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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/26/20 through 1/28/20. 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 1/26/20 through 1/28/20. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 5 complaints were investigated during the survey. The census in this 102 certified bed facility was 97 at the time of the survey. The survey sample consisted of 38 current Resident reviews and 5 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/20/2020

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(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility failed to ensure 3 of 43 residents in the survey sample on admission had an advance directive or determined the residents wish to formulate an advance directive, Residents #61, #78 and #348.

The findings included:

1. Resident #61 was admitted to the facility on 1/2/20 with diagnoses to include but not limited to end stage renal disease requiring hemodialysis

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three times a week. The admission MDS (Minimum Data Set) with an assessment reference date of 1/8/20 coded the resident with a score of 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact.

A review of the Advance Directives Discussion Document dated 1/2/20 was not completed. The section that allows for the resident to indicate whether they possess any of the following: Advance Directive, Health Care Agent, Conservator of Person, Living Will, or Durable Power of Attorney was blank. There was no documentation in the clinical record that determined whether the resident wished to formulate an Advance Directive.

The above findings was shared with the Director of Nursing on 1/27/20. She stated that upon admission the nurse is responsible for completing the Advance Directives Discussion Document with the resident. She stated the document was incomplete and stated that there was an opportunity for education.

2. Resident #78 was admitted to the facility on 11/15/19 and a readmission on 1/21/20 with diagnoses to include but not limited to diabetes type I. The admission MDS with an assessment reference date of 11/20/19 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact.

A review of the clinical record failed to evidence an Advance Directives Discussion Document or Advance Directive. There was no documentation in the clinical record that determined whether the

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resident wished to formulate an Advance Directive.

The above findings was shared with the Director of Nursing on 1/27/20. She reviewed the clinical record for an Advance Directives Discussion Document or Advance Directive and stated, "I don't see one, it's not here".

3. Resident # 348 was admitted to the facility on 1/9/20 with diagnoses to include but not limited to sepsis due to methicillin resistant staphylococcus aureus. The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact.

A review of the Advance Directives Discussion Document dated 1/11/20 was not completed. The section that allows for the resident to indicate whether they possess any of the following: Advance Directive, Health Care Agent, Conservator of Person, Living Will, or Durable Power of Attorney was blank. There was no documentation in the clinical record that determined whether the resident wished to formulate an Advance Directive.

The above findings was shared with the Director of Nursing on 1/27/20. She stated that upon admission the nurse is responsible for completing the Advance Directives Discussion Document with the resident. She stated the document was incomplete and stated that there was an opportunity for education.

The facility Policies and Procedures titled Advance Directives with a revision date of

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F 578	Continued From page 4 11/14/18 read in part: Policy: The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by the resident and/ or resident representative. Process: 1. Upon admission, Social Service Director or Business Development Coordinator/ designee will: b) Determine whether the resident has an advance directive and, if not, determine whether the resident wishes to establish an advance directive.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		

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(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 clinical record review, staff interviews, facility document review and during the course of a complaint investigation, the facility staff failed to notify the physician and Resident Representative after an unwitnessed fall for 1 of 43 residents in the survey sample, Resident #350.

The findings include:

Resident #350 was admitted to the facility on 4/4/19 with diagnoses to include cerebrovascular

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disease, diabetes, unspecified abnormalities of gait, mobility, and muscle weakness. Approximately 48 hours later the resident was sent to the Emergency Room (ER) on 4/6/19 and admitted.

The facility Admission/Readmission Data Collection document dated 4/4/19 assessed the resident as arriving to the facility at 5:30 p.m., oriented to person, usually makes self understood, understands, pleasant and content, no obvious behaviors, required one person assist with bed mobility, transfers, ambulation with use of a walker. Section N3. Fall Risk identified the resident did not have a history of falls in the last 30 to 90 days. The resident was oriented to the bathroom, activities, roommate, mealtimes, call light/bell and staff. The nurse documented, "Very pleasant lady with no complaints for skilled nurdsing {sic}."

The complainant alleged that on 4/6/19 upon arrival to the resident's beside at approximately 2:00 p.m., she immediately identified that there was something wrong with the resident. She described the resident as "didn't respond to me, shaking her head from side to side and mumbling." The complainant went to the nurses station to ask the nurse what happened. She indicated the nurse came to the room and told her she had found the resident in the bathroom earlier that morning at approximately 8:00 a.m. The complainant asked why was she not notified of the fall, the nurses response was that "they" normally don't call family members that early, the complainant stated it was now 2:00 p.m. why had she not been called by now. The complainant also asked if the physician had been notified and the nurse stated no because she thought that

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was the resident's normal state. The complainant told the nurse that she needed to call the physician immediately. The nurse then called the physician and obtained an order to send the resident to the ER for evaluation.

LPN #6 was no longer employed at the facility. A voicemail request for an interview was made on 1/27/20, however prior to exit LPN #6 had not returned the phone call. A review of LPN#6's employee record evidenced an Employee Corrective Action Form dated 4/9/19, date of infraction was 4/6/19. LPN #6 received a written warning for failure to perform fall procedure, failure to notify MD, and failure to assess patient and identify change in condition. LPN #6 declined to sign the form. Re-education was provided on 4/17/19 for fall protocol, neuro checks, notification of MD and Resident Representative (RR) immediately after a fall, any resident change in condition is to be documented and Resident Representative and MD to be notified.

The Details of Hospital Stay-Hospital Course-"...There was concern for seizures, therefore EEG was obtained which was suggestive of seizures, showing sharp waves emanating from the right tempoparietal region consistent with cortical irritability. Therefore, neurology started Keppra (Anti-epileptic drug) 500 milligram bid (twice a day).
Primary Discharge Diagnosis- Principal Problem
1. Metabolic encephalopathy due to probable seizures
3. Acute right cerebellar CVA (stroke).

The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior

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F 580	Continued From page 8 to exit. The facility Policies and Procedures subject: Fall Management revised date 7/29/19 read in part, as follows: Purpose-Is to identify residents at risk for falls and establish/ modify interventions to decrease the risk of a future fall and minimize the potential for a resulting injury. C. Post Fall Strategies: 3. Notify the Physician and resident representative Complaint deficiency.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		

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services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
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 evidence that an Advanced Beneficiary Notice was issued to one of 43 residents in the survey sample, Resident #92.

The findings included:

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Resident #92 was admitted to the facility on 6/5/19 with diagnoses that included but were not limited to, diabetes mellitus type one. Resident #92's most recent MDS (minimum data set) assessment was an admission MDS assessment with an ARD (assessment reference date) of 6/12/19. Resident #92 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #92's census report revealed that she became long term care under "Medicaid Pending" on 6/25/19.

Review of Resident #92's clinical record revealed a note from social services dated 6/25/19 that documented the following: "SW (social work) spoke with daughter regarding skilled nursing services ending on 6/24/19. In addition, SW educated daughter on her mother transitioning to long term care status."

There was no evidence that an Advanced Beneficiary Notice (SNF ABN) was issued to Resident #92 and/or her RP (representative) prior to skilled services being discontinued (cut).

On 1/28/19 at 9:26 a.m., an interview was conducted with OSM (Other staff member) #3 , the former social worker. When asked when Resident #92 was cut from skilled services, OSM #3 stated that he could not remember and he no longer worked for the facility. OSM #3 stated that the facility staff should be able to locate the ABNs that he issued to Resident #92 and her daughter. OSM #3 stated that he used to keep a binder full of cut letters. When asked when an ABN should be issued, OSM #3 stated that the ABN should be

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F 582	Continued From page 11 issued at least 48 hours from being cut from skilled services. OSM #3 stated that the 48 hours notice gave the representative the right to appeal. OSM #3 stated that he thought he wrote a note documenting when he had presented the ABN to Resident #92's daughter. When asked why his note was documented the day she was cut from skilled services, OSM #3 stated that he must have documented late. OSM #3 stated that he should have documented a note sooner. On 1/28/19 at 10:05 a.m., ASM (administrative staff member) #1, the Administrator stated that she could not find the ABN for Resident #92. No further information was presented prior to exit. Facility policy titled "SNF (Skilled Nursing Facility) Advanced Beneficiary Notification (ABN) and Notice of Medicare Non-Coverage, documents in part, the following: "SNFs must provide the Notice of Medicare Provider Non-Coverage and the SNF ABN to Medicare beneficiaries no later than two days (48 hours) before the effective date of the end of the coverage that their Medicare coverage will be ending. If the beneficiary does not agree that coverage should end, the beneficiary may request an expedited review of the termination decision by the Quality Improvement Organization (QIO) in the State. The provider then must furnish the Detailed Explanation of Non-Coverage (Detailed Notice) to the beneficiary explaining why services are no longer covered."	F 582		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		

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resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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F 623	Continued From page 13 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623		

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as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on medical record review, staff interviews and facility document review the facility failed to notify the State Long-Term Care Ombudsman of a facility discharge for 1 of 43 residents in the survey sample, Resident #94.

The findings included:

Resident #94 was admitted tot he facility on 11/05/19 with diagnoses to include but not limited to, Acute Kidney Failure and Vascular Dementia.

The most recent Minimum Data Set (MDS) was a Discharge Assessment-return not anticipated with an Assessment Reference Date (ARD) of 11/25/19. Under Section A0310 G. Type of discharge Resident #94 was coded as 1 (Planned). Under Section A2000 Discharge Date Resident #94 was coded as 11-25-2019. Under Section A2100 Discharge Status Resident #94 was coded 01 (Community).

Resident #94's Discharge Plan and Instructions document dated 11/25/19 was reviewed and is

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documented in part, as follows:

Summary of Discharge:
g. Date and time of Discharge: 11/25/19 12:00.
h. Your Discharge Destination: 4. Other
h1. Describe Other: Home with home health services.

On 1/28/20 at 10:30 A.M. an interview was conducted with the Admissions Director regarding discharge notifications being submitted to the Ombudsman. The Admissions Director stated, "I only send notices to the Ombudsman for residents who are discharged to the hospital. I think the Social Worker was sending them about the the residents discharged home."

On 1/28/20 at 10:40 A.M. an interview was conducted with the State Ombudsman regarding notifications of residents that had been discharged home from the facility. The Ombudsman stated, "I am getting notified when a resident goes to the hospital, but I don't recall seeing then on residents who go home."

On 1/28/20 at 10:45 A.M. the Administrator stated, "We don't have any documentation to show that the notices wee sent to the Ombudsman for the residents who were discharged home."

The facility policy titled "Transfer/Discharge Notification and Right to Appeal" revised 3/26/2018 was reviewed and is documented in part, as follows:

POLICY: Transfer and discharges of residents, initiated by the center will be conducted according to Federal and/or State regulatory requirements.

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F 623	Continued From page 16 Timing of the Notice: Notices to the Ombudsman can be sent when practicable, such as a list on a monthly basis. On 1/29/20 at 4:43 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing, the Vice President of Operations and the Clinical Corporate Nurse where the above information was shared. Prior to exit no further information was provided.	F 623		
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. (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-	F 655		

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(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 and staff interview the facility failed to develop/complete a baseline care plan within 48 hours of a resident's admission for 4 of 43 residents in the survey sample, Residents # 61, #78, #348 and #351.

The findings include:

1. Resident #61 was admitted to the facility on 1/2/20 with diagnoses to include but not limited to, end stage renal disease requiring hemodialysis three times a week. The admission MDS (Minimum Data Set) with an assessment reference date of 1/8/20 coded the resident a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact.

Review of the clinical record evidenced a

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Baseline Care Plan and Summary dated 1/2/20. The document was not completed as the Orders and Services failed to include dialysis services. The section for nurse and resident signatures and dates of those participating in the initial baseline care plan development were blank.

On 1/27/20 at 5:15 p.m., the Director of Nursing was asked to review the baseline care plan. She reviewed the document and stated, "It wasn't completed, it should have been signed and completed within 48 hours".

The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit.

2. Resident #78 was admitted to the facility on 11/15/19 and with a readmission on 1/21/20 with diagnoses to include but not limited to, diabetes type I. The admission MDS with an assessment reference date of 11/20/19 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact.

Review of the clinical record failed to evidence a 48 hour baseline care plan. On 1/27/20 at 5:15 p.m., the Director of Nursing was asked about the care plan. She reviewed the record and stated, "It should be in here.". She then stated she remembered seeing one for the resident and asked for an opportunity to go to the unit and look for it.

The above findings was shared with the Administrator on 1/28/20 at approximately 2:30

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p.m. No additional information was provided prior to exit.

3. Resident # 348 was admitted to the facility on 1/9/20 with diagnoses to include but not limited to, sepsis due to methicillin resistant staphylococcus aureus. The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact.

A Baseline Care Plan and Summary dated 1/10/20 was found in the record but was not filled out.

On 1/27/20 at 5:15 p.m., the Director of Nursing was asked to review the baseline care plan. She reviewed the document and stated, "It wasn't completed."

4. Resident #351 was admitted to the facility on 1/13/20 with diagnoses to include but not limited to, stroke. The admission MDS (Minimum Data Set) had not been completed prior to survey.

Clinical record review failed to evidence a 48 hour baseline care plan for Resident #351.

On 1/28/19 a request to review the 48 hour baseline care plan was made. The Corporate Nurse stated there was no 48 hour baseline care plan found for Resident #351.

The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit.

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F 657	Continued From page 20	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs 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: 2. For Resident #77, the facility staff failed to ensure the resident was invited to her care plan meetings. Resident #77 was admitted to the facility on 02/08/2019. Diagnosis included but were not limited to, Type 2 Diabetes Mellitus and Essential Hypertension.	F 657		

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Resident #77's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/13/2019 coded Resident #77 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment.

On 01/27/2020 at 9:03 a.m., an interview was conducted with Resident #77, when asked if she attended care plan meetings, Resident #77 stated, "No." When asked if she had been invited, asked by anyone to attend a care plan meeting to discuss her care, Resident #77 stated, "No, I've never been invited to a care plan meeting."

On 01/27/2020 documentation was requested to evidence that Resident #77 was invited to care plan meetings. Social Service's Progress Note dated 05/10/2019 was reviewed and documented in part, as follows: "Letter was taken to resident to see if they wanted to attend the care plan meeting and invite RP (Responsible Party) received signature from resident."

An interview was conducted with Registered Nurse (RN) #3, MDS Coordinator, on 01/28/2020 at 9:30 a.m., when asked who sends out invitations to care plan meetings, RN #3 stated, "Social Services has a calendar and they send out invitations to care plan meetings."

On 01/28/2020 requested documentation evidencing that Resident #77 was provided an invitation to attend care plan meetings since May 2019.

On 01/28/2020 at approximately 4:00 p.m., an interview was conducted with Divisional ED

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(Executive Director), when asked if the facility could provided documentation evidencing Resident #77 was invited to care plan meetings since May 2019, Divisional ED stated, "There are no invitation notes to care plan."

The Administrator and Director of Nursing were informed of the finding at the pre-exit meeting on 01/09/2020 at approximately 4:45 p.m. The facility did not present any further information about the findings.

The facility policy titled - Care Plan Invitation
Revision Date: 09/25/2017
Policy: The resident and/or the resident representative shall be invited to attend each of the interdisciplinary Care Planning Conferences for the specified resident.

3. The facility staff failed to revise the Comprehensive Care Plan for Resident #61 to include dialysis three times a week scheduled on Mondays, Wednesdays and Fridays.

Resident # 61 was admitted to the facility on 1/2/20 with diagnoses to include but not limited to end stage renal disease requiring hemodialysis three times a week. The admission MDS (Minimum Data Set) with an assessment reference date of 1/8/20 coded the resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact.

Review of the Comprehensive Care Plan failed to evidence a revision of the comprehensive person-centered plan of care for the resident's hemodialysis treatments three times a week.

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On 1/27/20 at 10:00 a.m., Resident #61 was at the dialysis center receiving treatment.

On 1/27/20 at 5:15 p.m., the Director of Nursing was asked if comprehensive care plan should have been revised to include a dialysis care plan, she stated, "Yes, there should have been a care plan for dialysis...the MDS staff should have ensured it was done."

The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit.

The facility's Policies and Procedures titled Plans of Care with a revision date of 90/25/17 read, in part:
Policy- An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/ or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements.
Procedure"
4. Review, update and/ or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment (except discharge assessment), and as needed.

Based on Resident and staff interviews, and review of the clinical record, the facility failed to provide advanced notice of the Care Plan Conference for 2 residents, Resident #75 and Resident #77, out of 43 residents in the survey sample; and failed to revise the care plan for one

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resident, Resident #61, out of 43 sampled residents.

The findings included:

1. Resident #75 was admitted to the facility on 12/19/2018 with admitting diagnoses including, but not limited to, type 2 diabetes mellitus without complications, dementia in other diseases classified elsewhere with behavioral disturbance, cognitive communication deficit, and psychotic disorder with delusions due to known physiological condition.

Resident #75's most recent MDS (Minimum Data Set) was an Annual Assessment with an ARD (Assessment Review Date) of 11/13/2019. Resident #75 was coded as severely impaired in cognitive functioning, scoring a 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #75's Person-Centered Care Plan dated 1/02/2019 incorporated as a Focus: "(Resident #75) has impaired cognitive function/dementia or impaired thought processes due to Dx (diagnosis of): Dementia and Psychosis. Goal: (Resident #75) will be able to communicate basic needs on a daily basis through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Allow (Resident #75) and Guardian from (Representative Agency) time to express feelings, concerns, and fears as needed.

On 1/26/2020 at approximately 4:00 p.m., Resident #75 was asked about participation in Care Plan meetings. Resident #75 responded, "What is that? I don't know what that is."

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On 1/28/2020 at approximately 11:12 a.m., the facility Administrator was asked for copies of Care Plan meeting invitations for Resident #75. The facility Administrator responded, "We don't have Care Plan invitations for Resident #75 from the last year."

The Facility Policies and Procedures regarding Care Plan Invitations state:

The resident and/or the resident representative shall be invited to attend each of the interdisciplinary Care Planning Conferences for the specified resident.

Procedure:

Deliver a Care Planning Invitation to the resident 7-14 days prior to the date of the conference. Place a copy of the invitation in the medical record.

If resident has capacity, ask if they wish to have the resident representative at the care conference. Per resident choice or determination of capacity, mail Care Planning Invitation to the resident representative 7-14 days prior to the date of the conference.
Place a copy of the invitation in the medical record.

Request that the resident and/or resident representative contact the facility designee to confirm or reschedule the date/time for the resident's conference.

Have all attendees to the Care Planning Conference, including resident and resident representative sign the Care Plan Conference

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F 657	Continued From page 26 Record to verify their attendance. These findings were reviewed with the Facility Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed to meet professional standards of practice for transcribing physician orders for 1 of 43 residents in the survey sample, Resident #192. The findings included: Resident #192 was admitted to the facility on 01/09/2020. Diagnoses included but were not limited to, Malignant Neoplasm of Larynx, unspecified and Dysphagia following other Cerebrovascular Disease. Resident #192's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 01/15/2020 coded Resident #192 with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. On 01/27/2020 at approximately 3:30 p.m., review of Resident #192's clinical record revealed	F 658		

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the following:

"Order Summary Report" dated with Active Orders As Of: 01/27/2020 revealed an order for "Respiratory: Suction as needed" with an order date of 01/09/2020; and an order for "Trach care as needed" with an order date of 01/09/2020.

Review of Resident 192's Medication Administration Record (MAR) for period of 01/01/2020 through 01/31/2020 and Treatment Administration Record (TAR) for period of 01/01/2020 through 01/31/2020 did not evidence an order for "Respiratory: Suction as needed" or an order for "Trach care as needed."

On 01/27/2020 at 4:45 p.m., an interview was conducted with Registered Nurse (RN) #1, ADON (Assistant Director of Nursing). Resident #192's "Order Summary Report" was reviewed with RN #1 and when asked if the orders for "Respiratory: Suction as needed" and "Trach care as needed" should be on the MAR or TAR, RN #1 stated, "The orders should be on the TAR." When asked if the orders were on the TAR, RN #1 stated, "No, they aren't there." RN #1 stated, "When the nurse enters the physician order into PCC (Point Click Care) the nurse needs to select where the order is going, either the MAR or the TAR. The nurse did not select when the order was put into PCC."

The Administrator and Director of Nursing were informed of the finding on 01/28/2020 at approximately 4:45 p.m. at the pre-exit meeting. The facility staff did not present any further information about the finding.

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F 658	Continued From page 28 The facility policy titled - Physician Orders Revision Date: 08/22/2017 included: Procedure: ADMISSION ORDERS: Information received from the referring facility or agency to be reviewed and transcribed to the admission physician order form or electronic equivalent. The attending physician reviews and confirms the orders. ROUTINE ORDERS: The order is transcribed to all appropriate areas (MAR, TAR, etc.) or electronic equivalent.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, facility document review and during the course of a complaint investigation the facility staff failed to provide ongoing assessments, monitoring and identification of a change in condition after an unwitnessed fall for 1 of 43 residents in the survey sample, Resident #350. Subsequently, six hours later the Resident Representative visited the resident, identified a change in condition and requested the staff call the physician. The	F 684		

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resident was sent to the Emergency Room and found to have an acute encephalopathic (brain) change as a result of new onset seizure in addition to an acute/subacute infarct right cerebellar hemisphere (stroke), resulting in harm.

The findings include:

Resident #350 was admitted to the facility on 4/4/19 with diagnoses to include cerebrovascular disease, type II diabetes, unspecified abnormalities of gait, mobility, and muscle weakness. Approximately 48 hours later the resident was sent to the Emergency Room (ER) on 4/6/19 and admitted.

The facility Admission/Readmission Data Collection document dated 4/4/19 assessed the resident as arriving to the facility at 5:30 p.m., oriented to person, usually makes self understood, understands, pleasant and content, no obvious behaviors, required one person assist with bed mobility, transfers, ambulation with use of a walker. Section N3. Fall Risk identified the resident did not have a history of falls in the last 30 to 90 days. The resident was oriented to the bathroom, activities, roommate, mealtimes, call light/bell and staff. The nurse documented, "Very pleasant lady with no complaints for skilled nurdsing {sic}".

The Physical Therapy Initial Evaluation conducted on 4/5/19 documented the resident presented with decreased overall endurance and cadence as well as CGA (contact guard assist) for all mobility. The resident had a history of stroke with moderate to severe cognition deficits on evaluation and demonstrated good rehab potential as evidenced by active participation with

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plan of treatment, motivated to return to prior level of function and supportive family/ caregivers. The resident was identified as having one fall in the last year and ambulated at home utilizing a single point cane.

The skilled nursing note dated 4/5/19 entered at 1:07 p.m., documented the resident was aware of self and surroundings with episodes of confusion, able to make needs known, and needs assistance with activities of daily living.

The complainant alleged in the complaint form received at the Office of Licensure and Certification, that on 4/6/19 upon arrival to the resident's beside at approximately 2:00 p.m., she immediately identified that there was something wrong with the resident. She described the resident as "didn't respond to me, shaking her head from side to side and mumbling." The complainant went to the nurses station to ask the nurse what happened. She indicated the nurse came to the room and told her she had found the resident in the bathroom earlier that morning at approximately 8:00 a.m. The complainant asked why was she not notified of the fall, the nurses response was that "they" normally don't call family members that early, the complainant stated it was now 2:00 p.m. why had she not been called by now. The complainant also asked if the physician had been notified and the nurse stated no because she thought that was the resident's normal state. The complainant told the nurse that she needed to call the physician immediately. The nurse then called the physician and obtained an order to send the resident to the ER for evaluation.

Further investigation evidenced the identified

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nurse as Licensed Practical Nurse (LPN) #6. LPN #6 failed to provide ongoing assessments and monitoring for an acute change in condition for Resident # 350 following the unwitnessed fall in the bathroom from approximately 8:30 a.m. through 2:30 p.m., a total of six hours. There were no assessments, monitoring or neurological evaluations conducted per the facility's policies and procedures; also the incident was not documented until four days later on 4/10/19.

The two late entries dated 4/10/19 from LPN #6 were as follows: at 10:54 a.m., "resident was found sitting up on the floor in the bathroom with both legs in one pajama pant leg. Also noted to have pull-up half way pulled up. No apparent injuries noted. Able to move all extremities as before. Transferred back to bed with 2 person assist and made comfortable. Noted to be sluggish but responsive to writer. VS-127/73-74-96.9-20-94% RA (room air). Resting quietly in bed at this time. Call bed in reach." The second entry at 11:13 p.m., read as follows: "Daughter was in to visit around 2:30 PM and stated that this is not her (the resident) normal self and wanted to know if anything happened to her. Daughter was made aware of resident being found on floor in bathroom. Laying in bed sluggish and now unable to respond or answer questions. VS-126/71-85-97.1 AX (axillary)-98% on room air-18. On-call made aware and new order received to send to ER."

LPN #6 was no longer employed at the facility. A voicemail request for an interview was made on 1/27/20 however, prior to exit LPN #6 had not returned the phone call. A review of LPN#6's employee record evidenced an Employee Corrective Action Form dated 4/9/19, date of

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infraction was 4/6/19. LPN #6 received a written warning for failure to perform fall procedure, failure to notify MD, and failure to assess patient and identify change in condition. LPN #6 declined to sign the form. Re-education was provided on 4/17/19 for fall protocol, neuro checks, notification of MD and Resident Representative (RR) immediately after a fall, any resident change in condition is to be documented and Resident Representative and MD to be notified. LPN#6's employee file and the staffing as worked schedule evidenced date of hire was 3/9/19, facility classroom orientation on 3/27/19, 3/29/19, and 4/1/19. The first work shift on the unit was 4/6/19. There was no orientation staff identified as assigned with LPN #6 on 4/6/19, there was no RN supervisor scheduled until the 3 p.m.-11 p.m. shift.

The hospital records evidenced the following documentation, diagnostics and findings:
On 4/6/19 at 4:57 p.m.-Presented in the ED (Emergency Department) with altered mental state. Patient was found in the bathroom floor with change in mental status. There was no witnessed fall. On presentation in the ED CT of the head was done (4/6/19 at 7:13 p.m.) with no acute intracranial abnormality. Chest x-ray done shows evidenced of early CHF (congestive heart failure)...Patient was given Lasix IV (a diuretic). Will admit patient for altered mental status work up to rule out stroke. Physical exam-appears lethargic.
4/7/19 at 12:02 a.m.-MRI results-1. Abnormal study 2. Acute/subacute infarct (obstruction of the blood supply/stroke) right cerebellar hemisphere.
4/9/19-Neurology Consult-MRI of brain demonstrated several new areas of ischemia (blood flow is restricted) including right

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cerebellum. Also EEG (electroencephalogram-a test that detects electrical activity in the brain) with sharp waves arising from the left parietal area. Consistent with cortical irritability and decreased threshold for seizures. She has not been on AED therapy (Anti-epileptic drug)...They report that the day prior she had been conversational. Was able to get herself ready and was walking with a walker.
The Details of Hospital Stay-Hospital Course-"...There was concern for seizures, therefore EEG was obtained which was suggestive of seizures, showing sharp waves emanating from the right tempoparietal region consistent with cortical irritability. Therefore, neurology started Keppra (anti-epileptic drug) 500 milligram bid (twice a day).
Primary Discharge Diagnosis- Principal Problem
1. Metabolic encephalopathy due to probable seizures
3. Acute right cerebellar CVA (stroke).

The Nurse Practitioner who gave the order to send the resident to the ER was interviewed on 1/28/20 at 1:15 p.m. She stated when a resident falls they can present without injuries. The main reasons neuro checks are conducted after falls it to catch altered mental status changes/ injuries and assist with determining whether a resident needs to be sent to the ER for emergency interventions. She stated, "The neuro checks definitely should have been done."

The above findings was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit.

The facility Policies and Procedures subject: Fall

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F 684	Continued From page 34 Management revised date 7/29/19 read in part, as follows: Purpose-Is to identify residents at risk for falls and establish/ modify interventions to decrease the risk of a future fall and minimize the potential for a resulting injury. C. Post Fall Strategies: 2. Initiate Neurological checks as per policy or directed by physician order 3. Notify the Physician and resident representative The facility Policies and Procedures subject: Neurological Evaluation revised 8/22/17 read in part, as follows: Perform neurological checks as follows unless otherwise ordered by the physician: Every 15 minutes for 1 hour. Every hour for the next 4 hours. Every 4 hours for the next 19 hours. Document neurological checks, vital signs and observations on the appropriate form. Place in medical record. Notify physician of any changes in condition. The neurological assessment includes; level of consciousness-alert, drowsy, stuporous, coma, pupil response, hand grasps, extremities and pain response. Complaint deficiency.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		

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condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observations, medical record review, staff interviews and facility document review the facility failed to ensure a verbal telephone order for the discontinuation of an indwelling Foley catheter was written and transcribed at the time of the order on 1/26/20, for 1 of 43 resident's in the survey sample, Resident #21.

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The findings included:

Resident #21 was admitted to the facility on 11/27/2019 with diagnoses to include but not limited to, Malignant Neoplasm of Parotid Gland and Benign Prostatic Hyperplasia.

Resident #21's most recent comprehensive Minimum Data Set (MDS) was a Significant Change with an Assessment Reference (ARD) of 1/6/2020. The Brief Interview for Mental (BIMS) was a 14 out of a possible 15 which indicates that Resident #21 was cognitively intact and capable of daily decision making. Under Section H Bladder and Bowel Resident #21 was coded as having an indwelling (urinary) catheter.

On 1/26/20 at 1:30 P.M. Resident #21 was observed in bed with no visible indwelling catheter.

On 1/27/20 at 12:15 P.M. Resident #21 was once again observed in bed lying on the left side with no visible indwelling catheter. LPN (Licensed Practical Nurse) #6 was asked about Resident #21's indwelling catheter. LPN #6 stated, "He is hospice and he had a catheter I will check on it."

On 1/28/20 at 11:00 A.M. Resident #21 was again observed in bed with no visible Foley catheter.

Resident #21's Physician Orders were reviewed and are documented in part, as follows:

11/27/19: Foley Catheter 16 French 10 milliliters. Catheter care every shift and as needed.

1/27/20 16:15 (4:15) P.M. Discontinue foley.

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1/28/20 14:25 (2:25) P.M. leave foley out, please monitor for bladder distention and pain.

Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows:

1/28/20 14:04 (2:04) P.M. Note written by the Director of Nursing: Late Entry: On 1/26/2020, this writer was notified by nurse on unit that the foley had become dislodged. Hospice and NP (Nurse Practitioner) were notified and the recommendation from both was not to reinsert the foley and to observe resident for any signs of urinary distention.

On 1/28/20 at approximately 2:00 P.M. an interview was conducted with the Nurse Practitioner (NP) regarding Resident #21's indwelling catheter. The NP stated, "I got a call on Sunday around 4:00 P.M. that the Foley had come out and I gave an order to leave the Foley out and to see how he did and if there was no urine or any bladder distention to put it back in."

On 1/28/20 at 2:15 P.M. an interview was conducted with the Director of Nursing and she was asked what would have been her expectations for new resident orders. The Director of Nursing stated, "I would expect any orders that the NP gives to be put in and followed and for the residents to be monitored and to chart if there is any distention or discomfort with the resident.:"

The facility policy titled "Physician Orders" last revised 8/22/17 was reviewed and is documented in part, as follows:

Routine Orders:

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F 690	Continued From page 38 A nurse may accept a telephone order from the Physician, Physician Assistant or Nurse Practitioner. The order shall be repeated back to the Physician, Physician Assistant or Nurse Practitioner for his/her verbal confirmation. The order is transcribed to all appropriate areas (MAR (medication administration record), TAR (treatment administration record) , etc) or electronic equivalent. The nurse shall sign off the orders upon completion or verification of transcription. On 1/29/20 at 4:43 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing, the Vice President of Operations and the Clinical Corporate Nurse where the above information was shared. Prior to exit no further information was provided.	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 43 residents in the survey sample received the appropriate care and services for the management of a PICC line, Resident #348. A PICC line is a peripherally inserted central	F 694		

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catheter, a form of intravenous access that can be used for a prolonged period of time (e.g., for extended antibiotic therapy).

The findings include:

Resident #348 was admitted to the facility on 1/9/20 with diagnoses to include but not limited to, sepsis due to methicillin resistant staphylococcus aureus. The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. Section O. Special Treatments, Procedures, and Programs indicated the resident was receiving IV medications.

The physician orders dated 1/10/20 were for PICC dressing change every Monday evening shift and to discontinue PICC at the end of antibiotic therapy, and Meropenem (an antibiotic) 2 grams IV every 8 hours until 2/3/20.

On 1/26/20 during the initial tour the resident was observed in bed. A PICC line was noted to the resident's right arm. The dressing was dated 1/18/20 and loose on the right lower edge.

The January 2020 Treatment Administration Record (TAR) was reviewed. The TAR indicated by documentation of the nurses initials that the PICC dressing was changed on Monday 1/20/20, however the PICC dressing was dated as last changed on 1/18/20.

On 1/27/20 at 2:45 p.m., the Licensed Practical Nurse (LPN# 1) was observed preparing and administering the Meropenem 2 gram IV dose.

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F 694	Continued From page 40 She observed the PICC dressing was dated 1/18/20 and stated, "It should have been changed on the 25th (1/25/20), the standard is to change the PICC dressing once a week." She then stated, "I'm going to change it and I will let my ADON (Assistant Director of Nursing) know about it." The above finding was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit. The facility policy and procedure titled 4.10 Midline Catheter Dressing Change, revised 7/1/12 read in part: Guidance 1. Sterile dressing change using transparent dressings is performed: 1.2 At least weekly 1.3 If the integrity of the dressing has been compromised (wet, loose or soiled)	F 694		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 727		

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F 727	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on review of Facility documentation, the facility failed to provide the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The findings included: A review of the facility as-worked staffing documentation revealed that on the date of 08/16/2019, there was no coverage provided by a RN (Registered Nurse) within a 24-hour time-frame. An interview with the Director of Nursing (DON) on 01/27/2020 at approximately 6:30 p.m. when asked about RN coverage for 8/16/2019 the DON responded, "I agree that there was no RN coverage documented for 8/16/2019." These findings were reviewed with the facility Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m. No further information was provided prior to exit.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		

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(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation and facility posting information, the facility staff failed to provide the current staffing information to residents and visitors.

Findings included:

Upon entrance of the facility on 01/26/2020 at approximately 11:05 a.m., the posted staff information was observed to not be current to date, listing staffing information for 01/24/2020.

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F 732	Continued From page 43 During an interview with Licensed Practical Nurse (LPN) #1, on 01/26/2020 at approximately 11:37 a.m. regarding the posted staffing information, LPN #1 stated, she called the facility Administrator and said "Please go make sure that (as-worked scheduled) is changed." LPN #1 stated that 25th, 26th and 27th were behind the 24th as worked schedule. LPN #1 stated that all she had to do was flip the 26th in front, and that she usually has a liaison on weekends that will change out the schedule. She also stated, "I only work a few hours on weekends and then I leave." When asked who was responsible for doing the "As-Worked" scheduled, LPN #1 stated, 'I couldn't tell you." I am just a floor nurse. These findings were reviewed with the Facility Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m. No further information was provided by facility staff.	F 732		
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	F 812		

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from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations, facility documentation review, and staff interviews, the facility kitchen staff failed to ensure that food was stored, labeled, and served under sanitary conditions.

The findings included:

During an initial inspection of the facility kitchen occurring on 01/26/2020 at approximately 11:21 a.m., the following was observed:

1. Partially covered Salisbury steak in the refrigerator.
2. No dates for 2 rolls of raw hamburger stored in the refrigerator.
3. No use by dates for milk stored and purposed for fluid restriction diets.
4. No use by dates for thickener stored in the refrigerator.
5. Undated, dried noodles in the storage room.

During an interview on 01/26/2020 at approximately 12:00 p.m. with the Dietary Manager yielded, "We just hired another cook, he has not been here that long. He should have known better."

During an interview on 01/28/2020 at approximately 1:53 p.m. with the Dietary Manager, the Dietary Manager stated, "Once staff open items, they are supposed to label and date items. I agree with you regarding the items

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F 812	Continued From page 45 discovered unlabeled and not covered." Facility provided policy dated 09/2017 regarding Food Storage: Dry Goods included the following: All dry goods will be appropriately stored will be appropriately stored in accordance with the FDS Food Code. Procedures: 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. Facility provided policy dated 04/2018 regarding Food Storage: Cold Foods stated the following: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. Procedures: 5. All foods will be stored, wrapped, or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. These findings were reviewed with the Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m. No further information was provided by facility staff.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced	F 814		

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by:
Based on observation and staff interview, the facility staff failed to ensure that the garbage disposal area was free from debris and refuse.

The findings included:

During an initial inspection of the facility's disposal dumpsters occurring on 01/26/2020 at approximately 12:30 p.m., debris to include paper and plastic soda bottles were discovered around the garbage disposal dumpsters.

During an interview on 01/26/2020 at approximately 12:30 p.m. with the Dietary Manager, the Dietary Manager stated "We are supposed to check the area daily."

During an interview on 01/28/2020 at approximately 1:53 p.m. the Dietary Manager stated, "Normally we check dumpsters everyday. I will meet with my cooks to direct them to keep dumpster area clean.

Facility provided policy dated 08/2017 regarding Dispose of Garbage and Refuse:

All garbage and refuse will be collected and disposed of in a safe and efficient manner.

Procedures:

1. The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris.

These findings were reviewed with the facility

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F 814	Continued From page 47 Administrator during a meeting on 01/28/2020 at approximately 4:30 p.m. No further information was provided by facility staff.	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		

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activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
2. The facility staff failed to ensure the Treatment Administration Record (TAR) was accurate for Resident #348's PICC dressing change date.

A PICC line is a peripherally inserted central catheter, a form of intravenous access that can

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be used for a prolonged period of time (e.g., for extended antibiotic therapy).

Resident #348 was admitted to the facility on 1/9/20 with diagnoses to include but not limited to sepsis due to methicillin resistant staphylococcus aureus. The admission MDS with an assessment reference date of 1/16/20 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the residents cognition was intact. Section O. Special Treatments, Procedures, and Programs indicated the resident was receiving IV medications.

The physician orders dated 1/10/20 were for PICC dressing change every Monday evening shift and to discontinue PICC at the end of antibiotic therapy and Meropenem (an antibiotic) 2 grams IV every 8 hours until 2/3/20.

On 1/26/20 during the initial tour the resident was observed in bed. A PICC line was noted to the resident's right arm. The dressing was dated as changed on 1/18/20; the dressing was loose on the right lower edge.

The January 2020 Treatment Administration Record (TAR) was reviewed. The TAR indicated by documentation of the nurses initials that the PICC dressing was changed on Monday 1/20/20, however, the PICC dressing was dated as last changed on 1/18/20.

The above finding was shared with the Administrator on 1/28/20 at approximately 2:30 p.m. No additional information was provided prior to exit.

3. Resident #192 was admitted to the facility on

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01/09/2020. Diagnoses included but were not limited to, Malignant Neoplasm of Larynx, unspecified and Dysphagia following other Cerebrovascular Disease. Resident #192's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 01/15/2020 coded Resident #192 with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #192 as requiring supervision with setup help only for bed mobility, dressing, eating and personal hygiene and supervision with assistance of 1 for transfer and toilet use and total dependence of 1 for bathing.

On 01/26/2020 at approximately 1:30 p.m., during initial tour of facility, Resident #192 was observed lying in bed. Resident was observed to have a tracheostomy stoma. (A tracheostomy is a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing. mayoclinic.org).

On 01/27/2020 at approximately 3:30 p.m., review of Resident #192's "Order Summary Report" dated with active orders as of : 01/27/2020 revealed the following orders dated 1/9/2020: "Keep extra trach tube at bedside" and "Tracheostomy - Assess skin around stoma site and under ties during trach care."

An interview was conducted with Registered Nurse (RN) #1, the ADON (Assistant Director of Nursing), on 01/27/2020 at 4:45 p.m. When asked if Resident #192 has a trach tube, RN #1 stated, "No, the resident does not have a trach tube, he only has a stoma." Reviewed order "Keep extra trach tube at bedside" with RN #1,

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and when asked if it was an accurate order, RN #1 stated, "No, the order should not have been entered into PCC (Point Click Care)." When asked if Resident #192 has ties around his tracheostomy, RN #1 stated, "No." When asked if the order "Tracheostomy - Assess skin around stoma site and under ties during trach care" was an accurate order, RN #1 stated, "No, the order should reflect what the resident has which is a trach button, not ties." RN #1 stated, "I expect the nurses to put orders in accurately and actually reflect the resident and the orders need to reflect what is being done."

The facility policy titled - Clinical / Medical Records Revision Date: 08/25/2017 included:

Policy: Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care.

The Administrator and Director of Nursing were informed of the findings on 01/28/2020 at approximately 4:45 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.

Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for three of 43 residents

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in the survey sample, Resident #92, #348, and #192.

The findings included:

1. Resident #92 was admitted to the facility on 6/5/19 with diagnoses that included but were not limited to, diabetes mellitus type one. Resident #92's most recent MDS (minimum data set) assessment was an admission MDS assessment with an ARD (assessment reference date) of 6/12/19. Resident #92 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #92 was coded as requiring limited assistance with one staff member with bed mobility, dressing, toileting, and personal hygiene; total dependence on staff with bathing; and supervision only with all other ADLS (activities of daily living).

Review of Resident #92's June POS (physician order summary) revealed the following admission orders dated 6/5/19 for insulin:

"1. Novolin R (1) Solution 100 unit/ml inject as per sliding scale if
200-249 = 2 units
250 - 299 = 4 units
300 -349 = 6 units;
350-399 = 8 units under 60 and above 400 call MD (medical doctor).

2. Insulin NPH-insulin (2) 70/30 Inject 10 units under the skin 2 (two) times a day before meals."

Review of Resident #92's June 2019 MAR revealed that on 6/6/19 at 1600 (4:00 p.m.) Resident #92's blood sugar was documented at

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"496." The following code was documented: "Insulin not required."

A nursing note dated 6/6/19 documented the following: "16:30 (4:30 p.m.) The patient's BS (blood sugar) read HI on the glucometer, and she was given Hum. (Humulin R (regular)) coverage for greater than 400 per protocol and then I advised I would check her blood sugar in one hour. At 5:30 p.m. her BS again read HI and coverage was given (for a second time) and her routine dose of insulin 10 units. Shortly after she ate dinner and again her BS was tested and registered 496. (Name of NP) was made aware of the patient's status and her family came in and asked about her BS and decided they wanted to take her to the hospital. (NP) made aware of family request and patient was taken to the hospital by family. "

Review of the "Emergency Department Visit Summary" revealed that Resident #92 was seen for hyperglycemia with a blood sugar reading of 413 at 8:51 p.m. There were no new orders on the after visit summary.
Review of a 6/7/19 note revealed that Resident #92 returned back to the facility at 12:15 a.m. from the ER with no new orders.

On 1/26/20 at 11:36 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #1, the nurse who worked on 6/6/19 with Resident #92. When asked how many units of insulin Resident #92 received on 6/6/19 when her sugar read "HI, " LPN #1 stated that it must have been 10 units per standard scale of insulin protocol. LPN #1 then stated that she notified the Nurse Practitioner per physician's order and was instructed to give 10 units of Novolin. LPN #1

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stated that she rechecked Resident #92's blood sugar an hour later and her level was still high. LPN #1 stated that she notified the NP for the second time and was told to administer 10 units of Novolin for a second time as well as her 10 units of scheduled NPH insulin. LPN #1 stated that Resident #92's blood sugar read "496" right after dinner. LPN #1 stated that Resident #92's daughter had decided to take the resident to the hospital. LPN #1 stated that she documented the latest blood sugar of "496" on the MAR. LPN #1 stated that she did not administer any further insulin after the reading of "496." When asked if it should be documented how many units of insulin is given to a resident in the Resident's clinical record, LPN #1 stated that she should have documented in the clinical record the amount of insulin administered and should have documented who gave her the orders. LPN #1 stated, "I can assure you I called the NP because she (Resident #92) was a brittle diabetic." LPN #1 also confirmed that she did not write an order for the one extra dose of SSI (sliding scale insulin).

On 1/27/20 at 12:15 p.m., an interview was conducted with ASM (administrative staff member) #3, the Nurse Practitioner. When asked about the incident on 6/6/19, ASM #3 stated that she was not able to remember if she was notified regarding the insulin that was given to Resident #92 prior her being sent to the hospital. ASM #3 stated that she would expect the nurses to notify her of an elevated blood sugar so she could give an order for insulin based on the reading. ASM #3 read the above nursing note and stated that she could not determine how much insulin was given. ASM #3 stated that typically for a type one diabetic she would not give an order to give SSI a

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second time because they typically are so brittle. ASM #3 stated that she would expect the nursing staff to notify her prior to administering a second dose of SSI. ASM #3 stated that the nurse may have received the order from the on-call physician or Resident #92's physician.

On 1/27/20 at 12:30 p.m., further interview was conducted with LPN #1. LPN #1 stated again that everything she did that day on 6/6/19 was verified with the NP prior to administering the two doses of SSI to Resident #92.

On 1/27/20 at 3:55 p.m., an interview was conducted with ASM #4, the Physician. ASM #4 stated that he could not recall the above allegation. ASM #4 stated that he could not remember that far back.

On 1/28/19 at 4:35 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #2, the Divisional Executive Director were made aware of the above concern.

(1) Novolin R (regular)/Humulin R (regular)- Both brand names for same type of insulin; fast acting insulin used to improve glycemic control in patients with diabetes. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=11f9e71d-249d-4de5-be02-a6eb8bf373cd.

(2) NPH insulin- An intermediate-acting insulin used in the treatment of diabetes mellitus. The National Institutes of Health. https://www.cancer.gov/publications/dictionaries/cancer-drug/def/insulin-nph.

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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 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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(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 observations, staff interview, clinical record review and facility documentation review the facility staff failed to ensure infection control practices were followed during wound care for 1 of 43 residents in the survey sample, Resident #57.

The findings included:

Resident #57 was admitted to the facility on 12/12/2017. Diagnoses included but were not

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limited to, Pressure Ulcer of Sacral Region, Stage 4, Chronic Kidney Disease and Heart Failure unspecified. Resident #57's Minimum Data Set (MDS assessment protocol) with as Assessment Reference Date of 12/19/2019 coded Resident #57 with short-term memory problems, long-term memory problems and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #57 as requiring extensive assistance of 1 for toilet use, extensive assistance of 2 for bed mobility, dressing and personal hygiene and total dependence of 1 for eating.

On 01/28/2020 at 10:17 a.m., Registered Nurse (RN) #2 provided wound care to Resident #57's sacral pressure ulcer. After setting up to perform the wound care appropriately, the following was observed: RN #2 removed the old dressing and packing from Resident #57's sacral wound and disposed of dressing in a plastic bag, removed her dirty gloves, and applied hand sanitizer. RN #2 applied clean gloves, cleaned the sacral wound with gauze 4x4 and Normal Saline, disposed of dirty 4x4 gauze, cleaned skin around sacral wound with 4x4 gauze and Normal Saline, removed dirty gloves, and applied hand sanitizer. RN #2 applied clean gloves, and as she was drying around the residents wound with a gauze 4x4 the resident began to expel feces (bowel movement). RN #2 continued drying the resident's skin and then used the gauze 4x4 to clean the feces from the residents buttocks and then disposed of the soiled 4x4. RN #2 picked up a clean package of Calcium Alginate and opened the package. RN #2 did not remove per dirty gloves and perform hygiene after wiping feces from the residents buttocks. RN #2 placed the opened package of Calcium Alginate back down

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on the barrier drape. RN #2 removed her dirty gloves, applied hand sanitizer, went out to the treatment cart outside of the room and obtained the scissors laying on top of the cart and placed them on the barrier. RN #2 washed her hands with soap and water, applied clean gloves, removed the Calcium Alginate from the package and cut it with the scissors. RN #2 then placed the Calcium Alginate in the sacral wound, opened package of 4x4 gauze dressing and dipped the 4x4 gauze in Normal Saline and folded it up and placed it over the Calcium Alginate. RN #2 placed a dry 4x4 gauze dressing over packing in wound and applied dated tape to borders of dressing. RN #2 disposed of left over supplies and barrier drape in plastic trash bag and removed her dirty gloves. RN #2 washed her hands with soap and water, removed scissors and hand sanitizer from room and placed them on top of the treatment cart. RN #2 pushed the treatment cart up next to the Medication Cart and obtained alcohol swabs from the med cart and proceeded to clean the blades of the scissors. RN #2 did not clean the handles of the scissors. RN #2 took the bottle of hand sanitizer from the top of the treatment cart without cleaning it and placed it on the medication cart.

A copy of facility Policy and Procedure titled Dressing Change was received on 01/28/2019 at approximately 11:45 a.m. and included:
The facility policy titled - Dressing Change Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used only if specifically ordered.

On 01/28/2020 at 12:05 p.m., conducted an interview with RN #2 and discussed observations

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during wound care. When asked if she should have performed hand hygiene after she wiped the feces from Resident #57's buttocks, RN #2 stated, "Yes I should have removed my gloves, used hand sanitizer and applied clean gloves." When asked if she should have cleaned the scissors and bottle of hand sanitizer before coming out of the residents room, RN #2 stated, "Yes." When asked why you should clean the scissors and hand sanitizer before coming out of the room, RN #2 stated, "To prevent spread of infection from dirty to clean." When asked if she cleaned the handles of the scissors, RN #2 stated, No." When asked if she should have cleaned the handles in addition to the blades of the scissors, RN #2 stated, "Yes I should have. I had my hands on it." When asked if her dirty gloves were also touching the handle of the scissors, RN #2 stated, "Yes."

On 01/28/2020 at approximately 4:00 p.m., the wound care observations were reviewed with the Director of Nursing.

The Administrator and Director of Nursing was informed of the finding on 01/28/2020 at approximately 4:45 p.m. at the pre-exit meeting. The facility did not present any further information about the findings.