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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

(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 on 01/28/2020. 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 standard survey was conducted 1/28/20 through 1/30/20. Complaints were investigated during this survey [VA00048154, VA00048022 and VA00047586 and were unsubstantiated]. 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 111 certified bed facility was 103 at the time of the survey. The survey sample consisted of 48 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		3/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/17/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under 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 a dignified dining experience for four of 51 residents in the survey sample, Residents #33, #58, #42, #80. The facility staff failed to serve lunch to Resident #33, #58 and #42 in a dignified manner. Other residents seated at the same tables as Resident #33, 58 and #44 were served a meal, a meal for Resident #33 and #58 was not served and the residents assisted until 11 minutes later. Resident	F 550	1. Residents #33, 58, 42, and 80 were provided their lunch in the dining room and are currently receiving meals as their table mates receive them. CNA #5 was re-educated by Director of Nursing (DON) on 1/30/20 in regard to serving all residents at the same table at the same time and not allowing interruptions when assisting residents with eating. 2. Residents receiving meals in the 1st floor dining room and the Terrace dining	

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#42' was not served a meal until 22 minutes later. The facility staff failed to feed Resident #80 lunch in a dignified manner. CNA (certified nursing assistant) #5 stood up and left Resident #80 multiple times while feeding the resident.

The findings include:

1. Resident #33 was admitted to the facility on 6/15/10. Resident #33's diagnoses included but were not limited to intellectual disabilities, high blood pressure and thyroid disorders. Resident #33's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #33 as requiring extensive assistance of one staff with eating.

On 1/29/20 at 12:08 p.m., an observation of the second floor dining room was conducted. On 1/29/20 at 12:14 p.m., CNA (certified nursing assistant) #5 served and began feeding another resident seated at Resident #33's table. Resident #33 was not served and assisted with her meal until 1/29/20, at 12:25 p.m. eleven minutes later.

On 1/29/20 at 4:19 p.m., an interview was conducted with CNA #5. CNA #5 stated the meal trays are packed on a cart by the dietary staff and brought to the second floor. CNA #5 stated she was not sure of the order the trays are placed on the cart but the CNAs removes the trays from the cart in a top to bottom order and serve the trays to residents in their rooms and in the dining room. CNA #5 confirmed residents seated at the same

F 550

room were observed by the DON. No identified issues were present. IDT to review order of meal trays on food carts to ensure that meal trays are distributed in a way that allows residents at the same table to be served at the same time.

3. DON/designee will re-educate Nursing staff by 3/9/20 in regard to a dignified dining experience and proper procedure for assisting residents with meals. Executive Director (ED)/designee will re-educate Dietary staff by 3/9/20 in regard to proper meal tray order for each floor.

4. DON/designee will conduct Quality Monitoring Review of dining service daily for 10 days, then weekly for 4 weeks, then monthly, for 3 months, to ensure residents are receiving a dignified dining experience. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.

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table in the dining room may not be served at the same time, because of the order the meal trays are taken off the cart. CNA #5 was asked how she would feel if someone seated at her table received a meal, tray and she observed that other person eating for several minutes before she received her meal. CNA #5 stated, "It would not feel good."

Resident #33's comprehensive care plan dated 6/30/17 "EATING: Provide finger foods which (name of Resident #33 is able to pick up and eat but can not feed self with utensils and needs staff assistance with feeding..." The comprehensive care plan failed to document information regarding a dignified dining experience.

On 1/29/20 at 5:39 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, "Social Dining Program" documented, "12. All residents shall be served at one table before proceeding to the next table..."

The facility document titled, "VIRGINIA RESIDENT'S RIGHTS AND RESPONSIBILITIES" documented, "Each nursing facility resident has a right to a dignified existence...A facility must protect and promote the rights of each resident..."

No further information was presented prior to exit.

2. Resident #58 was admitted to the facility on 4/17/16. Resident #58's diagnoses included but were not limited to urinary retention, heart failure and hearing loss. Resident #58's most recent

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MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/19/19, coded the resident as being cognitively intact. Section G coded Resident #58 as requiring supervision and set up with eating.

On 1/29/20 at 12:08 p.m., an observation of the second floor dining room was conducted. On 1/29/20 at 12:17 p.m., CNA (certified nursing assistant) #5 served a meal to another resident seated at Resident #58's table. Resident #58 was not served a meal until 1/29/20 at 12:28 p.m., eleven minutes later.

Multiple attempts to interview Resident #58 were made on 1/30/20. The resident was unavailable for interview.

On 1/29/20 at 4:19 p.m., an interview was conducted with CNA #5. CNA #5 stated the meal trays are packed on a cart by the dietary staff and brought to the second floor. CNA #5 stated she was not sure of the order the trays are placed on the cart but the CNAs removes the trays from the cart in a top to bottom order and serve the trays to residents in their rooms and in the dining room. CNA #5 confirmed residents seated at the same table in the dining room may not be served at the same time because of the order the meal trays are taken off the cart. CNA #5 was asked how she would feel if someone seated at her table received a meal, tray and she observed that other person eating for several minutes before she received her meal. CNA #5 stated, "It would not feel good."

Resident #58's comprehensive care plan dated 8/12/19 failed to document information regarding a dignified dining experience.

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On 1/29/20 at 5:39 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.

3. Resident #42 was admitted to the facility on 1/12/18. Resident #42's diagnoses included but were not limited to weakness, diabetes and chronic kidney disease. Resident #42's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/4/19, coded the resident as being cognitively intact. Section G coded Resident #42 as requiring supervision and set up with eating.

On 1/29/20 at 12:08 p.m., an observation of the second floor dining room was conducted. On 1/29/20 at 12:09 p.m., CNA (certified nursing assistant) #5 served a meal to another resident seated at Resident #42's table. Resident #42 was not served a meal until 1/29/20 at 12:31 p.m. (22 minutes later).

On 1/29/20 at 4:19 p.m., an interview was conducted with CNA #5. CNA #5 stated the meal trays are packed on a cart by the dietary staff and brought to the second floor. CNA #5 stated she was not sure of the order the trays are placed on the cart but the CNAs removes the trays from the cart in a top to bottom order and serve the trays to residents in their rooms and in the dining room. CNA #5 confirmed residents seated at the same table in the dining room may not be served at the same time because of the order the meal trays are taken off the cart. CNA #5 was asked how she would feel if someone seated at her table

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received a meal, tray and she observed that other person eating for several minutes before she received her meal. CNA #5 stated, "It would not feel good."

Resident #42's comprehensive care plan dated 4/10/18 failed to document information regarding a dignified dining experience.

On 1/29/20 at 5:39 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 1/30/20 at 9:07 a.m., an interview was conducted with Resident #42 regarding the lunch observation and delay in receiving her meal tray documented above. Resident #42 stated, "I guess they forgot. I don't know why it took them so long." Resident #42 stated this made her feel "left out."

No further information was presented prior to exit.

4. Resident #80 was admitted to the facility on 8/1/12. Resident #80's diagnoses included but were not limited to diabetes, high cholesterol and muscle weakness. Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/7/20, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #80 as requiring extensive assistance of one staff with eating.

On 1/29/20 at 12:14 p.m., CNA #5 was observed seated and feeding Resident #80. CNA #5 was the only employee in the second floor dining room. On 1/29/20 at 12:17 p.m., CNA #5 stood

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up and left Resident #80 to assist another resident with his meal tray. On 1/29/20 at 12:18 p.m., CNA #5 returned to Resident #80, sat down and continued to feed the resident. On 1/29/20 at 12:20 p.m., CNA #5 stood up, left Resident #80, exited the dining room, returned to the dining room and gave a lunch item to another resident. On 1/29/20 at 12:21 p.m., CNA #5 returned to Resident #80, sat down and continued to feed the resident. On 1/29/20 at 12:22 p.m., CNA #5 stood up, left Resident #80, exited the dining room, returned to the dining room and served a meal tray to another resident. On 1/29/20 at 12:24 p.m., CNA #5 returned to Resident #80, sat down and continued to feed the resident. On 1/29/20 at 12:24 p.m. (within that same minute), CNA #5 stood up, left Resident #80, and removed an empty meal tray from another table. On 1/29/20 at 12:25 p.m., CNA #5 returned to Resident #80, sat down and continued to feed the resident. On 1/29/20 at 12:25 p.m. (within that same minute), CNA #5 stood up, left Resident #80, exited the dining room, entered the dining room and served a meal tray to another resident. On 1/29/20 at 12:28 p.m., CNA #5 returned to Resident #80, sat down and continued to feed the resident.

On 1/29/20 at 4:19 p.m., an interview was conducted with CNA #5. When asked how she would feel, if she had to be fed her meal and the person feeding her repeatedly got up during her meal to assist others, CNA #5 stated, 'It's not going to be a good feeling."

Resident #80's comprehensive care plan dated 4/13/16, documented "EATING: (Name of Resident #80) requires extensive to total assistance by staff to eat..." The care

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F 550	Continued From page 8 comprehensive plan failed to document information regarding a dignified dining experience. On 1/29/20 at 5:39 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.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs by ensuring the call bell [a device with a button that can be pushed to alert staff when assistance is needed] was within reach for one of 51 residents in the survey sample, Resident # 68. The findings include: Resident # 68 was admitted to the facility with diagnoses that included but were not limited to: lack of coordination, and Parkinson's disease [1]. Resident # 68's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 558	1. Resident #68 had her call bell placed within reach and is maintained within resident's reach. 2. Current residents in facility were assessed to ensure their call bells were in reach and accessible. Follow up based on findings. 3. DON/designee will re-educate Center staff by 3/9/20 in regard to ensuring residents' call bells are within reach and accessible. 4. DON/designee will conduct Quality Monitoring Review of 10 residents daily for 2 weeks, then weekly for 4 weeks,	3/9/20

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F 558	Continued From page 9 (assessment reference date) of 12/03/19, coded Resident # 68 as scoring an 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 68 was coded as requiring extensive assistance of one staff member for activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 68 as "No impairment" of their upper extremities [shoulder, elbow, wrist, hand] and "Impairment on both sides" of their lower extremities [hip, knee ankle, foot]. On 01/28/20 at 6:29 p.m., an observation of Resident # 68 revealed the resident was lying in bed, with the call bell on the floor next to the bed. When asked where the call light was Resident # 68 stated, "I guess it's on the floor." When asked if they were able to reach it Resident # 68 stated, "No." On 01/28/20 at 6:39 p.m., an observation of Resident # 68's room revealed a nurse stopped at Resident # 68's room, stepped inside the room and looked at Resident # 68. Further observation revealed Resident # 68 was lying in bed, awake and the call bell remained on the floor next to the bed. On 01/29/20 at 8:07 a.m., an observation of Resident # 68 revealed they were lying in bed, awake. The call bell was on the floor next to the bed. On 01/29/20 at 9:12 a.m., upon entering Resident #68's room, nurse was observed leaving the room after checking Resident # 68. An observation of Resident # 68 revealed they were lying in bed, awake. The call bell was directly on	F 558	then monthly, for 3 months, to ensure that residents' call bells are in reach and accessible. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	

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the floor next to the bed.

The comprehensive care plan for Resident # 86 with a revision date of 11/26/2018 documented, "Focus: [Resident # 86] has an ADL [activities of daily living] self-care performance deficit r/t [related to] OA [osteoarthritis]. Revision on: 11/26/2018." Under "Interventions" it documented, "Encourage [Resident # 86] to use bell to call for assistance. Date Initiated: 10/01/2018."

On 01/29/20 at 4:27 p.m., an interview was conducted with RN [registered nurse] # 3, unit manager, regarding the above observations of Resident # 68's call bell, and was asked to describe the procedure for the call bell placement. RN # 3 stated, "Keep it where the resident can reach it. When you round [checking the resident] they [nursing staff] should be checking to make sure the call bell is within reach."

The facility's policy "Resident Rights and Responsibilities" documented in part, "Accommodation of Needs: A. To be cared for in a manner and in an environment that promotes maintenance or enhancement of your quality of life. B. To reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of other residents would be endangered."

On 01/29/2020 at approximately 5:40 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

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F 558	Continued From page 11 No further information was provided prior to exit. References: [1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.	F 558		
F 600 SS=D	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, 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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure one of 51 residents, (Resident #47), right to be free from abuse from abuse by another resident (Resident #98). The findings include:	F 600	1. Resident #47 was removed from the room and placed in a safe environment of another room. Resident #95 no longer resides in the Center. 2. Social Worker/designee will interview residents who are able to be interviewed regarding their interactions with their roommates by 2/3/20. Follow up based on findings. Social Worker/designee will	3/9/20

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A review of the facility policy, "Abuse, Neglect Exploitation & Misappropriation" documented, "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse."

Resident #47 was admitted to the facility on 2/27/19; diagnoses included but are not limited to stroke, dysphagia, gastrostomy, aphasia and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/7/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting, eating, dressing, and transfers; extensive assistance for hygiene and bed mobility; and was incontinent of bowel and bladder.

Resident #98, was admitted to the facility on 1/25/18, and was discharged on 1/10/20. Diagnoses include but are not limited to, stroke, alcohol abuse, depression, bipolar disorder, high blood pressure, left and right leg below-the-knee amputation, phantom pain syndrome, and cellulitis. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/4/20 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for dressing; limited

F 600

interview families of non-interviewable residents regarding the interactions between roommates. Skin assessments completed to ensure no injuries present. Follow up based on findings.

3. DON/designee will re-educate Center staff by 3/9/20 regarding monitoring interactions between residents and monitoring for changes in mood or behavior and reporting any issues observed to Supervisor. ED/designee will re-educate residents in Resident Council meeting on 2/3/20 regarding reporting any issues between roommates to the Supervisor or Social Worker.

4. DON/designee will conduct Quality Monitoring Review weekly for 4 weeks, then monthly, for 3 months, to monitor for behavior or mood changes, changes in interactions between roommates, or reports of issues between roommates. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.

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F 600	Continued From page 13 assistance for hygiene and transfers; supervision for bed mobility, eating and toileting; and was occasionally incontinent of bowel and bladder. A review of a Facility Reported Incident (FRI) dated 12/27/19 documented, "On 12/27/19 at approximately 6:30 p.m., Nursing Supervisor (name of LPN [Licensed Practical Nurse] #1) notified the DON (Director of Nursing) of a resident on resident altercation involving roommates (names of Resident #47 and Resident #98). (Resident #47) was moved to another room. Police notified. Full investigation initiated." A review of the facility's FRI investigation revealed a note dated 12/27/19, that documented, "Writer was doing his routine rounds when I stop by room (number) and saw (Resident #47) face was cover with a pillow. Writer enter the room and removed the pillow from (Resident #47) face and asked him how could you cover your face with a pillow but (Resident #47) winked his left eye and his left part of his face towards the roommates bed because he is not verbally responsive, but can respond when using eye contact. So writer asked him again if that's the roommate (name of Resident #98) who did that and (Resident #47) winked his left eye again. So writer asked (Resident #98) if he did use a pillow to cover (Resident #47) face. (Resident #98) responded by saying "yes" he did because (Resident #47) is making noises and spitting all over so that why he use the pillow to cover his face. Writer then told him he shouldn't put a pillow to cover (Resident #47) face, what he should have done put the call light on or call the nurse or CNA (certified nursing assistant) and they will take care of that noise or	F 600		

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spitting. In reply (Resident #98) stated that he do not care about calling or not calling who so ever, and I told him I am gonna report you to the supervisor, and he stated that he don't care. So I went and told the supervisor." The nurse that wrote this note was no longer at the facility and could not be interviewed.

The CNA on duty at the time was unavailable by phone for interview. The supervisor, LPN #1, was interviewed, below.

A nurse's note in Resident #98's clinical record dated 12/30/19 written by ASM #2 (Administrative Staff Member, the DON)documented, "On 12/27/19 at approx (approximately) 1830 (6:30 PM) this writer rec'd (received) call from 3-11 supervisor stating (Resident #98) had put a pillow over top his roommates mouth. Supervisor stated (Resident #98) said he did it to "make him be quiet." (Resident #98) immediately placed on 1:1 (one on one) supervision and his roommate removed from the room. This writer interviewed (Resident #98) at 10:00 am this morning with the social worker present. (Resident #98) stated his roommate frequently makes noises and spits and that it bothers him. (Resident #98) stated he "threw" a pillow at him, hoping to make him be quiet. Writer asked (Resident #98) if the privacy curtain between the two beds was in place and he stated "yes". When asked how the pillow was resting directly over his roommates mouth when he claims to have thrown the pillow, (Resident #98) remained silent. (Resident #98) apologized and stated he didn't realize it was "a big deal." Writer discussed discharge options with (Resident #98). (Resident #98) is independent in ADLs (activities of daily living) and mobility. (Resident #98) has 2 prosthetic legs that he is

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able to ambulate with and an electric w/c (wheel chair). (Resident #98) agreed to d/c (discharge) to the community once an appropriate place was located. Writer assisted (Resident #98) with calling DMV (department of motor vehicles) to obtain a replacement ID to assist with D/C planning." (Note: Resident #98 was discharged to a community setting on 1/10/20).

A "Geriatric Psychiatry Progress Note" in Resident #98's clinical record dated 1/7/20 documented, "Joking and smiling on exam. Staff reported he had put a pillow on roommates face last week. Pt laughs about it, "he was spitting and making noises and I couldn't sleep." He is clear he was not trying to harm him but doesn't seem to understand he could have."

On 1/30/20 at 10:43 AM, in an interview with LPN #1 (Licensed Practical Nurse), he stated that he was notified by the nurse (who no longer works at the facility) that Resident #98 had put a pillow on the face of Resident #47. He stated that in conversation with the residents, Resident #98 stated that he did it because Resident #47 was snoring and spitting, and disturbing his sleep. He stated he was not trying to harm the resident. He stated that he was not sure if Resident #98 tossed the pillow from his bed to the other side, so that it landed on Resident #47's face, or if Resident #98 went over to Resident #47's side of the room, and placed the pillow on his face and went back to bed. He stated the police were also notified and the police did not feel there was ill intent to harm the resident. He stated that Resident #98 was moved to another room.

On 1/30/20 at 11:52 AM, in an interview with ASM

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F 600	Continued From page 16 #2 (Administrative Staff Member, the Director of Nursing), ASM #2 stated, "It was a Friday night about 6pm or so, the supervisor called me and said they found a pillow over top of (Resident #47) mouth. (Resident #47) is nonverbal and not able to move any but can understand and use his eyes. When asked how the pillow got on his face, he used his eyes to motion to his roommate. (Resident #98) did not like people in his room, making noise, using his bathroom, so (Resident #47) was the perfect roommate because he didn't make noise or use the bathroom. There had not been any issues before. (Resident #98) stated he threw it [pillow] over there but it was clearly placed. We called the cops and they came. The cops did not see a big deal. They said he just wanted him to stop making noises. I interviewed (Resident #98), he said (Resident #47) was making noises and spitting and so he threw a pillow "over there." I asked if the privacy curtain was pulled. He said it was but then he could not explain how he threw a pillow through the curtain. He did not think it was a big deal; he just wanted him to stop spitting. I educated him that (Resident #47) cannot move the pillow, and it restricts air. He showed no remorse. We discussed discharge options with him after that. (Resident #98) lost both legs from frostbite, his sisters are not involved, and he has history of alcohol abuse. He had previously refused discharge to community placement due to restrictions of the community facility (drug and alcohol testing every time you come and go). After this incident, he realized it was time to go. The community facility had private rooms and could help him get disability. He was placed on 1:1 the rest of his time here and he didn't like being on 1:1." ASM #2 provided the 1:1 documentation sheets from the date of the	F 600		

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incident through date of discharge for Resident #98. ASM #2 stated, "(Resident #47) was immediately put in a different room for his safety. Before this, he had no other incidents like this towards others. Nothing physical ever, with anyone and nothing with this roommate prior to this, there were no flags this might happen. They had been roommates for 10 months without incident. He told the cop he had no intention to harm, no ill intent, and the police did not pursue a legal situation. (Resident #47) was here (in the US) alone from Ghana. After he got here, he had a stroke. He has no family or anyone here (in the US). A third party lawyer was given guardianship. Shortly after he got here (at the facility), a daughter in Ghana tracked him down here and called. Staff that are from there spoke to her. We have no contact for her and she has never called back. The hospital pays for his stay here indefinitely."

On 1/30/10 at 12:07, in an interview with OSM #2 (Other Staff Member - the Director of Social Services), OSM #2 stated he followed up with Resident #47 several times to ensure the resident was ok and not suffering any distress from the incident. He provided notes dated 12/30/19, 12/31/19, and 1/3/20 wherein he documented that, the resident was calm, stable and safe.

A review of the comprehensive care plan for Resident #98 revealed one dated 12/30/19 that documented, "(Resident #98) has a behavior problem put pillow on his roommate's face d/t (due to) the noise he made, while the roommate is total dependent who does not have ability to move the pillow or push the call light for help."

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F 600	Continued From page 18 A review of the comprehensive care plan for Resident #47 revealed one dated 3/8/19 for risk of falls. This care plan included an update dated 12/30/19 for "(Resident #47) was found his face covered by the pillow that his roommate throw it on purpose." On 1/30/20 at 1:50 PM, ASM #1 (the Administrator), ASM #2, ASM #3 (Senior Director of Operations) and ASM #4 (Regional Director of Clinical Services) were made aware of the findings. 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 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	F 656		3/9/20

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F 656	Continued From page 19 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 resident interview, staff interview and clinical record review it was determined that the facility staff failed to implement the comprehensive care plan for two of 51 residents in the survey sample, Resident #37 and #53. The facility staff failed implement the comprehensive care plan for non-pharmacological interventions prior to the administration of prn (as needed) pain medication to Resident # 37. The facility staff failed develop a care plan to address Resident # 53 tube feeding. The findings include: 1. Resident # 37 was admitted to the facility with diagnoses that included but were not limited to: muscle spasms and arthritis. Resident # 37's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 656	1. Care plan for resident #37 was updated to reflect current pain management program, including non-pharmacological interventions. Care plan for resident #53 was updated to reflect current feeding tube status. 2. Current residents receiving PRN pain medications were reviewed to ensure that non-pharmacological interventions were identified, implemented and care planned by 2/8/20. Follow up based on findings. Current residents with feeding tubes were reviewed to ensure their feeding tubes and enteral feedings were care planned. Follow up based on findings. 3. DON/designee re-educated the MDS Coordinator and Unit Managers on 2/1/20 about ensuring residents’ care plans	

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F 656	Continued From page 20 (assessment reference date) of 12/03/19, coded Resident # 37 as scoring an 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 37 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 37 as having severe pain frequently. The POS [physician's order sheet] dated January 2020 for Resident # 37 documented, "Ibuprofen [1] 600MG [milligrams] Tablet. 1 [one] tab [tablet] by mouth every 8 [eight] hours as needed for pain. Date: 09/06/2019." The comprehensive care plan with a revision date of 09/17/2019 for Resident # 37 documented in part, "Focus: The resident has pain r/t [related to] arthritis, muscle spasm. Revision on: 09/17/2019." Under "Interventions" it documented, "Monitor/record pain." "Characteristics q [every] shift and PRN [as needed]: Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset: Duration (e.g. continuous, intermittent); Aggravating factors; Relieving factors.. Date Initiated: 09/17/2019." The MAR [medication administration record] for Resident # 37, dated "January 2020" documented the same physician's order as above. Review of the MAR revealed Resident # 37 received Ibuprofen on 01/01/2020 through 01/07/2020, and on 01/09/2020, 01/10/2020, 01/13/2020, 01/14/2020, 01/15/2020, and on 01/16/2020, 01/18/2020, and 01/19/2020 and on 01/20/2020 at 5:00 p.m. each day. Further review of the MAR failed to evidence documentation of	F 656	accurately reflect their non-pharmacological pain interventions and enteral feeding status. 4. DON/designee will conduct Quality Monitoring Review of residents with PRN pain medications to ensure their care plans accurately reflect their non-pharmacological pain interventions, and review residents with feeding tubes, to ensure their care plans accurately reflect their enteral status, weekly for 4 weeks, then monthly for 3 months. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	

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non-pharmacological interventions.

The facility's nurse's notes dated 01/01/2020 through 01/28/2020 failed to evidence documentation of non-pharmacological interventions prior to the administration of Ibuprofen for the above dates and times.

On 01/29/2020 at approximately 1:40 p.m., an interview was conducted with Resident # 37. When asked if the staff attempt to alleviate the pain before administering pain medication Resident # 37 stated no, they just give me the pain medication.

On 01/29/20 at 5:15 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked how they interpreted the statement "Relieving factors" as part of Resident # 37's interventions for their pain care plan ASM # 2 stated, "I take it to mean both pharmacological and non-pharmacological interventions."

On 01/29/20 at 4:17 p.m., an interview was conducted with RN [registered nurse] # 3, unit manager. When asked where they would document the attempt of non-pharmacological interventions, RN # 3 stated, "It would be documented on the back of the MAR or the nurse's notes." After reviewing the nurses notes for Resident # 37's and the residents MAR for January 2020, RN # 3 stated that there was no documentation of non-pharmacological interventions. When asked if the non-pharmacological interventions were being attempted for Resident # 37, RN # 3 stated no.

On 01/30/2020 at approximately 9:15 a.m., an

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interview was conducted with RN # 3. When asked to describe the purpose of a resident's care plan RN # 3 stated, "It's a guide to provide care for the patient." When asked how they interpreted the statement "Relieving factors" as part of Resident # 37's interventions for their pain care plan, RN # 3 stated, "It is what relieves the pain. I could be the medication or repositioning." After reviewing the lack of documentation of non-pharmacological interventions for Resident # 37's pain as documented above, RN # 3 stated that the care plan was not being followed for the implementation of non-pharmacological interventions.

On 01/30/2020 at approximately 1:33 p.m., ASM # 1, the administrator, ASM # 2, director of nursing, ASM # 3, director of operations, and LPN # 4, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Prescription ibuprofen is used to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis (arthritis caused by a breakdown of the lining of the joints) and rheumatoid arthritis (arthritis caused by swelling of the lining of the joints). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682159.html.

2. Resident # 53 was admitted to the facility with diagnoses that included but were not limited to: difficulty swallowing, and stroke. Resident # 53's most recent MDS (minimum data set), a significant change assessment with an ARD

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(assessment reference date) of 01/17/2020, coded Resident # 53 as scoring an four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. Section K0510 "Nutritional Approaches" coded Resident # 53 as "B. Feeding Tube - nasogastric or abdominal (PEG)."

The POS [physician's order sheet] dated January 2020 for Resident # 53 documented, "Jevity [supplement] 1.5 Liquid. 1 [one] - can via [by] PEG Tube @ [at] 8AM [8:00 a.m.], 12N [12:00 p.m.], 4PM [4:00 p.m.], 8PM [8:00 p.m.], 12AM [12:00 a.m.]. CAL [calories] = 1775."

Review of the comprehensive care plan for Resident # 53 dated 09/17/2019 failed to evidence documentation regarding Resident # 53's tube feeding or the feeding protocol above.

On 01/30/2020, an interview was conducted with RN # 2, MDS coordinator. When asked to describe the process for developing a resident's care plan for tube feeding, RN # 2 stated, "Review the physician's orders, and conduct a bedside assessment consult with nursing and speech therapy if necessary." After reviewing Resident # 53's care plan and the physician's orders dated January 2020, RN # 2 stated that the care plan did not address Resident # 53's tube feeding. RN # 2 stated, "A care plan should have been developed for tube feeding."

On 01/30/2020 at approximately 1:33 p.m., ASM # 1, the administrator, ASM # 2, director of nursing, ASM # 3, senior director of operations, and LPN # 4, director of clinical services were made aware of the findings.

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F 656	Continued From page 24 No further information was provided prior to exit.	F 656		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services according to professional standards to maintain a resident's highest level of well-being, resulting in harm for one of 51 residents in the survey sample, Resident #16. The facility staff failed to implement the proper positioning technique while repositioning Resident #16 in bed on 2/14/19. CNA (Certified nursing assistant) #7 repositioned Resident #16 by grabbing both sides of the resident's torso and pulling on the resident. This improper technique resulted in a right shoulder dislocation and a transfer to the emergency room for a dislocation reduction (returning the shoulder to the normal position) under sedation. The findings include: Resident #16 was admitted to the facility on 9/14/18. Resident #16's diagnoses included but	F 684	Past noncompliance: no plan of correction required.	2/17/20

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were not limited to muscle weakness, heart failure and high blood pressure. Resident #16's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/23/19, coded the resident as being cognitively intact. Section G coded Resident #16 as requiring extensive assistance of two or more staff with bed mobility.

Resident #16's quarterly MDS assessment with an ARD of 12/21/18 coded the resident as being cognitively intact. Section G coded Resident #16 as requiring extensive assistance of one staff with bed mobility. Resident #16's comprehensive care plan dated 9/24/18 documented, "(Name of Resident #16) has an ADL (activities of daily living) self-care performance deficit r/t (related to) left BKA (below the knee amputation) and burn wounds to right leg...Interventions: BED MOBILITY: (Name of Resident #16) requires extensive assistance by (1-2) staff to turn and reposition in bed at times and at times is able to turn self with use of quarter side rails..."

Review of Resident #16's clinical record revealed a nurse's note dated 2/14/19 that documented Resident #16 complained of right arm and shoulder pain. The night shift supervisor and physician were notified, a physician order was obtained for an x-ray and the resident was medicated for pain.

A right shoulder x-ray dated 2/14/19 documented an anterior dislocation of the humerus (arm/shoulder). Resident #16 was transferred to the emergency room on 2/14/19.

An emergency room history and physical dated 2/14/19 documented Resident #16's shoulder

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dislocation was reduced under sedation.

A FRI (facility reported incident) form submitted to the state agency on 2/14/19 documented, "Report date: 2/14/19 Incident date: 2/14/19
Describe incident, including location, and action taken:
On 2/14/19 resident (name of Resident #16) complained of pain to her right shoulder. Resident medicated for pain and STAT (immediate) x-ray was completed. At approximately 2:30 pm Director of Nursing, (name), received x-ray results showing the resident had an anterior dislocation of the right humerus. MD (Medical doctor) notified and orders received to send resident to the ER (emergency room). DON (Director of nursing) spoke with resident who stated the night CNA 'pulled' her arm to try to get her back in bed. CNA identified as (name of CNA #7). Employee suspended immediately pending investigation. Local police notified..."

A final FRI report form submitted to the state agency on 2/20/19 documented, "Summary of Investigation:
(Name of Resident #16) is a 62 year old female resident, initially admitted to the Center on 9/14/18. (Name of Resident #16's) medical diagnoses include left BKA amputation, burns to right lower leg, muscle weakness, anemia (a blood disorder), schizophrenia (mental illness), heart failure and chronic obstructive pulmonary disease (lung disease). (Name of Resident #16's) most recent BIMS (brief interview for mental status) (a scale to rate the level of one's cognition) was 14 (on a scale from 0 to 15). (Name of Resident #16) has a low to the floor bed with mats on the floor due to a care planned

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F 684	Continued From page 27 behavior of crawling out of bed on to the floor. On 2/14/19 at approximately 6:55 am CNA (name of another CNA) entered (Name of Resident #16's) room to provide morning care to her. (Name of other CNA) stated that (sic) asked (Name of Resident #16) if she was ready to get up and (name of Resident #16) replied, 'No way.' (Name of other CNA) asked (name of Resident #16) why she did not want to get up and (name of Resident #16) replied, 'My arm is killing me.' (Name of other CNA) asked what happened to her arm and (name of Resident #16) replied, 'it was how the night aide moved me.' (Name of other CNA) informed the nurse, (name of LPN [licensed practical nurse] #12), who medicated (name of Resident #16) with PRN (as needed) Oxycodone (1). (Name of LPN #12) evaluated (name of Resident #16) and notified the physician, who ordered a STAT (immediate) x-ray of the right arm. After receiving the pain medication (name of Resident #16) told (name of LPN #12) she was 'okay.' (Name of other CNA) stated that after (name of Resident #16) received pain medication she requested to get up into the wheelchair. (Name of LPN #12) notified the night shift supervisor, (name) at approximately 7:10 am saying (name of Resident #16) had a complaint about how the night aide 'positioned her.' (Name of ASM [administrative staff member] #2 [the director of nursing]) arrived at the Center at approximately 7:55 am and went to speak with (name of Resident #16). When (name of ASM #2) asked (name of Resident #16) what happened during the night she replied, 'I don't want to talk about it right now.' (Name of Resident #16) denied pain at that time but was observed holding her right arm close to her body. (Name of ASM #2) spoke with the night shift	F 684		

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F 684	Continued From page 28 CNA, (name of CNA #7), regarding what occurred during the night shift with (name of Resident #16). (Name of CNA #7) stated that she pulled the resident up in bed at approximately 1:00 am but that she did not complain of any pain at that time or throughout the night. X-ray of the right shoulder and arm was completed at approximately 12:00 pm. The Director of Nursing received the results at approximately 2:30 pm showing an anterior dislocation of the right humerus. The physician was notified and a new order was received to send the resident to the emergency room for evaluation and treatment. (Name of ASM #2) went to notify (name of Resident #16) of the ordered transfer and speak with her about what occurred. (Name of Resident #16) stated, 'it was the night aide, she pulled me up in bed by my arm.' (Name of Resident #16) stated she was checking on some things in the hallway when the CNA, (name of CNA #7), entered the room and pulled her up in bed by her arm. (Name of Resident #16) stated her roommate was asleep and there was no other employee in the room when this occurred. (Name of ASM #2) notified the local police who responded to the Center and interviewed (name of Resident #16). The police officers asked (name of Resident #16) to explain what occurred during the night shift. (Name of Resident #16) stated the incident occurred around 1:00 am. (Name of Resident #16) stated she was 'checking on somethings (sic) in the hallway,' when the CNA entered the room and 'pulled me up' by her arm. The police officer asked (name of Resident #16) if the CNA was yelling at her or saying bad things to her and (name of Resident #16) replied, 'No, but she wasn't in a good mood.' The police officer then asked (name of Resident #16) if she	F 684		

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felt the CNA had intentionally hurt her and (name of Resident #16) replied, "Intentionally? No.' The police officer then asked (name of Resident #16) if she felt the CNA 'just got her improperly into bed?' and (name of Resident #16) replied, 'Yes.'
On 2/15/19 (name of ASM #2) had an additional interview with (name of CNA #7) regarding the care she provided to (name of Resident #16) during the night of 2/14/19. (Name of CNA #7) stated that at approximately 1:00 am she observed (name of Resident #16's) call light on and she went to the room. Upon entering the room (name of CNA #7) stated she observed (name of Resident #16's) bed very high in the air and she was sitting with her legs dangling near the foot of the bed. (Name of CNA #7) stated that she was concerned (name of Resident #16) was going to fall so she laid her down and then pulled her up in bed by grabbing both sides of her torso. (Name of CNA #7) stated there was no pad or draw sheet underneath (name of Resident #16) to aid in pulling her up in bed. (Name of CNA #7) stated after she positioned the resident in bed and lowered the bed to the floor; (LPN #7) entered the room and provided medication to (name of Resident #16). (Name of CNA #7) stated she checked on (name of Resident #16) every 1.5-2 hours throughout the night and she made no complaints of pain and was observed sleeping during the remainder of the shift.
Based on the completed investigation the Center has determined that (name of Resident #16) obtained a dislocation of the right humerus due to improper positioning technique performed by a CNA.
Corrective Measures Implemented to Prevent Recurrence:
1. (Name of CNA #7) is no longer employed at the Center.

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2. Facility staff re-educated about abuse, neglect, and injuries of unknown origin.
3. Licensed nursing staff re-educated about safe methods to position and reposition residents..."

A witness statement signed by CNA #7 on 2/14/19 documented, "I was assign (sic) to (name of Resident #16). At around 1 AM resident pull (sic) the call light and I went there. I met her at the feet (sic) of the bed and I help (sic) her by putting my hands around her and pull (sic) her up on the bed."

A witness statement signed by CNA #7 on 2/15/19 documented, "When I came on duty I met the resident. Call light was on and I met the resident sitting on the edge of the bed which is by the feet (sic) side and I (blank space) her down on the bed and I put my hands around her body and I pull her up the bed and I position her while I was doing that the nurse went in the room to give her a medication and I also told her that she was trying to hurt herself. She was putting the bed all the way up and the nurse told me that (sic) the same thing she was doing yesterday which was on Tuesday and I put the bed down and I hide (sic) the bed remote so she will not get to it. Still then, I was been (sic) checking on her not complaind (sic) of any pain until when (name of another CNA) came in the morning. She was dress (sic) her. She came and tell (sic) the nurse that the resident complained (sic) that her shoulder is hurting her."

On 1/29/20 at 9:41 a.m., an interview was conducted with Resident #16. Resident #16 was asked to describe the events that occurred in February 2019 when her right shoulder was dislocated. Resident #16 stated, "I forgot what

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happened but I wound up on the floor and an aide came and dragged me by my arm and picked me up and put me back to bed by herself." Resident #16 stated she did not experience pain at that time but later on that same night she was lying in bed and felt pain. Resident #16 stated she told staff something was wrong with her shoulder and the staff obtained an x-ray.

On 1/29/20 at 3:42 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how a resident should be repositioned if he/she was on the edge of the bed at the foot of the bed. LPN #3 stated this depended on the resident. LPN #3 stated she would ask the resident to stand up, move over and sit back down if he/she was ambulatory. LPN #3 stated if the resident required physical assistance, then the staff should call someone to help and use a draw sheet to reposition the resident. LPN #3 stated two staff and a draw sheet should be utilized for a resident who requires physical assistance. LPN #3 was asked if a staff should reach around both sides of a resident and pull them up. LPN #3 stated a staff should not do this because he/she does not want to cause any injury. LPN #3 stated Resident #16 is able to sit up but will call if she needs assistance with positioning. LPN #3 confirmed the assistance of two staff and a draw sheet should be used if Resident #16 is seated at the foot and edge of the bed.

On 1/29/20 at 4:19 p.m., an interview was conducted with CNA #5. CNA #5 stated residents' bed mobility and transfer needs are communicated to CNAs via a kardex. CNA #5 was asked how a resident should be repositioned if he/she was on the edge of the bed at the foot of

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the bed. CNA #5 stated the staff member should call for a co-worker and two people should reposition the resident using a draw sheet. CNA #5 stated, "You don't pull them up. It's a no no no to pull them with their arms. You can dislocate something or injure them in another way." CNA #5 was asked what should be done if the resident does not have a draw sheet under them. CNA #5 stated a staff member should go get a draw sheet because a resident cannot be pulled by his/her arms.

On 1/29/20 at 4:43 p.m., an interview was conducted with ASM #2. ASM #2 was asked to describe the events regarding Resident #16's dislocated right shoulder on 2/14/19. ASM #2 stated she was initially told that Resident #16 reported arm pain so an x-ray was obtained and showed a dislocated shoulder. ASM #2 stated there was no immediate explanation for the cause of the dislocation so Resident #16 was transferred to the hospital and she (ASM #2) began an investigation. ASM #2 stated CNA #7 told her that she entered Resident #16's room and the resident was almost falling off the edge of the bed. ASM #2 stated CNA #7 said she had to get Resident #16 back on the bed and prevent her from falling. ASM #2 stated CNA #7 said there was no pad or draw sheet on the bed and the bed was in a high position so CNA #7 grabbed Resident #16's waist on each side, pulled the resident up then put the bed in a low position and removed the bed remote. ASM #2 stated she asked CNA #7 why she didn't just lower the bed and get help instead of pulling the resident up or tell the resident to sit and yell for someone to help. ASM #2 stated CNA #7 only provided the response that the situation was critical. ASM #2 stated CNA #7 was terminated

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due to the improper positioning technique and because there was inconsistencies in her story. When asked to elaborate, ASM #2 stated CNA #7 said she got Resident #16 repositioned in bed then the nurse came in to administered medications but the nurse said Resident #16 was in a sitting position when she administered medications. ASM #2 stated Resident #16 said the CNA pulled her up in bed and the resident was reliable, alert and oriented. ASM #2 confirmed CNA #7 used an improper positioning technique. When asked what should have been done, ASM #2 stated a resident should be repositioned by two people using a draw sheet, pad or moving device; not by grabbing his/her body and physically moving him/her. ASM #2 was asked if this technique should be used even when a resident is on the edge of the bed. ASM #2 stated CNA #7 could have repositioned the resident's legs back on the bed and get staff to assist or stand with the resident and yell for help. ASM #2 stated she thought there were other ways the CNA could have repositioned Resident #16 without hurting her. ASM #2 was asked for the facility policy or standard of practice regarding positioning. ASM #2 stated she would look and the best practice is to have two people at all times for the safety of the resident and proper body mechanics for the staff.

On 1/29/20 at 5:01 p.m., an interview was conducted with LPN #12 (the nurse caring for Resident #16 during the night shift on 2/14/19). LPN #12 stated that between 12:00 a.m. and 2:00 a.m. she was completing rounds and CNA #7 was in the room with Resident #12 and providing care. LPN #12 stated Resident #16 was lying down on the bed during her observation. LPN #12 stated a couple hours later, at approximately 5:15 a.m.

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or 5:30 a.m., a CNA told her that Resident #16 was complaining of her arm hurting. LPN #12 stated she talked to the resident who told her that her right arm and shoulder was hurting so she administered pain medication to the resident and notified the supervisor. LPN #12 stated someone else notified the physician and obtained an x-ray.

On 1/29/20 at 5:10 p.m., another interview was conducted with ASM #2. ASM #2 stated she could not access Resident #16's kardex from February 2019 (because the kardex is updated when the resident's condition changes) and the facility did not have a policy or standard of practice (from Lippincott) regarding positioning.

On 1/29/20 at 5:39 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern and the concern for harm.

On 1/30/20 at 10:18 a.m., an interview was conducted with OSM (other staff member) #7 (the rehab director). OSM #7 was asked how a resident should be repositioned if he/she was on the edge of the bed at the foot of the bed. OSM #7 stated if the resident has any lower extremity strength then staff could help the resident scoot to the head of the bed and assist the resident with lying down but this depended on the resident's needs. OSM #7 was asked if a staff member should put his/her hands on each side of a resident's torso and pull the resident up. OSM #7 stated staff should use a transfer gait belt or just guide the resident with contact guard by placing his/her hands on the resident's torso. OSM #7 stated she would not grab a resident up by under the resident's arms and confirmed this is not a preferred or proper technique.

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F 684	Continued From page 35 Review of an employee corrective action form revealed CNA #7 was terminated on 2/21/19. Review of education in-service attendance records revealed nursing staff was educated regarding resident positioning from 2/15/19 through 2/17/19. Education of the nursing staff was verified via multiple interviews during the survey. No other concerns regarding positioning were identified during the survey. No further information was presented prior to exit. PAST NON-COMPLIANCE REFERENCE: (1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/007285.htm	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to safely transfer on one 51 residents in the survey sample, Resident #10. During observation of a transfer of Resident #10 by Hoyer lift on	F 689	1. Resident #10 is now being transferred in a safe manner. CNA #1 and #2 were re-educated about safety procedures when operating a mechanical lift. 2. Interdisciplinary Team (IDT) will identify residents who use mechanical lift for	3/9/20

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F 689

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1/29/2020, the facility staff failed to prevent Resident #10's toes from bumping the wall multiple times, and failed to lock the wheelchair.

The findings include:

Resident #10 was admitted to the facility on 4/3/15; and most recently readmitted on 7/5/17, with diagnoses including, but not limited to: history of a stroke, dysfunctional bladder, diabetes (1), spinal stenosis (2), and peripheral neuropathy (3). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 11/7/19, Resident #10 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having no impairment for understanding others or for being understood by others. He was coded as requiring the extensive assistance of two staff for bed mobility, and as being completely dependent on the assistance of two staff for transfers. He was coded as never walking. He was coded as needing a wheelchair for mobility.

On 1/29/2020 at 1:35 p.m., two CNAs (certified nursing assistants) (CNAs #1 and #2) were observed using a Hoyer (mechanical) lift to transfer Resident #10 from the bed into a wheelchair. During the transfer, while the resident was in the lift sling at its highest point, Resident #10's toes on both the right and left feet bumped the wall multiple times. While the CNA#2 was lowering the resident into the wheelchair by using the lift, CNA #1 tilted the unlocked wheelchair back onto the two big wheels in an effort to accommodate the resident's preference to not be sitting straight up when his buttocks made

F 689

transfers by 2/1/20. Current residents who use the mechanical lift will have skin integrity assessments to identify any injuries that may be related to lift transfers. Follow up based on findings.

3. DON/designee will re-educate Nursing staff by 3/9/20 in regard to the appropriate steps to safely transfer residents with the mechanical lift. Nursing staff will complete return demonstration.

4. DON/designee to conduct Quality Monitoring Review of 5 mechanical lift transfers daily for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, to ensure safe practices are maintained. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.

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contact with the wheelchair.

A review of Resident #10's comprehensive care plan, dated 11/12/18 and most recently updated 1/2/2020, revealed, in part: "TRANSFER: [Resident #10] requires Mechanical Hoyer Lift with 2 staff assistance for transfers."

On 1/29/2020 at 2:01 p.m., CNA #1 was asked if she locked the wheelchair prior to assisting the resident into it from the Hoyer lift. She stated, "I thought I did. Maybe I didn't, but I thought I did." When asked if the wheelchair should be locked during a transfer, CNA #1 stated, "Sometimes when we are trying to lean it back, we can't lock it." When asked if it is safe to transfer a resident into an unlocked wheelchair that is tipped back on two wheels, she stated it was not safe. When asked if she was aware, Resident #10's toes had bumped the wall while he was in the air, she stated she was not.

On 1/29/2020 at 2:05 p.m., CNA #2 was interviewed. When asked if he knew whether or not the wheelchair had been locked during the transfer, he stated he did not know for sure. CNA #2 stated, "It should always be locked." When asked if he was aware that Resident #10's toes had bumped the wall while he was in the air, CNA #2 stated, "No." When asked if it was safe for the resident's toes to bump the wall during the transfer, CNA stated, "No, it was not."

On 1/29/2020 at 4:22 p.m., Resident #10 was interviewed regarding the above transfer. Resident #10 stated, "I don't think the wheelchair was locked. Was it locked? It did not feel like it was locked." Resident #10 also stated his toes bumped against the wall multiple times, and

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caused him pain. He stated he has repeatedly asked the staff to be particularly careful with his toes because of the pain, and his diabetic neuropathy. He stated he had not required additional pain medication because of the bumped toes.

On 1/29/2020 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were informed of these concerns.

On 1/30/2020 at 10:12 a.m., LPN (licensed practical nurse) #6, the unit manager, was interviewed. He stated it is not acceptable to bump the resident's toes against the wall during a transfer. LPN #6 stated, "That is absolutely not a safe transfer." He stated not locking the wheelchair is "very dangerous," as it can cause an injury.

On 1/30/2020 at 11:16 a.m., ASM #2 was interviewed. When asked if it is safe to transfer a resident using a Hoyer lift into an unlocked wheelchair that has been tipped back on the back two wheels, ASM #2 stated it is not. When asked if it was safe to have bumped the resident's toes on the wall during the transfer, ASM #2 stated, "His toes are a big point. He has diabetes and neuropathy. No, they should not have hit the wall." She stated one of the reasons two people are required to transfer a resident using a mechanical lift is so that one staff member can operate the lift, and the other staff member can support the resident's body, and assist with safe positioning.

A review of the facility policy, "Lifting and Moving Residents," revealed, in part: "Use of a

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F 689	Continued From page 39 mechanical lift to transfer a resident who cannot stand from the bed to the wheelchair...Position the wheelchair with enough space to maneuver the lift and set the brakes...Raise the lifting bar with the resident in the sling straps so that the body clears the bed. It is necessary to support the resident's head until or she has reached a 45 degree angle or sitting position, unless he or she has full neck control." No further information was provided prior to exit. COMPLAINT DEFICIENCY (1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (2) "Your spine, or backbone, protects your spinal cord and allows you to stand and bend. Spinal stenosis causes narrowing in your spine. The narrowing puts pressure on your nerves and spinal cord and can cause pain." This information is taken from the website https://medlineplus.gov/spinalstenosis.html. (3) "Peripheral nerves carry information to and from the brain. They also carry signals to and from the spinal cord to the rest of the body. Peripheral neuropathy means these nerves don't work properly. Peripheral neuropathy may occur because of damage to a single nerve or a group of nerves. It may also affect nerves in the whole body." This information is taken from the website https://medlineplus.gov/ency/article/000593.htm.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		3/9/20

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§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 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, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for two of 51 residents in the survey sample, Residents #46 and #82. The facility staff failed to assess Resident #46 for the risk of entrapment prior to the use of bed rails. The facility staff failed to evidence Resident #82, was assessed for the use of bed rails, failed to evidence a review of the risks and benefits for the use of bed rails and consent was obtained prior to use and failed to obtain a physician's order prior to the use of bed rails.

1. Resident #46 had a complete Bed Rail Evaluation completed. Bed safety evaluation completed 01/30/20. Resident #82 had a complete Bed Rail Evaluation completed on 1/30/20; physician’s order for bed rails, and consent obtained on 1/30/20. Bed safety evaluation was completed by Maintenance Director on 01/30/20.

2. Current residents with side rails were reviewed by IDT on 2/3/20 to identify those without the bed rail evaluation, consents and bed safety evaluations.

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The findings include:

1. Resident #46 was admitted to the facility on 10/7/11. Resident #46's diagnoses included but were not limited to seizures, paralysis and muscle weakness. Resident #46's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/6/19, coded the resident's cognition as severely impaired. Section G coded Resident #46 as requiring extensive assistance of two or more staff with bed mobility.

Review of Resident #46's clinical record revealed a physician's order dated 9/2/17 that documented an order for quarter side rails (bed rails) for positioning and mobility.

Resident #46's comprehensive care plan dated 10/31/18 documented, "(Name of Resident #46) has an ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia and history of TBI (traumatic brain injury) and Hemiplegia (paralysis)...Interventions: SIDE RAILS: 1/4 rails to assist with bed mobility & positioning..."

Further review of Resident #46's clinical record revealed an evaluation for use of bed rails dated 1/21/20 that documented the use of bed rails was considered due to safety and family request. However, the evaluation failed to document an assessment for the risk of entrapment. The form further documented the question, "Could the use of bed rails create an accident hazard or barrier for this resident? (Could this resident attempt to climb over, around or between the rails, exit the bed in an unsafe manner or be at-risk for getting

F 700

Evaluations and consents (including discussion of risks and benefits) will be obtained/completed by Unit Managers for those residents, as indicated, by 3/9/20.

3. DON/designee will re-educate Nursing staff by 3/9/20 in regard to side rail use, evaluations, consent, risks, and how to discuss process with families and residents requesting bed rails. New residents will be evaluated by Nursing and Rehab staff to determine need and consideration of alternative devices or assistance. Maintenance will conduct bed safety evaluations on beds of residents with side rails, when rails are added and when beds or mattresses are changed out on those beds, then report findings to Nursing. Nursing will alert Maintenance, as residents with side rails are discharged, to remove rails before a new admission is admitted to the bed. Rail removal will be verified during Morning Meeting. Nursing will verify in Clinical Morning Meeting that residents with new orders for side rails have completed evaluations and consents. Nursing will also verify that alternatives were considered/tried and documented.

4. DON/designee will conduct Quality Monitoring Review of 10 residents weekly for 4 weeks, then monthly for 3 months, to verify appropriate evaluation, consents and orders have been completed for bed rails. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.

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caught between the rails or the rails and the mattress, etc)." This section of the evaluation was blank. (Note: Resident #46's representative consented to the use of bed rails on 1/21/20).

On 1/29/20 at 8:22 a.m., Resident #46 was observed in bed with bilateral quarter bed rails up.

On 1/30/20 at 7:45 a.m., ASM (administrative staff member) #2 (the director of nursing) presented a bed rail four point plan. The plan documented the Center had residents with bed rails without proper evaluation and consent. The plan documented corrective steps the facility would take to ensure proper evaluations and consents. The plan was currently being implemented and was not due to be completed until 3/1/20.

On 1/30/20 at 9:50 a.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding bed rail assessments. LPN #6 stated bed rail assessments consist of an assessment as to whether a resident requires bed rails for bed mobility and transfers. LPN #6 was unable to explain the process for assessing residents for the risk of entrapment. LPN #6 stated all residents are at risk for entrapment and if he were going to assess for the risk of entrapment then he would assess the resident's cognition because residents with cognitive impairment have a higher risk.

On 1/30/20 at 10:29 a.m., an interview was conducted with ASM #2. ASM #2 was asked about the facility process for bed rail assessments. ASM #2 stated each resident should be assessed on admission and then quarterly and with any change. ASM #2 stated

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the facility uses a form (the evaluation for use of bed rails) that has changed a couple of times in the past three months. ASM #2 stated the form directs staff to assess for sleeping habits, bed mobility, transfer mobility, cognition, vision, continence and history of falls. ASM #2 stated the form also directs staff to assess the need for bed rails and guides staff to figure out if the bed rails serve a functional purpose, a safety purpose or pose more of a risk. When asked if the residents should be assessed for the risk of entrapment, ASM #2 stated, "Yes. You look at the patient as a whole and the entrapment zones, and the measurements and what is the recommended amount of space that can be in those zones." ASM #2 stated part of the bed rail four-point plan consisted of a form to assess entrapment zones; however, the plan was ongoing, and the assessments had not yet been completed.

On 1/30/20 at 1:43 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2, ASM #3 (the senior director of operations) and ASM #4 (the regional director of clinical services) were made aware of the above concern.

The facility policy titled, "Side Rail/Bed Rail" documented,
"1. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment..."

No further information was presented prior to exit.

2. Resident #82 was admitted to the facility 01/04/2018 with a readmission on 01/02/2020 with diagnoses, that included but were not limited to pneumonia (1) and sepsis (2). Resident #82's

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most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/11/20, coded Resident #82 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident #82 was coded as requiring extensive assistance of one staff member for bed mobility.

An observation on 1/28/20 at 7:30 p.m. revealed Resident #82 in bed with bilateral upper quarter bed rails on the bed. When asked about the bed rails, Resident #82 stated that he used them to grab on to turn in bed and position himself. When asked if the facility staff reviewed the risks and benefits of using bed rails and had him sign anything regarding the bed rails Resident #82 stated he did not think so, but he liked having them on the bed and would sign something if needed.

An additional observation on 1/29/20 at 8:40 a.m. revealed the same observation as stated above.

The comprehensive care plan for Resident #82 documented, "[name of Resident #82] has an ADL (activities of daily living) self-care performance deficit r/t (related to) fatigue, impaired balance, limited mobility, limited ROM (range of motion) Date Initiated: 1/25/20. Revision on 1/25/20." Under "Interventions", it is documented, "Bed Mobility: The resident uses upper bed rails to maximize independence with turning and repositioning in bed. Date Initiated: 01/25/2020."

On 1/29/20 at approximately 5:40 p.m., a request was made to ASM (administrative staff member) #2 the director of nursing for required

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documentation for the use of side rails including risk of entrapment, current physician order and consent for bedrails for Resident #82.

On 1/30/20 at 7:45 a.m., ASM #2 presented a bed rail four-point plan. The plan documented the facility had residents with bed rails without proper evaluation and consent. The plan documented corrective steps the facility would take to ensure proper evaluations and consents. The plan was in progress was not due to be completed until 3/1/20.

On 1/30/20 at 9:45 a.m., an interview was conducted with RN (registered nurse) #3, the unit manager. When asked if residents are assessed for the use of bed rails, RN #3 stated that any resident with bed rails were assessed for the use of them. When asked when residents are assessed for the use of bed rails, RN #3 stated that they are assessed on admission, prior to having side rails and reassessed quarterly as needed. RN #3 stated that each resident is assessed individually, for the reason why the resident needs the bed rails. RN #3 stated that not all residents require bed rails, some use them for positioning, some for safety and some at their request. RN #3 stated that if a resident required bed rails the evaluation is completed which includes the reasons why they are using them, alternatives to bed rails and a risk assessment. RN #3 stated that in addition to the bed rail assessment, a physician order and a consent for bed rail use is obtained. RN #3 stated that the care plan is also updated to reflect the use of bed rails. When asked about the bed rails for Resident #82, RN #3 stated that the assessment had been completed that day.

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On 1/30/20 at 10:29 a.m., an interview was conducted with ASM #2. ASM #2 was asked the facility process for bed rail assessments. ASM #2 stated that each resident should be assessed on admission, quarterly and with any change in status. ASM #2 stated the facility uses a form (the evaluation for use of bed rails) that has changed a couple of times in the past three months. ASM #2 stated the form directs staff to assess for sleeping habits, bed mobility, transfer mobility, cognition, vision, continence and history of falls. ASM #2 stated the form also directs staff to assess for the need for bed rails and guides staff to figure out if the bed rails serve a functional purpose, a safety purpose or pose more of a risk. ASM #2 stated part of the bed rail four-point plan consisted of a form to assess entrapment zones; however, the plan was ongoing and the assessments had not yet been completed.

On 1/30/20 at approximately 12:45 p.m., ASM #2 provided the following documents for Resident #82:
-A telephone order dated "1/30/2020 0900 (9:00 a.m.)" which documented "Quarter side rails for bed mobility and positioning."
-"Evaluation for use of Bed Rails" dated "1/30/2020" which documented in part "Quarter side rails for bed mobility."
-"Informed Consent for use of Bed Rails" dated "1/30/2020."

The facility policy "Side Rail/Bed Rail" dated "Effective Date: 04/19/2018" documented in part, "Procedure: 1. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment.
2. Review the risk and benefits with the resident

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and/or resident representative.
3. Obtain consent from the resident and/or resident representative.
4. Obtain physician order for side rail/bed rail ..."

On 1/30/20 at approximately 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the senior director of operations and ASM #4, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

1. Pneumonia is an infection in one or both of the lungs. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.

2. Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

F 757 SS=E — Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) — F 757 — 3/9/20

§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

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F 757	Continued From page 48 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure the medication regimen was free from unnecessary medication for two of 51 sampled residents, Resident #37 and # 87. The facility staff failed attempt non-pharmacological interventions prior to the administration of the prn (as needed) pain medication, Ibuprofen to Resident # 37 and prior to the administration of the as needed pain medication, Oxycodone for to Resident # 87. The findings include: 1. The facility staff failed attempt non-pharmacological interventions prior to the administration of prn pain medication of Ibuprofen to Resident # 37. Resident # 37 was admitted to the facility with diagnoses that included but were not limited to: muscle spasms and arthritis. Resident # 37's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/03/19, coded Resident # 37 as	F 757	1. Resident #37 had pain evaluation completed, pain medication scheduled, non-pharmacological interventions identified, and care plan updated. Resident #87 had pain evaluation completed, non-pharmacological interventions identified, and care plan updated. 2. Current residents in the Center on PRN pain medications were reviewed by IDT on 2/8/20, to ensure non-pharmacological interventions are identified and care planned. Pain level, location of pain, and non-pharmacological interventions tried will be documented on residents who receive PRN medications. 3. DON/designee will re-educate Licensed Nursing staff by 3/9/20 about documenting pain evaluation, including location, intensity, and duration of pain. DON/designee will re-educate Licensed Nursing staff by 3/9/20 about identifying and offering non-pharmacological	

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scoring an 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 37 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 37 as having severe pain frequently.

The POS [physician's order sheet] dated January 2020 for Resident # 37 documented, "Ibuprofen 600MG [milligrams] Tablet. 1 [one] tab [tablet] by mouth every 8 [eight] hours as needed for pain. Date: 09/06/2019."

The MAR [medication administration record] for Resident # 37, dated "January 2020" documented the physician's order as above. Review of the MAR revealed Resident # 37 received Ibuprofen on 01/01/2020 through 01/07/2020, 01/09/2020, 01/10/2020, 01/13/2020, 01/14/2020, 01/15/2020, and 01/16/2020, 01/18/2020, 01/19/2020 and on 01/20/2020 at 5:00 p.m. each day. Further review of the MAR failed evidence documentation of non-pharmacological interventions.

The comprehensive care plan with a revision date of 09/17/2019 for Resident # 37 documented in part, "Focus: The resident has pain r/t [related to] arthritis, muscle spasm. Revision on: 09/17/2019." Under "Interventions" it documented, "Monitor/record pain." "Characteristics q [every] shift and PRN [as needed]: Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset: Duration (e.g. continuous, intermittent); Aggravating factors; Relieving factors.. Date Initiated: 09/17/2019."

interventions for pain prior to providing medication, and documenting the administration and effectiveness of non-pharmacological and pharmacological interventions for pain.

4. DON/designee will conduct Quality Monitoring Review daily for 2 weeks, weekly for 4 weeks, then monthly for 3 months, to ensure non-pharmacological interventions for pain are offered and documented prior to administering PRN pain medication. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.

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The facility's nurse's notes dated 01/01/2020 through 01/28/2020 failed to evidence documentation of non-pharmacological interventions prior to the administration of Ibuprofen for the above dates and times.

On 01/29/2020 at approximately 1:40 p.m., an interview was conducted with Resident # 37. When asked if the staff attempt to alleviate the pain before administering pain medication Resident # 37 stated no, they just give me the pain medication.

On 01/29/20 at 5:15 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked how they interpreted the statement "Relieving factors" as part of Resident # 37's interventions for their pain care plan ASM # 2 stated, "I take it to mean both pharmacological and non-pharmacological interventions."

On 01/29/20 at 4:17 p.m., an interview was conducted with RN [registered nurse] # 3, unit manager. When asked to describe the procedure for administering prn pain medication when a resident requests it RN # 3 stated, "Assess the pain, site, the intensity of the pain using a scale of zero to ten if the resident is verbal, zero means no pain and ten the worse pain. Offer some non-pharmacological interventions, if they don't work, check the physician's orders for the prescription of prn pain medication, follow up assessment to determine the effectiveness of the medication 30 min to an hour after giving the medication." When asked where they would document the attempt of non-pharmacological interventions RN # 3 stated, "It would document

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on the back of the MAR or the nurse's notes." After reviewing nurse's notes for Resident # 37 and the resident's MAR for January 2020, RN # 3 stated that there was no documentation of non-pharmacological interventions. When asked if the staff attempted non-pharmacological interventions for Resident # 37 prior to administering the as needed pain medication ibuprofen, RN # 3 stated no.

On 01/30/2020 at approximately 1:33 p.m., ASM # 1, the administrator, ASM # 2, director of nursing, ASM # 3, director of operations, and LPN # 4, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Prescription ibuprofen is used to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis (arthritis caused by a breakdown of the lining of the joints) and rheumatoid arthritis (arthritis caused by swelling of the lining of the joints). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682159.html.

2. Resident #87 was admitted to the facility on 12/12/2019 with diagnoses that included but were not limited to sepsis (1) and diabetes mellitus (2).

Resident #87's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/21/2019, coded Resident #87, as scoring a 15 on the staff assessment for mental status (BIMS) of a score

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of 0 - 15, 15- being cognitively intact for making daily decisions. Section J coded Resident #87 as having pain almost constantly.

The POS (physicians order sheet) dated "December 12, 2019" for Resident #87 documented the following as needed orders for pain medication:
- "Oxycodone Immediate 5mg (milligram) tablet 1 (one) tab (tablet) by mouth every 4 (four) hours as needed for pain mild for 7 (seven) days. 12/12/19."

The POS dated "January 2020" for Resident #87 documented the following as needed orders for pain medication:
- "Oxycodone 10mg 1 (one) tab (tablet) po (by mouth) q (every) 4 (four) hrs (hours) as needed pain."

On 1/29/20 at approximately 8:45 a.m., an interview was conducted with Resident #87. When asked about pain, Resident #87 stated that he has pain frequently due to the recent below the knee amputation (3) and the wound he has on the surgical incision to the area. Resident #87 stated that he takes scheduled pain medication to help to control the pain, which is working well for him but he takes as needed pain medication also. When asked if the staff assess his pain Resident #87 stated that the staff ask him to rate his pain on a one to ten scale before he takes the as needed pain medication. When ask if staff attempt non-pharmacological interventions prior to administering as needed pain medication, Resident #87 stated that they just give him the medication when he needs it.

The comprehensive care plan for Resident #87

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documented, "[Name of Resident #87] has pain r/t (related to) right TTA (transtibial amputation) (below the knee) Date Initiated: 01/02/2020; Revision on 01/02/2020." Under "Interventions" it documented, "Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Date Initiated 01/02/2020."

The MAR (medication administration record) dated "December 2019" documented, "12/12/19; Oxycodone Immediate 5mg (milligram) tablet 1 (one) tab (tablet) by mouth every 4 (four) hours as needed for pain mild for 7 (seven) days." Review of the MAR revealed that Oxycodone 5mg was administered on the following dates and times: On 12/23/19 at 12:50 a.m. and on 12/24/19 at 8:00 a.m.

The MAR (medication administration record) dated "01/01/20-01/31/20" documented "Oxycodone 10mg 1 (one) tab (tablet) po (by mouth) q (every) 4 (four) hrs (hours) as needed pain." Review of the MAR revealed that Oxycodone 10mg was administered on the following dates and times: on 1/2/20 at 8:45 p.m. and on 1/5/20 at 9:30 p.m.

The MAR notes failed to evidence documentation of non-pharmacological interventions prior to the administration of the as needed Oxycodone for the dates and time documented above.

The nurse's progress notes for Resident #87 failed to evidence documentation of non-pharmacological interventions prior to the administration of the as needed Oxycodone for the dates documented above.

On 1/20/20 at 9:45 a.m., an interview was

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conducted with RN (registered nurse) #3, the unit manager. When asked about the process for as needed pain medication administration to residents, RN #3 stated that a pain assessment is completed on the resident. RN #3 stated that non-pharmacological interventions are attempted prior to administration of as needed pain medications to see if they are effective in relieving the pain. RN #3 stated that if the non-pharmacological interventions do not relieve the pain, the physician orders are confirmed and the as needed pain medication is administered and is followed up with a reassessment to assess if the medication was effective or not. When asked if the non-pharmacological interventions attempted, or provided, are documented, RN #3 stated that the pain assessment is documented on the MAR and non-pharmacological interventions may be documented in the progress notes. RN #3 stated that non-pharmacological interventions are attempted for all residents prior to as needed pain medication administration.

On 1/30/20 at 11:35 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked about the process staff follows for the administration of needed pain medication to residents, ASM #2 stated that staff complete the pain assessment and attempt non-pharmacological interventions prior to administering the as needed pain medications. ASM #2 stated that if the non-pharmacological interventions do not relieve the pain the as needed pain medication is administered and a reassessment is performed to assess the effectiveness of the medication. When asked if the non-pharmacological interventions attempted or provided are documented, ASM #2 stated that

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the MAR is set up with the pain assessment but does not have an area specifically for documentation of non-pharmacological interventions currently. ASM #2 reviewed the MAR's dated December 2019 and January 2020 for Resident #87 and agreed that there was no documentation of non-pharmacological interventions prior to the administration of the as needed pain medications on 12/23/19, 12/24/19, 1/2/20 and 1/5/20. ASM #2 stated that she would review the progress notes to see if any non-pharmacological interventions were documented there.

On 1/30/20 at 12:35 p.m., ASM #2 stated that she had reviewed the progress notes for Resident #87 and they did not contain any documentation of non-pharmacological interventions prior to the administration of the as needed pain medication on 12/23/19, 12/24/19, 1/2/20 and 1/5/20.

The facility policy "Pain Management Guideline, Effective Date: 11/30/2014" documented in part, "The center strives to improve patient/resident comfort and minimize pain in order to help a resident attain or maintain his or her highest practicable level of well-being ...Treatment: Develop patient centered interventions (pharmacologic and non-pharmacologic) to manage pain. Document the interventions on the care plan."

On 1/30/20 at approximately 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the senior director of operations and ASM #4, the regional director of clinical services were made aware of the findings.

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F 757	Continued From page 56 No further information was provided prior to exit. Reference: 1. Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm. 2. Diabetes is a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 3. Below the knee amputation- Leg or foot amputation is the removal of a leg, foot or toes from the body. These body parts are called extremities. Amputations are done either by surgery or they occur by accident or trauma to the body.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		3/9/20

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F 761	Continued From page 57 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to failed to store medications with a visible manufacturer expiration date in one of three medication carts observed, second floor medication cart The findings include: On 1/30/20 at 11:15 a.m., an observation was made of the medication cart located on the second floor medication cart with LPN #10. Observation of the medication cart revealed a bottle of 100 tablets of Senna (medication used as stool softener) 8.6mg (milligram) approximately one-quarter full. Further observation revealed the bottle did not contain a manufacturer's expiration date. When asked about the bottle LPN #10 confirmed that she did not see an expiration date on the bottle. LPN #10 stated that she had not used that medication during her medication pass. LPN #10 stated that she had opened another new bottle of Senna that morning and used that one during her medication	F 761	1. LPN #10 discarded the bottle of Senna that did not have an expiration date present. LPN #10 was re-educated about discarding any medications that do not have a visible expiration date. 2. DON reviewed remaining 4 medication carts on 1/30/20 to ensure no additional items were present without an expiration date. No further issues identified. 3. Director of Nursing, or designee, to re-educate Licensed Nursing staff by 3/9/20, regarding ensuring all medications have a visible expiration date and discarding any medications immediately that do not have a visible expiration date. 4. Director of Nursing, or designee, to conduct Quality Monitoring Review of medication carts weekly for 4 weeks, then monthly, for 3 months, to ensure all medications have a visible expiration date. The DON will report findings to the QAPI	

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F 761	Continued From page 58 pass and proceeded to produce an opened bottle of Senna from the medication cart with a manufacturer's expiration date on the bottle. LPN #10 stated that she thought that the expiration date had been rubbed off from handling the bottle and that it should be discarded. LPN #10 stated that it could not be determined when the expiration date of the medication was by looking at the bottle and that it was available for use on the medication cart. LPN #10 took the bottle to be discarded. The facility policy "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, Effective Date: 12/01/07" documented in part, "4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier ..." On 1/30/20 at approximately 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the senior director of operations and ASM #4, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 761	Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		3/9/20

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F 812	Continued From page 59 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to serve and store food in a sanitary manner. The findings include: 1. The facility failed to fully dry and store cookware in a sanitary manner in the kitchen and dispose of refrigerated food items past their expiration date in the facility kitchen stand up refrigerator. On 1/28/20 at approximately 6:10 p.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #4, the dietary manager. Observation of the kitchen revealed a double door stand up refrigerator, which contained two five-pound containers of cottage cheese. One five-pound container of cottage cheese was observed opened with the date	F 812	1. Dietary Manager discarded the 2 containers of expired cottage cheese. Dietary Manager rewashed steam tray pans and allowed pans to be air dried. OSM #4 and OSM #5 were re-educated regarding ensuring hair restraints are worn when serving food. 2. Dietary Manager inspected food storage areas in Kitchen to ensure no items were expired. Identified issues addressed. Dietary Manager inspected dish drying areas to ensure no pans/pots were stacked while still drying. Identified issues addressed. Executive Director inspected meal service to ensure Dietary staff had hair restraints present and covering hair. Identified issues addressed. 3. HCSG Operations Director/designee	

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F 812	Continued From page 60 "12-24" written on the top lid. OSM #4 stated that the "12-24" meant that the container had been opened on 12/24/19. Observation of the container revealed it was approximately one-half full and labeled by the manufacturer with "Best if used by 1/25/20." The other container was observed unopened and labeled by the manufacturer with "Best if used by 1/25/20." When asked about the process the facility staff follows in regards to manufacturer dates, OSM #4 stated that they follow the manufacturer best used by dates and discard items past that date. OSM #4 discarded the two containers of cottage cheese. OSM #4 stated that when items are opened they are dated and are good for 30 (thirty) days or the manufacturer's expiration dates whichever comes first. Further observation of the kitchen revealed four silver steam tray pans stacked inside of each other located on a four shelf metal rack in the kitchen. When asked about the pans, OSM #4 stated that they were clean, dry and available for use. Further observation of the pans revealed that the two pans stacked in the center of the four pans contained water droplets on the insides of the pans. When asked about the water inside of the pans, OSM #4 stated that the pans should be separated until they were completely dried before stacking. On 1/29/20 at 4:00 p.m., an interview was conducted with OSM #4. When asked about the two containers of cottage cheese with the "best if used by 1/25/20" date on them OSM #4 stated that they should have been discarded on 1/25/20. When asked about the process for cleaning and storage of cookware, OSM #4 stated that all cookware is washed, dried completely and then	F 812	will re-educate Dietary Manager and Dietary staff by 3/9/20 in regard to expired food items, drying of dishes, and proper usage of hair restraints. 4. ED/designee will conduct Quality Monitoring Review of food storage, expiration dates, and dish drying area to ensure no expired items are present and pots/pans are dried appropriately; and review use of hair restraints by Dietary staff, daily for 2 weeks, then weekly for 4 weeks, then monthly, for 3 months, to ensure compliance. The ED will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	

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stacked for storage. OSM #4 stated that pots and pans are not to be stacked wet for infection control purposes.

On 1/29/20 at 4:00 p.m., a request was made to OSM #4 for the facility policy for storage of refrigerated foods, and storage of cookware.

The facility policy "Food Storage: Cold Foods, Revised 9/2017" documented in part, "Food Storage and Retention Guide, Time/Temperature Control for Safety Foods (TCS) - Foods that requires time/temperature control for safety to limit pathogenic microorganism growth or toxin formation ...Items: Cheese, Cottage or Ricotta (opened) - Refrigerator at [symbol for less than or equal to] 41o (degrees) F (Fahrenheit) - 1 (one) week."

The facility policy "Warewashing, Revised 9/2017" documented in part, "4. All dishware will be air dried and properly stored."

Federal food code: 4-901.11 Equipment and Utensils, Air-Drying Required.
Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.

2. The facility staff failed to distribute food in a sanitary manner in the dining room of the facility.

On 1/29/20 at 12:00 p.m., an observation was made of the lunch service from the steam table in

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the dining room in the facility. At approximately 12:05 p.m. OSM (other staff member) #4, dietary manager was observed plating the meals for the 20 residents seated in the dining room with OSM #5, dietary aide. During the plating of the meals for the residents, observation of the beard guard worn by OSM #4, revealed it was pulled down around his neck with the beard and mustache exposed. During the plating of the meals for the residents, the beard guard worn by OSM #5 was located covering the beard with the mustache exposed.

On 1/29/20 at 4:00 p.m., an interview was conducted with OSM #4, the dietary manager regarding how hair restraints are worn. OSM #4 stated all hair is covered including beards and mustaches. When asked about the dining room food service observed on 1/29/20 at 12:00 p.m., OSM #4 stated that his beard cover must have fallen down and he did not notice it to pull it back up. OSM #4 stated that he did not notice that OSM #5's mustache was uncovered or he would have asked him to pull it up. OSM #4 stated that OSM #5 is still new at the facility and probably did not feel comfortable speaking up to remind him to pull his beard guard up during the service but all staff are trained to remind each other to wear their hair restraints and beard/mustache covers. OSM #4 stated that the staff always wear beard guards and hair restraints when serving food in the dining room that he just forgot to pull it up during the service after it had slipped down. OSM #4 stated that the elastic in the beard guards stretch out frequently causing them to fall down and they change them frequently due to this issue.

On 1/29/20 at 4:00 p.m., a request was made to

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F 812	Continued From page 63 OSM #4 for the facility policy for use of hair/beard restraints. On 1/30/20 at approximately 7:30 a.m., OSM #4 provided a document, which stated, "All hair must be completely covered. It does not matter if it's on your head or on your face (mustache or beard)." The 2009 Food and Drug Administration Food Code documents: - "2-4 HYGIENIC PRACTICES Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		3/9/20

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§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or

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(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 51 residents in the survey sample, Resident #39. The facility staff failed to document a complete pain assessment and attempted non-pharmacological interventions when prn (as needed) pain medication was administered to Resident #39 on multiple dates in January 2020.

The findings include:

Resident #39 was admitted to the facility on 9/20/18. Resident #39's diagnoses included but were not limited to paralysis, muscle weakness and major depressive disorder. Resident #39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/4/19, coded the resident as being cognitively intact. Section J coded Resident #39 as reporting almost constant pain rated, as a six,

Provider's Plan of Correction:

1. LPN #3 was re-educated by the DON on 2/2/20 regarding documenting a complete and accurate pain assessment, including the quality and severity of pain, and offering non-pharmacological interventions.

2. Current residents receiving PRN pain medications were reviewed by the IDT on 2/8/20 to ensure there were complete pain assessments documented prior to the administration of pain medication. Follow up based on findings.

3. DON/designee will re-educate Licensed Nursing staff by 3/9/20, regarding documenting a complete pain assessment, including pain location, severity, quality and non-pharmacological interventions prior to administering a PRN pain medication.

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F 842	Continued From page 66 on a scale from zero to ten. Resident #39's comprehensive care plan dated 10/12/18 documented, "(Name of Resident #39) has acute pain r/t (related to) osteoarthritis, Hemorrhoids...Interventions: Attempt non-pharmacological interventions to include: changing positions, cool compresses, warm compresses, extra blankets for warmth or adjust temperature of environment, diversional activities, etc. Monitor/record pain characteristics Q (every) shift and PRN (as needed): Quality; Severity; anatomical location..." Review of Resident #39's clinical record revealed a physician's order dated 12/20/19 for oxycodone (1) 5 mg (milligrams) - one tablet by mouth every 12 hours PRN. Review of Resident #39's January 2020 MAR (medication administration record) revealed the resident received PRN oxycodone on the following dates: -1/5/20-1/10/20 -1/13/20-1/14/20 -1/16/20 -1/18/20-1/24/20 -1/27/20-1/29/20 Further review of Resident #39's clinical record, including the January 2020 MAR and nurses' notes) failed to reveal the resident's pain quality and severity was assessed prior to the administration of PRN oxycodone on all the above dates. The review failed to reveal non-pharmacological interventions were offered prior to the administration of PRN oxycodone on all the above dates. The review further failed to reveal the anatomical location of the pain that was assessed on all the above dates from 1/13/20 through 1/29/20.	F 842	4. DON/designee will conduct Quality Monitoring Review of residents who received PRN pain medication to ensure a complete pain assessment is present and that non-pharmacological interventions were offered prior to the administration of PRN pain medication, daily for 2 weeks, weekly for 4 weeks, then monthly, for 3 months. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	

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Multiple attempts to interview Resident #39 were conducted on 1/30/20. The resident was unavailable for interview.

On 1/30/20 at 11:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse responsible for administering PRN oxycodone to Resident #39 on all the above dates). LPN #3 stated she completes an assessment of Resident #39's pain prior to administering PRN oxycodone. LPN #3 stated the assessment consists of the location of pain, type of pain, how bad the pain is. LPN #3 stated she also attempts non-pharmacological interventions such as positioning and other things. LPN #3 confirmed she does not always document the full assessment and the attempted non-pharmacological interventions.

On 1/30/20 at 1:43 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the senior director of operations) and ASM #4 (the regional director of clinical services) were made aware of the above concern.

The facility policies titled, "Pain Management Guideline" and "Documentation of Progress" failed to document specific information regarding documentation of pain assessments and non-pharmacological interventions prior to the administration of PRN pain medication.

No further information was presented prior to exit.

Reference:
(1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/007285.htm

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/9/20

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F 880	Continued From page 69 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement infection control practices for one of 51 residents in the survey sample, Residents #10. During observation of care for Resident #10 on 1/29/2020, the facility staff failed to cleanse hands between glove changes. The findings include:	F 880	1. Resident #10 is currently being provided care with staff utilizing the appropriate handwashing and infection control practices. CNA #2 was re-educated by the DON on 1/30/20 about the proper procedure for handwashing when changing gloves, including washing hands between gloving and after handling bodily fluids. 2. All residents have the potential to be	

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Resident #10 was admitted to the facility on 4/3/15, and was most recently readmitted on 7/5/17, with diagnoses including, but not limited to: history of a stroke, dysfunctional bladder, diabetes (1), spinal stenosis (2), and peripheral neuropathy (3). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 11/7/19, Resident #10 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having no impairment for understanding others or for being understood by others. He was coded as being dependent on the assistance of staff for bathing and toileting. He was coded as having an indwelling catheter (4) in his bladder.

On 1/29/2020 at 1:35 p.m., CNA (certified nursing assistant) #2 was observed providing care to Resident #10. CNA #2 was wearing gloves when he used a paper towel to clean up drops of urine on the floor. He threw away the paper towel, and discarded his gloves. Without cleaning his hands, he put on a new pair of gloves and continued to work with Resident #10 to transfer him from the bed to the wheelchair, using a mechanical lift. CNA #2 repeatedly touched Resident #10's clothing and bare skin during this process.

A review of Resident #10's comprehensive care plan, dated 11/12/18 and most recently updated 1/2/2020, revealed, in part: "[Resident #10] is totally dependent on staff for incontinent care of bowels and care of Foley (4)."

On 1/29/2020 at 2:05 p.m., CNA #2 was interviewed. When asked if he remembered what

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affected by poor infection control practices.

3. DON/designee will re-educate Nursing staff by 3/9/20 in regard to proper infection control procedures related to handwashing. Nursing staff to complete return demonstration.

4. DON/designee will conduct Quality Monitoring Review daily for 2 weeks, weekly for 4 weeks, then monthly, for 3 months, to ensure staff are following infection control procedures related to handwashing. The DON will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.

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process he followed after he cleaned the urine drops off the floor, CNA #2 stated he threw away the paper towel, threw away his gloves, and put a new pair of gloves on his hands. When asked what he should have done before putting on the new pair of gloves, CNA #2 stated, "I should have washed my hands. I forgot."

On 1/29/2020 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were informed of these concerns.

On 1/30/2020 at 10:12 a.m., LPN (licensed practical nurse) #6, the unit manager, was interviewed. He stated all staff should wash hands before putting on any pair of gloves.

On 1/30/2020 at 11:16 a.m., ASM #2 was interviewed. She stated all staff members should cleanse their hands between removing contaminated gloves and putting new gloves on.

A review of the facility policy "Hand Hygiene" revealed, In part: " Purpose: To reduce the spread of germs in the healthcare setting...Hand hygiene should be performed:...after glove removal."

No further information was provided prior to exit.

COMPLAINT DEFICIENCY

(1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(2) "Your spine, or backbone, protects your spinal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING ____ B. WING ____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 72 cord and allows you to stand and bend. Spinal stenosis causes narrowing in your spine. The narrowing puts pressure on your nerves and spinal cord and can cause pain." This information is taken from the website https://medlineplus.gov/spinalstenosis.html. (3) "Peripheral nerves carry information to and from the brain. They also carry signals to and from the spinal cord to the rest of the body. Peripheral neuropathy means these nerves don't work properly. Peripheral neuropathy may occur because of damage to a single nerve or a group of nerves. It may also affect nerves in the whole body." This information is taken from the website https://medlineplus.gov/ency/article/000593.htm. (4) "A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder." This information is taken from the website https://medlineplus.gov/ency/article/003981.htm.	F 880		