STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	490 HILLSDALE DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/18/20 through 02/20/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Two complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/18/2020 through 2/20/2020. Two complaints were investigated: VA00045932 was substantiated without a deficiency, and VA00048260 was substantiated with a deficiency. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 24 current Resident reviews and three closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, facility staff failed to assess one of 27 residents in the survey sample, Resident #321, for self administration of a medication, Aspercreme.	F 554	Self-Administer Medication Aspercreme was removed from bedside of resident #321. MD and RP were notified. Other residents who may have medications at bedside could be affected.	3/31/20

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

Electronically Signed | 03/12/2020

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F 554	Continued From page 1 Findings included: Resident #321 was admitted to the facility on 12/12/2019 and readmitted on 01/28/2020 with diagnoses including, but not limited to: Acute Cholecystitis with drain placement, Difficulty walking, Muscle weakness and Gout. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 12/16/2019. Resident #321 was assessed as moderately impaired in his cognitive status with a total cognitive score of 11 out of 15. Resident #321 was interviewed on 02/18/2020 at 3:05 p.m. Resident #321 was observed sitting up in a chair with a bedside table in front of him. Lying on the table was tube of Aspercreme. Resident #321 stated, "I use that when my leg starts aching. I rub it on my right knee. It helps a little." During the review of Resident #321's clinical record on 02/19/2020 at approximately 2:00 p.m., no physician order or resident assessment for self administration of medications was noted in the record. It was also not included in the CCP (comprehensive care plan). An assessment for self administration of medications was requested during a meeting with the Administrator and the DON (director of nursing) on 02/19/2020 at approximately 4:00 p.m. On 02/20/2020 at 8:15 a.m. the ADON (assistant director of nursing) stated, "There isn't one."	F 554	Every room will be searched for meds at bedside. Remove medication, notify MD/RP and complete evaluation when appropriate. Licensed nurses will receive education on the policy regarding self-administration of medications and the evaluation. Upon admission, the RP will be notified that resident cannot have medications at bedside without an evaluation and a physician□s order. Unit Managers will make rounds on each unit weekly x 4, then monthly x 2 to assess for medications at bedside and review evaluations to ensure completion. Licensed nurses will receive re-education up to disciplinary action for infractions. DON/Designee will report findings to the QA Committee Monthly x 3.	

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F 554	Continued From page 2 The facility policy, "Medication self-administration, long-term care, Revised: 06/14/2019," included, "...the interdisciplinary (ID) team is responsible for determining whether it's safe for the resident to do so before the resident may exercise that right. The ID team must also determine who will be responsible for storing and documenting administration of drugs as well as the site of drug administration. You should document this information in the resident's care plan. The resident's ability to self-administer medications is subject to quarterly reevaluation; it may be needed more frequently if the resident's status changes... Document your assessment findings concerning the resident's medication self-administration competency using a facility-approved documentation form. Record your teaching and the resident's ability to teach back what you taught..." No further information was received by the survey team prior to the exit conference.	F 554		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced	F 557		3/31/20

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F 557	Continued From page 3 by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure the right to retain and use of personal property for one of 27 residents in the survey sample, Resident #209. Resident #209's cell phone was locked in the medication cart for over a week without the resident's permission or knowledge and without identifying the phone as the resident's property. The findings include: Resident #209 was admitted to the facility on 2/7/20 with diagnoses that included lower limb cellulitis, dementia with behaviors, chronic obstructive pulmonary disease, morbid obesity, high blood pressure, delusional disorder and osteoarthritis. The admission nursing assessment dated 2/7/20 assessed Resident #209 as alert and oriented to person only. Resident #209's clinical record documented a physician's history and physical note dated 2/10/20 stating, "...She [Resident #209] said she slept well however the nurse told me that she did not sleep well last night because she was trying to call her daughter at 2:00 in the morning and said that she was expecting a call from her daughter. Patient told me that people took her phone. When I asked the nurse who brought patient's purse while I was in the room, she told me that patient was calling 911 at nighttime so the nurses took away the phone..." (Sic) On 2/19/20 at 9:46 a.m., Resident #209 was interviewed about her cell phone and her quality of care since her admission to the facility. Resident #209 was tearful and stated staff	F 557	Right to retain and use personal property Cell phone was returned to resident # 209 on 2/19/2020 Other residents who have cell phones may be affected Cell phones of residents will be audited to ensure they have the residents name and the cell phone is on the inventory sheets. Nursing Staff will be in-serviced on Resident Rights, inventory sheets, removal of personal property w/o permission. New admissions will be assessed for having cell phones and whether or not they are labeled and on the inventory sheet. Nursing staff will receive re-education up to disciplinary action for infractions. DON/Designee will report findings to the QA Committee Monthly x 3.	

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members took her pocketbook and cell phone not long after she came here. Resident #209 stated "two guys" walked around, "messed with" her cell phone and then took it from her. Resident #209 stated one of the staff members told her he was going to "flush" the phone if she did not stop calling numbers. When asked if she had called 911, Resident #209 stated, "That's what they said. I was trying to call my daughter." Resident #209 stated she now had her pocketbook but she did not have her cell phone and she had no idea what happened to it. Resident #209, tearful and crying, again stated staff took her cell phone shortly after she arrived at the facility and she had not seen it since.

Resident #209's clinical record nursing notes made no mention of the resident calling 911 or any issues with the resident's cell phone. There was no documentation regarding staff members taking the resident's phone as listed in the physician's 2/10/20 note. A skilled nursing notes dated 2/8/20 documented the resident was alert, confused and "restless at times but easily redirected."

Resident #209's plan of care (revised 2/11/20) listed the resident had behavior problems due to delusions, paranoia and dementia. The plan documented, "Calling 911 at night" but did not mention the resident's cell phone. Interventions for behaviors included, "Anticipate and meet resident's needs...Approach in calm manner...Stop and talk with him/her as passing by...Document behaviors, and resident response to interventions...Explain/reference why behavior is inappropriate and/or unacceptable to resident...Provide program of activities that is of interest...Review concerns as needed..."

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Resident #209's clinical record documented no inventory list of personal items with the resident at the time of her admission.

On 2/19/20 at 10:00 a.m., the registered nurse (RN #2) working on Resident #209's living unit was interviewed about the location of the resident's cell phone. RN #2 stated she cared for Resident #209 "at times" and was not aware of any information about the resident's cell phone.

On 2/19/20 at 10:04 a.m., the licensed practical nurse (LPN #2) caring for Resident #209 was interviewed about the cell phone. LPN #2 stated nothing had been reported to her about any problems and/or issues regarding the resident's cell phone or that staff had taken the phone from the resident.

On 2/19/20 at 10:07 a.m., the social worker (other staff #3) was interviewed about Resident #209's cell phone. The social worker stated she had no knowledge of an issue with the resident's cell phone and no staff members had reported to her that the cell phone was taken from the resident. The social worker stated certified nurses' aides were responsible for recording a personal property inventory for residents at the time of admission.

On 2/19/20 at 10:11 a.m., the certified nurses' aide (CNA #2) caring for Resident #209 was interviewed about the cell phone. CNA #2 stated other staff members told her that the resident kept calling 911 so the nurse locked up the phone. CNA #2 stated the resident had a cell phone when she first came to the facility but she did not know where the cell phone was now

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located.

On 2/19/20 at 10:13 a.m., accompanied by LPN #2 and CNA #2, the medication cart on Resident #209's living unit was inspected. A black cell phone was locked in the narcotic box on the medication cart. CNA #2 identified the cell phone as belonging to Resident #209. The cell phone was not labeled with any resident name or any information indicating ownership of the phone.

On 2/19/20 at 2:54 p.m., the unit manager (RN #1) was interviewed about Resident #209's cell phone. RN #1 stated she was not aware the cell phone was locked in the medication cart. After reviewing records, RN #1 stated she found no inventory list of personal items completed for Resident #209. RN #1 identified CNA #3 as working when Resident #209 was admitted.

On 2/19/20 at 3:12 p.m., CNA #3 was interviewed about Resident #209's cell phone and personal items inventory. CNA #3 stated Resident #209 had a purse, a bag of chips, a pair of pants and a shirt upon admission. CNA #3 stated the resident refused to let her look through her purse. CNA #3 stated, "We took the cell phone away from her, me and the nurse [LPN #1]." CNA #3 stated this happened on 2/9/20, the day after the resident was admitted. CNA #3 stated the resident was on her cell phone and said she was calling an Uber. CNA #3 stated she was listening to the conversation and she took the phone and the person on the phone was actually a 911 operator. CNA #3 stated the 911 operator reported the resident kept calling them and was asking to speak to someone. CNA #3 stated the 911 operator told her to take the phone away from the resident. CNA #3 stated she reported this to the

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nurse and the nurse took the phone from the resident. CNA #3 stated it was a busy shift and she did not know why she did not complete an inventory sheet for Resident #209's personal items.

On 2/20/20 at 8:06 a.m., LPN #1 caring for Resident #209 on 2/9/20 was interviewed about the cell phone. LPN #1 stated CNA #3 reported to her that the resident had been calling different numbers and was argumentative on the phone. LPN #1 stated the CNA reported the resident had also called 911. LPN #1 stated, "The phone was put in the cart." LPN #1 stated the resident was able to use the phone whenever she wanted and the resident was not upset when they took the phone. LPN #1 stated, "We told her [Resident #209] we would put it [cell phone] away so it would be safe." LPN #1 stated she did not think to put the resident's name on the phone. When asked why the other nurses knew nothing about the phone's location, LPN #1 stated she passed the information along during the shift report and the nurse caring for Resident #209 on 2/19/20 "was new." LPN #1 stated, "It could have fell through with the communication about it." When told that Resident #209 did not know what happened to the phone or the location of the phone, LPN #1 stated the resident had confusion. LPN #1 stated she would have let Resident #209 use the phone if she asked.

On 2/19/20 at 11:00 a.m., the director of nursing (DON) was interviewed about Resident #209's cell phone. The DON stated, "Only thing I know, when she was first admitted, she was calling 911." The DON stated she was not aware the resident's phone was taken or locked in the medication cart.

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F 557	Continued From page 8 On 2/20/20 at 10:54 a.m., the administrator was interviewed about Resident #209. The administrator stated he talked with Resident #209 and confirmed that the cell phone found locked in the medication cart belonged to Resident #209. The administrator stated no inventory sheet was completed upon admission listing Resident #209's personal items, including the cell phone. These findings were reviewed with the administrator and director of nursing during a meeting on 2/20/20 at 2:15 p.m.	F 557		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to implement their abuse prevention policies regarding reporting of an allegation of mistreatment/abuse for one of 27 residents in the survey sample. Resident #209's allegations of mistreatment/abuse/misappropriation of property	F 607	Each resident will be interviewed to determine if anyone feels they have been mistreated or abused. ALL STAFF Abuse and Mandated Reporting Each allegation of mistreatment/abuse will	3/31/20

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F 607	Continued From page 9 reported to a therapist and a physician were not immediately reported to the administrator as required in their abuse prevention policies for abuse prevention. The findings include: Resident #209 was admitted to the facility on 2/7/20 with diagnoses that included lower limb cellulitis, dementia with behaviors, chronic obstructive pulmonary disease, morbid obesity, high blood pressure, delusional disorder and osteoarthritis. The admission nursing assessment dated 2/7/20 assessed Resident #209 as alert and oriented to person only. Resident #209's clinical record documented a physician's history and physical note dated 2/10/20 stating, "...She [Resident #209] said she slept well however the nurse told me that she did not sleep well last night because she was trying to call her daughter at 2:00 in the morning and said that she was expecting a call from her daughter. Patient told me that people took her phone. When I asked the nurse who brought patient's purse while I was in the room, she told me that patient was calling 911 at nighttime so the nurses took away the phone..." Under the physician's assessment the physician documented, "...Mild dementia, patient is not on any medication at currently. Has been seen by...psychiatry for history of persistent delusions/paranoia. The fact that she said the maintenance person may have done something to her is probably an evidence of her paranoia..." (Sic) On 2/19/20 at 9:46 a.m., Resident #209 was interviewed about her cell phone and her quality	F 607	be reported to OLC immediately. Staff who fail to report allegations of mistreatment/abuse will receive re-education up to disciplinary action. DON/Designee will report findings to the QA Committee monthly x 3.	

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of care since her admission to the facility. Resident #209 stated, "I have been abused here." Resident #209 was tearful and stated staff members took her pocketbook and cell phone not long after she came to the facility. Resident #209 stated "two guys" walked around, "messed with" her cell phone and then took it from her. Resident #209 stated one of the staff members told her he was going to "flush" the phone if she did not stop calling numbers. When asked if she had called 911, Resident #209 stated, "That's what they said. I was trying to call my daughter." Resident #209 stated "a guy" came in "the other night" and made her take her clothes off in front of him, would not give her clothes back to her and made her go to bed. Resident #209 stated the staff at bedtime were "demanding" and made her go to bed. When asked if she had reported the abuse/mistreatment to anyone in the facility, the resident stated she reported being mistreated to one of the therapist in the gym but nobody had done anything. The resident stated she now had her pocketbook but she did not have her cell phone and she had no idea what happened to it. The resident, tearful and crying, again stated staff took her cell phone shortly after she arrived at the facility and she had not seen it since.

Resident #209's clinical record nursing notes made no mention of the resident calling 911 or any issues with the resident's cell phone. There was no documentation regarding staff members taking the resident's phone as listed in the physician's 2/10/20 note. A skilled nursing notes dated 2/8/20 documented the resident was alert, confused and "restless at times but easily redirected."

The resident's plan of care (revised 2/11/20)

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listed the resident had behavior problems due to delusions, paranoia and dementia. The plan documented, "Calling 911 at night" but did not mention the resident's cell phone. Interventions for behaviors included, "Anticipate and meet resident's needs...Approach in calm manner...Stop and talk with him/her as passing by...Document behaviors, and resident response to interventions...Explain/reference why behavior is inappropriate and/or unacceptable to resident...Provide program of activities that is of interest...Review concerns as needed..."

On 2/19/20 at 10:11 a.m., the certified nurses' aide (CNA #2) caring for Resident #209 was interviewed about the cell phone. CNA #2 stated other staff members told her the resident kept calling 911 so the nurse locked up the phone. CNA #2 stated the resident had a cell phone when she first came but she did not know where it was now located.

On 2/19/20 at 10:12 a.m., the licensed practical nurse (LPN #2) caring for Resident #209 was interviewed about the cell phone and any reports of mistreatment. LPN #2 stated she was not aware of any reported mistreatment and nothing had been reported to her about the resident's cell phone.

On 2/19/20 at 10:13 a.m., accompanied by LPN #2 and CNA #2, the medication cart on Resident #209's unit was inspected. A black cell phone was locked in the narcotic box on the medication cart. CNA #2 identified the cell phone as belonging to Resident #209.

On 2/19/20 at 10:45 a.m., the physical therapist (other staff #1) that treated Resident #209 was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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interviewed about any report from the resident of mistreatment, abuse or missing cell phone. The therapist stated, "Yes. She mentioned it." The therapist stated Resident #209 reported that everyone was mean to her and said someone knocked her down. The therapist stated the resident was frequently tearful and "has a little bit of psychosis and paranoia." The therapist stated the resident reported missing items but did not state one particular item that had been taken. The therapist stated the resident's stories were "unspecific" and "all over the place" and from his understanding "when she tells you stuff it is not reliable." The therapist stated the resident reported mistreatment by family, staff and visitors. The therapist stated Resident #209 comes in the gym, cries and tells him "great long stories that go all over the place." The therapist stated he did not report any of the concerns of mistreatment to the administrator. The therapist stated he did not think the resident's report of mistreatment was cause for concern. The therapist stated the resident was "labile" and considered the stories related to the resident's diagnoses of paranoia and psychosis. The therapist stated the resident cried frequently and most recently cried in therapy yesterday (2/18/20).

On 2/19/20 at 10:52 a.m., the administrator and director of nursing (DON) were interviewed about any allegations of mistreatment, abuse or misappropriation of the resident's property (cell phone). The administrator stated there had been no reports from any staff members, including therapy, nursing or the physician regarding allegations of mistreatment, abuse or missing personal items. The administrator stated from reviewing the physician's note of 2/10/20, he was not sure why the physician had not reported the

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alleged mistreatment by a maintenance employee. The DON stated, "Only thing I know, when she was first admitted, she was calling 911." The DON stated she was not aware the resident's phone was taken or locked in the medication cart. The DON stated all allegations of abuse and/or mistreatment were supposed to be immediately reported to the administrator for investigation.

The facility's policy titled Abuse Prohibition, Investigation, and Reporting (revised 7/2019) documented, "It is the policy of this facility to prohibit mistreatment, neglect, and abuse of guests/residents and/or misappropriation of guest/resident property or resources. The facility shall not allow verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, or exploitation and all facility personnel will promptly report any incident or suspected incident of guest mistreatment, injuries of unknown source or misappropriation of property/resources. Reports of alleged abuse and/or misappropriation will be immediately reported to the Administrator and thoroughly investigated...Misappropriation of guest property/resources is defined as the deliberate misplacement, exploitation, or wrongful (temporary or permanent) use of an guest's belongings or money without the guest's/legal representative's consent...All allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property must be reported immediately to the Administrator..."

This finding was reviewed with the administrator and director of nursing on 2/19/20 at 10:52 a.m. and during meetings on 2/19/20 at 4:00 p.m. and

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F 607	Continued From page 14 on 2/20/20 at 2:15 p.m.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to immediately report to the administrator allegations of mistreatment and	F 609	Abuse Reporting FRI was completed for resident #209 and her allegation of mistreatment and	3/31/20

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F 609	Continued From page 15 potential misappropriation of property for one of 27 residents in the survey sample. Resident #209's report of mistreatment/misappropriation of property to a therapist and a physician were not reported to the administrator. Nursing staff locked Resident #209's personal cell phone in a medication cart without consent and without any report to nursing or facility administration. The findings include: Resident #209 was admitted to the facility on 2/7/20 with diagnoses that included lower limb cellulitis, dementia with behaviors, chronic obstructive pulmonary disease, morbid obesity, high blood pressure, delusional disorder and osteoarthritis. The admission nursing assessment dated 2/7/20 assessed Resident #209 as alert and oriented to person only. Resident #209's clinical record documented a physician's history and physical note dated 2/10/20 stating, "...She [Resident #209] said she slept well however the nurse told me that she did not sleep well last night because she was trying to call her daughter at 2:00 in the morning and said that she was expecting a call from her daughter. Patient told me that people took her phone. When I asked the nurse who brought patient's purse while I was in the room, she told me that patient was calling 911 at nighttime so the nurses took away the phone..." Under the physician's assessment the physician documented, "...Mild dementia, patient is not on any medication at currently. Has been seen by...psychiatry for history of persistent delusions/paranoia. The fact that she said the maintenance person may have done something to her is probably an evidence of her paranoia..."	F 609	misappropriation of personal belongings on 2/19/2020 All residents potentially affected Each resident will be interviewed to determine if anyone feels they have been mistreated or abused. All staff will be educated on Abuse and Mandated Reporting Each allegation of mistreatment/abuse will be reported to OLC immediately. Staff who fail to report allegations of mistreatment/abuse will receive re-education up to disciplinary action. DON/Designee will report findings to the QA Committee monthly x 3.	

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On 2/19/20 at 9:46 a.m., Resident #209 was interviewed about her cell phone and her quality of care since her admission to the facility. Resident #209 stated, "I have been abused here." Resident #209 was tearful and stated staff members took her pocketbook and cell phone not long after she came here. Resident #209 stated "two guys" walked around, "messed with" her cell phone and then took it from her. Resident #209 stated one of the staff members told her he was going to "flush" the phone if she did not stop calling numbers. When asked if she had called 911, Resident #209 stated, "That's what they said. I was trying to call my daughter." Resident #209 stated "a guy" came in "the other night" and made her take her clothes off in front of him, would not give her clothes back to her and made her go to bed. Resident #209 stated the staff at bedtime were "demanding" and made her go to bed. When asked if she had reported any abuse/mistreatment to anyone in the facility, the resident stated she reported being mistreated to one of the therapist in the gym but nobody had done anything. The resident stated she now had her pocketbook but she did not have her cell phone and she had no idea what happened to it. The resident, tearful and crying, again stated staff took her cell phone shortly after she arrived at the facility and she had not seen it since.

Resident #209's clinical record nursing notes made no mention of the resident calling 911 or any issues with the resident's cell phone. There was no documentation regarding staff members taking the resident's phone as listed in the physician's 2/10/20 note. A skilled nursing note dated 2/8/20 documented the resident was alert,

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confused and "restless at times but easily redirected."

The resident's plan of care (revised 2/11/20) listed the resident had behavior problems due to delusions, paranoia and dementia. The plan documented, "Calling 911 at night" but did not mention the resident's cell phone. Interventions for behaviors included, "Anticipate and meet resident's needs...Approach in calm manner...Stop and talk with him/her as passing by...Document behaviors, and resident response to interventions...Explain/reference why behavior is inappropriate and/or unacceptable to resident...Provide program of activities that is of interest...Review concerns as needed..."

On 2/19/20 at 10:11 a.m., the certified nurses' aide (CNA #2) caring for Resident #209 was interviewed about the cell phone. CNA #2 stated other staff members told her that the resident kept calling 911 so the nurse locked up the phone. CNA #2 stated the resident had a cell phone when she first came but she did not know where it was now located.

On 2/19/20 at 10:12 a.m., the licensed practical nurse (LPN #2) caring for Resident #209 was interviewed about the cell phone and any reports of mistreatment. LPN #2 stated she was not aware of any reported mistreatment and nothing had been reported to her about the resident's cell phone.

On 2/19/20 at 10:13 a.m., accompanied by LPN #2 and CNA #2, the medication cart on Resident #209's unit was inspected. A black cell phone was locked in the narcotic box on the medication cart. CNA #2 identified the cell phone as

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belonging to Resident #209.

On 2/19/20 at 10:45 a.m., the physical therapist (other staff #1) that treated Resident #209 was interviewed about any report from the resident of mistreatment and/or abuse. The therapist stated, "Yes. She mentioned it." The therapist stated Resident #209 reported that everyone was mean to her and said someone knocked her down. The therapist stated the resident was frequently tearful and "has a little bit of psychosis and paranoia." The therapist stated the resident reported missing items but did not state one particular item that had been taken. The therapist stated the resident's stories were "unspecific" and "all over the place" and from his understanding "when she tells you stuff it is not reliable." The therapist stated the resident reported mistreatment by family, staff and visitors. The therapist stated the resident comes in the gym, cries and tells him "great long stories that go all over the place." The therapist stated he did not report any of the concerns of mistreatment to the administrator. The therapist stated he did not think the resident's report of mistreatment was cause for concern. The therapist stated the resident was "labile" and considered the stories related to the resident's diagnoses of paranoia and psychosis. The therapist stated the resident cried frequently and most recently cried in therapy yesterday (2/18/20).

On 2/19/20 at 10:52 a.m., the administrator and director of nursing (DON) were interviewed about any allegations of mistreatment, abuse or misappropriation of the resident's property (cell phone). The administrator stated there had been no reports from any staff members, including therapy, nursing or the physician regarding

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F 609	Continued From page 19 allegations of mistreatment, abuse or personal items taken. The administrator stated from reviewing the physician's note of 2/10/20, he was not sure why the physician had not reported the alleged mistreatment by a maintenance employee. The DON stated, "Only thing I know, when she was first admitted, she was calling 911." The DON stated she was not aware the resident's phone was taken or locked in the medication cart. The DON stated all allegations of abuse and/or mistreatment were supposed to be immediately reported to the administrator for investigation. This finding was reviewed with the administrator and director of nursing on 2/19/20 at 10:52 a.m. and during meetings on 2/19/20 at 4:00 p.m. and on 2/20/20 at 2:15 p.m.	F 609		
F 655 SS=E	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.	F 655		3/31/20

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F 655	Continued From page 20 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, facility staff failed to develop a baseline care plan for a PICC (peripherally inserted central catheter) line, for one of 27 residents in the survey sample, Resident #318. Findings included: Resident #318 was originally admitted to the facility on 02/03/2020 and readmitted on 02/14/2020 with diagnoses including, but not	F 655	Incomplete Care Plans The care plan for resident #318 had been updated to include PICC line. All residents with a PICC line or IV access were potentially affected A care plan audit will be conducted to ensure all guests with PICC lines have a care plan indicating line is present.	

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F 655	Continued From page 21 limited to: UTI with ESBL (urinary tract infection with extended spectrum beta lactamase), PICC Line placement, and Contact Isolation. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 02/18/2020. Resident #318 was assessed as cognitively intact with a total cognitive score of 14 out of 15. Resident #318 was readmitted to the facility on 02/14/2020 with a PICC line in place. This resident was receiving IV (intravenous) antibiotics for a UTI. Resident #318's CCP (comprehensive care plan) was reviewed on 02/19/2020 at approximately 1:00 p.m. No documentation was included regarding a PICC line or care of a PICC line. RN #4 (registered nurse) was interviewed on 02/20/2020 at 11:05 a.m. RN #4 stated, "Care plans are updated by MDS, by using morning report, admission data, physician orders and during required assessments." Regarding Resident #318's PICC line, RN #4 stated, "I remember talking about that. I guess we haven't gotten to it yet." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with survey team on 02/20/2020 at 2:10 p.m. No further information was received prior to the exit conference.	F 655	MDS and unit managers will receive education regarding inclusion of PICC lines in care plans. Nurse managers will review all new admissions for PICC lines and care plan updates 5 x weekly x 4 weeks. Nursing staff failing to care plan PICC lines will receive re-education up disciplinary action. DON/Designee will report findings to the QA committee monthly x 3.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		3/31/20

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F 656	Continued From page 22 §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 23 section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, facility staff failed to develop a comprehensive care plan for one of 27 residents in the survey sample, Resident #318, for care of a PICC (peripherally inserted central catheter) line. Findings included: Resident #318 was originally admitted to the facility on 02/03/2020 and readmitted on 02/14/2020 with diagnoses including, but not limited to: UTI with ESBL (urinary tract infection with extended spectrum beta lactamase), PICC Line placement, and Contact Isolation. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 02/18/2020. Resident #318 was assessed as cognitively intact with a total cognitive score of 14 out of 15. Resident #318 was readmitted to the facility on 02/14/2020 with a PICC line in place. This resident was receiving IV (intravenous) antibiotics for a UTI. Resident #318's CCP (comprehensive care plan) was reviewed on 02/19/2020 at approximately 1:00 p.m. No documentation was included regarding a PICC line or care of a PICC line. RN #4 (registered nurse) was interviewed on 02/20/2020 at 11:05 a.m. RN #4 stated, "Care plans are updated by MDS, by using morning report, admission data, physician orders and	F 656	Incomplete Care Plans The care plan for resident #318 had been updated to include PICC line. All residents with a PICC line or IV access were potentially affected A care plan audit will be conducted to ensure all guests with PICC lines have a care plan indicating line is present. MDS and unit managers will receive education regarding inclusion of PICC lines in care plans. Nurse managers will review all new admissions for PICC lines and care plan updates 5 x weekly x 4 weeks. Nursing staff failing to care plan PICC lines will receive re-education up disciplinary action. DON/Designee will report findings to the QA committee monthly x 3.	

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F 656	Continued From page 24 during required assessments." Regarding Resident #318's PICC line, RN #4 stated, "I remember talking about that. I guess we haven't gotten to it yet." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with survey team on 02/20/2020 at 2:10 p.m. No further information was received prior to the exit conference.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, facility staff failed to obtain a physician order for use of Aspercreme, for one of 27 residents in the survey sample, Resident #321; and failed to coordinate with Hospice services for one of 27 residents, Resident #214. Findings include: 1. Resident #321 was admitted to the facility on 12/12/2019 and readmitted on 01/28/2020 with diagnoses including, but not limited to: Acute Cholecystitis with drain placement, Difficulty	F 684	Failure to obtain order for Aspercreme and Failure to coordinate with Hospice Services. Aspercreme was removed from bedside of resident #321. MD and RP were notified. Resident #331 was discharged from the facility. Resident #214 has had Hospice records scanned in to the EMR. Residents who have medications at bedside and or who receive Hospice Services	3/31/20

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F 684	Continued From page 25 walking, Muscle weakness and Gout. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 12/16/2019. Resident #321 was assessed as moderately impaired in his cognitive status with a total cognitive score of 11 out of 15. Resident #321 was interviewed on 02/18/2020 at 3:05 p.m. Resident #321 was observed sitting up in a chair with a bedside table in front of him. Lying on the table was tube of Aspercreme. Resident #321 stated, "I use that when my leg starts aching. I rub it on my right knee. It helps a little." During the review of Resident #321's clinical record on 02/19/2020 at approximately 2:00 p.m., no physician order was located. The Administrator and DON (director of nursing) were informed of Resident #321's use of Aspercreme during a meeting with the survey team on 02/19/2020 at approximately 4:00 p.m. LPN #4 (licensed practical nurse) was interviewed on 02/20/2020 at 8:25 a.m. regarding Resident #321's use of Aspercreme. LPN #4 stated, "I wasn't aware of that. His family sometimes brings stuff into him." No further information was received prior to the exit conference on 02/20/2020. 2. Resident #214 was admitted to the facility on 2/8/20 with diagnoses that included metastatic colon cancer, depression, and edema. The admission nursing assessment dated 2/8/20 assessed Resident #214 as alert and oriented to	F 684	Guests can not have any medication at bedside if not able to self-administer. Every room will be searched for meds at bedside. Remove medication, notify MD/RP and complete evaluation. An order will be obtained for the medication at bedside if the resident requests to have the medication added to current regimen whether it be self-administered or clinician administered. Audit all resident records who receive hospice services and ensure all documentation has been scanned to EMR Licensed nurses will receive education on the policy regarding self-administration of medications and the evaluation. Social Services/Medical Records will receive education regarding receiving hospice service notes timely and scanning them in the EMR as soon as possible once received. Education will be provided to hospice providers regarding delivery of oxygen to the facility including notifying staff of deliveries and the proper storage technique. Nurse managers will round rooms 3 x week x 4 weeks to assess for medications at bedside, then weekly x 4. If meds are found at bedside, evaluations will be completed and MD/RP notifications. Licensed nurses responsible for the infractions will receive re-education up to	

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F 684	Continued From page 26 time, place and person. Resident #214's clinical record documented a physician's order dated 2/8/20 for hospice services. Resident #214's plan of care (revised 2/10/20) documented the resident received hospice services to address a potential for a decline in function, pain, weight loss and depression due to a terminal diagnosis. Interventions for end of life care included, "...Coordinate with hospice to see what they are providing: medication, treatment, supplies, O2 [oxygen], etc...Refer to Hospice POC [plan of care]...Work cooperatively with hospice team so that the resident's spiritual, emotional, intellectual, physical and social needs are met..." Resident #214's clinical record documented no assessment, plan of care, or nursing visits by the contracted hospice service. There was no plan of care indicating hospice services provided versus facility provided services. On 2/19/20 at 11:20 a.m., Resident #214 was interviewed about hospice care/services provided for him in the facility. Resident #214 stated nurses and aides from hospice had visited him but he did not remember when or the frequency of the visits. On 2/20/20 at 8:10 a.m., the registered nurse unit manager (RN #1) was interviewed about any hospice assessments, plan of care or visit notes for Resident #214. RN #1 stated she looked and did not find any hospice plan of care or visit notes for Resident #214. RN #1 stated she would check with the hospice and advise.	F 684	disciplinary action. DON/Designee will report findings to the QA Committee monthly x 3 Social Services will follow up with Hospice Services weekly to ensure notes are obtained at time of service delivery. Infractions will result in re-education up to disciplinary action. Medical records will report findings to the QA Committee monthly x 3	

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On 2/20/20 at 8:45 a.m., RN #4 responsible for MDS assessments was interviewed about a hospice care plan, assessments and care visits. RN #4 stated, "We don't have a plan of care about services from hospice." RN #4 stated no visit notes or care plan had been provided since the resident's admission. RN #4 stated she called hospice last night (2/19/20) and they reported visits had been conducted with Resident #214. RN #4 stated she did not have any notes and/or documentation of the visits. RN #4 stated hospice was supposed to leave documentation of their visits and provide a plan of care regarding coordination of their services with the facility.

On 2/20/20 at 8:47 a.m., the unit manager (RN #1) stated she did not know if or when the hospice nurses came to assess or treat Resident #214. RN #1 stated again, there were no records of the hospice visits or communication from hospice regarding care provided to Resident #214.

On 2/20/20 at 12:15 p.m., RN #4 stated she contacted hospice and hospice had no explanation of why the hospice care plan, visit notes and assessments were not provided to the facility.

Resident #214's patient agreement with the contracted hospice service dated 2/18/20 documented, "Hospice assumes responsibility for the professional management of the Hospice Patient's hospice services provided in accordance with the Plan of Care...Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for

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F 684	Continued From page 28 documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day...All services provided to Hospice Patients...must be in accordance with the Plan of Care...The Plan of Care shall identify the care and services needed and specifically identify whether Hospice or Facility is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care..." This finding was reviewed with the administrator and director of nursing during a meeting on 2/20/20 at 2:15 p.m.	F 684		
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 by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to safely store portable oxygen cylinders for one of 27 residents (Resident #214). Findings include: Resident #214 was admitted to the facility on 2/8/20 with diagnoses that included metastatic	F 689	Oxygen Storage The oxygen cylinders were removed from Resident #214 room on 2/18/20. A portable concentrator was delivered to Resident #214 on 2/18/20 and cylinders were picked up by ABC supplier. Hospice oxygen vendors were notified where to store oxygen and to notify nurse management of deliveries.	3/31/20

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F 689	Continued From page 29 colon cancer, depression, and edema. The admission nursing assessment dated 2/8/20 assessed Resident #214 as alert and oriented to time, place and person. On 2/18/20 at 11:05 a.m., Resident #214 was observed in his room. Five small oxygen cylinders (6 cubic feet) were stored in the floor against the left wall upon entrance to the room. The cylinders were not secured in any type of rack or cart. Resident #214 was interviewed at this time about the cylinders. Resident #214 stated four of the cylinders were empty and one was full. Resident #214 stated he used the small oxygen tanks when he left the facility for outings and was able to attach the tubing and use the oxygen on his own. Resident #214 was carrying a small tote bag with a small oxygen cylinder enclosed in the bag and stated, "I have a full one [oxygen tank] in here." Resident #214 stated the oxygen company representative told him they were going to come back and provide a rack for storage of the cylinders but they had not returned. Resident #214 stated he was going to a meeting outside the facility today. Resident #214, carrying the oxygen cylinder manually in the tote bag, ambulated out of his room and left the facility. On 2/18/20 at 11:37 a.m., the five unsecured oxygen cylinders were stored in the floor along the left wall upon entrance to Resident #214's room. Resident #214's roommate was observed at this time self-propelling in a wheelchair into the room to the right of the unsecured tanks. The tanks were observed again on 2/18/20 at 12:51 p.m. stored unsecured in Resident #214's room. On 2/18/20 at 2:23 p.m., Resident #214 was observed walking in the hall near the front lobby,	F 689	All residents with oxygen were potentially affected. The entire facility will be assessed for oxygen cylinder storage. Unsecured oxygen cylinders will be removed immediately. All staff will be educated regarding oxygen storage and safety. Department managers will conduct rounds 5 x weekly x 4 weeks, then weekly to ensure oxygen is securely stored. Staff members responsible for infractions will receive re-education up to disciplinary action. DON/Designee will report findings to the QA Committee monthly x 3.	

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carrying the small oxygen cylinder in a tote bag. Resident #214 stated he was looking for his room. After finding his room, Resident #214 placed the tote bag with oxygen tank on the seat of a rolling walker located beside his bed. On 2/18/20 at 2:45 p.m., Resident #214 had one small cylinder of oxygen on his bed with tubing connected. The regulator on this small cylinder indicated the tank was less than half-full. Resident #214 stated he was using the oxygen remaining in the small tank before connecting to the oxygen concentrator in his room. Resident #214 stated concerning his use/placement of the tanks, "I just set it [tank] down wherever I am. I lay it down usually."

On 2/18/20 at 2:49 p.m., the licensed practical nurse (LPN #1) caring for Resident #214 was interviewed about the unsecured oxygen. LPN #1 stated the resident went out of the facility to meetings a few times each week and took the small oxygen tanks with him. LPN #1 stated the resident had an "as needed" order for oxygen and the resident liked to have the oxygen with him in case he became short of breath. When asked about a rack or any type of secure storage of the cylinders, LPN #1 stated hospice provided the oxygen and she did not know anything about a rack. LPN #1 stated, "Hospice would be taking care of that [storage]."

Resident #214's clinical record documented a physician's order dated 2/8/20 for oxygen at 2 liters per minute as needed for shortness of breath. Resident #214's plan of care (initiated 2/10/20) made no mention of the resident's use of oxygen, use of the portable oxygen tanks or the resident's independent handling of the full oxygen cylinders. The clinical record documented no

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plan of care from hospice.

On 2/19/20 at 4:26 p.m., the administrator was interviewed about Resident #214's unsecured oxygen cylinders. The administrator stated the portable oxygen tanks were provided by hospice and were delivered directly to Resident #214's room by the oxygen vendor. The administrator stated the tanks were supposed to be in a rack or secured in some manner.

On 2/20/20 at 9:26 a.m., the director of nursing (DON) was interviewed about Resident #214's unsecured oxygen tanks. The DON stated she called hospice and hospice reported that the oxygen vendor brought the portable tanks and placed them directly in Resident #214's room without notifying staff. The DON stated the vendor indicated the oxygen cylinders were delivered on 2/12/20 but the nurse working that day did not recall the oxygen delivery. The DON stated the tanks were supposed to be in a rack.

The facility's policy titled Oxygen Storage & Assembly (revised 10/2019) documented, "Oxygen and oxygen equipment is stored in a safe manner...Secure each tank individually, by a chain, on a cart, or on a stand...When oxygen is discontinued or empty, place in the designated oxygen storage area..." Concerning small tanks this policy documented, "...Place cylinder in stand or cart..." A reference provided by the facility from Lippincott Procedures - Oxygen administration, long term care (print date 2/18/20) documented concerning use of oxygen tanks, "Commonly used for residents who need oxygen on a standby basis...an oxygen tank has several disadvantages, including its cumbersome design and the need for frequent replacement. Because

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F 689	Continued From page 32 oxygen is stored under high pressure, an oxygen tank also poses a potential for fire or explosion hazard..." This finding was reviewed with the administrator and director of nursing during a meeting on 2/19/20 at 4:00 p.m. and on 2/20/20 at 2:15 p.m.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		3/31/20

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F 725	Continued From page 33 by: Based on observation, resident interview and staff interview, the facility staff failed to ensure sufficient staffing on one of three nursing units (Unit 1) in the facility. Findings include: During the survey on 02/18/20 through 02/20/20, Unit 1 was observed and toured multiple times throughout the survey process. On 02/18/20 at approximately 11:00 AM, during the initial tour of the facility on Unit 1, Resident #21 and her daughter were interviewed. Resident #21 stated that the facility was short staffed and that the CNAs (certified nursing assistants) were doing all they could do. Resident #21stated that she was admitted in November 2019 and was getting rehab services for strengthening. The resident stated that rehab services stopped in January. Resident #21 stated that after rehab therapy ended, she was now supposed to be get restorative services. Resident #21 stated that she had not received any restorative services and that this was attributed to short staffing. Resident #21's daughter stated that she believed her mother wasn't getting restorative because they don't have enough staff to do it. On 02/18/20 at approximately 11:30 AM, LPN (Licensed Practical Nurse) #3 was interviewed regarding staffing on the unit. LPN #3 stated that there were three staff today on day shift (02/18/20), two CNA's (certified nursing assistants) and herself (one LPN). LPN #3 was asked if there was a supervisor or manager to help. LPN #3 stated, "That's me, I'm the manager." LPN #3 was asked about the census	F 725	Failure to ensure Sufficient Nursing Staff Resident #258 was sent to hospital for evaluation. All residents are potentially affected Ads continue to run on Indeed. DON runs job search daily on Indeed and emails all CNAs/Nurses within a 50-mile radius requesting they come in for an interview. $50.00 bonuses are offered to current CNAs to pick up additional shifts. The wage scale for CNAs was increased in February 2020. Administrator will communicate staffing needs to Regional Director of Operations. Nursing Staff will receive education regarding attendance policy. Staffing coordinator will receive education regarding adequate staffing and communication with DON regarding staffing needs. DON/Designee will continue to review daily and monthly schedule with staffing coordinator daily to ensure adequate staffing is available. DON/Designee will report findings to the QA Committee monthly x 3.	

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on the unit for today. LPN #3 stated, "Twenty-eight." LPN #3 stated that it can be difficulty at times. LPN #3 stated that, usually they (on Unit 1) like to have three CNAs, but sometimes they just have two.

On 02/19/20 at 8:23 AM, CNA #5 was interviewed regarding staffing and was asked about tasks, such as bathing. CNA #5 stated that if they can't give all the baths on day shift, then they will give them in the evening. CNA #5 stated that she typically works 8 hours shifts, but sometimes will work 16 hours due to not enough staff. CNA #5 stated that if there isn't anyone to come in, she will work. CNA #5 stated that was by choice and that if management asks her to work because someone called off on the the evening shift, most of the time she will work to cover.

On 02/19/20 approximately 10:00 AM, a resident was heard yelling for help. LPN (Licensed Practical Nurse) #3 was attempting to give out medications, while two CNAs were down the hall assisting other residents. Approximately three to four minutes later, CNA #5 yelled to LPN #3, "Stat." LPN #3 ran down the hall to Resident #258's room, where Resident #258 was found laying on the floor in her room.

On 02/19/20 at 10:12 AM, LPN #3 was asked about staffing again. LPN #3 stated that they (on Unit 1) had three again, herself and the two CNAs. LPN #3 stated that they had three all morning, until just now. LPN #3 stated that CNA #7 just came in to help. LPN #3 stated that CNA #6 called CNA #7 and CNA #7 came in. LPN #3 stated, "I am just now giving meds." LPN #3 stated that everyone calls on me and it's hard to get things done.

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On 02/19/20 at 4:36 PM, the DON (director of nursing), the administrator and the corporate consultant were made aware of the above information. The DON and administrator stated that they try to have three (CNAs) on that Unit.

On 02/20/20 at 8:50 AM, CNA #5 was asked about staffing. CNA #5 stated that there are only two CNAs on this unit and that they are supposed to have three. CNA #5 stated that the other person was on vacation and sometimes they will try to send someone over to help, but if they do, they don't stay long. CNA #5 stated that a lot of times it was just two of them (CNA #5 and CNA #6). CNA #5 stated that night shift is short handed and that sometimes they only have one CNA and one nurse and stated, "One person can't get all of the residents up." CNA #5 stated, then she and CNA #6 come in and "We are running around like chickens with their head cut off." CNA #5 stated that a lot of times they don't get breaks or even get to eat lunch because they are so busy when it is just two of them working. The CNA stated, "We have a lot of feeders."

CNA #5 stated that the day Resident #258 fell (02/19/20), the resident was trying to take herself to the bathroom. CNA #5 stated that after the fall, staff got the resident up off the floor and put her in the bed. CNA #5 stated that later, after the fall, the resident used the call bell for assistance. CNA #5 stated that by the time she got to the room the resident was sitting on the side of the bed and had already had a bowel moment. CNA #5 stated that it's just hard to get to everyone on time. The CNA was asked if more staff would have helped to prevent Resident #258's fall. CNA #5 stated, "We can't prevent falls, but if we have

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F 725	Continued From page 36	F 725		

enough staff we'd have a lot less...these people need care and they try to go to the bathroom then they fall."

On 02/20/20 at approximately 9:00 AM, LPN #3 was again interviewed regarding staffing and presented the staffing sheet. LPN #3 confirmed that again Unit 1 had three staff (one nurse and two CNA's) for 27 residents. At 9:45 AM, LPN #3 stated that they needed more staff. LPN #3 stated, "We do better with three and they aren't going to put another nurse back here."

On 02/20/20 at 11:00 AM, RN [Registered Nurse] #4 was asked for restorative nursing documentation for Resident #21, a resident on Unit 1. RN #4 stated that it was in the computer; however, no documentation could be found. RN #4 then stated that it wasn't in computer yet, it was on paper. RN #4 stated that she was over the restorative program and was late getting the information in the computer. RN #4 stated that she has two restorative aids and if one calls out sick or is on vacation, then restorative doesn't get done. RN #4 stated that if the one or both restorative aids get pulled to the floor to work in regular staffing then there was restorative that doesn't get done. RN #4 was made aware of Resident #21 not getting restorative nursing as recommended by therapy and that the resident had an order for restorative.

At approximately 12:20 PM, RN #4 stated, "Our restorative program is broken, I know that."

On 02/20/20 at approximately 2:45 PM, the DON, administrator, and corporate consultant were again made aware of concerns with staffing. The corporate consultant stated that they were trying

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F 725	Continued From page 37 to recruit additional staff, but that it has been challenging. No further information and/or documentation was presented prior to the exit conference on 02/20/20 at 3:00 PM, to evidence that sufficient nursing staff were available to provide nursing and related services to assure resident safety and attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		3/31/20

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F 761	Continued From page 38 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure a medication was properly labeled on one of three nursing units. An insulin pen was stored in the medication cart on unit one with no resident name or date opened. The findings include: On 2/19/20 at 2:00 p.m., accompanied by licensed practical nurse (LPN) #3, the medication cart on unit one was inspected. Stored in the cart was an opened and unlabeled Humalog Kwick insulin pen (100 units/milliliter). The insulin pen was not labeled with a resident name and was not marked with the date opened. The pen was stored in a plastic bag along with another insulin pen labeled for a current resident. On 2/19/20 at 2:03 p.m., LPN #3 was interviewed about the unlabeled insulin pen. LPN #3 stated the unlabeled insulin pen was not in the medication cart yesterday (2/18/20). LPN #3 stated, "I don't know who put it [insulin pen] there." LPN #3 stated the insulin should have been labeled from the pharmacy with a resident name and nurses were supposed to write the date opened on the label. The facility's pharmacy reference titled Insulin Storage Recommendations (April 2019) documented Humalog U-100 pens should be used within 28 days after opening. The facility's policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles	F 761	Failure to ensure medication is properly labeled The unlabeled insulin was discarded on 2/19/2020 All residents potentially affected All med carts have been audited to ensure that all medications have proper labeling and an opened date if applicable. Licensed Nurses will receive education regarding medication labeling and storage. Unit managers will audit medication carts 5 x week x 4 weeks then weekly to ensure all medications have been properly labeled. Infractions will be reported to the DON. DON/Designee will report findings to the QA Committee monthly x 3.	

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F 761	Continued From page 39 (revised 1/1/13) documented, "...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels..." This finding was reviewed with the administrator and director of nursing during a meeting on 2/19/20 at 4:00 p.m.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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	F 812		3/31/20

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F 812	Continued From page 40 by: Based on observation and staff interview, facility staff failed to procure, store and prepare food in a sanitary manner in the main kitchen. Findings included: A tour of the main kitchen was conducted on 02/18/2020 at 10:45 a.m. with the Dietary Manager (DM). A rack of 58 bowls was observed and three (3) were found with dried food debris. The hood over the cooking area was observed with dust particles on the top surface of the hood. Dust was also noted on the chains holding a hanging utensil/pot rack, as well as on top of the rack itself. The can opener was observed with black, sticky, built-up debris. Dust, food particles and debris were noted on the bottom shelves of the food prep tables. In the dry storage room a bag of pancake mix was observed opened, and not sealed or placed in a storage container. The Dietary Manager was interviewed on 02/18/2020 at 11:25 a.m. The Dietary Manager stated, "The can opener should go in the dishwasher everyday, clearly it was not. It will be my expectation that everything will be wiped down everyday. I have only been here a little over a week. It is a work in progress." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 02/19/2020 at approximately 4:00 p.m. No further information was received prior to the exit conference on 02/20/2020.	F 812	Failure to procure, store and prepare food in a sanitary manner The bowls with food debris were cleaned. The hood over the cooking area were, dust was removed from the chains and pot rack holding utensils. The can opener was cleaned removing the build-up of debris and the bottom shelves of the food prep tables were cleaned. The pancake mix that was not sealed was discarded. All residents The kitchen was inspected by the Dietary Manager and Administrator for cleanliness with all infractions corrected. The Dietary Department will receive education regarding cleanliness of the kitchen and dry storage protocols. A cleaning schedule has been developed and implemented. The dietary manager will review the completed cleaning schedules 5 x weekly and ensure the kitchen has been cleaned accordingly. Infractions will result in re-education up to disciplinary action for dietary staff that have failed to comply with the cleaning schedule. Dietary Manager will report findings to the QA Committee monthly x 3.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)	F 825		3/31/20

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F 825	Continued From page 41 §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, clinical record review, and staff interview, the facility staff failed to ensure one of 27 residents received restorative nursing services. Restorative services for Resident #21 was not provided per the PT (Physical Therapist) recommendations and physician's order. Findings include: Resident #21 was admitted to the facility on 11/08/19. Diagnoses for Resident #21 included, but were not limited to: osteoarthritis, osteoporosis, muscle weakness, atrial fibrillation, over active bladder and difficulty walking.	F 825	Specialized Rehab Services Resident #21 has received a physician□s order for Restorative Nursing and is receiving the service. All residents potentially affected An audit will be conducted of all resident records for Restorative Nursing Orders and compared to the residents who are currently on the Restorative Program to ensure all guests are receiving restorative nursing per orders. Therapy, MDS, and Restorative Nursing	

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F 825	Continued From page 42 The resident's most current full MDS (minimum data set) was the admission assessment dated 11/15/19. This MDS assessed the resident with a cognitive score of 13, indicating the resident is intact for daily decision making skills. The resident was assessed as requiring extensive assistance from one staff person for transfers, dressing, toileting and hygiene. The resident was assessed as requiring limited assistance with one staff person for ambulation. On 02/18/20 at approximately 11:00 AM, Resident #21 and her daughter were interviewed. Resident #21 stated that she felt the facility was short staffed and that the CNAs (certified nursing assistants) were doing all they could do. Resident #21 stated that she was admitted in November 2019 and was getting rehab services. Resident #21 stated that the rehab was stopped and she was now supposed to be getting restorative services for ambulation and strengthening. Resident #21 stated that she had not received any restorative services. Resident #21's daughter confirmed that the resident had not been getting any type of restorative services. Resident #21 and the resident's daughter stated that staff were supposed to come and walk with her and do exercises to keep the resident's strength up. Resident #21 stated that she felt like she had lost some of her strength, since therapy stopped. Resident #21 stated that she can do a lot for herself and does as much as she can, but she needs restorative to keep her from losing what she gained and to continue to walk. The resident's daughter stated that she had spoken with the resident's physician the other day [did not provide a date] in the hall. Resident #21's daughter stated that the physician told her that the resident was already ordered restorative	F 825	assistants will receive education regarding the RNP and how to communicate that guests need to be added or removed from the program. The DON and MDSC will receive a copy of the rehab recommendation for each resident referred to RNP. Once the physician□s order and evaluation have been completed, the MDSC will inform the DON to ensure a timely process. DON/Designee will report findings to the QA Committee monthly x 3.	

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services and should be getting it.

The current physician's orders were reviewed and included an order for: "May participate in nursing restorative programs...Active [Start Date: 11/08/19]..."

The resident's clinical record was reviewed and there were no PT/OT (physical therapy/occupational therapy) notes found. There were no restorative nursing notes or documentation related to restorative services.

On 02/20/20 at 11:00 AM, RN [Registered Nurse] #4 was asked for restorative nursing documentation for Resident #21. RN #4 stated that it was in the computer. No documentation could be found. RN #4 then stated that it wasn't in computer yet, that it was on paper. RN #4 stated that she was over the restorative program and was late getting the information in the computer. RN #4 stated that the CNAs (certified nursing assistants) were documenting restorative on paper if it isn't in the computer. RN #4 stated that she has two restorative aids and if one or both call out sick or is on vacation, then there is restorative that doesn't get done. RN #4 stated that if the two restorative aids get pulled to the floor to work in regular staffing the restorative isn't getting done. RN #4 was asked if there was a separate care plan for restorative nursing. RN #4 stated that if it isn't on the regular nursing care plan, then there isn't one.

On 02/20/20 at approximately 11:20 AM, the rehab director was interviewed. The rehab director stated that Resident #21 was released from therapy on January 3, 2019 and it was recommended at that time for the resident to

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receive restorative nursing services.

The PT discharge summary dated 11/09/19 through 01/03/20 was reviewed and documented, "...patient...prognosis to maintain CLOF [current level of functioning] = Good with consistent staff follow-through...D/C [discharge] per physicians...Discharge recommendations: Restorative nursing for maintaining ambulation...restorative ambulation program...referred to restorative nursing..."

At approximately 12:20 PM, RN #4 presented restorative documentation for Resident #21. According to the documentation Resident #21 received restorative on the 10th, 11th, 12th and 14th of February. RN #4 was made aware that the resident was discharged from therapy on 01/03/20. RN #4 stated that therapy was supposed to put it into PCC (point click care) to complete and put it in her box, then she does evaluations and then gets the physician's order and then it is care planned. RN #4 stated that wasn't done. RN #4 was made aware that the resident had an order. RN #4 stated that wasn't a "real" order, it's a batch order and never should have been on the resident's order sheet. RN #4 was then asked if the resident didn't have a physician's order for restorative, then how were the restorative aides doing restorative nursing on the dates above and how would they know what type of exercises to do and for how long if there wasn't an order? RN #4 stated, "Our restorative program is broken, I know that."

The resident's CCP (comprehensive care plan) was reviewed and documented, "...provide therapy and encourage participation as ordered [12/02/19]...encourage physical activity and daily

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ambulation...use assistive device if necessary [12/02/19]...if unsteady on feet, use cane, walker, or have someone help you walk...self care performance...requires assistance with ADL's and mobility related to generalized weakness...encourage resident to participate to the fullest...use bell/call light to call for assistance...PT/OT [physical therapy/occupational therapy] evaluation and treatment as needed/as ordered [11/08/19]...provide assistance as needed for each activity until resident performs skill competently and is safe in independent care; re-evaluate regularly to be certain that the skill level is maintained and the resident remains safe in the environment.."

A late entry progress note dated effective for 02/18/20 and timed 7:35 PM, written by the NP (Nurse Practitioner) documented, "...CC [chief complaint]: restorative nursing request...request for restorative therapy need...generalized osteoarthritis...muscle weakness...difficulty in walking...Muscle weakness: restorative therapy...please walk the patient 3-4 days a weak [sic]...activity as tolerated...NP."

On 02/20/20 at approximately 2:00 PM, the administrator, DON (director of nursing) and the corporate consultant were made aware of the above information. The facility staff did not have any questions and did not comment on the above information.

No further information and/or documentation was presented prior to the exit conference on 02/20/20 at 3:00 PM to evidence that restorative services were provided to Resident #21 as ordered by the physician and as recommended

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F 825	Continued From page 46 by PT.	F 825		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		3/31/20

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F 880	Continued From page 47 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, facility staff failed to ensure proper infection control practices for contact isolation were implemented for one of 27 residents in the survey sample, Resident #318. Findings included:	F 880	Infection Prevention and Control Staff members who did not wear the PPE necessary to enter the room of resident #318 received education and provided a return demonstration to ensure they were competent in dressing out for isolation rooms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 48 Resident #318 was originally admitted to the facility on 02/03/2020 and readmitted on 02/14/2020 with diagnoses including, but not limited to: UTI with ESBL (urinary tract infection with extended spectrum beta lactamase), PICC (peripherally inserted central catheter) Line placement, and Contact Isolation. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 02/18/2020. Resident #318 was assessed as cognitively intact with a total cognitive score of 14 out of 15. The clinical record review included a physician order sheet dated February 2020 documenting, "...Contact Isolation for ESBL in urine..." The current comprehensive care plan documented: "...has a potential for impaired social interaction or social isolation R/T [related to]: Medical Isolation: ESBL in urine..." Resident #318 was interviewed on 02/19/2020 at 10:45 a.m. A single lumen PICC line was noted in her left, upper arm. The PICC line was capped and saline locked at the time of the observation. During this interview, housekeeping came into the room mopping the floor. The Housekeeper was not wearing a gown and only had a glove on her left hand. The Housekeeper was observed moving the bedside table, picked up Resident #318's glasses, picked up an empty yogurt container, removed a spoon from the yogurt container with a tissue, and emptied the trash. Also, during this interview with Resident #318, CNA #4 (certified nursing assistant) was observed obtaining vital signs on Resident #318. CNA #4 did not have a gown on, but was wearing	F 880	All residents with isolation precautions. All staff will be educated regarding Isolation Precautions and donning appropriate PPE. Random audits will be completed by nurse managers 5 x weekly x 4 weeks then 2 x weekly x 4 weeks to ensure staff are donning PPE appropriately for Isolation Rooms. Infractions will result in re-education up to disciplinary action. ADON will report findings to the QA Committee monthly x 3.	

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F 880	Continued From page 49	F 880		

gloves.

Other #4 (Housekeeper) was interviewed at 11:00 a.m. about contact isolation. Other #4 stated, "No, I haven't been wearing a gown into the room. I am aware that I should gown and glove before going into the room. I will from now on."

CNA #4 was interviewed at 11:05 a.m. regarding contact isolation. CNA #4 stated, "I didn't put a gown on. I should have."

The contact isolation policy was requested and received on 02/19/2020 at 2:15 p.m. from the ADON (assistant director of nursing). The policy, "Infection Control 403.00, Contact Precautions" included,..."II. Gloves, Gowns and Hand Hygiene: A. Healthcare personnel caring for guests/residents on Contact Precautions wear a gloves (sic) and gowns for all interactions that may involve contact with the guest/resident or potentially contaminated areas in the guest's/resident's environment..."

The housekeeping isolation policy was requested and received on 02/19/2020 at 3:15 p.m. from the ADON. The policy, "Guest Room - Isolation Procedure" included, "Policy: To prevent the cross contamination of bacteria from the isolation room to the rest of the facility...Procedure: 1. Tools and materials needed: ...PPE [personal protective equipment]...2. Prior to entering the isolation room: Wash hands thoroughly. Don PPE..."

The Administrator and DON (director of nursing) were informed of the above observations during a meeting with the survey team on 02/19/2020 at approximately 3:55 p.m. No further information

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F 880	Continued From page 50 was received prior to the exit conference on 02/20/2020.	F 880		