STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/25/2020 through 2/27/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) was/were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/25/20 through 2/27/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 75 certified bed facility was 67 at the time of the survey. The survey sample consisted of 34 current resident reviews and four closed record reviews.	F 000		
F 578 SS=E	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		4/3/20

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

Electronically Signed | 03/13/2020

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F 578	Continued From page 1 (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 resident interview, staff interview, family interview, facility document review, and clinical record review, it was determined the facility staff failed to implement the facility policies to meet the requirements for advanced directives for four of thirty-eight residents, (Residents #31, Resident #33, Resident #14 and Resident #45). The facility staff failed to evidence documentation of an annual review of the advanced directives and wishes with Resident #31 and/or the resident's responsible party (RP), Resident #33 and/or the residents RP, Resident #14 and /or the	F 578	The filing of this plan of correction does not constitute and admission that the deficiencies alleged to in fact occurred. This plan of correction is filed as evidence of Our Lady of Hopes desire to comply with the requirements of participation and to continue to provide high-quality resident care. F578, E: Request/Refuse/Discontinue	

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F 578	Continued From page 2 residents RP, and Resident #45 and/or the resident's responsible party. The findings include: 1. Resident #31 was admitted to the facility on 3/29/17. Resident #31's diagnoses included but were not limited to: Alzheimer's disease (progressive loss of mental ability and function) (1), chronic kidney disease (decreased function of the kidneys) (2) and hydronephrosis (distension of the kidney, caused by accumulation of urine that cannot flow out due to an obstruction) (3). Resident #31's most recent MDS (minimum data set) assessment, a quarterly admission assessment, with an assessment reference date of 1/15/20, coded the resident as scoring 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. Resident #31's care plan revised 2/24/20, documented "Problem-Change in condition with sepsis and renal failure. Approach- No hospitalization, admit to hospice and coordinate care with hospice." Review of Resident #31's clinical record revealed the resident had an advanced directive in place with no evidence of the periodic annual review. The care plan conference summary dated 1/16/20 documented next to Advanced Directive/Code Status- DNR (do not resuscitate) with no further details. An interview was conducted on 2/26/20 at 9:32	F 578	Treatment, Formulate Advanced Directives: 1.Advanced directives have been reviewed and updated as family desires for residents #31, #33, #14, #45. 2.All residents who are in the facility need advanced directives reviewed annually. 3.Administrator has in-serviced Social Service Director and the IDT on review of the advanced directives annually during care plans which will be captured on the care plan sheet. 4.Social Service Director or designee will review 100% of advanced directives in care plans with family consent x3 weeks, and then review monthly and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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AM with ASM (administrative staff member) #1, the administrator and OSM (other staff member) #5, the director of admissions. When asked about the process for obtaining advanced directive on admission, OSM #5, the director of admissions, stated, "It is part of the admission packet with the disclosure agreement. We ask them to bring a copy of the advanced directive to us." When asked about periodic reviews of advanced directives, OSM #5, the director of admissions stated, "During the care plan meetings, the staff verify code status and if there are any changes the advanced directive would be revised at that time." ASM #1, the administrator, stated, "Social Services participate in the periodic care plan reviews. They capture the code status and change advanced directives at that time."

An interview was conducted on 2/26/20 at 9:38 AM with OSM #4, the director of social services. When asked about her role with resident advanced directives, OSM #4 stated, "We review if they have provided advanced directives and their code status. Care plan meetings are two weeks after admission and quarterly. Advanced directives are reviewed quarterly." When asked what information was reviewed, OSM #4 stated, "We review the code status. I am not part of the nursing review portion where there is a review of specific information. The details are reviewed by nursing, such as feeding, hospitalizations and medications. Social services and the MDS coordinator make notes in the record."

An interview was conducted on 2/26/20 at 10:07 AM with ASM #2, the director of nursing and RN #2, the MDS coordinator. When asked to define advanced directive, RN #2 states, "The advanced directive is the documentation to direct medical

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care of the resident when they are in declining health are at the end stage of their life. When asked about the process staff follows for advance directive review during the care plan process, RN #2 stated, "We discuss the advanced directive, but I don't specifically review it. We review the code status." The facility advanced directive policy "A written notation indicating the type of advance directives will be reviewed annually by the interdisciplinary team" was reviewed with ASM #2 and RN #2. When asked where documentation of the periodic annual review was located in the medical record, ASM #2 stated, "So we need to have something written to document this, I did not know. We might have something that is written." RN #2 did not answer.

The facility's "Implementation of Advance Directives" policy dated 3/5/19, documents "The social worker or admissions counselor will interview the resident/legal representative at time of admission to determine if the resident has executed an Advanced Medical Directive or Durable Power of Attorney for Health Care. Copies of any directive or power of attorney will be placed in the resident's clinical file. A written notation indicating the type of advance directives will be reviewed annually by the interdisciplinary team."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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Chapman, page 25.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 278.

2. Resident #33 was admitted to the facility on 3/7/16. Resident #33's diagnoses included but were not limited to: Alzheimer's disease (progressive loss of mental ability and function) (1), dementia (progressive state of mental decline, memory function and judgement) (2) and bronchitis (inflammation of the bronchi often following an upper respiratory infection) (3).

Resident #33's most recent MDS (minimum data set) assessment, a quarterly admission assessment, with an assessment reference date of 1/20/20, coded the resident as scoring 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

Review of Resident #33's clinical record revealed the resident had an advanced directive in place with no documented evidence of the periodic annual review.
The care plan conference summary dated 10/31/19, documented next to Advanced Directive/Code Status- DNR (do not resuscitate) with no further details.

An interview was conducted on 2/26/20 at 9:32 AM with ASM (administrative staff member) #1, the administrator and OSM (other staff member) #5, the director of admissions. When asked about the process for obtaining advanced

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directive on admission, OSM #5, the director of admissions, stated, "It is part of the admission packet with the disclosure agreement. We ask them to bring a copy of the advanced directive to us." When asked about periodic reviews of advanced directives, OSM #5, the director of admissions stated, "During the care plan meetings, the staff verify code status and if there are any changes the advanced directive would be revised at that time." ASM #1, the administrator, stated, "Social Services participate in the periodic care plan reviews. They capture the code status and change advanced directives at that time."

An interview was conducted on 2/26/20 at 9:38 AM with OSM #4, the director of social services. When asked about her role with resident advanced directives, OSM #4 stated, "We review if they have provided advanced directives and their code status. Care plan meetings are two weeks after admission and quarterly. Advanced directives are reviewed quarterly." When asked what information was reviewed, OSM #4 stated, "We review the code status. I am not part of the nursing review portion where there is a review of specific information. The details are reviewed by nursing, such as feeding, hospitalizations and medications. Social services and the MDS coordinator make notes in the record."

An interview was conducted on 2/26/20 at 10:07 AM with ASM #2, the director of nursing and RN #2, the MDS coordinator. When asked to define advanced directive, RN #2 states, "The advanced directive is the documentation to direct medical care of the resident when they are in declining health are at the end stage of their life. When asked about the process staff follows for advance directive review during the care plan process, RN

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#2 stated, "We discuss the advanced directive, but I don't specifically review it. We review the code status." The facility advanced directive policy "A written notation indicating the type of advance directives will be reviewed annually by the interdisciplinary team" was reviewed with ASM #2 and RN #2. When asked where documentation of the periodic annual review was located in the medical record, ASM #2 stated, "So we need to have something written to document this, I did not know. We might have something that is written." RN #2 did not answer.

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 25.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 88.
3. Resident #14 was admitted to the facility on 9/19/17 with diagnoses that included but were not limited to: dementia, depression, stroke and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/23/19, coded the resident as unable to complete the interview and coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive

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decisions.

Review of the clinical record revealed an "Acknowledgement of Receipt of Advance Directive Information" form. This form was dated 10/14/10. There was an "Advance Medical Directive" for (Resident #14) in the clinical record.

Further review of the clinical record failed to evidence documentation of an annual review of the advanced directive with Resident #14 and or the resident responsible party.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 2/26/2020 at 9:32 a.m. When asked if the advanced directive is reviewed periodically with the resident and/or resident representative, ASM #1 stated the staff during the care plan meetings, verify the code status and if there are any changes they would make to the advanced directive at that time.

An interview was conducted with OSM (other staff member) #4, the director of social services, on 2/26/2020 at 9:39 a.m. When asked about the role she plays with the review of advanced directives, OSM #4 stated it's mostly through the care plan, especially the new admissions. We review if it (advanced directive) was provided during the admission process. When asked if the staff review the residents advanced directives during their care plan meeting, OSM #4 stated, "I have not seen that in our process where the advanced directive has been reviewed, it's usually just the code status."

An interview was conducted with RN (registered nurse) #2, the MDS nurse on 2/26/2020 at 10:07

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a.m. When asked if she reviews the advanced directives of residents during the care plan process, RN #2 stated, "I don't specifically review it. We discuss them. We go over the code status." When asked what an advanced directive is, RN #2 stated it's the documentation to direct medical care of a resident when they are declining or at the end stage of their life. The facility policy was reviewed with RN #2. RN #2 stated the facility reviews the advanced directive in the quality assurance program as to who has DNR (do not resuscitate). When asked about the location of the documentation of the individual resident review of the advanced directives, RN #2 did not answer.

A "Care Plan Conference Summary" dated, 1/23/2020, documented in part, "Discussed with RP/POA (responsible party/power of attorney)" a check mark was documented next to "Adv (advanced) directive/code status." Under the comments column it was documented, "Reviewed DNR (do not resuscitate)."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #1, the quality assurance nurse, were made aware of the above concern on 2/26/1010 at 5:45 p.m.

No further information was obtained prior to exit.

4. Resident #45 was admitted to the facility on 3/27/18 with diagnoses that included but were not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.) (1), abnormal posture, cough, and gastroesophageal reflux disease

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(backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/31/2020, coded the resident as unable to understand other and unable to make herself understood. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #45 was coded as being totally dependent of one or more staff members for all of her activities of daily living.

Review of the clinical record revealed a documented "Virginia Advance Medical Directive" dated 6/24/2005.

Further review of the medical record failed to evidence documentation that the advanced directive wishes were reviewed on an annual basis with Resident #45 or her responsible party.

An interview was conducted with the resident's sitter on 2/27/2020 at 10:45 a.m. When asked if she attends the care plan meeting, the sitter stated she was here seven days a week for eight hours a day. She does attend care plan meetings and she does not recall them reviewing her (Resident #45's) advanced directive, just verifying her code status.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 2/26/2020 at 9:32 a.m. When asked if the advanced directive is reviewed

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periodically with the resident and/or resident representative, ASM #1 stated the staff during the care plan meetings, verify the code status and if there are any changes they would make to the advanced directive at that time.

An interview was conducted with OSM (other staff member) #4, the director of social services, on 2/26/2020 at 9:39 a.m. When asked about the role she plays with the review of advanced directives, OSM #4 stated it's mostly through the care plan, especially the new admissions. We review if it (advanced directive) was provided during the admission process. When asked if the staff review the residents advanced directives during their care plan meeting, OSM #4 stated, "I have not seen that in our process where the advanced directive has been reviewed, it's usually just the code status."

An interview was conducted with RN (registered nurse) #2, the MDS nurse on 2/26/2020 at 10:07 a.m. When asked if she reviews the advanced directives of residents during the care plan process, RN #2 stated, "I don't specifically review it. We discuss them. We go over the code status." When asked what an advanced directive is, RN #2 stated it's the documentation to direct medical care of a resident when they are declining or at the end stage of their life. The facility policy was reviewed with RN #2. RN #2 stated the facility reviews the advanced directive in the quality assurance program as to who has DNR (do not resuscitate). When asked about the location of the documentation of the individual resident review of the advanced directives, RN #2 did not answer.

The Care Plan Conference Summary sheet dated

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F 578	Continued From page 12 2/6/2020 documented in part, "Discussed with RP/POA (responsible party/power of attorney)" a check mark was documented next to "Adv (advanced) directive/code status." Under the comments column it was documented, "DNR (do not resuscitate)." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #1, the quality assurance nurse, were made aware of the above concern on 2/26/1010 at 5:45 p.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.	F 578		
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:	F 607		4/3/20

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F 607	Continued From page 13 Based on staff interview and facility document review, it was determined the facility staff failed to implement their abuse policy for three of twenty-five employee record reviews, (CNA (certified nursing assistant) #8, LPN (licensed practical nurse) #5 and LPN #7). The facility failed to perform a timely criminal background check for CNA #8 and failed to obtain references for LPN #5 and LPN #7. The findings include: A review of twenty-five employee records revealed the following: - Review of the employee file for CNA #8 revealed a hire date of 4/17/19. Further review of the employee file failed to evidence documentation of a criminal background check for CNA #8. - Review of the employee file for LPN #5, revealed a hire date of 4/17/19. Further review of the employee file failed to reveal any reference checks at or before the date of hire. - Review of the employee file for LPN #7, revealed a hire date of 5/22/19. Further review of the employee file failed to reveal any reference checks at or before the date of hire. An interview was conducted on 2/27/20 at 8:07 AM with OSM (other staff member) #1, the acting director of admissions, business office and human resources. When asked to provide a background check for CNA #8 (hire date 4/17/19), OSM #1 stated, "I started in 10/19 in this office and immediately did audit due to concerns with the previous office manager's processes. I found that (CNA #8) did not have a criminal background check at all. I obtained a criminal background check which is dated 10/17/9."	F 607	F607, D: Develop/Implement Abuse/Neglect Policies Abuse/ Neglect: 1.a. background check on C.N.A. #8 has been complete. b. references for LPN #5 and LPN#7 has been complete. 2.All employees hired need a background check and 2 references. 3.Administrator has in-serviced Business Office Manager and Talent Development Staff on following policy on obtaining background checks and references prior to an employee□s first day. 4.Business Office Manager will audit 100% of hires x 3 weeks, and then review monthly to ensure background checks and references are being complete prior to employment and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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When asked to provide reference checks for LPN #5 (hire date 4/17/19) and LPN #7 (hire date 5/22/19), OSM #1 stated, "When I started and performed the audit, I found no references for (LPN #5) and (LPN #7).

On 2/27/20 at 12:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #1, the quality manager, were made aware of the above concerns.

The facility policy, "Abuse, Neglect, Exploitation & Misappropriation" dated 11/28/16, documented in part, "Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse. Abuse includes sexual abuse (sexual harassment/inappropriate touching, sexual coercion, sexual assault or allowing a patient to be sexually assaulted by another)."

The facility's "Right to Dignity, Freedom from Abuse, Neglect and Exploitation" policy dated 1/8/18, documents in part, "The administrator or department supervisors will use job descriptions, interviews, sworn disclosure statements, appropriate licensing board/agency registry check and reference checks to screen, select and employ only those staff considered able to perform their job duties in a considerate and respectful manner. All employees are hired pending a criminal background check by the State Police. A person cannot be employed in a position that involves direct contact with a resident unit results of a criminal history background check has been received."

No further information was provided prior to exit.

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F 622	Continued From page 15	F 622		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §	F 622		4/3/20

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431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information

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F 622	Continued From page 17 (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence transfer discharge requirements to the hospital for one of thirty-eight residents, Resident #31, when the resident was transferred to the hospital on 2/8/20. The findings include: Resident #31 was admitted to the facility on 2/11/20. Resident #31's diagnoses included but were not limited to: Alzheimer's disease (progressive loss of mental ability and function) (1), chronic kidney disease (decreased function of the kidneys) (2) and hydronephrosis (distension of the kidney, caused by accumulation of urine that cannot flow out due to an obstruction) (3). Resident #31's most recent MDS (minimum data set) assessment, a quarterly admission assessment, with an assessment reference date of 1/15/20, coded the resident as scoring 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility and dressing, total dependence for transfer,	F 622	F622, D: Transfer/Discharge Requirements: 1.Resident # 31 is a current resident in our facility with proper documentation. 2.All residents who discharge the facility need the proper documentation and evidence that it has been given. 3.Director of Nursing or designee has in-serviced license nursing staff on proper documentation to be sent and tracked that it was sent with a resident transferring to a hospital. 4.Director of Nursing or designee will audit 100% those transferred from the facility to the hospital x 3 weeks, and then review monthly to ensure proper paperwork and tracking has been done and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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locomotion on unit, bathing, and toilet use; and supervision in eating.

Review of Resident #31's clinical record revealed the resident was transferred to the hospital on 2/8/20 for lethargy, vomiting and positive urinary tract infection. A nurse's progress note dated 2/8/20 at 9:53 PM, documented "Resident was sent to hospital for change of condition and lethargy. At the time of writing this report, the resident has been admitted for further monitoring and observation. No further information has been given. We shall continue to monitor her situation as communicated from the hospital." Unable to interview staff person as not in town.
An interview was conducted on 2/26/20 at 10:36 AM with LPN (licensed practical nurse) #3. When asked what documentation is provided to the hospital, LPN #3 stated, "We print the continuity of care document, face sheet, physician orders, and the comprehensive care plan including goals." When asked how it would be evidenced that documentation was provided, LPN #3 stated, "I would chart that in a note. There is a transfer form of what is given. We would have that documentation."

An interview was conducted on 2/26/20 at 1:49 PM with LPN #5. When asked what information was provided to the hospital when Resident #31 was transferred, LPN #5 stated, "I would provide the physician orders, copy of DNR (do not resuscitate), bed hold policy, continuity of care document and the care plan goals." When asked if she could provide a copy of what was provided to the hospital, LPN #5 stated, "No." When asked if there was a written progress note regarding the documentation sent with Resident #31, LPN #5 stated, "No, there's no note that

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documents all that was sent."

An interview was conducted on 2/27/20 at 9:17 AM with ASM (administrative staff member) #2, the director of nursing. When asked to provide a copy of the "Transfer Form Nursing Facility to Emergency Department/Hospital" for Resident #31, ASM #2 provided a blank form. When asked for documentation specific to Resident #31, ASM #2 stated, "I do not have a copy of the documentation, (LPN #5) did not follow the checklist." When asked if there was a progress note that detailed the information sent to the hospital on 2/8/20, ASM #2, the director of nursing, stated, "No, there was no progress note written either."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

The facility's "Transfers Discharges" policy dated 1/3/19, documents in part, "Prior to transfer or discharge of a resident, documentation will be made in the medical record that: the attending physician was notified, a family member who is the responsible party was notified and identified, the reason for the transfer or discharge and the specific resident needs that cannot be met at the facility. Information will be provided to the receiving provider to include a minimum of the following: contact information of the practitioner responsible for the care of the resident, responsible party contact information, advance directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals and all other necessary

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F 622	Continued From page 20 information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care." References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 25. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 278.	F 622		
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 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		4/3/20

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 22 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide written notification upon transfer for one of thirty-eight residents in	F 623	F623, D: Requirements before transfer/discharge: 1.Resident # 31 is a current resident in	

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F 623	Continued From page 23 the survey sample, Resident #31. The facility staff failed to provide written notice of the reason for transfer to Resident #31 and or to the resident responsible party, when Resident #31 was transferred to the hospital on 2/8/2020. The findings include: Resident #31 was admitted to the facility on 2/11/2020. Resident #31's diagnoses included but were not limited to: Alzheimer's disease (progressive loss of mental ability and function) (1), chronic kidney disease (decreased function of the kidneys) (2) and hydronephrosis (distension of the kidney, caused by accumulation of urine that cannot flow out due to an obstruction) (3). Resident #31's most recent MDS (minimum data set) assessment, a quarterly admission assessment, with an assessment reference date of 1/15/2020, coded the resident as scoring 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. Review of Resident #31's clinical record revealed the resident was transferred to the hospital on 2/8/2020 for lethargy, vomiting and positive urinary tract infection. A nurse's progress note dated 2/8/2020 at 9:53 PM, documented "Resident was sent to hospital for change of condition and lethargy. At the time of writing this report, the resident has been admitted for further monitoring and observation. No further information has been given. We shall continue to monitor her situation as communicated from the hospital." The staff that wrote this note was not available for interview at the time of the survey. An interview was conducted on 2/26/2020 at	F 623	our facility with proper documentation. 2.All residents who discharge the facility need written notice and the proper documentation and evidence that it has been given. 3.Administrator has in-serviced admissions staff and IDT to send written notice to any resident who has a transfer to a hospital. 4.Admissions director or designee will audit 100% those transferred from the facility to the hospital x 3 weeks, and then review monthly to ensure proper paperwork and tracking has been done and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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10:36 AM with LPN (licensed practical nurse) #3. When asked if written notification of the reason for transfer to the hospital is provided to the responsible party, LPN #3 stated, "We call the RP (responsible party), nothing is provided in writing." When asked how the RP notification would be evidenced, LPN #3 stated, "I would chart that in a note."

An interview was conducted on 2/26/20 at 1:49 PM with LPN #5. When asked what information was provided to Resident #31's RP in writing, LPN #5 stated, "We call the RP." When asked if she could provide a copy of the written RP notification and progress note documenting the written RP notification of the reason for transfer to the hospital on 2/8/2020, LPN #5 stated, "No."

An interview was conducted on 2/27/2020 at 9:17 AM with ASM (administrative staff member) #2, the director of nursing. When asked to provide a copy of the RP written notification of the reason for Resident #31's transfer to the hospital on 2/8/2020, ASM #2 stated, "I do not have a copy of the documentation; (LPN #5) did not follow the checklist." When asked if there was a progress note that detailed the RP notification on 2/8/2020, ASM #2, the director of nursing, stated, "No, there was no progress note written either."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/2020 at 5:40 PM.

The facility's "Transfers Discharges" policy dated 1/3/19, documented in part, "In the event of an emergency discharge, the administrator or designee will provide written notification containing the reason for discharge in a manner

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F 623	Continued From page 25 and in the language understood by the Resident and/or legal representative as soon as practicable before the move." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 25. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 119. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 278.	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or	F 645		4/3/20

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(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental

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F 645	Continued From page 27 disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure a PASAAR (Pre-Admission Screening and Resident Review) was completed prior to admission for two of 38 residents in the survey sample, (Residents #34 and #55). The facility staff failed to ensure a level I PASARR was completed for Resident #34 and Resident #55, to ensure the residents were evaluated and receiving care and services in the most integrated setting appropriate for the residents' needs. The findings include: Resident #34 was admitted to the facility on 10/22/19 with diagnoses that included but were not limited to: anxiety disorder, Bipolar disorder (a mental disorder characterized by episodes of mania and depression) (1), and major depressive disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/21/2020 coded the resident as scoring a "1" on her BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section I - Active Diagnoses the resident was coded as having depression and Bipolar Disorder.	F 645	F645, D: PASARR screening from MD & ID CFR(s): 1.Resident # 34 and #55 is a current resident in our facility with a screening. 2.All residents who are admitted with an indication of MI/MR to the facility are required to have a PASARR or other mental disorder screening. 3.Administrator has in-serviced admissions staff and social service staff to obtain a mental health screening prior to admissions. 4.Admissions director or designee will audit 100% those admitted to the facility x 3 weeks, and then review monthly to ensure proper paperwork and tracking has been done and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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Review of the clinical record failed to evidence documentation of a PASAAR completed prior to the resident's admission to the facility.

On 2/26/2020 at 2:47 p.m. ASM (administrative staff member) #1, the administrator, stated they did not have a PASAAR for Resident #34. He stated the facility director of social services completed it today.

The Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions for Resident #34 dated 2/26/2020, documented a circle around the word "No" when asked if the resident had a current serious mental illness.

An interview was conducted with OSM (other staff member) #4, the director of social service, on 2/26/2020 at 3:16 p.m. The above form was reviewed with OSM #4. When asked who is responsible for completing the PASAAR forms, OSM #4 stated, the hospital. When asked who normally requests these forms, OSM #4 stated admissions but this resident came up from the assisted living here. OSM #4 stated, "In the process I was to fill it out when she came up and I'm not sure that they would need to be completed prior to coming up (to the health care center)."

An interview was conducted with OSM #5, the director of admissions; on 2/26/2020 at 3:28 p.m., OSM #5 was asked if a resident should have a PASAAR upon admission to the facility. OSM #5 stated yes. OSM #5 was asked about the process staff follows for a resident who does not have a PASARR on admission. OSM #5 stated the social worker should be completing one.

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When asked how that is communicated to the social worker, OSM #5 stated in the morning meetings we communicate these types of things. When asked if she told someone that (Resident #34) needed a PASARR completed, OSM #5 stated she could not recall whom she told. When asked if there was, a process to ensure all of the admission paperwork is completed; OSM #5 stated there was a check off list. A copy of the check off list for Resident #34 was requested. Review of the check off list provided, revealed the check off list did not document the PASAAR as something to be completed as part of the admission process.

The facility policy, "PASAAR for MIMR (mental illness/mental retardation)" documented in part, "1. All admissions to this facility must be screened for MI/MR before any consideration for admission is made. ...The Admissions Committee will review all admissions for conditions of MI and MR and to ensure that applicants meet the level of care criteria (Level I evaluation)."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #1, the quality assurance nurse, were made aware of the above concern on 2/26/1010 at 5:45 p.m.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.
2. Resident #55 was admitted to the facility on 1/31/20. Resident #55's diagnoses included but were not limited to: pneumonia (inflammation of

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the lungs usually caused by an infection) (1), bipolar disorder (mental disorder characterized by mania and depression) (2), schizophrenia (mental disorder characterized by gross distortions of reality, disturbances of thought, language and perception) (3). Resident #55's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/7/20, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section I- Active Diagnosis: coded the resident with diagnosis of bipolar disorder and schizophrenia.

A review of Resident #55's clinical record revealed the resident did not have a PASAAR (Pre-Admission Screening and Resident Review) completed prior to and or upon admission on 1/31/20. The PASARR for Resident #55 was completed by the OSM (other staff member) #4, the director of social services on 2/2/20 at 2:47 PM. The PASAAR Question #2 "Does the individual have a current serious mental illness" was incorrectly coded for Resident #55 as "No".

On 2/26/20 at 3:14 PM, an interview was conducted with OSM #4, the director of social services. When asked if she completed the PASAAR, "OSM #4 stated, "Yes, I've been checked off to complete the PASAAR form." When reviewing the PASAAR for Resident #55, OSM #4 stated, "The mental illness is not (Resident #55's) primary diagnosis. In the hospital we did not consider mental illness unless it was primary diagnosis." When asked if a diagnosis of bipolar and schizophrenia are considered a serious mental illness, OSM #4 stated, "Yes, I would consider those diagnosis as

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mental illness." When asked why the PASAAR for Resident #55 was completed on 2/26/20 instead of on admission 1/31/20, OSM #4 stated, "I personally don't feel like we should have filled it out now. The PASAAR should have come from the hospital." When asked who is responsible to obtain the information from the hospital, OSM #4 stated, "Admissions is responsible for obtaining forms prior to admission to the facility."

An interview was conducted on 2/26/20 at 3:28 PM with OSM #5, the director of admissions. OSM #5 was asked if a resident should, they have a PASAAR when admitted. OSM #5 stated, "Yes, that should come with their admission paperwork." When asked what should be done if the PASAAR is not present, OSM #5 stated, "The social worker should complete one." OSM #5 was asked about the process staff follows for communicating that a PASAAR needs to be completed for a resident. OSM #5 stated, "It would be discussed in the morning huddle." When asked if OSM #5 had communicated that Resident #55's PASAAR needed to be completed, OSM #5 stated, "I really don't remember but I would assume I did." When asked if there was an admission checklist to ensure the PASAAR was completed, OSM #5 stated, "Yes we have a checklist that we fill out. I will bring you a copy." The facility "Nursing Center documentation and chart order" form provided by OSM #5, the director of admissions, does not list the PASARR.

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

The facility's "PASAAR for MIMR (mental illness

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F 645	Continued From page 32 mental retardation)" documents in part, "The facility will not admit any individual who has an indication of mental retardation (or a related condition) or mental illness unless it has been determined that he or she requires the level of services provided by a nursing facility and does not require active treatment in an ICF (intermediate care facilities). No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 71. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		4/3/20

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F 655	Continued From page 33 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not 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, it was determined that the facility staff failed to develop a complete baseline care plan for one of 38 residents in the survey sample, Resident #162. The facility staff failed to develop a baseline care plan to address Resident #162's use of bed rails.	F 655	F655, D: Baseline Care Plan: fail to develop a base-line care plan on 1/38 residents. Bed rails not care planned. 1.Residents #162, baseline care plan has been updated to properly reflect the residents informed consent to side rail preference. 2.All residents in beds with bed rails are at	

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F 655	Continued From page 34 The findings include: Resident #162 was admitted to the facility on 2/21/20. Resident #162's diagnoses included but were not limited to diabetes, constipation and pulmonary fibrosis (a lung disease). Resident #162's admission MDS (minimum data set) assessment had not been completed yet at the time of the survey. An admission observation report dated 2/21/20 documented Resident #162 was alert and oriented to person, place, time and situation. Resident #162's baseline care plan with an admission date of 2/21/20 documented a section titled, "Required Safety/Enablers measures." There was an option for side rails (bed rails); however, this option was not checked. On 2/25/20 at 3:57 p.m., Resident #162 was observed in bed with bilateral quarter bed rails up. On 2/26/20 at 10:36 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 confirmed residents' care plans should reflect the use of bed rails. On 2/26/20 at 2:35 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked if residents' care plans should include the use of bed rails. RN #2 stated, "Yes because it's a part of their plan of care for their care." On 2/26/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Comprehensive	F 655	risk. 3.Director of Nursing or designee will review all baseline care plans for the use of bed rails. 4.Director of Nursing or designee will do a 100% audit on new admits x3 weeks, and then review monthly to identify the baseline care plan addresses the use of bed rails and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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F 655	Continued From page 35 Person-Centered Care Planning" documented, "1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission...The baseline care plan will include at a minimum: -The resident's initial goals for care; -The instructions needed to provide effective and person-centered care that meets professional standards of quality care; -The resident's immediate health and safety needs..." No further information was presented prior to exit.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (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	F 656		4/3/20

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F 656	Continued From page 36 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for two of 38 residents in the survey sample, ((Residents #163 and #14). The facility staff failed to implement Resident #163's oxygen care plan and failed to implement the Resident # 14's comprehensive care plan for side rail protectors. During separate observations, Resident #14 was observed lying in bed with bilateral side rails up. One side rail was covered, the other rail was uncovered and the black side rail covering was observed on the floor under the resident's bed. The findings include: 1. Resident #163 was admitted to the facility on	F 656	F656, D: Develop/Implement Comprehensive Care Plan: 1.Residents #163 comprehensive care plan has been updated to properly reflect the residents need for physician order for oxygen. Resident # 14 comprehensive care plan has been updated to properly reflect the residents informed consent to side rail preference. 2.All residents with oxygen are at risk. All residents with bed rails are at risk. 3.Director of Nursing or designee will review all comprehensive care plans for the use of oxygen and bed rails. 4.Director of Nursing or designee will do a 100% audit on new admits x3 weeks, and then review monthly to identify that the	

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F 656	Continued From page 37 5/17/19. Resident #163's diagnoses included but were not limited to respiratory failure, acute kidney failure and muscle weakness. Resident #163's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/20/19, coded Resident #163's cognition as severely impaired. Section G coded the resident as requiring extensive assistance of one staff with bed mobility and personal hygiene. Section O coded Resident #163 as receiving oxygen therapy. Resident #163's comprehensive care plan dated 5/28/19 documented, "Risk for respiratory distress due to: shortness of breath...Administer O2 (oxygen) as ordered..." Review of Resident #163's clinical record revealed a physician's order dated 2/19/20 for oxygen at three liters per minute. On 2/25/20 at 12:05 p.m., Resident #163 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the ball in the concentrator flow meter positioned between the two and a half and three-liter lines. On 2/25/20 at 1:28 p.m., Resident #163 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate of two and a half liters as evidenced by the middle of the ball in the concentrator flow meter positioned on the two and a half liter line.	F 656	comprehensive care plan addresses the use of oxygen and the use of bed rails and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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On 2/25/20 at 4:01 p.m., Resident #163 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the ball in the concentrator flow meter positioned between the two and a half and three-liter lines.

On 2/26/20 at 10:36 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for three liters. LPN #3 stated the three-liter line should run through the middle of the ball at eye level.

On 2/26/20 at 3:30 p.m., LPN #1 and LPN #2 (nurses caring for Resident #163) stated Resident #163 does not adjust the oxygen concentrator flow meter.

On 2/26/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 2/27/20 at 8:05 a.m., ASM #2 and RN (registered nurse) #1 (the quality assurance nurse) requested a demonstration of this surveyor's observations of the rates Resident #163's oxygen concentrator was set on. A demonstration of an oxygen concentrator set at two and a half liters and set between two and a half liters and three liters was provided to ASM #2.

The oxygen concentrator manufacturer's instructions documented, "5. Adjust the flow to

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the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate."

The facility policy titled, "Comprehensive Person-Centered Care Planning" documented, "9. The resident will receive the services and/or items included in the plan of care."

No further information was presented prior to exit.
2. Resident #14 was admitted to the facility on 9/19/17 with diagnoses that included but were not limited to: dementia, depression, stroke and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/23/19, coded the resident as unable to complete the interview and coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed.

The comprehensive care plan dated 2/24/2020 documented in part, "Problem: Resident with a hx (history) of pressure ulcers/impaired skin integrity due to: impaired mobility, incontinence, fragile skin, hx of skin tears." The "Approach" documented in part, "Bilateral grab bars were zip tied to bed frame...Side rail protectors in place to prevent skin bruising and injuries."

An interview was conducted with Resident #14's daughter on 2/25/2020 at 12:20 p.m. She stated that her mother had had a fall Saturday night into Sunday morning. They had contacted her around 5:30 a.m. She informed the surveyor that her

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mother was supposed to have padded rails on her bed but it was not on the bed.

Resident #14 was observed in her bed on 2/26/2020 at 8:02 a.m. The resident's bed had both side rails up in the upright position. On the side next to the window, there was a black covering over the side rail. On the side closest to the door, there was a black covering observed lying under the bed, not on the side rail. On 2/26/2020 at 2:00 p.m., a second observation was made of Resident #14 in her bed with both side rails up; only the rail closest to the window had a cover over it.

A third observation was made on 2/26/2020 at 5:18 p.m. of Resident #14's room with RN (registered nurse) # 4. When asked if the resident was supposed to have side rail covers, RN #4 stated she believed she was supposed to have them on. RN #4 observed the one black side rail, cover under the bed on the side closet to the door. The side by the window had the rail up and the black cover was on.

On 227/2020 at 7:32 a.m., a copy of Resident #14's care plan was presented. The "Approach: bilateral grab bars were zip tied to bed frame, was circled. A handwritten note documented, "She does not utilize grab bars."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 2/27/2020 at 8:09 a.m. When asked what the documentation meant, ASM #2 stated her care plan says that her grab bars are zip tied to the bed frame. ASM #2 was informed of the observations above of Resident #14 in her bed with both rails up with only one protective covers

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F 656	Continued From page 41 on one side of the bed. ASM #2 stated they zip tied the grab bars so the resident would not get skin tears. With them zip tied, they still had a cover that is supposed to be on them even in the down position. ASM #2 was informed again of the observations of the resident in bed without bilateral protective covers in place and ASM #2 was informed the observations did not evidence the rails zip tied to the bed. ASM #1, the administrator, ASM #2, and RN #1, the quality assurance nurse, were made aware of the above concern on 2/27/2020 at 12:05 p.m. No further information was obtained prior to exit.	F 656		
F 657 SS=E	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 657		4/3/20

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F 657	Continued From page 42 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for five of thirty-eight residents in the survey sample, (Residents #17, #27, #55, #161, and #9). The facility staff failed to review and revise the comprehensive care plans for Resident #17, Resident # 27, Resident #55, Resident # 161 and Resident #9 to address and include the use of bed rails. The findings include: 1. Resident #17 was admitted to the facility on 12/24/19 with diagnoses that included but were not limited to: acute respiratory failure [inability of the heart and lungs to maintain an adequate level of gas exchange.] (1), atherosclerotic heart disease, [plaque consisting of cholesterol and lipids form on inner arterial walls of the heart.] (2); and pneumonia [inflammation of the lungs usually by bacterial infection.] (3). Resident #17's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 12/31/19, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section	F 657	F657, E: Care Plan timing and revision: 1.Residents #17, #27, #55, #161 and #9, comprehensive care plans have been reviewed and revised to include the use of side rails preference. 2.All residents in beds with bed rails are at risk. 3.Director of Nursing or designee will review and revise all comprehensive care plans for the use of bed rails and bed rail preferences. 4.Director of Nursing or designee will do a 100% audit on new admits x3 weeks, and then review monthly to identify and addresses the use of bed rails in comprehensive care plans. Director of Nursing or designee will regularly review comprehensive care plans for bed rail assessment and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating.

Observation of Resident #17 on 2/26/20 at 7:30 AM, revealed the resident in bed with bilateral upper bed rails raised on the bed.

A review of Resident #17's comprehensive care plan dated 1/2/20 failed to evidence documentation for the use of bed rails.

An interview was conducted with Resident #17 on 2/26/20 at 7:30 AM. When asked if she used the bed rails, Resident #17 stated, "Yes, I use them to help with getting in and out of bed."

An interview was conducted on 2/26/20 at 10:36 AM with LPN (licensed practical nurse) #3. LPN #3 was asked about the assessment process staff follows for residents' use of bed rails. LPN #3 stated, "When they are admitted we do an assessment to see if the rails are needed, if bed rail is there and it is used for positioning and mobility we leave it in place. We determine the need to leave it in place." When asked the purpose of the comprehensive care plan, LPN #3 stated, "It is the individualized plan of care for the patient." When asked if bed rails should be included in the care plan, LPN #3 stated, "Yes, the care plan should reflect the use of the bed rails."

A review of Resident #17's bed rail with OSM (other staff member) #3, the director of maintenance, was conducted on 2/26/20 at 2:35 PM. When asked how he would identify the rails on Resident #17's bed, OSM #3 stated, "I would

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call it a one half rail."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

The facility's "Comprehensive Person-Centered Care Planning" policy dated 11/15/17, documents in part, "A person-centered comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident. The comprehensive care plan will aid in preventing or reducing declines in the resident's functional status and/or functional levels."

The facility's "Side Rail Assessment" policy dated 11/21/17, documented in part, "The reason for the side rails and their proper use will be integrated into the comprehensive care plan."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 502.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 52.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461.

2. Resident #27 was admitted to the facility on 10/4/19 with diagnoses that included but were not limited to: right knee replacement [replacement

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of the kneecap and joints, which connect the thighbone and lower leg bone.] (1), osteoarthritis of the knees bilaterally [common form of arthritis characterized by degenerative changes in the joints.] (2); and hypertension [high blood pressure.] (3)

Resident #27's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/11/20, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring supervision in bed mobility, dressing, bathing and personal hygiene; limited assistance with transfers and toilet use and independent in eating.

Observation of Resident #27 on 2/26/20 at 7:40 AM, revealed, the resident in bed, with the right upper bed rail raised on the bed, and the left upper bed rail lowered at mattress level.

A review of Resident #27's comprehensive care plan dated 1/22/20 failed evidence the use of bed rails.

An interview was conducted with Resident #27 on 2/26/20 at 7:40 AM. When asked if she used the bed rails, Resident #27 stated, "Yes, I use them to help with turning. The one on my left side does not work correctly. It does not latch properly. It will be up and when you put pressure on it to get back in bed, then it falls down. It does not fall down all the way; it gets stuck at the mattress level." When asked if she had reported the bed rail concern to anyone, Resident #27 stated, "Yes, I did last evening. I do not remember their

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name."

The staff member that Resident #27 reported bed rail concern to could not be identified.

An interview was conducted on 2/26/20 at 10:36 AM with LPN (licensed practical nurse) #3. LPN #3 was asked about the assessment process staff follows for residents' use of bed rails. LPN #3 stated, "When they are admitted we do an assessment to see if the rails are needed, if bed rail is there and it is used for positioning and mobility we leave it in place. We determine the need to leave it in place." When asked the purpose of the comprehensive care plan, LPN #3 stated, "It is the individualized plan of care for the patient." When asked if bed rails should be included in the care plan, LPN #3 stated, "Yes, the care plan should reflect the use of the bed rails."

A observation of Resident #27's bed rail with OSM (other staff member) #3, the director of maintenance, was conducted on 2/26/20 at 2:35 PM. OSM #3 was asked how he would identify the rails on Resident #27's bed. OSM #3 stated, "I would call it a one half rail." When asked if he had received a work order or phone call regarding Resident #27's left bed rail, OSM #3 stated, "No, we have not. It (left bed rail) does not retract all the way and I am having difficulty raising it."

On 2/27/20 at 10:00 AM, OSM #3, the director of maintenance was asked if he had received an order for bed rail repair for Resident #27. OSM #3 stated, "No, we did not. We immediately repaired the rail yesterday. There was a screw that had worked out."

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The facility's "Comprehensive Person-Centered Care Planning" policy dated 11/15/17, documents in part, "A person-centered comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident. The comprehensive care plan will aid in preventing or reducing declines in the resident's functional status and/or functional levels."
The facility's "Side Rail Assessment" policy dated 11/21/17, documents in part, "The reason for the side rails and their proper use will be integrated into the comprehensive care plan."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 319.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 420.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 282.

3. Resident #55 was admitted to the facility on 1/31/20. Resident #55's diagnoses included but were not limited to: pneumonia (inflammation of the lungs usually caused by an infection) (1), bipolar disorder (mental disorder characterized by mania and depression) (2), schizophrenia (mental

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disorder characterized by gross distortions of reality, disturbances of thought, language and perception) (3).

Resident #55's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/7/20, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as being totally dependent in bed mobility, dressing, toilet use, personal hygiene and bathing; requires supervision in eating.

Observation on 2/25/20 at 3:40 PM of Resident #55, revealed the resident in bed with bilateral upper bed rails raised on bed.

A review of Resident #55's comprehensive care plan dated 2/11/20 fails to evidence documentation for the use of bed rails.

An interview was conducted with Resident #55 on 2/26/20 at 9:40 AM. When asked if she used the bed rails, Resident #55 stated, "Yes, I use them to help with turning in bed and getting in and out of bed."

An interview was conducted on 2/26/20 at 10:36 AM with LPN (licensed practical nurse) #3. LPN #3 was asked about the assessment process staff follows for residents' use of bed rails. LPN #3 stated, "When they are admitted we do an assessment to see if the rails are needed, if bed rail is there and it is used for positioning and mobility we leave it in place. We determine the need to leave it in place." When asked the purpose of the comprehensive care plan, LPN #3

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stated, "It is the individualized plan of care for the patient." When asked if bed rails should be included in the care plan, LPN #3 stated, "Yes, the care plan should reflect the use of the bed rails."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 71.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518.
4. Resident #161 was admitted to the facility on 1/31/20. Resident #161's diagnoses included but were not limited to high blood pressure, muscle weakness and osteoporosis. Resident #161's admission MDS (minimum data set) with an ARD (assessment reference date) of 2/7/20, coded the resident's cognition as moderately impaired. Section G coded Resident #161 as requiring extensive assistance of one staff with bed mobility.

Resident #161's comprehensive care plan dated 2/10/20 failed to document information regarding the resident's use of bed rails.

On 2/25/20 at 1:58 p.m., Resident #161 was observed in bed with bilateral quarter bed rails up.

On 2/26/20 at 3:11 p.m., an interview was

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conducted with Resident #161. The resident stated she uses bed rails to turn in bed.

On 2/26/20 at 10:36 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 confirmed residents' care plans should reflect the use of bed rails.

On 2/26/20 at 2:35 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked if residents' care plans should include the use of bed rails. RN #2 stated, "Yes because it's a part of their plan of care for their care."

On 2/26/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.
5. Resident #9 was admitted to the facility on 4/8/19, with diagnoses that included but were not limited to: fracture of her femur, high blood pressure, abnormalities of gait and mobility, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/3/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed.

Resident #9 was observed and interviewed on 2/25/2020 at 1:48 p.m. The resident was in her bed with both bed rails up. The resident stated she used them to help position herself.

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F 657	Continued From page 51 Review of the comprehensive care plan dated, 12/6/19, failed to evidence documentation of the use of bed rails. Review of the physician's order failed to evidence documentation for an order for bed rails. On 2/26/20 at 10:36 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 confirmed residents' care plans should reflect the use of bed rails. When asked the purpose of the care plan LPN #3 stated it's the individualized care of the patient. On 2/26/20 at 2:35 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked if residents' care plans should include the use of bed rails. RN #2 stated, "Yes because it's a part of their plan of care for their care." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN #1, the quality assurance nurse, were made aware of the above findings on 2/27/2020 at 12:05 p.m. No further information was provided prior to exit.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		4/3/20

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F 695	Continued From page 52 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services for one of 38 residents in the survey sample, (Resident #163). The facility staff failed to administer oxygen to Resident #163 at the physician prescribed rate of three liters per minute. The findings include: Resident #163 was admitted to the facility on 5/17/19. Resident #163's diagnoses included but were not limited to respiratory failure, acute kidney failure and muscle weakness. Resident #163's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/20/19, coded Resident #163's cognition as severely impaired. Section G coded the resident as requiring extensive assistance of one staff with bed mobility and personal hygiene. Section O coded Resident #163 as receiving oxygen therapy. Review of Resident #163's clinical record revealed a physician's order dated 2/19/20 for oxygen at three liters per minute. Resident #163's comprehensive care plan dated 5/28/19 documented, "Risk for respiratory distress due to: shortness of breath...Administer O2 (oxygen) as ordered..." On 2/25/20 at 12:05 p.m., Resident #163 was observed lying in bed receiving oxygen via a	F 695	F695, D: Respiratory/Tracheostomy Care and Suction: 1.Resident # 163 oxygen is set to flow per physician prescribed rate at the time of survey. 2.All residents who are on oxygen in the facility are at risk. 3.Director of Nursing or designee has in serviced license nursing staff following physician orders and checking oxygen rates during their shift. 4.Director of Nursing or designee will audit 100% those on oxygen daily x 3 weeks, and then review monthly to ensure proper oxygen flow per physician orders and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the ball in the concentrator flow meter positioned between the two and a half and three liter lines.

On 2/25/20 at 1:28 p.m., Resident #163 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate of two and a half liters as evidenced by the middle of the ball in the concentrator flow meter positioned on the two and a half liter line.

On 2/25/20 at 4:01 p.m., Resident #163 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the ball in the concentrator flow meter positioned between the two and a half and three liter lines.

On 2/26/20 at 10:36 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for three liters. LPN #3 stated the three liter line should run through the middle of the ball at eye level.

On 2/26/20 at 3:30 p.m., LPN #1 and LPN #2 (nurses caring for Resident #163) confirmed Resident #163 does not adjust the oxygen concentrator flow meter.

On 2/26/20 at 5:56 p.m., ASM (administrative

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F 695	Continued From page 54 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 2/27/20 at 8:05 a.m., ASM #2 and RN (registered nurse) #1 (the quality assurance nurse) requested a demonstration of this surveyor's observations of the rates Resident #163's oxygen concentrator was set on which was provided. The oxygen concentrator manufacturer's instructions documented, "5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate." The facility policy titled, "Oxygen Therapy" documented, "The facility will ensure that safety precautions shall be met and maintained when oxygen therapy is provided." No further information was presented prior to exit.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure dialysis services, were provided consistent with	F 698	F698, D: Dialysis: 1.Resident # 55 has discharged from the facility.	4/3/20

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F 698	Continued From page 55 professional standards of practice, and the comprehensive person-centered care plan, for one of 38 residents in the survey sample, Resident #55. The facility staff failed to evidence communication with the dialysis center and failed to have a contract with the dialysis center provider. The findings include: Resident #55 was admitted to the facility on 1/31/20. Resident #55's diagnoses included but were not limited to: pneumonia [inflammation of the lungs usually caused by an infection.] (1), bipolar disorder [mental disorder characterized by mania and depression.] (2); schizophrenia [mental disorder characterized by gross distortions of reality, disturbances of thought, language and perception.] (3) Resident #55's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/7/20, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as being totally dependent in bed mobility, dressing, toilet use, personal hygiene and bathing; requires supervision in eating. MDS Section O- Special Treatments and Procedures: coded the resident with receiving dialysis while a resident. A review of the physician's orders dated 1/31/20 documented in part, "Hemodialysis on Tuesday, Thursday and Saturday at 5:00 AM." A review of Resident #55's comprehensive care	F 698	2.All residents who go to dialysis are at risk. 3.Director of Nursing or designee has in-serviced license nursing staff on having dialysis contract and communication book for each person going to dialysis. 4.Director of Nursing or designee will audit 100% those on dialysis daily x 3 weeks, and then review monthly to ensure the communication book is in order and report any findings in the QAPI meeting monthly. Admissions Director or designee audit 100% of admissions daily x 3 weeks, and then review monthly to ensure dialysis patient□s contracts are on file and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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plan dated 2/11/20 documented in part, "Problem-I have ESRD (end stage renal disease) and receive dialysis on Tuesday, Thursday and Saturday. Approach-Dialysis three days a week. Check dialysis shunt for bruit and thrill."

When asked to review the dialysis communication book for Resident #55, ASM (administrative staff member) #2, the director of nursing, provided the book on 2/25/20 at 4:40 PM. A review of the book, documented communication forms with the dialysis company on 2/3/20, 2/15/20, 2/20/20 and 2/22/20. Eleven dialysis treatments occurred from 2/3/20 through 2/25/20; seven communication forms were not evidenced in the book.

An interview was conducted on 2/25/20 at 4:45 PM with LPN (licensed practical nurse) #3. When asked the purpose of the dialysis communication book, LPN #3 stated, "It is to communicate the resident's vital signs and any resident issues with the dialysis facility." When asked if a form is completed for each dialysis trip, LPN #3 stated, "Yes, we are to complete one form for each treatment." LPN #3 was shown Resident #55's dialysis communication book and forms for the dates of 2/3/20, 2/15/20, 2/20/20 and 2/22/20 and was asked what this meant. LPN #3 stated, "It means that the forms were not completed on her other days of dialysis." LPN #3 was asked about which days of the week Resident #55 received dialysis. LPN #3 stated, "She goes on Tuesday, Thursday and Saturday."

An interview was conducted on 2/26/20 at 5:35 PM with ASM #2, the director of nursing. When asked about the dialysis communication book for Resident #55, ASM #2 stated, "I talked with the

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night nurse (LPN #6). She evidently created a dialysis book of her own. She did not know that a dialysis book was already started." When asked if LPN #6 was working night shift 2/26/20, ASM #2 stated, "Yes, you can talk with her in the morning."

An interview was conducted on 2/27/20 at 7:35 AM with LPN #6, the night shift nurse. When asked to describe the second dialysis communication book for Resident #55, LPN #6 stated, "(Resident #55) was admitted on 1/31/20. The first day I was there when she went to dialysis was 2/4/20. I could not find a dialysis book for her, so I made one. Since I work nights and get her ready on most mornings, I put the book in the drawer at the nurse's station." When asked about the purpose of the book, LPN #6 stated, "It is to provide communication between us and the dialysis center. Vital signs, any resident issues or concerns. The dialysis center sends us back any labs [laboratory tests] or new orders on the form." When asked how staff are made aware of new orders if there are two books, LPN #6 stated, "I guess they would not know about new orders and I did not know there was another book, which is why I made a book for her. (ASM #2), the director of nursing, in-serviced us on 2/26/20 to make sure we kept the book at the nurses station."

The second dialysis book was not available for review on 2/25 or 2/26. On 2/27/2020, the LPN #6 left without leaving 'second' dialysis's book for Resident #55's for review.

An interview was conducted on 2/27/20 at 7:51 AM, with ASM #2, the director of nursing. When asked where the dialysis book should be kept,

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F 698	Continued From page 58 ASM #2 stated, "It should be kept at the nurse's station. I in-serviced all the nurses about this yesterday morning, I told them there should be only one book, and that they need to merge the two books of (Resident #55)." On 2/27/20 at 12:35 PM, when asked to provide the documented arrangement with the dialysis company for Resident #55, ASM #1, the administrator stated, "We do not have a contract with that dialysis company. We have been trying to get one implemented." ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 71. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518.	F 698		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following	F 700		4/3/20

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F 700	Continued From page 59 elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, it was determined that the facility staff failed to implement bed rails requirements for eight of 38 residents in the survey, Residents #9, #14, #45, #161, #162, #17, #27, and #55. The facility staff failed to attempt appropriate alternatives prior to use, failed to assess for the risk of entrapment, failed to review risks and benefits and failed to obtained informed consent prior to the use of bed rails for Residents ##9, #14, #45, #161, #162, #17, #27, and #55. The findings include: 1. Resident #9 was admitted to the facility on 4/8/19, with diagnoses that included but were not limited to: fracture of her femur, high blood pressure, abnormalities of gait and mobility, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 700	F700, E: Quality of Care: 1.Residents #9, #14, #45, #161, #162, #17, #27, and #55 beds have been inspected for possible areas of entrapment. And informed consent has been signed. 2.All residents in beds with bed rails are at risk. 3.Maintenance director or designee will assess all beds for possible areas of entrapment. Director of Nursing will have all residents in beds with bed rails to have a signed informed consent. 4.Director of Nursing or designee will do a 100% audit for bed rail informed consent on new admits x3 weeks, and then monthly after and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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assessment reference date of 12/3/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed.

Review of the physician's order failed to evidence a documented order for bed rails.

On 2/25/2020, at 1:48 p.m., an observation and interview was conducted with Resident #9. The resident was in her bed with both bed rails up. Resident #9 stated she used them (bed rails) to help position herself.

Review of the clinical record failed to evidence documentation related to the assessment for the use of bed rails, a review/ assessment for the risk of entrapment, or an informed consent with the risks versus benefits prior to the use of bed rails. Review of Resident #9's comprehensive care plan failed to evidence documentation for the use of bed rails.

A list was provided to ASM #1, the administrator, on 2/25/2020 at 5:00 p.m. The list consisted of a request for evidence of documentation of the assessment, for the use of bed rails, documentation of the assessments/evaluations for the risk of entrapment and informed consents with the risks versus benefits obtained prior to the use of bed rails for each resident listed. Resident #9 was documented on the list.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3.

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When asked about the process staff follows for the use of bed rails including any assessments, LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/2020 at 5:40 p.m.

The facility's policy "Side Rail Assessment" dated 11/21/17, documented in part, "Any resident being considered for using a bed with side rails is assessed by the facility's interdisciplinary team to determine whether the resident's functional status and bed mobility is improved through the use of side rails, to identify individual characteristics that

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may increase the risk of entrapment by side rails or mattress. The side rail assessment is completed upon admission and at least annually."

No further information was provided prior to exit.

2. Resident #14 was admitted to the facility on 9/19/17 with diagnoses that included but were not limited to: dementia, depression, stroke and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/23/19, coded the resident as unable to complete the interview and coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed.

Review of the physician's order failed to evidence a documented order for the use of bed rails.

On 2/26/2020 at 8:02 a.m., Resident #14 was observed in her bed with both bed rails up in the upright position. A second observation was made of Resident #14 in her bed with both side bed rails up on 2/26/2020 at 2:00 p.m.

Review of the clinical record failed to evidence documentation related to the assessment for the use of bed rails, a review/ assessment for the risk of entrapment, or an informed consent with the risks versus benefits prior to the use of bed rails.

The comprehensive care plan for Resident #14, dated 2/24/2020, documented in part, "Problem: ADL (activities of daily living)

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Functional/Rehabilitation Potential." The "Approach" documented in part, "Both grab bars in bed to assist with bed mobility due to generalized weakness."

A list was provided to ASM #1, the administrator, on 2/25/2020 at 5:00 p.m. The list consisted of a request for evidence of documentation of the assessment, for the use of bed rails, documentation of the assessments/evaluations for the risk of entrapment and informed consents with the risks versus benefits obtained prior to the use of bed rails for each resident listed. Resident #9 was documented on the list.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for the use of bed rails including any assessments, LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1 stated, "I don't have an answer for that. You

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cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

RN (registered nurse) #1, the quality assurance nurse, presented a form titled, "Side Rail Evaluation" dated 7/27/18 with Resident #14's name documented on form and the resident's use of bilateral side rails. The "Resident/Family" section was blank and there was no signature of the responsible party on the reverse side where indicated.

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/2020 at 5:40 p.m.

No further information was provided prior to exit.

3. Resident #45 was admitted to the facility on 3/27/18 with diagnoses that included but were not limited to: Alzheimer's disease [a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.] (1), abnormal posture, cough, and gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn.] (2)

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/31/2020, coded the resident as unable to understand other and unable to make herself understood. The resident

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was coded as being severely impaired to make daily cognitive decisions. Resident #45 was coded as being totally dependent of one or more staff members for all of her activities of daily living.

Review of the physician's order failed to evidence a documented order for bed rails.

An interview was conducted with the resident's sitter on 2/27/2020 at 10:45 a.m. The resident was observed in bed with bilateral bed rails up at this time. When asked if the resident uses the bed rails, the sitter stated that she doesn't use them and they, the family, has put pillows on the inside of the rails so she doesn't hit her head on them. When asked if the staff ever explained the risk of entrapment or obtained a consent for the use of bed rails, Resident #45's sitter, stated they were there when she first came in and are still there. She stated she had been involved with her admission as the resident's husband was about to have surgery the next day so she would have recalled this.

The comprehensive care plan for Resident #45 dated 2/7/2020, documented in part, "Problem: ADL (activities of daily living) Functional/Rehabilitation Potential." The "Approach" documented in part, "Both grab bars in bed to promote independence with bed mobility due to age related debility."

A list was provided to ASM #1, the administrator, on 2/25/2020 at 5:00 p.m. The list consisted of a request for evidence of documentation of the assessment, for the use of bed rails, the documentation of the risk for entrapments and a consent for the use of the bed rails for each

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resident listed. Resident #14 was documented on the list.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for the use of bed rails including any assessments, LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/2020 at 5:40 p.m.

No further information was provided prior to exit.

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References:
(1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
4. Resident #161 was admitted to the facility on 1/31/20. Resident #161's diagnoses included but were not limited to high blood pressure, muscle weakness and osteoporosis. Resident #161's admission MDS (minimum data set) with an ARD (assessment reference date) of 2/7/20, coded the resident's cognition as moderately impaired. Section G coded Resident #161 as requiring extensive assistance of one staff with bed mobility.

Review of Resident #161's clinical record failed to reveal the facility attempted appropriate alternatives prior to the use of bed rails, failed to assess Resident #161 for the risk of entrapment, failed to review the risks and benefits with Resident #161 (or the resident's representative) and failed to reveal informed consent was obtained.

Resident #161's comprehensive care plan dated 2/10/20 failed to document information regarding the resident's use of bed rails.

On 2/25/20 at 1:58 p.m., Resident #161 was observed in bed with bilateral quarter bed rails up.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for the use of bed rails including any assessments, LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If

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the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

On 2/26/20 at 3:11 p.m., an interview was conducted with Resident #161. The resident stated she uses bed rails to turn in bed but staff has never explained risks and benefits or had a consent form signed.

On 2/26/20 at 5:56 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

5. Resident #162 was admitted to the facility on 2/21/20. Resident #162's diagnoses included but were not limited to diabetes, constipation and

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pulmonary fibrosis (a lung disease). Resident #162's admission MDS (minimum data set) assessment was not completed. An admission observation report dated 2/21/20 documented Resident #162 was alert and oriented to person, place, time and situation. The report further documented Resident #162 transferred with two-person assistance.

Review of Resident #162's clinical record failed to reveal the facility attempted appropriate alternatives prior to the use of bed rails, failed to assess Resident #162 for risk of entrapment, failed to review the risks and benefits with Resident #162 (or the resident's representative) and failed to reveal informed an consent was obtained prior to the use of bed rails.

Resident #162's baseline care plan with an admission date of 2/21/20 failed to document the resident's use of bed rails.

On 2/25/20 at 3:57 p.m., Resident #162 was observed in bed with bilateral quarter bed rails up.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for the use of bed rails including any assessments, LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

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An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

On 2/26/20 at 5:56 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.
6. Resident #17 was admitted to the facility on 12/24/19 with diagnoses that included but were not limited to: acute respiratory failure [inability of the heart and lungs to maintain an adequate level of gas exchange.] (1), atherosclerotic heart disease [plaque consisting of cholesterol and lipids form on inner arterial walls of the heart.] (2); and pneumonia [inflammation of the lungs usually by bacterial infection.] (3)

Resident #17's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 12/31/19, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility,

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transfers, dressing, bathing, toileting and personal hygiene; supervision in eating.

Observation of Resident #17 on 2/26/20 at 7:30 AM, revealed the resident in bed with bilateral upper bed rails raised on the bed.

A review of Resident #17's comprehensive care plan dated 1/2/20 failed to evidence documentation for the use of bed rails.

An interview was conducted with Resident #17 on 2/26/20 at 7:30 AM. When asked if she used the bed rails, Resident #17 stated, "Yes, I use them to help with getting in and out of bed."

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documentation of the assessment for the use of bed rails, documentation of the risks of entrapment assessments and informed consent for the use of the bed rails for each resident listed. Resident #17 was included on this list. None of the requested information was provided for Resident #17.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for the use of bed rails including any assessments, LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed

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rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 502.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 52.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461.

7. Resident #27 was admitted to the facility on 10/4/19 with diagnoses that included but were not limited to: right knee replacement [replacement

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of the kneecap and joints, which connect the thighbone and lower leg bone.] (1), osteoarthritis of the knees bilaterally [common form of arthritis characterized by degenerative changes in the joints.] (2); and hypertension (high blood pressure) (3).

Resident #27's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/11/20, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status coded the resident as requiring supervision in bed mobility, dressing, bathing and personal hygiene, limited assistance with transfers and toilet use and independent in eating.

On 2/26/20 at 7:40 AM, Resident #27 was Observation resting in bed with right upper bed rail raised on the bed and the left upper bed rail lowered at mattress level.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documentation of the assessment for the use of bed rails, documentation of the risks of entrapment assessments and informed consent for the use of the bed rails for each resident listed. Resident #27 was included on this list. None of the requested information was provided for Resident #27.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for the use of bed rails including any assessments,

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LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 319.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 420.

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(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 282.
(4) Medline Industries Inc., Owners & Maintenance Guide 2008, page 4 and 12.

8. Resident #55 was admitted to the facility on 1/31/20. Resident #55's diagnoses included but were not limited to: pneumonia [inflammation of the lungs usually caused by an infection.] (1), bipolar disorder [mental disorder characterized by mania and depression] (2); schizophrenia [mental disorder characterized by gross distortions of reality, disturbances of thought, language and perception.] (3)

Resident #55's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/7/20, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as being totally dependent in bed mobility, dressing, toilet use, personal hygiene and bathing; requires supervision in eating.

On 2/25/20 at 3:40 PM, Resident #55 was observed resting in bed with bilateral upper bed rails raised on bed.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documentation of the assessment for the use of bed rails, documentation of the risks of entrapment assessments and informed consent

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for the use of the bed rails for each resident listed. Resident #55 was included on this list. None of the requested information was provided for Resident #55.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documentation of the assessment for the use of bed rails, documentation of the risks of entrapment assessments and informed consent for the use of the bed rails for each resident listed. Resident #55 was included on this list. None of the requested information was provided for Resident #55.

An interview was conducted on 2/26/2020 at 10:36 a.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for the use of bed rails including any assessments, LPN #3 stated, "When they are admitted we do an assessment to see if the bed rail is needed. If the bed rail is there and it is used for positioning and mobility, we leave it in place. When asked if the risks/benefits or alternatives are reviewed, LPN #3 stated, "No." When asked if informed consent was obtained and assessment for risk of entrapment was completed prior to the use of bed rails, LPN #3 stated, "I will have to get back with you on that, but I don't believe so."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (Administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for the risk of entrapment, informed consent, explaining risks and benefits prior to the use of bed rails, ASM #1

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F 700	Continued From page 77 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity." ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 71. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518. (4) Joerns User-Service Manual, 2013 Joerns Healthcare, page 2.	F 700		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff	F 730	F730, E: Nurse Aide Perform Review -12 hr/yr In-Service.	4/3/20

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F 730	Continued From page 78 failed to complete annual CNA (certified nursing aide) performance reviews for seven of ten CNA employee records reviewed. The facility staff failed to complete annual performance reviews for CNA #1, CNA #2, CNA #3, CNA#4, CNA #5, CNA #6 and CNA #7. The findings include: The employee files of ten CNAs was completed and revealed the following: CNA #1 was hired on 10/11/05. Review of CNA #1's employee record revealed the last performance review was completed on 3/2/17. CNA #2 was hired on 6/13/17. Review of CNA #2's employee record revealed no performance review. CNA #3 was hired on 9/27/02. Review of CNA #3's employee record revealed no performance review. CNA #4 was hired on 5/16/11. Review of CNA #4's employee record revealed the last performance review was completed on 1/27/17. CNA #5 was hired on 8/22/18. Review of CNA #5's employee record revealed no performance review. CNA #6 was hired on 7/7/08. Review of CNA #6's employee record revealed the last performance review was completed on 2/22/18. CNA #7 was hired on 11/7/18. Review of CNA #7's employee record revealed no performance review. On 2/26/20 at 5:55 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated CNA performance reviews should be completed six months after an employee is hired then annually. ASM #2 stated she was initially	F 730	1.Performance reviews for C.N.A. #1, #2, #3, #4, #5, #6, and #7 have been complete. 2.All C.N.A.s must receive annual performance reviews. 3.Administrator has in-serviced Business office manager and IDT staff on following policy on annual employees□ reviews. 4.Business office manager will audit 100% of annual reviews x 3 weeks to ensure they are being completed in the proper month. Business office manager or designee will then review monthly for employees review status and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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F 730	Continued From page 79 completing performance reviews based on employee's anniversary date but now the acting business office manager sends her emails to remind her of performance reviews that are due. At this time, ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Performance/Review/Employee Evaluation" documented, "It is the supervisor's responsibility to conduct a written evaluation of each staff member directly reporting to him/her at a minimum of the following periods: -Completion of six months of employment. -Annually on the anniversary date (one year from the date the staff member is removed from the initial period of employment)." No further information was presented prior to exit.	F 730		
F 814 SS=F	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 by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain the dumpster area in a clean and sanitary manner to prevent pests. Behind the three facility dumpsters, Styrofoam cups, three used gloves, one green and two blue were observed on the ground. Bits of trash were observed behind all three dumpsters The findings include: Observation was made of the three facility	F 814	F814, F: Dispose Garbage and Refuse Properly. 1.Dumpster area was cleaned up at time of survey. 2.Dumpster area is at risk for becoming unclean. 3.Administrator has in serviced maintenance and food service directors on keeping the dumpster areas free of debris and maintained clean daily. 4.Maintenance or food service director will	4/3/20

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F 814	Continued From page 80 dumpsters was conducted on 2/27/2020 at 9:17 a.m., with OSM (other staff member) #3, the director of maintenance. Between two dumpsters, a puddle of spilled milk was observed on the ground. Behind the dumpsters, Styrofoam cups, three used gloves, one green and two blue were observed on the ground. There were bits of trash behind all three dumpsters. There were leaves and pine needles in the debris behind the dumpsters. When asked who is responsible for maintaining the area, OSM #3 stated ultimately, the grounds department. A copy of the policy for maintaining the dumpsters and dumpster area was requested. The facility policy titled, "Dumpster Cleaning and Inspection" documented in part, "Policy: each community dumpster is to be kept free of litter, cleaned and disinfected according to the following procedure. The dumpster lid is to be kept closed. The Maintenance Director is responsible for maintaining the dumpster according to this policy...1. All staff members who discard trash/debris into the dumpster area will police the area to pick up any loose litter or debris. The staff person will close the dumpster lid prior to leaving the dumpster area. 2. The dumpster area will be swept daily. 3. The dumpster area will be cleaned as detailed in the procedure outline below at least monthly...5. The Maintenance Director, Administrator or designee, will inspect the dumpster area daily and document the inspection on the Dumpster Inspection Log. Any items needing attention will be corrected. 6. The Administrator will inspect the log and dumpster area at least monthly." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and	F 814	audit the dumpster area 2xs a day, x 3 weeks to ensure the areas is clean and sanitary. Maintenance or food service director will then monitor the dumpster area daily and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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F 814	Continued From page 81 RN (registered nurse) #1, the quality assurance nurse, were made aware of the above concern on 2/27/1010 at 12:05 p.m. No further information was provided prior to exit.	F 814		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to inspect beds to identify areas of possible entrapment for eight of 38 residents, Residents #9, #14, #45, #161, #162, #17, #27, and #55. The findings include: 1. Resident #9 was admitted to the facility on 4/8/19, with diagnoses that included but were not limited to: fracture of her femur, high blood pressure, abnormalities of gait and mobility, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/3/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the	F 909	F909, E: Resident Bed: 1.Residents #9, #14, #45, #161, #162, #17, #27, and #55 beds have been inspected for possible areas of entrapment. 2.All residents in beds with bed rails are at risk. 3.Maintenance director or designee will assess all beds for possible areas of entrapment. 4.Maintenance director or designee will do a 100% bed check on all bed moves and mattress changes x3 weeks, and then monthly to identify possible areas of entrapment and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	4/3/20

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resident was coded as requiring extensive assistance of one staff member for moving in the bed.

On 2/25/2020, at 1:48 p.m., an observation and interview was conducted with Resident #9. The resident was in her bed with both bed rails up. Resident #9 stated she used them (bed rails) to help position herself.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documented evidence of the annual bed safety inspection. Resident #9 was included on this list. None of the requested information for Resident #9 was provided.

An interview was conducted on 2/26/2020 at 10:57 a.m. with OSM (other staff member) #3, the director of maintenance, regarding the maintenance program for inspecting of all bed frames, mattresses, and bed rails, to identify areas of possible entrapment. OSM #3 stated, "We perform a monthly room check that is random. We check that the bed and rails are functioning properly. We do not check every room monthly. Housekeeping informs maintenance if there is an issue. We do not have anything to do with checking for risk of entrapment."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for risk of entrapment

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completed regularly, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/2020 at 5:40 p.m.

The facility's policy "Bed Safety Inspection" dated 11/22/17, documented in part, "Resident beds will be inspected at least annually for safe operation, risk of entrapment, resident comfort and potential for other adverse events. The community will establish a mechanism for completing the bed inspections at least annually or when a concern is identified."

No further information was provided prior to exit.

2. Resident #14 was admitted to the facility on 9/19/17 with diagnoses that included but were not limited to: dementia, depression, stroke and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/23/19, coded the resident as unable to complete the interview and coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed.

On 2/26/2020 at 8:02 a.m., Resident #14 was

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observed in her bed with both bed rails up in the upright position. A second observation was made of Resident #14 in her bed with both side bed rails up on 2/26/2020 at 2:00 p.m.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documented evidence of the annual bed safety inspection. Resident #14 was included on this list. None of the requested information for Resident #14 was provided.

An interview was conducted on 2/26/2020 at 10:57 a.m. with OSM (other staff member) #3, the director of maintenance, regarding the maintenance program for inspecting of all bed frames, mattresses, and bed rails, to identify areas of possible entrapment. OSM #3 stated, "We perform a monthly room check that is random. We check that the bed and rails are functioning properly. We do not check every room monthly. Housekeeping informs maintenance if there is an issue. We do not have anything to do with checking for risk of entrapment."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for risk of entrapment completed regularly, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed

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integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/2020 at 5:40 p.m.

No further information was provided prior to exit.

3. Resident #45 was admitted to the facility on 3/27/18 with diagnoses that included but were not limited to: Alzheimer's disease [a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.] (1), abnormal posture, cough, and gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn.] (2)

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/31/2020, coded the resident as unable to understand other and unable to make herself understood. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #45 was coded as totally dependent of one or more staff members for all of her activities of daily living.

An observation was conducted on 2/27/2020 at 10:45 a.m., and revealed Resident #45 in bed with bilateral bed rails up at this time.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for

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documented evidence of the annual bed safety inspection. Resident #45 was included on this list. None of the requested information for Resident #45 was provided.

An interview was conducted on 2/26/2020 at 10:57 a.m. with OSM (other staff member) #3, the director of maintenance, regarding the maintenance program for inspecting of all bed frames, mattresses, and bed rails, to identify areas of possible entrapment. OSM #3 stated, "We perform a monthly room check that is random. We check that the bed and rails are functioning properly. We do not check every room monthly. Housekeeping informs maintenance if there is an issue. We do not have anything to do with checking for risk of entrapment."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for risk of entrapment completed regularly, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/2020 at 5:40 p.m.

No further information was provided prior to exit.

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References:
(1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
4. Resident #161 was admitted to the facility on 1/31/20. Resident #161's diagnoses included but were not limited to high blood pressure, muscle weakness and osteoporosis. Resident #161's admission MDS (minimum data set) with an ARD (assessment reference date) of 2/7/20, coded the resident's cognition as moderately impaired. Section G coded Resident #161 as requiring extensive assistance of one staff with bed mobility.

On 2/25/20 at 1:58 p.m., Resident #161 was observed in bed with bilateral quarter bed rails up.

Review of Resident #161's clinical record failed to reveal the facility staff assessed the resident's bed for areas of possible entrapment.

On 2/26/20 at 4:14 p.m., an interview was conducted with OSM (other staff member) #3 (the maintenance director). OSM #3 stated the maintenance staff does conduct periodic random inspections of beds but does not assess beds for areas of possible entrapment.

On 2/26/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

5. Resident #162 was admitted to the facility on

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2/21/20. Resident #162's diagnoses included but were not limited to diabetes, constipation and pulmonary fibrosis (a lung disease). Resident #162's admission MDS (minimum data set) assessment was not completed. An admission observation report dated 2/21/20 documented Resident #162 was alert and oriented to person, place, time and situation. The report further documented Resident #162 transferred with two person assistance.

On 2/25/20 at 3:57 p.m., Resident #162 was observed in bed with bilateral quarter bed rails up.

Review of Resident #162's clinical record failed to reveal the facility staff assessed the resident's bed for areas of possible entrapment.

On 2/26/20 at 4:14 p.m., an interview was conducted with OSM (other staff member) #3 (the maintenance director). OSM #3 stated the maintenance staff does conduct periodic random inspections of beds but does not assess beds for areas of possible entrapment.

On 2/26/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

6. Resident #17 was admitted to the facility on 12/24/19 with diagnoses that included but were not limited to: acute respiratory failure [inability of the heart and lungs to maintain an adequate level of gas exchange.] (1), atherosclerotic heart disease [plaque consisting of cholesterol and lipids form on inner arterial walls of the heart.] (2); and pneumonia [inflammation of the lungs usually

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by bacterial infection.] (3)

Resident #17's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 12/31/19, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating.

Observation of Resident #17 on 2/26/20 at 7:30 AM, revealed the resident in bed with bilateral upper bed rails raised on the bed.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documented evidence of the annual bed safety inspection. Resident #17 was included on this list. None of the requested information for Resident #17 was provided.

An interview was conducted on 2/26/20 at 10:57 AM with OSM (other staff member) #3, the director of maintenance. When asked what checks are done for safety inspections of beds and bed rails, OSM #3 stated, "We perform a monthly room check that is random. We check that the bed and rails are functioning properly. We do not check every room monthly. Housekeeping informs maintenance if there is an issue. We do not have anything to do with checking for risk of entrapment."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (administrative staff member) #1,

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the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for risk of entrapment completed regularly, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 502.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 52.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461.

7. Resident #27 was admitted to the facility on 10/4/19 with diagnoses that included but were not limited to: right knee replacement [replacement of the kneecap and joints, which connect the thighbone and lower leg bone.] (1), osteoarthritis of the knees bilaterally [common form of arthritis characterized by degenerative changes in the joints.] (2); and hypertension (high blood pressure) (3).

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Resident #27's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/11/20, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status coded the resident as requiring supervision in bed mobility, dressing, bathing and personal hygiene, limited assistance with transfers and toilet use and independent in eating.

On 2/26/20 at 7:40 AM, Resident #27 was Observation resting in bed with right upper bed rail raised on the bed and the left upper bed rail lowered at mattress level.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documented evidence of the annual bed safety inspection. Resident #27 was included on this list. None of the requested information for Resident #27 was provided.

An interview was conducted on 2/26/20 at 10:57 AM with OSM (other staff member) #3, the director of maintenance. When asked what checks are done for safety inspections of beds and rails, OSM #3 stated, "We perform a monthly room check that is random. We check that the bed and rails are functioning properly. We do not check every room monthly. Housekeeping informs maintenance if there is an issue. We do not have anything to do with checking for risk of entrapment." When the manufacturer's recommendations for Resident #27's bed were requested, OSM #3 stated, we do not have the manufacturer's guidelines for that bed, but I can

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get it."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (administrative staff member) #1, the administrator. When asked for bed rail evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for risk of entrapment completed regularly, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

A review of Resident #27's bed rail with OSM (other staff member) #3, the director of maintenance, was conducted on 2/26/20 at 2:35 PM. When asked how he would identify the rails on Resident #27's bed, OSM #3 stated, "I would call it a one half rail." When asked if he had received a work order or phone call regarding Resident #27's bed rail, OSM #3 stated, "No, we have not. It does not retract all the way and I am having difficulty raising it."

2/26/20 at approximately 2:38 PM, the manufacturer's guidelines for Resident #27's bed, were provided, and reviewed with OSM (other staff member) #3, the director of maintenance. The guidelines documented in part the "Safety Summary- Variations in side rail design and thickness, size or density of the mattress could cause entrapment." "Maintenance and Cleaning- Maintenance and cleaning procedures should be performed at least once every three months." (4)

ASM #1, the administrator and ASM #2, the

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director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

On 2/27/20 at 10:00 AM, OSM #3, the director of maintenance was asked if he had received an order for bed rail repair for Resident #27. OSM #3 stated, "No, we did not. We immediately repaired the rail yesterday. There was a screw that had worked out."

No further information was provided prior to exit.
References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 319.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 420.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 282.
(4) Medline Industries Inc., Owners & Maintenance Guide 2008, page 4 and 12.

8. Resident #55 was admitted to the facility on 1/31/20. Resident #55's diagnoses included but were not limited to: pneumonia [inflammation of the lungs usually caused by an infection.] (1), bipolar disorder [mental disorder characterized by mania and depression] (2); schizophrenia [mental disorder characterized by gross distortions of reality, disturbances of thought, language and perception.] (3)

Resident #55's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/7/20, coded the resident as scoring 12 out of 15 on the BIMS

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(brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as being totally dependent in bed mobility, dressing, toilet use, personal hygiene and bathing; requires supervision in eating.

On 2/25/20 at 3:40 PM, Resident #55 was observed resting in bed with bilateral upper bed rails raised on bed.

A list was provided to ASM (administrative staff member) #1, the administrator, on 2/25/20 at 5:00 PM. The list consisted of a request for documented evidence of the annual bed safety inspection. Resident #55 was included on this list. None of the requested information for Resident #55 was provided.

An interview was conducted on 2/26/20 at 10:57 AM with OSM (other staff member) #3, the director of maintenance. When asked what checks are done for safety inspections of beds and rails, OSM #3 stated, "We perform a monthly room check that is random. We check that the bed and rails are functioning properly. We do not check every room monthly. Housekeeping informs maintenance if there is an issue. We do not have anything to do with checking for risk of entrapment." When asked to be provided with the manufacturers recommendations for Resident #55's bed, OSM #3 stated, we do not have the manufacturer's guidelines for that bed, but I can get it."

An interview was conducted on 2/26/2020 at 2:04 p.m. with ASM (administrative staff member) #1, the administrator. When asked for bed rail

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evaluations, ASM #1 stated, "We have no side rail evaluations since 2018." When asked if there should be an assessment for risk of entrapment completed regularly, ASM #1 stated, "I don't have an answer for that. You cannot add bed rails with the new regulations. The bed rail evaluation is not consistently being done. If we take off the bed rails, we would be nullifying the bed warranty and modification of the bed may change bed integrity."

On 2/26/20 at approximately 2:010 PM, the manufacturer's guidelines for Resident #55's bed, were provided and reviewed with OSM (other staff member) #3, the director of maintenance. The guidelines documented in part the "Important Precaution: An optimal bed system assessment should be conducted on each resident by a qualified clinician to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the U.S. Food and Drug Administration." (4)

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns on 2/26/20 at 5:40 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 461.

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F 909	Continued From page 96 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 71. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518. (4) Joerns User-Service Manual, 2013 Joerns Healthcare, page 2.	F 909		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure required annual in-service training's for CNAs (certified nursing aides) was completed for three of ten CNA records reviewed,	F 947	F947, D: Required In-Service Training for Nurses Aides. 1.C.N.A. #3, #5 and #7 are up to date on their annual in-service training.	4/3/20

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F 947	Continued From page 97 (CNAs #3, #5 and #7). The facility staff failed to ensure CNAs #3, #5 and #7 completed the required annual 12 hours of training, including dementia management training and resident abuse prevention training. The findings include: Review of the employee records for ten CNAs revealed the following: CNA #3 was hired on 9/27/02. Review of CNA #3's employee record failed to reveal any completed trainings. CNA #5 was hired on 8/22/18. Review of CNA #5's employee record failed to reveal any completed trainings. CNA #7 was hired on 11/7/18. Review of CNA #7's employee record failed to reveal any completed trainings. On 2/26/20 at 5:55 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the facility staff utilizes an online training company that determines the types of trainings that must be completed and these training's are based on state requirements. ASM #2 stated CNAs are responsible for completing the required trainings. ASM #2 stated CNAs do not receive a raise if they do not complete the required trainings. At this time, ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Employee Assigned Educational Courses" documented, "All employees will remain up-to-date and current in required company education as assigned. Failure to complete assigned educational courses	F 947	2.All C.N.A.s must have 12 hours of training annually, including dementia management and resident abuse prevention. 3.Administrator has in-serviced the Director of nursing and the IDT staff on following policy on the required annual training. 4.Business office manager or designee will audit 100% C.N.A□s annual training requirement x 3 weeks to ensure education is being complete. The Business office manager or designee will then review monthly employees records for completed education and report any findings in the QAPI meeting monthly. 5.Date of correction: April 3, 2020	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 98 shall result in disciplinary and/or compensatory action." No further information was presented prior to exit.	F 947		