STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495390	A. BUILDING _____ B. WING _____	01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRMINGHAM GREEN	8605 CENTREVILLE ROAD MANASSAS, VA 20110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/28/2020 through 01/31/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 1/28/2020 through 1/31/2020. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety report will follow. No complaints were investigated during the survey. The census in this 180 certified bed facility was 167 at the time of the survey. The survey sample consisted of 46 resident reviews	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		3/15/20

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

Electronically Signed | 02/21/2020

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F 583	Continued From page 1 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and facility documentation review, the facility staff failed to ensure privacy and confidentiality of resident clinical records for 1 resident (Resident #99) in a sample size of 46 residents. Findings included. For Resident #99, the facility staff left the Resident's protected health information on top of the medication cart unattended while LPN "D" was in a resident room at the end of a hallway rendering care to a resident. Resident #99 was admitted with diagnoses of, but not limited to; Pneumonia, chronic obstructive pulmonary disease, gastric hemorrhage, anemia, congestive heart failure, and stage 3 kidney disease.	F 583	The submission of the Plan of Correction does not constitute agreement on the part of Birmingham Green that the deficiencies cited within the report represent deficient practices on the part of Birmingham Green. This plan represents the facility□s ongoing pledge to provide quality care that is rendered in accordance with all regulatory requirements. The Plan of Correction shall serve as our allegation of compliance. The medical information for resident #99 and assignment sheets were relocated from the medication chart. Other than the opportunity taken by the surveyor to read records, no other breach in confidentiality occurred. There were no residents affected by this	

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F 583	Continued From page 2 On 1-28-2020 during initial tour of the facility, documents were observed on a medication cart with no attendant. The documents were picked up and reviewed, revealing chest x-ray results, new physician's orders for medications with diagnoses for them, labs with diagnoses, and descriptions of blood in the Resident's sputum for Resident #99. Also found in the documents was a form with every resident name and room number on the hallway, to include diagnoses, diets, allergies, those who were fall risks, vital signs and blood sugar checks for diabetics, CPR resuscitation status, and notes about resident's activities of daily living needs. The surveyor waited at the cart for approximately 10 minutes and asked another nurse who eventually approached if he was responsible for the medication cart, and he stated "no", and supplied the surveyor with the name of the nurse responsible (LPN D) Licensed Practical Nurse. LPN D finally returned to the cart and stated she had been assisting a resident and knew she should not have left the documents open and available to view. Copies of the documents were provided by her to surveyors. During the end of day debriefing on 1-29-2020 at 4:30 p.m., the Administrator, and Director of Nursing were informed of the findings. No further information was provided by the facility.	F 583	deficient practice. All residents may be at risk of disclosure of protected health information if staff do not properly safeguard resident records and/or assignment sheets. All staff in all departments will be re-educated on personal privacy/confidentiality of records and protected health information (PHI) by Learning and Development or designee to include PHI to be safeguarded in designated staff work areas. Nursing Leadership will conduct random observations of medication carts weekly x4 weeks and then monthly to ensure compliance with privacy and confidentiality of records. Summary of audit findings will be reviewed through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		3/15/20

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F 600	Continued From page 3 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to ensure 8 residents were free from abuse (Residents #118, #161, #69, #120, #167, #20, #368, #95) by two residents (#50, #61) in a survey sample of 46 residents. This resulted in harm to Resident #118. The findings included; 1) For Residents #118, #69, #20, #161, and #120, the facility staff failed to ensure that they were free from abuse by Resident #50. Resident #118's diagnoses upon admission included; peripheral vascular disease, sleep apnea, hypertension, morbid obesity, and depression single episode. The Minimum Data Set assessment tool review revealed that Resident #118 was coded as having a Brief Interview of Mental Status Score of 15 out of a possible 15 points indicating no impaired cognition. The Resident was coded as requiring 1 staff member for physical assistance with all	F 600	Resident #167 & #368 no longer reside in our community. Social Work interviewed residents #161, #69, #120, #20 & #95 on 02/20/2020 and residents expressed they feel safe, know how to report any concerns, no issues identified during the interviews. There have been no resident-to-resident altercations involving the above residents since the recent survey. There have been no resident-to-resident altercations involving resident #50 since 12/10/2019 and for resident #61 since 10/13/2019. Resident #118 continues to receive ongoing services from psychiatry, neuropsychology, and social work; these services are currently being provided weekly. Resident and her guardian have been offered the option to change rooms/neighborhoods and/or consider alternate placement in another appropriate setting and both have	

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F 600	Continued From page 4 activities of daily living, with the exceptions of, eating with set up help only, and the Resident was able to self propel a wheel chair, although, slowly. Resident #50's diagnoses upon admission included; Anoxic brain damage, dementia with behavioral disturbance, diabetes, major depressive disorder single episode, and heart disease. The Minimum Data Set assessment tool review revealed that Resident #50 was coded as having a Brief Interview of Mental Status Score of unable to complete indicating severe impaired cognition. The Resident was coded as requiring staff members for physical assistance with activities of daily living, with the exceptions of locomotion off of the unit in a wheel chair, and the Resident was able to self propel a wheel chair, and was coded as needing supervision. On 1-28-2020 at 11:30 a.m., on initial tour of the facility, an observation and interview were conducted with 2 surveyors and Resident #118 in the hallway of the Resident's room. The Resident was sitting in a wheel chair. An activity was being conducted in the dining room area of the unit and Resident #118 was asked by surveyors if she would like to attend. The Resident stated "no, I can't do that because (Resident #50's name) is in there and she is mean." Resident #118 was asked if Resident #50 had hurt her in the past, and she stated "yes, twice, the first time she pinched me and left a big bruise on my arm, and the second time she grabbed my arms and hit me and left bruises on me." Immediately following the 1-28-2020 11:30 a.m.	F 600	declined. Currently resident #118 states she feels safe and supported by staff. A Level 2 PASRR screen was completed on 01/23/2020 as required related to her diagnosis of intellectual disabilities. Service recommendations remained the same from the previous PASRR completed on 05/21/2019 with one addition of transportation to specialized services. Ongoing recommendations include assisted technology evaluation, basic grooming, non-customized durable medical equipment, OT, PT, restorative nursing, sensor stimulation, psychiatric consultation, psychotropic medication management, and targeted case management. Resident #50 continues with enhanced supervision at the level of one-to-one supervision during waking hours when resident is mobile. The resident continues to receive ongoing services from psychiatry and social work. Recent medication adjustments were made by the psychiatrist and a family meeting has been scheduled to explore discharge options to a setting that can more appropriately meet her needs. The facility will continue to consider an internal room move when an appropriate room becomes available. Resident #61 continues to receive ongoing services from psychiatry, neuropsychology, social work and neurology. Discharge planning continues to include making regular referrals to	

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F 600	Continued From page 5 interview with Resident #118, an interview was conducted with Resident #50's room mate (Resident #53). The room mate stated that Resident #50 did curse and yell at her and the staff, and threatened to "Kill" staff, but stated that Resident #50 had not hit her, and further stated "when she's like that I just stay quiet, and don't say anything, she is sick in the head, you know, you can't get mad at someone acting that way if they are sick in the head." On 1-30-2020 at 3:20 p.m., an interview was conducted with Resident #118. Two surveyors, and the Administrator were present in an open empty dining room. The Resident was asked to tell the Administrator if Resident #50 had hurt her. She stated "yes...". When asked how many times she had been hurt by Resident #50, she stated "Twice, I told [LPN "C"] the first time when she pinched me, and then the nurses came and saw when she grabbed me the second time." Resident #50's clinical records and facility records were reviewed. On 7-8-19 facility investigation documents revealed Resident #50 wandered into the room of Resident #161, grabbing and hitting Resident #161 inflicting bruises. Note: Residents #161 was not able to be interviewed due to dementia. 8-6-19 Psychiatric physicians notes read "Per staff acute worsening of behavior, having difficulties sleeping. Patient aggressive toward peer this morning, entered peer's room. Often sleeps during the day and awakes at night. Agitated attempted to elope during exit. Start Ativan 0.5 mg (milligrams) for PRN (as needed) aggression with risk of harm to self or others."	F 600	other long-term care settings that may be able to better meet her needs. A behavioral contract remains in place with the agreement of the resident and their RR and is regularly reviewed with the resident. A safety plan remains in effect for resident #61 in the event the resident presents with behaviors placing self or others at risk of harm. All residents may be affected by this alleged deficient practice. Resident group meetings will be held to reinforce education to residents about their rights to report any concerns, as well as their right to be free from abuse, neglect, misappropriation of property, and exploitation. All staff in all departments will receive re-education on providing supervision, reporting criteria, and additional mental and behavioral health education and training conducted by Learning and Development or designee. The IDT (which consists of nursing, social work, activities, dietary, and therapy services when applicable) will collaborate with neuropsychological services in the development of a formal mental health group to focus on residents with serious mental and/or behavioral health diagnoses. Residents who have been the recipient of resident-to-resident altercations will be reviewed weekly x 4 by psychology and/or social worker to identify if the resident	

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F 600	Continued From page 6 On 8-6-19 at 3:28 p.m., facility investigation documents revealed Resident #50 wandered down the hall of Resident #118, grabbed and pinched the Resident on the elbow while Resident #118 was gazing outside from the exit door where she liked to sit, inflicting bruises. On 8-6-19 at 3:38 (nursing notes) Resident #50 wandered down the hall of Resident #118 again, and grabbed her arms inflicting bruises. The 2 Resident's rooms are on different halls. The record review showed no other instances of Resident #50 assaulting Resident #118. 8-20-19 Psychiatric physicians notes read "Patient has been sleeping poorly, got almost no sleep last night. She's had more episodes of aggressive behavior toward staff and residents in the last week, and these are notably more frequent when she does not sleep well." 9-3-19 Psychiatric physicians notes read "Agitated /frustrated because she's tired. She just pierced another resident with a fork for no reason.....Close monitoring...as there is no medication even off label that is appropriate." On 9-3-19 facility investigation documents revealed Resident #50 was sitting at the dining table with Resident #69, and attempted to take meat off of Resident #69's plate with a fork. When Resident #69 tried to brush Resident #50's hand away from her plate, Resident #50 pierced her (per doctor's note) with the fork leaving a red mark on Resident #69. Residents #69 was not able to be interviewed due to due to extreme hearing loss and language barrier.	F 600	feels unsafe or expresses fear following the incident and if expressed, additional supportive services will be provided. Care plans will be reviewed and updated for residents who have been involved in resident-to-resident altercations to minimize recurrence and to address any concerns of fear or safety. The facility policy on Enhanced Level of Supervision was reviewed and revised on 02/21/2020. The IDT will be re-educated on the revised enhanced level of supervision policy conducted by Learning and Development or designee. Residents presenting with behavioral symptoms will be assessed by the IDT. The level of supervision and interventions will be determined by the IDT to address identified changes in behaviors, medical conditions, and/or psychosocial needs. Residents requiring ongoing enhanced supervision for behaviors affecting others will be assessed for appropriate placement and/or discharge planning. Director of Social Work or designee will conduct 100% audits of residents who initiated a resident-to-resident altercation weekly x4 weeks and then monthly to ensure care plans have been reviewed and updated. Director of Social Work or designee will conduct 100% audits of residents who are recipients of resident-to-resident altercations weekly X4 weeks and then	

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F 600	Continued From page 7 10-22-19 Psychiatric physicians notes read "Patient seen wheeling self about loud and hostile difficult to redirect is responding well to PRN (as needed) Ativan...." On 10-30-19 facility investigation documents revealed while in an activity, Resident #50 grabbed and hit Resident #20 on the left arm. On 1-29-2020 at 10:00 a.m., an interview was conducted with Resident #20. The Resident was alert, oriented to person, place, and situation. She stated she did remember Resident #50 leaving "bruises when she grabbed me, and I was minding my own business in my own room. She came in here." The Resident denied being afraid of Resident #50, however, did state that she stayed "out away from (name) Resident #50, so she can't get ahold of me." On 12-10-19 facility investigation documents revealed Resident #50 wandered into the room of Resident #120, and when Resident #120 told her to leave Resident #50 kicked her in the shin causing pain. On 1-29-2020 at 9:30 a.m. an interview was conducted with Resident #120. The Resident was oriented to person, place, time, and situation, and was also found to be a good historian. The Resident stated that Resident #50 wandered daily, and had wandered in her room several times, taking things that belonged to Resident #120. Resident #120 stated that the time she was kicked by Resident #50, she had told her to leave her room, and that Resident #50 kicked her in her "sore leg causing pain, but no other injury." Resident #120 stated that Resident #50 "(name) yells, curses you out, and beats on staff and Residents both, and if Resident #50 (name) comes back in my room, there's gonna be trouble." Resident #120 was asked what kind of	F 600	monthly to ensure weekly visits by social work and/or psychology have been completed and documented. Variances will be reviewed and revised if identified by Director of Social Work r designee. Assistant administrator or designee will provide a monthly summary of resident-to-resident altercations. In addition, a summary of resident-to resident alternations will be reviewed through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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trouble, she stated "I will kick her back."

Staff interviews on 2 units (staff wished to remain anonymous due to fear of retaliation) indicated that Resident #50 had aggressive behaviors of lashing out at Residents and staff. Nursing staff stated they were told to go to urgent care by Administration if Resident #50 hurt them, and asked if they wanted to press charges, however, the staff chose not to. Staff also stated that the Resident will routinely sleep for 3 days then be up for 3 days.

On 1-30-2020 after the 3:20 pm interview (see above), the Administrator joined the surveyors back in the conference room after the interview, and stated that the staff had already placed Resident #50 on 1:1 (one to one) supervision that morning, and it would continue at all times while she was out of bed. The Administrator stated that the Resident needed assistance to get out of bed, and so the only time supervision was required would be when Resident #50 was in her wheel chair.

The facility policy entitled "Freedom from abuse, neglect, and exploitation" was reviewed and revealed at area "6" "protection" The facility will provide increased supervision of the alleged victim and residents." "Room changes or staffing changes will occur if necessary to protect the resident(s) from the alleged perpetrator."

On 1-30-2020 at the end of day debrief, the Administrator and DON were notified of the findings for Resident #118. The facility stated they had no further information to provide.

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2a. For Resident #167 the facility staff failed to ensure the Resident was free from abuse from Resident #61.

Resident #167 was discharged from the facility on 1/15/2020, so a closed record review was performed. Diagnoses for Resident #167 included but were not limited to: Chronic obstructive pulmonary disease, schizoaffective disorder, diabetes, hypertension, and collapsed vertebra.

Resident #167's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/9/2020 was coded as an annual assessment. Resident #167 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. The Resident was also coded on this assessment as having had no behavioral symptoms. Resident #167 required extensive assistance of staff for dressing, personal hygiene and bed mobility. The Resident was totally dependent upon staff for transfers, bathing and toileting.

Resident #61 was an active Resident at the time of survey. Resident #61 is Spanish speaking. Diagnoses for Resident #61 included but were not limited to: personality disorder, major depressive disorder, sicca syndrome, and blindness left eye.

Resident #61's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 11/12/2019 was

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coded as an annual assessment. Resident #61 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. The Resident was coded as having required extensive assistance of staff for transfers, dressing, personal hygiene and toileting.

On 1/29/2020 the facility staff was asked to provide all FRI's (facility reported incidents) involving Resident #61. Review of these documents revealed that on 9/25/2018 the facility staff were made aware that Resident #61 had assaulted Resident #167 on 9/24/2018. Enclosed in the investigation file was a hand-written letter, signed by Resident #167 that read, "yesterday, Mon. 24, Sept. I had an altercation with [Resident #61's]. I know you know who that is. As I was entering the dining room to get a seat for Bingo, [Resident #61's] came up behind me, and started pushing my chair and assaulting me with hard blows. I was shocked. I wasn't going to sit at her table, I was just going past it. She even pulled my hair, hard, and continued hitting me! Someone pulled her away and I went on. I think you need to have a talk with her, as I was hurt with the blows and pulled hair. Thanks [Resident #167's signature].

The nursing notes in the closed record of Resident #167 revealed an entry on 9/25/2018 that read, "Resident states, "I was wheeling in the main dining room getting ready for bingo and [Resident #61] started pounding my back and pulled my hair and she hurt me".

On 1/31/2020 at 8:50 AM an interview was conducted with the facility Administrator (Employee A) and Assistant Administrator

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(Employee C) in the Administrator office. When asked who wrote the hand-written letter, Employee C stated Resident #167.

On 1/31/2020 at 11:53 AM, the Social Work Supervisor (Employee D) came into the conference room to discuss the incident of abuse towards Resident #167 by Resident #61. Employee D reported that Resident #167 had left the hand-written letter describing the assault under her office door. Employee D stated Resident #167 would frequently write letters when she had concerns. Employee D went on to state, "[Resident #167] was pretty upset by having her hair pulled, she said it hurt her. She felt she had done nothing to provoke it. She wanted us to talk to Resident #61 and tell her it wasn't appropriate. She had no lingering pain, just at the time. She denied being fearful of her, and said she just avoided her".

The facility investigation revealed that Resident #61 stated, "she did hit [Resident #167's] because she took a bingo card".

Further review of FRI's regarding Resident #61 revealed Resident #61 had displayed prior aggression toward other Residents prior to the assault of Resident #167.

2b. For Resident #20 the facility staff failed to ensure the Resident was free from abuse from Resident #61.

Resident #20 was an active Resident of the facility at the time of survey. Diagnoses for Resident #20 included but were not limited to:

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Hypertension, hyperlipidemia, vascular dementia without behavioral disturbance and bilateral osteoarthritis of the knee.

Resident #20's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/24/2019 was coded as a quarterly assessment. Resident #20 was coded as having had a BIMS (brief interview for mental status) score of 14, which indicated cognitively intact. The Resident was also coded on this assessment as having had no behavioral symptoms. Resident #20 required limited assistance of staff for bed mobility, dressing, toilet use, and personal hygiene.

On 1/29/2020 the facility staff was asked to provide all FRI's (facility reported incidents) involving Resident #61. Review of these documents revealed that on 6/18/2019 Resident #20 came to the dining room, sat at the table, Resident #61 got upset and intentionally knocked the cup of coffee over onto Resident #20. Included in the documents the facility provided was a witness statement that read, "she [Resident #20] went into the dining room and proceeded to sit at the table with [Resident #61's]. [Resident #61's] became very mad and agitated, shook the table, yelling at Resident. [Resident #20's] sat her coffee on the table and [Resident #61's] intentionally hit it and knocked it over onto [Resident #20's] lap. [Resident #20's] yelled out, you knocked over my coffee, it's hot".

Facility record review also revealed a two-page hand written note dated 6/25/2019 titled "Psychiatry", which read, "Staff has updated me on recent events- last week throwing cup of hot coffee on another resident for no reason then

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laughing about it. Patient is known to me since admission and above behaviors resulting in harm to others is not new. She has never shown any remorse. When her wants/needs are not immediately met, she acts out".

Resident #20 was assessed by nursing staff and not noted to have any injury as a result of Resident #61 knocking coffee into her lap. The facility had taken the temperature of the coffee prior to it leaving the kitchen and being delivered to the nursing unit.

Resident #61 was presented a behavioral contract as a result of this incident, which included not eating meals at the table with other Residents.

2c. For Resident #368 the facility staff failed to ensure the Resident was free from abuse by Resident #61.

Resident #368 was discharged from the facility on 12/7/19, therefore a closed record review was performed. Diagnoses for Resident #368 included but were not limited to: vascular dementia with behavioral disturbance, chronic obstructive pulmonary disease, chronic kidney disease stage 3, and major depressive disorder.

Resident #368's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/10/2019 was coded as a quarterly assessment. Resident #368 was coded as having had a BIMS (brief interview for mental status) score of 4, which indicated severe cognitive impairment. The Resident was

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also coded on this assessment as having had no behavioral symptoms. Resident #368 required limited assistance of staff for dressing, toilet use, and bed mobility. The Resident was totally dependent upon facility staff for bathing and required extensive assistance with personal hygiene.

On 1/29/2020 the facility staff was asked to provide all FRI's (facility reported incidents) involving Resident #61. Review of these documents revealed that on 5/6/18 Resident #61 started yelling at Resident #368, when Resident #368 walked over to Resident #61, Resident #61 kicked her on the leg. A witness statement was included in the documents from a staff member (not identified) who witnessed the altercation. After Resident #61 kicked Resident #368, Resident #368 hit Resident #61 with a plastic spoon and then Resident #61 grabbed the shirt of Resident #368 before staff could intervene.

Resident #61 was educated as a result of this incident of abuse towards Resident #368.

Following the end of day meeting held on 1/31/2020 the facility staff provided the survey team with a color coded copy of the "HEAR" (health, environment, approach, resident) document where they discussed interventions for Resident #61's behaviors and aggression/abuse towards other residents. Following the abuse inflicted on Resident #368 on 5/6/18, the following entry was made on this document: "different seating arrangement for her to protect others- we need to protect others from her because she becomes physically violent".

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2d. For Resident #95 the facility staff failed to ensure the Resident was free from abuse from Resident #61.

Resident #95 was an active Resident of the facility at the time of survey. Diagnoses for Resident #95 included but were not limited to: hemiplegia, personal history of traumatic brain injury, pseudobulbar affect, anxiety disorder, and pedestrian injured in traffic accident involving unspecified motor vehicles sequela.

Resident #95's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/2/2019 was coded as a quarterly assessment. Resident #95 was coded as having had a BIMS (brief interview for mental status) score of 14, which indicated cognitively intact. The Resident was also coded on this assessment as having had no behavioral symptoms. Resident #95 required extensive assistance of staff for all ADL's (activities of daily living), with the exception of bathing, in which the Resident was totally dependent upon staff.

Review of nursing notes revealed an entry on 7/31/19 that indicated Resident #95 and Resident #61 were observed hitting each other. The FRI prepared by the facility staff described the incident in more detail and stated, "On 7/31/19 at approximately 1:25 PM Resident #61 became physically and verbally aggressive with [Resident #95's]. [Resident #61] pushed another Resident's wheelchair out of her way but made no physical contact with the Resident. [Resident #61's] then struck [Resident #95] with her fists on his arms". This report further states that the two Residents began hitting each other and staff intervened.

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The community services board was contacted and recommended the facility contact the police for Resident #61's behavior. However, the facility chose not to carry out this recommendation and stated, "Resident's behavior was calm immediately following the incident".

Facility records revealed a letter dated 8/7/19 to Resident #61's son, with a copy being given to the Resident and other son as well. The letter stated, "[facility name redacted] has determined we can no longer meet her needs. In addition, we have determined that [Resident #61's] behavioral status continues to endanger the health of other in the facility.

Nursing notes revealed an entry dated 8/12/19 that read, "Staff witnessed Resident getting too close to Resident #61, who yelled at him [referring to Resident #95], and both Resident's observed hitting each other on the arms.

The facility investigation revealed the following details: Resident #61 was sitting at the nursing station when Resident #95 wheeled by, Resident #61 started yelling at him. Resident #95 yelled back and swung to hit Resident #61 and both started hitting each other.

On 1/31/19 an interview was conducted with Resident #95 regarding the relationship with Resident #61. Resident #95 indicated they don't get along. The facility investigation file revealed that on 10/16/19 Resident #95 reported to the facility social worker there was a personality conflict between the two.

Review of the facility policy titled "Freedom from Abuse, Neglect, and Exploitation" read on page 1

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F 600	Continued From page 17 under the definition heading, "abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm". Page 4 of this policy under the heading prevention read, "[facility name redacted] will prevent verbal, mental, sexual or physical abuse". Page 5 read, "[facility name redacted] will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur". During an end of day meeting held on 1/30/2020 the facility Administrator, Director of Nursing and Assistant Administrator were made aware of the concerns surrounding Resident #61's behaviors towards other Residents. No further information was provided.	F 600		
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	F 656		3/15/20

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F 656	Continued From page 18 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation the facility staff failed to implement care plan for 2 Residents #3 and #147 in a survey sample of 46 Residents.	F 656	The care plan for resident #3 was updated during survey. The care plan for resident #147 was reviewed during survey and the intervention remains applicable.	

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F 656	Continued From page 19 The findings included: 1. For Resident #3 the facility staff failed to develop a person centered care plan to address contractures to the Left hand. Resident # 3, a 56 year old man, was admitted to the facility on 9/4/06 with diagnoses of but not limited to intracranial injury, cerebrovascular disease, age related osteoporosis, primary left hand contracture, right knee contracture, right ankle contracture, left ankle contracture, muscle spasm and chronic pain syndrome. On 1/28/20 at 11:00 AM, the Resident was observed in his room lying in bed with no orthotics in his Left hand which was also contracted. On 1/29/20 at 9:00 AM, the Resident was observed in his room lying in bed, Left hand contracted, and without orthotic. On 1/28/20 at approximately 2:30 PM, an interview was conducted with RN A, and she was asked if Resident #3 wore any sort of orthotics for contractures. RN A responded that he did not. On 1/29/20 review of clinical record reveal the care plan did not reflect the past use of palm guards and did not address the use of orthotics or devices for prevention or treatment of contractures. On 1/29/20 at 4:30 PM, an interview was conducted with the Director of Nursing (DON). When asked about Resident #3 wearing orthotic for contracture she stated that she was not sure but would have PT/OT look at him.	F 656	All residents have the potential to be affected by the alleged deficient practice. Residents with contractures will be evaluated to ensure appropriate devices are being utilized and included in the resident□s care plan. The staff member involved will be re-educated by DON or designee on the importance of following the resident's plan of care related to the level of assistance required for bed mobility, turning, and positioning. Residents in need of 2-person assistance for bed mobility, turning, and repositioning will be reviewed by nurse manager or designee to ensure the level of assistance is appropriate and included in the resident□s plan of care. All licensed nurses will be re-educated by Learning and Development or designee on updating care plans to include assistive devices for contracture management. All direct care staff (licensed nurses and C.N.A's) will be re-educated by Learning and Development or designee on the importance of reviewing and following resident centered plans of care related to bed mobility, turning, and repositioning, information which is readily availability on the resident□s care plan and the Kardex. Nursing Leadership or designee will conduct audits on 3-records weekly X 4-weeks then 3 records per month to ensure care plan revisions have been completed. Nurse manager or QA-CNA	

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F 656	Continued From page 20 On 1/30/20, the DON submitted "Interdisciplinary Therapy Data Collection Form." Excerpts from the form are as follows: "Contractures - No recent changes per patient." "Comments - Patient screened per nursing request for hand contractures and possible palm guards. Patient reports not liking palm guards in the past and doesn't wish to have them. Patient stated he would like to have a ball [therapy ball]. Patient will benefit from OT eval to determine appropriate orthotics." On 1/31/20 during end of day meeting the Administrator was made aware of concerns no further information was provided. 2. For Resident #147 the facility staff failed to implement the care plan for use of 2 person assistance for turning and repositioning. Resident #147 an 89 year old woman admitted to the facility on 7/3/19 with diagnosis of but not limited to Osteoporosis, Chronic Kidney Disease, Major Depressive Disorder, Cerebral Vascular Disease and adult failure to thrive. Resident #147's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 12/27/19 the Resident was coded as having a BIMS (Brief Interview of Mental Status) score of 99 indicating severe cognitive impairment. Resident #147 was also coded as requiring 2 person assistance for bed mobility turning and positioning. The resident was also coded as	F 656	will complete observation of 3 residents per month who require 2-person assistance for bed mobility, turning, and repositioning to ensure that appropriate assistance is provided. Any observation variances will be immediately investigated, and re-education will be provided to the appropriate staff by nursing leadership or designee. Summary of audit findings will be reviewed through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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requiring 1 person physical assistance for bathing, dressing, eating as well as locomotion on and off the unit using a wheel chair.

On 1/30/2020 at 10:30 am this surveyor observed RN a performing wound care on Resident #147. The resident was in bed dressed with blanket over her. RN A gathered her supplies and placed them on the clean over bed table, on top of a disposable absorbent pad. RN A closed the door and pulled the privacy curtain before raising the bed to a comfortable working height (about waist high)

RN A positioned Resident to be able to observe heel wound, right foot first. RN A then turned Resident towards the window onto her left side as to observe the sacrum area. RN A did not engage the assistance of another person. The Resident has no order for side rails on her bed and RN A was standing on the side of the bed facing the Residents back.

On 1/30/20 during a clinical record review it was discovered that Resident #147's care plan read as follows:

FOCUS: I am at risk for falls related to impaired cognition, impaired mobility, and impaired safety awareness.
Date initiated - 7/3/19

Goal: I will not have any fall related injuries
Date initiated - 7/3/19

Interventions: After care make sure resident is in center of bed not too close to edge
Date initiated - 7/3/19

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F 656	Continued From page 22 Provide assistance of two with bed mobility and repositioning. Date initiated - 7/3/19 On 1/30/20 at 4:34 PM an interview with the DON was conducted and she stated that the care plan was correct, Resident #147 requires 2 person physical assistance for turning and repositioning. The DON said "There should have been someone standing on the other side of the bed." When asked why she replied "For safety, to prevent her falling out of the bed." On 1/31/20 during end of day meeting the Administrator was made aware of concerns no further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (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	F 657		3/15/20

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F 657	Continued From page 23 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to review and revise the careplan for 2 Residents (Resident #61, #24) in a survey sample of 46 Residents. The findings included: 1. The facility staff failed to review and revise the careplan for Resident #61 following 7 altercations with other Residents. Resident #61 was an active Resident at the time of survey. Resident #61 is Spanish speaking. Diagnoses for Resident #61 included but were not limited to: personality disorder, major depressive disorder, sicca syndrome, and blindness left eye. Resident #61's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 11/12/2019 was coded as an annual assessment. Resident #61 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. The Resident was coded as having required extensive assistance of staff for transfers, dressing, personal hygiene and	F 657	The care plan for resident # 61 and #24 were updated to include approaches and/or devices. All residents have the potential to be affected by this if care plans are not revised in a timely manner. Residents who have been involved in resident-to-resident altercations within the past 2 months will be reviewed to ensure that their care plans address resident-centered interventions to minimize recurrence. Residents who have specialty cushions provided to them within the past 2 months will be reviewed to ensure that care plans accurately reflect the use of the specialty cushion. All members of the care planning interdisciplinary team (nursing, social work, activities, dietary, and therapy services)will be re-educated by Learning and Development or designees on reviewing and making timely edits to resident□s care plans to ensure pertinent information is available for caregivers. Following a resident-to-resident	

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F 657	Continued From page 24 toileting. Review of the clinical record revealed the following incidents related to Resident #61: 1. 5/16/2018 Resident #61 yelled at Resident #368 and kicked her leg. 2. On 9/24/2018 Resident #61 assaulted Resident #167, pulled the Resident's hair and hit them. 3. On 11/3/2018 Resident #61 yelled at Resident #369 and hit them on the head, then kicked their wheelchair. 4. 6/18/2019 Resident #61 knocked coffee onto the lap of Resident #20. 5. On 7/31/2019 Resident #61 was physically and verbally aggressive with Resident #95. 6. On 8/12/2019 Resident #61 and Resident #95 had another altercation resulting in both Residents hitting each other. 7. On 10/13/2019 Resident #95 ran over Resident #61's toes with the wheelchair and Resident #61 slapped Resident #95 several times. Review of the careplan for Resident #61 revealed the following: * The behavioral careplan was initiated on 10/29/2016 * From the time of 5/16/2018-10/13/2019 (dates of the above referenced incidents) the careplan had the following intervention revisions:	F 657	altercation the IDT will conduct a review of the incident and update the care plan to ensure the resident-centered plan of care for the residents involved include interventions to minimize recurrence. The assistant administrator or designee will review 100% of the care plans for residents who have been involved in a resident-to-resident altercation weekly x4 weeks following the altercation to ensure that the care plans have been reviewed and revised with resident-centered interventions to minimize recurrence. Variances will be investigated, and corrections will be made as appropriate to the care plan by the assistant administrator or designee. Nurse manager or designee will conduct care plan review of 3 residents who utilize specialty cushions weekly X4weeks then monthly to ensure the care plans accurately reflect use of the cushions. Variances will be investigated, and corrections will be made as appropriate to the care plans by nurse manager or designee. Summary of audit findings will be reviewed through the monthly Clinical Operations Report(COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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1. "Staff to intervene when Resident because upset and yelling [sic] when another resident sits at her table. Staff will be calm and ask resident to calm down or we need to sit at another table. Give emotional support". This was initiated 12/15/2017 and revised on 5/30/2018.

2. "Minimize disruption/changes to Resident's environment and routine" was initiated 5/29/2019.

3. "Resident and family presented with behavioral contract with facility expectations that resident cannot hurt self or others. Also, resident presented with alternate dining choices but is no longer dining at group tables," was imitated on 8/14/2019, despite the behavioral contract being issued 6/18/2019.

The facility investigation files and "Behavioral Management Plan" for Resident #61 revealed the facility had consulted psychiatry for Resident #61, issued a discharge notice, attempted to avoid Resident #61's contact with specific Residents, called the Community Services Board to attempt to obtain psychiatric in-patient treatment, assist Resident's with maneuvering in the dining to prevent contact, and considered a private room. However, none of these interventions were noted in the clinical record for Resident #61.

On 1/31/2020 at 11:18 AM an interview was conducted with RN A. RN A was asked to describe what a careplan is and it's use. RN A stated, "the careplan is when the resident and family gets with IDT (interdisciplinary team) to discuss goals and what the plan of care will be. Everyone should use them to see how they want to be called, what treatment is needed, special

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needs, it drives the care." RN A was asked what the importance of the careplan being current was, RN A stated, "safety, satisfaction and well-being".

On 1/31/2020 at 11:21 AM an interview was conducted with CNA A. She was asked if she has access to the careplan, what it is for, if she uses it, etc. CNA A stated, "I do have access, right here [and showed the surveyor on the computer she was using]. It tells me what they like, don't like, resident care, splints, etc." CNA A was asked if it is important for her to use the careplan, CNA A stated, "yes, I don't want to walk in not knowing what to do. I look at them everyday".

On 1/31/2020 at 11:26 AM an interview was conducted with CNA B. CNA B stated, "I am just prn [as needed] the careplan tells me how to transfer the Resident, what they need". CNA B was asked how often she looks at the careplan for Residents. CNA B stated, "I look at it anytime I come to work, I look at the Kardex, it is important, we have to look at it day by day for what we are capable of doing for the Resident."

Review of the facility policy titled "Care Planning" revealed the following: "Each Resident will have a comprehensive, person-centered care plan developed to identify resident's care needs and goals for care". Page 3 of the policy stated, "the comprehensive careplan will be reviewed and revised by the IDT after each assessment, including comprehensive and quarterly review assessments.

The facility Administrator and Assistant Administrator were made aware of the facility staff's failure to review and revise the careplan for Resident #61 following incidents with other

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Residents during a meeting held in the Administrator's office the morning of 1/31/2019.

No further information was provided.

2. For Resident #24, the facility staff failed to revise the care plan to include the ROHO wheelchair cushion.

Resident #24's diagnoses included but not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side.

Resident #24's most recent Minimum Data Set with an Assessment Reference Date of 10/23/2019 was coded as a significant change in status assessment. The Brief Interview for Mental Status was coded as "99" meaning an incomplete interview. Cognitive skills for Daily decision-making were coded as severely impaired. Transfers and locomotion on unit were coded as total dependence on staff. Mobility device selected was wheelchair.

During the course of the survey, fall investigations for Resident #24 were requested and the facility staff provided two investigations dated 09/23/2019 and 11/10/2019. On the fall investigation document dated 09/23/2019 under the header "Staff/Other Interviews" it was documented that Resident #24 was "calm" and "sitting in dining area." Under the subheader, "Did you see or hear anything that may have resulted in the resident's fall?", it was documented, "Yes,

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she slipped." Under the header "Investigation Findings/Conclusions" and subheader "Action/Behavior/Reason for fall", it was documented "Related to resident behavior possible wheelchair cushion." Under the sub-header "Specific Action (s) Taken to Minimize Recurrence", it was documented, "PT/OT [physical therapy/occupational therapy] to eval [evaluate] and treat, possible wheelchair cushion replacement."

An excerpt of a physical therapy Treatment Encounter note dated 09/24/2019 under the header "Summary of Skill" documented, "Pt [patient] fitted for new cushion post fall yesterday."

The fall investigation dated 11/10/2019 was reviewed. Under the header "Witnessed Fall" it was documented, "no." Under the header "Staff/Other Interviews" and sub-header "What was the resident doing at the time of the fall?" it was documented, "sitting, at the dining room." [sic]. Under the header "Known Risk Factors", the option "poor trunk control" was selected. Under the header, "Environmental/Situational Conditions ...that may have impacted this fall", the options "Unsafe positioning in bed/chair" and "attempting to reach for fluid/food" were selected. Under the header "Investigation Findings/Conclusions" and subheader "Action/Behavior/Reason for fall", it was documented, "Res [resident] slipped out of w/c [wheelchair] on hoyer lift sling in sitting position in front of w/c (cushion thick on chair may be cause of sliding out of wheelchair). Under the sub-header "Specific Action (s) Taken to Minimize Recurrence", it was documented, "PT [physical therapy] to assess w/c cushion for safety."

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An excerpt of an occupational therapy Treatment Encounter note dated 11/11/2019 under the header "Summary of Skill" documented, "Pt [patient] encountered sitting in WC [wheelchair] with pt daughter at table; pt daughter noted concerns about new WC cushion firmness slippery texture of hoyer sling; OT [occupational therapy] informed daughter that gel wedge cushion and counter 2 chambered ROHO cushion ordered for trial to inc [include] pt WC positioning. Rolled towel placed at pt L [left] side in WC to inc posture."

On 01/31/2020 at approximately 11:30 AM, an interview with Registered Nurse B (RN B) was conducted. When asked about Resident #24's wheelchair cushion, RN B stated that therapy staff had trialed wheelchair cushions and found that the ROHO cushion was best. When asked if she would expect to see that on the care plan, RN B stated that she would put it on the care plan so staff would know. RN B and this surveyor observed the care plan on the electronic health record. RN B confirmed there were no interventions associated with use of the ROHO wheelchair cushion as recommended by therapy. RN B stated that she would update the care plan now.

On 01/31/2019 at approximately 12:00 PM, an interview with Employee E, Therapy Program Manager, was conducted. When asked about therapy recommendations for Resident #24's wheelchair cushion, Employee E stated that Resident #24 started using the ROHO cushion on 12/02/2019 and the staff was in-serviced on 01/08/2020 regarding management of ROHO cushion. Employee E provided a document dated 01/08/2020 entitled, "Inservice Training Sign-In

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Sheet." Under the header, "Topic", it was documented ""ROHO Cushion Management." Under the header, "Training Objectives", it was documented, "1. Management of ROHO Cushion 2. Storage of pump in tx [treatment] cart or decided location 3. Schedule to check cushion pressure 1x/wk [once a week] on shower day."

A physician's order dated 01/10/2020 under the header "Order Summary" documented, "REHAB orders: check pt WC [patient wheelchair] cushion for air pressure before placing pt in WC."

A copy of the updated care plan was requested and the facility provided a copy. A care plan focus initiated on 09/12/2016 entitled, "AT risk for injury from falls r/t [related to] impaired mobility, hx cva [history of cerebrovascular accident] w/right [with right] side weakness/hemiparesis ..." was reviewed. An intervention associated with this focus initiated on 01/31/2020 documented, "Resident is out of bed into wheelchair with a roho cushion."

The facility staff provided a copy of their policy entitled, "Care Planning." Under the header "Policy Statement", it was documented, "Each resident will have a comprehensive, person-centered care plan developed to identify resident's care needs and goals for care."

In summary, the care plan was not revised to include the implementation of ROHO wheelchair cushion as recommended by therapy and summarized in physician's orders.

On 01/31/2020 at approximately 1:00 PM, the administrator and DON were notified of findings. The DON stated that the care plan should have

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F 657	Continued From page 31 been updated.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow physician orders for 1 resident (Resident #166) in a survey sample of 46 residents. The findings included: For Resident #166, the facility staff failed to administer low blood pressure medication (Midodrine) as scheduled. Resident #166, a 86 year old male, was admitted to the facility on 10/01/2019. His diagnoses included but are not limited to Parkinson's disease, dementia, history of falls, hypotension (low blood pressure) and syncope (temporary loss of consciousness caused by a drop in blood pressure). On 01/30/2020, a clinical record review was conducted for Resident #166. Physician orders dated 1/13/2020 read, "Midodrine HCl tablet, 5mg, give 1 tablet by mouth two times a day for systolic BP [the first number in a blood pressure reading] below 110, hold for systolic BP above 110". Doses were scheduled to be given at 9:00	F 658	Staff re-education was conducted by the ADON for the licensed nurses caring for resident #166 during survey and a monitoring tool was developed. All residents on Midodrine have the potential to be affected. On 2/4/2020 all residents receiving Midodrine received a 100% audit by ADON with a focus on supplemental documentation for BP parameters. All licensed nurses will be re-educated by Learning and Development or designee on supplemental documentation on the eMAR in PCC including how to properly enter blood pressures and apply the correct code when Mitodrine is held based on parameters ordered by physicians. Learning and Development or designees will provide competency training to all licensed nurses to validate proficiency when recording blood pressures using the supplemental documentation tab in PCC□s eMAR. This will be validated with a return demonstration using eMAR. All	3/15/20

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F 658	Continued From page 32 AM and 6:00 PM every day. A Weights and Vitals Summary and a Medication Administration Audit Report for the month of January 2020 was requested and provided by facility staff. Review of these documents for Resident #166 revealed the following: 01/14/2020, time scheduled 9:00 AM and 6:00 PM, no blood pressure readings, no Midodrine administered 01/15/2020, time scheduled 9:00 AM, no blood pressure reading, no Midodrine administered On 01/31/2020 at approximately 11:30 AM, the Director of Nursing (DON, Employee B) was interviewed and stated, "[Resident #166] receives Midodrine to increase his low blood pressure, a blood pressure reading is necessary to be able to assess whether or not the Midodrine should be given, I have reviewed his [Resident #166] records and found that the nurses failed to document vital signs as ordered on January 14th and 15th, [Resident #166] could experience dizziness and low blood pressure if not treated properly with the Midodrine, the doctor would not be able to review his vital signs and adjust his treatments as needed, and there is no way to validate the clinical decision that was made by the nurse with regard to administering or holding the Midodrine, we will be re-educating these nurses". Review of the facility's policy entitled, "6.0 General Dose Preparation and Medication Administration" (revision date 01/01/13), under subheading "Procedure", item 6.1 read, "Document necessary medication administration/treatment information".	F 658	licensed nurses will be reeducated by Learning and Development or designee on the 7 rights of medication administration. Nursing leadership will conduct audits weekly x4 weeks then monthly on resident□s receiving Mitodrine with parameters. Variances will be immediately investigated, corrected and re-education will be provided to the appropriate staff by nursing leadership or designee. Summary of audit findings will be reviewed through the monthly Clinical Operations Report(COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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F 658	Continued From page 33 On 01/31/2020 at approximately 12:45 PM, the Facility Administrator (Employee A) and Director of Nursing (Employee B) were informed and no further information was received.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to mitigate accident hazards for one resident (resident #147) in a survey sample of 46 residents. The findings included; For Resident #147 the facility staff failed to provide interventions to prevent accidents. Resident #147, an 89 year old woman, was admitted to the facility on 7/3/19 with diagnosis of but not limited to Osteoporosis, Chronic Kidney Disease, Major Depressive Disorder, Cerebral Vascular Disease and adult failure to thrive. Resident 147's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 12/27/19 the Resident was coded as having a BIMS (Brief Interview of Mental Status of 99	F 689	Resident #147 was not impacted by this deficient practice. All residents have the potential to be impacted by this deficient practice. The staff member involved will be re-educated by the Director of Nursing or designee on the importance of following the resident□s plan of care related to the level of assistance required for bed mobility, turning, and repositioning. All direct care staff (licensed nurses and C.N.A's) will be re-educated by Learning and Development or designee on the importance of following the resident□s plan of care related to the level of assistance required for bed mobility, turning, and repositioning, information	3/15/20

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F 689	Continued From page 34 indicating severe cognitive impairment. Resident #147 was also coded as requiring 2 person assistance for bed mobility turning and positioning. The resident was also coded as recurring 1 person physical assistance for bathing, dressing, eating as well as locomotion on and off the unit using a wheel chair. On 1/30/2020 at 10:30am, this surveyor observed RN A performing wound care on Resident #147. The resident was in bed dressed with blanket over her. RN A gathered her supplies and placed them on the clean overbid table, on top of a disposable absorbent pad. RN A closed the door and pulled the privacy curtain before raising the bed to a comfortable working height (about waist high) RN A positioned Resident to be able to observe a heel wound.. RN A then turned Resident towards the window onto her left side as to observe the sacrum area. RN A did not engage the assistance of another person. The Resident has no order for side rails on her bed and RN A was standing on the side of the bed facing the Residents back. On 1/30/20 during clinical record review it was discovered that Resident #147's care plan read as follows: "FOCUS: I am at risk for falls related to impaired cognition, impaired mobility, and impaired safety awareness. Date initiated - 7/3/19 Goal: I will not have any fall related injuries Date initiated - 7/3/19	F 689	which is ready availability on the resident□s care plan and the Kardex. Nurse manager or QA-CNA will complete observation of 3 residents weekly x4 weeks then monthly who require 2-person assistance for bed mobility, turning, and repositioning to ensure that appropriate assistance is provided. Any observation variances will be immediately investigated, and re-education will be provided to the appropriate staff by the nurse manager or designee. Summary of audit findings will be reviewed through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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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 689	Continued From page 35 Interventions: After care make sure resident is in center of bed not too close to edge Date initiated - 7/3/19 Provide assistance of two with bed mobility and repositioning. Date initiated - 7/3/19" On 1/30/20 at 4:34 PM an interview with the DON was conducted and she stated that the care plan was correct, Resident #147 requires 2 person physical assistance for turning and repositioning. The DON said "There should have been someone standing on the other side of the bed." When asked why she replied "For safety, to prevent her falling out of the bed." On 1/30/20 the Administrator was made aware of the concerns and no further information was provided.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		3/15/20

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	495390	A. BUILDING _____ B. WING _____	01/31/2020

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F 755	Continued From page 36 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to properly secure active prescriptions for controlled substances on one of three units (neighborhoods). The findings included: On 01/30/2020 at approximately 2:20 PM, this surveyor approached the nurse's station and requested the hard chart clinical record for Resident #50. A facility nursing staff member was unable to locate the hard chart and stated she would look for it. Within approximately 10 minutes time, the facility staff confirmed the hard chart was in the MDS office and provided the hard chart to this surveyor. While reviewing Resident #50's hard chart clinical record, an active prescription dated 10/22/2019 for Lorazepam 0.5	F 755	No residents were impacted by this practice. All residents have the potential to be impacted by this deficient practice. All licensed nurses will be educated by Learning and Development or designee on revised policies related to New Orders for Controlled Substances and the process for faxing prescriptions and rendering them de-faced to assure they cannot be re-used. Nursing Leadership or designee will conduct weekly audits X4 weeks then monthly to ensure staff are following the proper procedure for controlled substance prescriptions.	

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F 755	Continued From page 37 mg (75 tablets, 4 refills) was observed in the hard chart in a plastic sleeve. The handwritten prescription contained the Resident #50's name; the physician's name, DEA number, and signature. There were no marks on the prescription to indicate it had already been filled. On 01/30/2020 at approximately 2:35 PM, an interview with Licensed Practical Nurse B (LPN B) was conducted. When asked about the process for handing of prescriptions, LPN B stated when a physician writes a prescription (from their prescription pad), the prescription gets faxed to the pharmacy and then the original prescription is placed in "the pharmacy bag" to go to the pharmacy. This surveyor requested to see the pharmacy bag. LPN B and this surveyor observed 2 unsealed plastic bags in a letter holder mounted on the wall behind the nurse's station. A quick glance in the bag revealed there were prescriptions for controlled substances that were not voided or marked as already being faxed to the pharmacy. When asked why it would be important to store active prescriptions in a secure (locked) area, LPN B stated "So that they can't be taken to another pharmacy and filled." When shown the active prescription for Lorazepam in Resident #50's hard chart, LPN B removed the prescription from the hard chart and stated that it shouldn't be there. On 01/30/2020 at approximately 2:50 PM, the administrator and DON were notified of findings and the DON stated the prescriptions should have been locked in the med room. On 01/31/2020 at approximately 12:45 PM, the DON provided contact information for their pharmacist consultant, Employee F. The facility	F 755	Summary of audit findings will be reviewed through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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F 755	Continued From page 38 staff also provided a copy of all the contents of the 2 unsealed pharmacy bags. Of the 56 documents in the bags (collectively), there were 14 active prescriptions handwritten from provider prescription pads. All medications on those 14 active prescriptions were either Schedule II, IV, or V controlled substances including hydrocodone, oxycodone, lorazepam, and alprazolam. On 01/31/2020 at approximately 12:55 PM, a telephone interview with Employee F was conducted. When notified an active prescription for lorazepam was observed in a resident's hard chart and active prescriptions were located in unsealed bags at the nurse's station, Employee E stated, "They should be secured." A copy of facility policy on handling of prescriptions and controlled substances was requested and the facility staff provided a copy of their policy entitled, "LTC [long-term care] Facilities Receiving Pharmacy Products and Services from Pharmacy." Under the header, "Applicability" it was documented, "This policy 4.2 sets forth procedures relating to new orders for Schedule II controlled substances." The policy did not address the secure handling of active prescriptions.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		3/15/20

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F 758	Continued From page 39 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 40 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview clinical record review and facility documentation the facility staff failed to ensure PRN Anti Anxiety medication was limited to 14 days for 1 Resident (#62) in a survey sample of 46 Resident. The finding include: For Resident # 62 the facility staff failed to ensure the PRN use of Ativan was for 14 days. Resident #62 a 79 year old woman admitted to the facility on 8/31/18 with diagnoses of but not limited to atrial fibrillation, anxiety disorder, diabetes, Lewy body dementia, COPD, and unspecified dementia with behavior disturbances. Most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date of 12/9/19 coded as a significant change. Resident was coded as having a BIMS (Brief Interview of Mental Status) score 0 indicating severe cognitive impairment. On 1/31/20 resident was selected for "Unnecessary Medication Review" and during clinical record review it was discovered that Resident # 62 had an order for PRN Lorazepam (anti-anxiety medication) that was longer than 14 days. Resident had the following orders for Lorazepam (Ativan): Lorazepam Intensol concentrate 2 MG (Milligrams) / ML (Milliliter) - Give 0.5 ml by mouth	F 758	Resident #62 was discharged on 02/11/2020 thus no further correction is needed for this resident. All residents are at risk for receiving a PRN psychotropic medication beyond 14-days if orders are not written with a 14-day stop date and/or physician rational for continuation and indicate the duration for the PRN order. A 100% audit will be conducted by the DON or designee of current residents who have a PRN order for psychotropic medication to ensure that orders do not exceed 14-days unless there is written documentation by the provider explaining the rationale for extending the order and includes the duration for use. All licensed nurses will be re-educated by Learning and Development or designee on the federal regulations related to prescribing of PRN antipsychotic and psychotropic medications. Director of Nursing or designee will conduct audits on 25% of residents who have orders for PRN psychotropic medications weekly x4 weeks then monthly to ensure that orders do not exceed 14-days unless there is written documentation by the provider explaining the rationale for extending the order and includes duration for use. Variances will be investigated by the DON or designee	

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F 758	Continued From page 41 every 4 hours as needed for Anxiety Start Date - 12/1/19 - D/C Date 12/27/19 On 1/31/20 an interview was conducted with the DON who stated that she didn't know the Resident's order was for longer than 14 days. On 1/31/20 DON provided copy of the pharmacy review that read as follows: "Recommendation date 12/7/19" "Comment: [Resident name redacted] has a PRN order for an anxiolytic without a stop date Lorazepam [Ativan]" "Recommendation: It continued greater than 14 days, current regulation require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period." "Rationale for Recommendation: CMS requires that PRN orders for non-antipsychotic, psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period and the duration of the PRN order." "Physician Response: [box checked] I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below." "Pt under hospice care now. - [physician signature redacted] - 12/23/19" Resident #62 was placed on hospice 12/23/19.	F 758	and orders will be clarified with the prescribing provider. Summary of audit findings will be reviewed through the monthly Clinical Operations Report(COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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F 758	Continued From page 42 On 1/31/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 758		