurses) will be reeducated to the above policies and the expectation to administer insulin in accordance with physician's orders. Furthermore, the nurses will be reeducated to the expectation of removing and safely storing discontinued medications for destruction in accordance with facility policy. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a)The DON and ADON will review conduct a review of all insulin orders weekly x 4 then monthly x 3 as well as a "cart" check; confirming the presence of insulins as ordered and	

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F 755	Continued From page 76 on 8/13/19. This vial was never removed from the medication cart. A medication administration pass observation was conducted with Licensed Practical Nurse #5 on 8/21/19 at 4:30 p.m., the nurse obtained the resident's blood sugar. The blood sugar was 240 and required 1 unit of sliding scale insulin. The nurse found only the insulin vial that read 6 units Novolog before meals. The sliding scale insulin was not available and therefore the nurse did not administer the 1 unit. LPN #5 called the pharmacy who requested a new prescription for the Humalog. A call was placed to the on-call practitioner. LPN #5 stated the pharmacy will be sending out the Humalog and should be expected on the next run. The medication cart was checked on 8/21/19 at 9:32 a.m.,. A vial of Humalog with the label that read to be administered subcutaneously per sliding scale before meals and at bedtime dated 8/21/9 was found and was delivered after midnight on 8/21/19. The above findings was shared during the pre-exit meeting with the Administrator, the Director of Nursing and the Regional Nurse. No additional information was provided prior to exit.	F 755	discontinued insulins to be removed from the cart for destruction. b) The DON or ADON will randomly check insulin availability monthly x 3 then quarterly x 2; confirming prescribed insulins are present. Findings will be addressed promptly and forwarded to the QAA team for processing. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		10/5/19

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F 758	Continued From page 77 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 78 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility staff failed to ensure that Resident #6 did not receive "as needed" Xanax for greater than 14 days without the physician and/or prescribing practitioner evaluating the resident for the appropriateness of continuous "as needed" use for 1 of 38 residents in the survey sample. The findings included: Resident #6 was originally admitted to the facility 1/23/14 and readmitted 9/2/18 after an acute care hospital stay. The current diagnoses included bipolar disorder, dissociative identity disorder, a major depressive disorder and an anxiety disorder. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were intact. The MDS assessment also revealed Resident #6 was without mood or behavior problems, required limited assistance of 1 person with bed mobility and was independent with all other activities of daily living. Review of the clinical record revealed from 6/14/19 through 7/15/19, Resident #6 was receiving Xanax 0.5 mg (milligrams) every eight hours.	F 758	F758 Resident #6 remains at baseline. On 9/12/2019 Resident #6 was evaluated by the attending physician; discontinuing his PRN order Xanax. Resident #6's response to this medicinal milieu change is being monitored. All residents receiving PRN psychoactive medications have the potential to be affected. The DON or ADON will conduct a review of all residents on PRN psychoactive medications; confirming the continuation of a PRN order is supported by the prescriber's assessment and support of continuation past fourteen (14) days from the original order date. Findings will be promptly addressed and forwarded to the QAA team for processing. Findings will be promptly addressed and forwarded to the QAA team for processing. The facility has reviewed its policy on "Psychoactive Medication Administration – Routine and PRN Usage"; ensuring clarity. No revisions are needed at this time. The DON or ADON will monitor all PRN psychoactive medication orders; ensuring orders are re-evaluated by prescribers by day fourteen (14) from the initial order date; supporting the continuance or discontinuation of the PRN psychoactive medication. All licensed	

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THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

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F 758	Continued From page 79 A physician's order dated 7/11/19, read: Xanax 0.5 milligram (mg) tablet. One tablet by mouth every 24 hours as needed for anxiety related to a generalized anxiety disorder. There was no stop date for the medication. Xanax is an antianxiety medication, use to slow down the central nervous system. (https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details) A psychiatric assessment dated 7/23/19, under History of Presenting Illness read: mostly stable in the same personae at time of this interview. Reports anxiety lessened and occurs every other day. Under Review of History the document read; charted history of major childhood abuse, long term treatment for bipolar disorder depressive. Claims no recent anxiety or use of Xanax. The psychiatric assessment did not include a rationale for continuing the use of the "as needed" Xanax. The Xanax 0.5 mg tablet, controlled medication utilization record revealed the medication Xanax was administered 8/13/19 and 8/14/19. Resident #6's active care plan dated 5/14/19, problem read I may experience anxiety related my diagnosis of anxiety. The goal read; I will demonstrate reduced anxiety as evidenced by response to proper medications through the next review date 10/6/19. The interventions read; please document my behaviors on the behavior sheets any anxiety related behaviors I have experienced. Please medicate me as ordered. I am on Xanax. Please provide me psych services	F 758	nurses (which includes full time, part time and active per diem nurses) will be re in-serviced on the above policies and expectations before 10/05/2019. The DON will partner with the consultant pharmacist to assess all PRN psychoactive medications during his/her monthly medication management reviews; documenting the absence of prescriber assessment for the continuation or discontinuation of the same within fourteen (14) days from the original order date. The Licensed Nursing Home Administrator (“LNHA”) is responsible for the Plan of Correction (“POC”) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The DON or ADON will review all PRN psychoactive medications ordered for current residents monthly to ensure prescriber assessment to continue or discontinue the same occurs by day fourteen (14) from the initial order date order is occurring. b) Monthly during the consultant pharmacist’s monthly medication review, the consultant pharmacist will document the absence of prescriber documentation to continue or discontinue the PRN psychoactive medication. c) Weekly during Resident at Risk meetings, the DON or ADON will review all residents on PRN psychoactive medications; ensuring the presence of prescriber documentation to continue or discontinue the PRN psychoactive medication. Findings will be addressed	

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F 758	Continued From page 80 as needed. On 8/22/19, at approximately 5:00 p.m., the above findings were shared with the Administrator, the Director of Nursing and the Corporate consultant. The Corporate consultant stated the medication should have been reassessed for appropriateness within 14 days.	F 758	promptly and forwarded to the QAA team for processing. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		10/5/19

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F 761	Continued From page 81 Based on observations, staff interviews and facility document review the facility staff failed to ensure drugs were dated when opened in accordance with currently accepted professional principles on 2 out of 4 medication carts; and failed to remove 2 boxes of expired Influenza Vaccine from the refrigerator in the Medication Storage Room. The findings included: On 08/20/2019 at 11:00 a.m., the "Blue" medication cart on the 100 Hall was inspected with Licensed Practical Nurse (LPN) #5. Dorzolamide 2% eye drops was observed opened and did not have an open date on the product. LPN #5 was asked, "Should the eye drops have been dated when they were opened?" LPN #5 stated, "Yes." LPN #5 was asked, "Are the eye drops dated indicating when they were opened?" LPN #5 stated, "No." LPN #5 was asked, "How long are the eye drops good for after opening?" LPN #5 stated, "28 days." LPN #5 stated, "I will get rid of them." The Surveyor inspected the "Immunization" refrigerator in the Medication Storage Room with LPN #5 and observed the following: a vial of Aplisol 50 5T Solution, marked "House Stock," that had been opened and did not have an open date. 2 boxes of pre-filled Influenza Vaccine syringes (one box of 10 syringes and one box of 9 syringes) with an expiration date of June 21, 2019 on each box was also observed. LPN #5 was asked, "Are these vaccines expired?" LPN #5 stated, "Yes." LPN #5 was asked, "Should expired medications be in the refrigerator?" LPN #5 stated, "No." LPN #5 stated, "I will get rid of these also." LPN #5 was asked, "What is the facility process for checking for expired medications?" LPN #5 stated, "I'm not	F 761	F761 The DON and ADON have conducted a medication storage review; removing and discarding any expired or undated medications; re-ordering as appropriate. LPN #3 and LPN #5 have been re-educated to the facility's policy on "Storage of medication" and the expectations of dating insulins and eye drops upon opening and discarding expired medications per the facility's policy and processes. All residents have the potential to be impacted. The DON and ADON have conducted a medication storage review; removing and discarding any expired or undated medications; re-ordering as appropriate. Findings will be addressed promptly with findings forwarded to the QAA committee. The facility has reviewed its' policy on "Storage of medications" ensuring clarity and comprehensiveness. No revisions are needed. Findings will be promptly addressed and forwarded to the QAA tam for processing. The DON and/or ADON will conduct weekly medication storage reviews of med carts and med room; ensuring all open medications to be dated upon opening while ensuring all are free from expiration. The DON and/or ADON will educate all facility nurses (which includes full time, part time and active per diem nurses) on the above policy which addresses dating of open medications, expiration dates post opening of medications inclusive of but not limited to insulins.	

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F 761	Continued From page 82 sure." On 08/20/2019 at 1:00 p.m., the "Back of Pink Hall" medication cart on the 200 Hall was inspected with LPN #3 and one Basagler KwikPen U-100 that had been opened did not have an open date. The KwikPen had a label that said, "Discard 28 days after opening." The Surveyor noted one (1) Lantus Solostar Insulin Pen 100/Unit that was opened and did not have an open date and it had a label that said, "Discard 28 days after opening." LPN #3 was asked, "When were these Insulin pens opened?" LPN #3 stated, "I don't know. The nurse was suppose to date them." The Surveyor also observed a vial of Novolog Insulin on the medication cart that had been opened and did not have an open date. The Administrator, Director of Nursing (DON) and Senior Director of Nursing was made aware of the findings during a briefing on 08/20/2019 at 4:10 p.m. The Senior DON and DON was asked what their expectations were of the licensed nurses when they opened drugs and biologicals such as the eye drops, insulin pens, multi-dose vials of insulin or Purified Protein Derivative (PPD) solution?" The Senior DON stated, "I expect the nurse to date them when they are opened." The Senior DON stated, "This afternoon we will review dating medications with the nurses and go through the medication carts and look for any more expired drugs." The facility did not present any further information about the findings. The facility policy titled - Storage of Medications. Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.	F 761	The Licensed Nursing Home Administrator (“LNHA”) is responsible for the Plan of Correction (“POC”) implementation. The Quality Assessment and Assurance (“QAA”) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process through a) Daily during medication administration, the assigned staff nurse will review all open medications; ensuring they are dated and also reviewing all medications in the cart ensuring they are free from expiration. b) Weekly the DON or ADON will conduct reviews of both medication carts and the medication room confirming all medications to be dated upon opening and free of expiration. Findings will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	

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F 761	Continued From page 83	F 761		

Policy Interpretation and Implementation:
The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

Definitions:

* Dorzolamide 2% Eye Drops Solution - Dorzolamide eye drops are used to control increased pressure within your eye (glaucoma). Storing Dorzolamide - Bottles of eye drops only keep for four weeks once the bottle has been opened, so do not use the drops if the bottle has been open for longer than this. This will help to prevent the risk of eye infections. (https://patient.info/medicine/dorzolamide-eye-drops-for-glaucoma-trusopt)

* Aplisol 50 5T - Aplisol (tuberculin PPD (Purified Protein Derivative), diluted) is a sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis. Storage - Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. (https://www.fda.gov>media>download)

* Basagler KwikPen - Used to lower blood sugar in patients with high blood sugar (diabetes). Storing Basaglar KwikPen: Store unopened containers in a refrigerator. Store opened cartridges and pens at room temperature. Throw away any part not used after 28 days. (https://www.drugs.com/cdi/basaglar-kwikpen.html)

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F 761	Continued From page 84 * Lantus Solostar Insulin Pen 100/Unit - Lantus (insulin glargine) is a man-made form of a hormone (insulin) that is produced in the body. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. Insulin glargine is a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours. Storing unopened (not in use) Lantus: Refrigerate and use until expiration date: or Store at room temperature and use within 28 days. Storing opened (in use) Lantus: Store the injection pen at room temperature and use within 28 days. (https://www.drugs.com/lantus.html) * Novolog - Novolog (insulin aspart) is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. Storing unopened (not in use) Novolog: Refrigerate and use until expiration date: or Store at room temperature and use within 28 days. Storing opened (in use) Novolog: Store the vial in a refrigerator or at room temperature and use within 28 days. (https://www.drugs.com/novolog.html)	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		10/5/19

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F 812	Continued From page 85 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to store and prepare foods in a sanitary manner. The findings included: The initial tour of the Kitchen was conducted on 08/20/19 at approximately 10:43 a.m. with Other Staff #10 (Dietary Director) and with Other Staff #13. The following was observed: 1. Dialysis lunch bag was unlabeled (no date, not labeled). Food service staff, Other Staff #13 stated that she made the extra Dialysis lunch bag this morning. 2. Thick N Easy Dairy Beverage with a use by date of 08/19/19. 3. Coleslaw 10 lb container about 1/2 full, with a prepare date 8/15/19 use by date 8/22/19 however the date printed on container was use by 8/02/19. 4. 3 packs of hamburger buns (12 buns in each bag) exp. 8/01/19 was observed located in the dry storage area.	F 812	F812 The identified dialysis lunch bag, Thick N Easy Dairy Beverage, Coleslaw and Hamburger Buns were discarded on 8/20/19. All residents have the potential to be impacted. On 8/20/19 a review was conducted of all foods stored on site; confirming all to be labeled, dated and free from expiration. The Food Service Manager was re-educated to the food receiving and storage policy and expectations food safety and service. A review of the facility's policy "Food Receiving, and Storage" was been conducted on 8/27/19 with the Food Service Manager by the LNHA to ensure clarity. No revisions are needed. The facility has activated a daily audit x 30 days to ensure that all foods stored in the refrigerator and freezer are covered, labeled and dated (use by date). Food Service Manager has re-educated the dietary staff to the policy and expectations on 8/27/19.	

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F 812	Continued From page 86 On 08/22/19 at approximately, 10:00 AM an Interview was conducted with Other Staff #10, concerning the above expired and unlabeled food observed on the initial tour. He was asked what should have been done concerning the issues? He stated that the "Dialysis meal should have been dated." and the expired food should have been "Checked and discarded." Review of the Facility's Policy titled "Food Receiving and Storage. "Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. (7). All foods stored in the refrigerator and freezer will be covered, labeled and dated ("use by date"). On 08/22/19 at approximately 4:50 PM a Pre-Exit interview was conducted with the Administrator, Director of Nursing and The Director of Clinical Services they were informed of the above findings. The Director of Clinical Services asked for and was given the expiration dates of the expired foods.	F 812	The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the on-going monitoring of this process as follows: a) A food storage audit will be conducted daily x 30 days by the Food Service Manager; ensuring food storage is compliant with safe food storage practices which include foods to be covered, labeled and dated (inclusive of a use by date) x 8 weeks then weekly x 3 months. b) The Food Service Manager/designee will audit monthly for (2) months then quarterly x (1) year which includes the monitoring of foods stored in the refrigerator and freezer will be covered, labeled and dated (use by date). Findings will be addressed promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter. Date of Compliance: 10/05/2019	
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	F 880		10/5/19

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F 880	Continued From page 87	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable 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

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F 880	Continued From page 88 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 that facility staff failed to maintain an effective infection control practices for one of 38 residents, Resident #12 and two of four medication carts. The findings included: 1. Facility staff failed to store respiratory equipment in a sanitary manner for Resident #12. Resident #12 was admitted to the facility on 10/21/15 and readmitted on 6/4/19 with diagnoses that included but were not limited to heart failure, high blood pressure, and dementia. Resident #12's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 8/12/19. Resident #12 was coded as being severely impaired in cognitive function scoring 99 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 880	F880 Resident #12 remains at baseline. CNA #3 was re-educated to proper infection control practices for oxygen tubing on 8/22/2019. LPN #5 was re-educated to the facility's process for following the manufacturer's instructions for cleaning resident's glucometers and the facility's process for cleaning medication carts on 8/22/2019. All residents have the potential to be impacted. The facility will conduct the following: a) Daily observations x 2 weeks of residents receiving oxygen therapy by the DON or ADON; ensuring oxygen tubing is free from contamination and that it is changed minimally, weekly and PRN. b) targeted reviews daily x 2 weeks by the DON or ADON of insulin administration; ensuring glucometers are being cleaned per the manufacturer's instructions; and 3) observations of all medication carts daily x 2 weeks by the DON and ADON to	

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THORNTON HALL NURSING AND REHABILITATION CENTER	827 NORVIEW AVENUE NORFOLK, VA 23509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 89 On 8/20/19 at 11:10 a.m., an observation was made of Resident #12. He was sleeping in his bed with his nasal cannula in place. The oxygen concentrator was set to 2 liters. The end of his oxygen tubing was not hooked up to the concentrator. The end of oxygen tubing was on the floor. On 8/20/19 at 11:57 a.m., Resident #12 was observed up in his wheel chair in the hallway with no oxygen in place. At 11:58 a.m. an observation was made of his room. His entire oxygen tubing was on the floor including the end of the tubing and nasal cannula. The date documented on the oxygen tubing was eligible. Brown debris was noted inside the nasal cannula. At this time Resident #12's certified nursing assistant (CNA) #3 put the oxygen tubing back on Resident #12's bed and stated, "I need to get a bag for it." On 8/20/19 at 12:01 p.m., the entire oxygen tubing was back on the floor. On 8/20/19 at 2:26 p.m., and 8/21/19 at 9:08 a.m., observations were made of Resident #12's oxygen. The same tubing that had been on the floor, was observed to be in a plastic bag available for use. Brown debris was still observed in the nasal cannula part of the oxygen tubing. On 8/21/19 at 10:51 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked if oxygen tubing is stored in a bag on the resident's concentrator if it is available to be used, RN #1 stated that it was. When asked if it was ever okay to put tubing that had fallen on the floor back in the plastic bag to be used, RN #1 stated that dirty or contaminated tubing should be	F 880	ensure medication carts are being cleaned per the facility's Protocol. Findings will be addressed promptly and forwarded to QAA committee for processing and ongoing monitoring. The facility will review its policies on "Oxygen Therapy", "Cleaning and Disinfection of Resident Care Items and Equipment" and "Storage of Medications"; ensuring clarity and comprehensiveness. No revisions are needed. All licensed nurses (which includes full time, part time and active per diem nurses) will be re in-serviced on the above policies before 10/05/2019. All CNAs (which includes full time, part time and active per diem nursing assistants) will be re in-serviced on "Oxygen Therapy" before 10/05/2019 The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC") implementation. The Quality Assessment and Assurance ("QAA") Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process through a) The DON and/or ADON will conduct weekly rounds x 4 then monthly x 3 of all resident's on oxygen; confirming one's nasal canula has been changed at least weekly and that it is free of contamination. b) The DON or ADON will conduct observations with nurses specific during glucometer usage; confirming proper cleaning technique in accordance with policy. c) The DON and/or ADON will conduct medication cart reviews monthly x 3 then quarterly x 1; confirming the carts to be clean and free of debris. Findings will be	

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F 880	Continued From page 90 thrown away. On 8/21/19 at 4:42 p.m., an interview was conducted with CNA #2. When asked if it was ever okay to place contaminated oxygen tubing that had touched the floor into the plastic bag for future use, CNA #2 stated, "That's germs and it could go up into the tubing and the resident breaths that it. I would ask for new tubing." CNA #3 could not be reached for further interview. On 8/22/19 at 4:52 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services and ASM #5, the regional nurse, were made aware of the above concerns. Facility policy titled, "Oxygen therapy," documents in part, the following: "Discard masks, cannulas, and tubing, of disposable, between residents, or whenever it has become soiled." No further information was presented prior to exit. 2. The facility failed to implement appropriate infection control practices after utilizing a shared blood glucose meter. Blood glucose meters are devices that measure blood glucose levels. A medication administration pass observation was conducted with Licensed Practical Nurse (LPN) #5 on 8/20/19 at 4:30 p.m. The nurse obtained Resident #24's blood glucose using a shared glucometer. After obtaining the reading the nurse put the glucometer back into the medication cart without cleaning or sanitizing it first. After the medication pass the observation was shared with the nurse. LPN #5 stated, "We	F 880	promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 10/05/2019	

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do know to clean it after use." LPN #5 was not observed removing the glucometer to clean it after the issue was identified. The glucometer was not observed being used on another resident. Resident #24 was admitted to the facility on 3/27/19 with diagnoses to include, but not limited to, type 2 diabetes.

The manufacturer's instructions for the blood glucose meter indicated the glucometer should be disinfected with approved agents and the cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter after use.

The facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, revised 2014 read, in part:
4. Reusable resident care equipment will be decontaminated and /or sterilized between resident's according to manufacturer's instructions.

The above findings was shared during the pre-exit meeting with the Administrator, the Director of Nursing and the Regional Nurse. No additional information was provided prior to exit.

*Whenever possible, blood glucose meters should be assigned to an individual person and not be shared.
*If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. Referenced from https://www.cdc.gov/injectionsafety/blood-glucose

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F 880	Continued From page 92 -monitoring.html 3. The facility staff failed to ensure that 1 of 4 medication carts was maintained in a clean and sanitary manner. On 08/20/2019 at 11:00 a.m., this Surveyor inspected the "Blue" medication cart on the 100 Hall with Licensed Practical Nurse (LPN) #5 and observed a dried liquid substance in the bottom of the bulk medication drawer. The substance was stuck to the bottom of medication bottles. LPN #5 was asked, "Does this cart need to be cleaned?" LPN #5 stated, "Yes." LPN #5 was asked, "How often are the medication carts cleaned?" LPN #5 stated, "I'm not sure." The Administrator, Director of Nursing and Senior Director of Nursing was made aware of the finding during a briefing on 08/20/2019 at 4:10 p.m. The Senior Director of Nursing stated that she expected the nurses to check and clean the medication carts weekly. No further information was presented about the finding. The facility policy titled - Storage of Medications. Policy Interpretation and Implementations: "The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner."	F 880		