| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid revisit to the Abbreviated survey conducted on 9/23/2020 through 9/25/2020 was conducted 11/17/2020 through 11/18/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements.<br><br>One complaint was investigated during the survey.<br><br>The census in this 196 certified bed facility was 109 at the time of the survey. The survey sample consisted of 5 resident reviews. | F 000 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(iii) Any specialized services or specialized | F 656 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/04/2020

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 656 | Continued From page 1 | F 656 | | |

rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility documentation review, the facility staff failed to develop and implement a care plan with measurable objectives and time frames for 1 Resident (Resident # 4) in a survey sample of 5 Residents.

The findings included:

For Resident #4, the facility staff did not develop and implement measurable interventions after a fall.

Resident #4, a 74 year old man was admitted to the facility on 7/31/20 with diagnoses of but not limited to: benign prostatic hyperplasia with lower urinary tract symptoms, muscle weakness (generalized), history of mental and behavioral

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| F 656 | Continued From page 2<br>disorders, schizophrenia, hypertension, bipolar disorder, pacemaker, abnormalities of gait and mobility, history of falls, and unsteadiness on feet and osteoarthritis. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/9/20, coded Resident # 4 as requiring "extensive assistance of one person/physical assistance for all bed mobility, transfers and all ADLs (Activities of Daily Living) except eating, which only required supervision.<br><br>On 11/17/20 during clinical record review, it was noted that Resident #4 had two falls in November 2020. A review of the care plan revealed that the Resident's care plan had not been implemented and included interventions that were not measurable.<br><br>Excerpts from the care plan were as follows:<br>"FOCUS"<br>"[Resident name redacted] has had an actual fall Date Initiated: 8/2/20 Revision on 11/4/20"<br>"GOAL"<br>"[Resident name redacted] will resume usual activities and minimize the risk of further incident through next review date Date Initiated: 8/3/20 Revision on 8/17/20 Target Date 2/2/20"<br>"INTERVENTIONS"<br>"Evaluate for UTI (Urinary Tract Infection) due to recent increased agitation and behaviors; Date Initiated: 11/17/20"<br>"Observe frequently when in bed, observe for restlessness, and offer assistance to get up in wheelchair when restless. Date Initiated: 11/17/20"<br>"Place bed in Low position Date Initiated: 11/17/20"<br>[Note: the above interventions were added during | F 656 | | |

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| F 656 | Continued From page 3<br>survey.]<br><br>A review of the physician order sheet revealed there was no order to get a urine sample to evaluate for UTI. On 11/18/20 at approximately 1:30 PM, an interview was conducted with Employee D (corporate nurse) who stated that based on Resident # 4's behaviors, they thought perhaps he had a UTI. However, the doctor declined to order a urine analysis. When she was asked why the care plan should have measurable goals, Employee D stated "So that the staff would know when and how to implement them."<br><br>A review of the facility policy N-10515 read: "Policy: An individualized person centered plan of care will be established by the interdisciplinary team (IDT) with the resident and or resident representative to the extent practicable and updated in accordance with state and federal regulatory requirements."<br><br>"Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment."<br><br>On 11/18/20, the Administrator was made aware of the concerns involving the care plans and no further information was provided. | F 656 | | |
| F 842 SS=B | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is | F 842 | | |

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| F 842 | Continued From page 4<br>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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. | F 842 | | |

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| F 842 | Continued From page 5<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for one Resident (Resident #2), in a survey sample of 5 Residents.<br><br>The findings included:<br><br>For Resident #2, the facility staff failed to accurately document ADL (Activities of Daily Living) care provided for a dependent resident.<br><br>Resident #2, an 86 year old woman with diagnoses of but not limited: to cerebral infarction (stroke), Schizoaffective disorder, bipolar disorder, hypertension, chronic kidney disease, | F 842 | | |

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| F 842 | Continued From page 6<br>atrial fibrillation, post traumatic stress disorder, anxiety disorder, major depressive disorder, muscle weakness, and unspecified dementia with behavioral disturbance.<br><br>On 11/17/20 at approximately 2:00 PM, a clinical record review was conducted. Review of the record revealed that for the current month, November 2020, there had been no documentation of ADLs being performed on 11/4/20, 11/8/20 and 11/9/20. Employee E provided surveyor B with copies of the ADL tracker log for November. However, showers were not listed under ADL. When asked about the showers Employee E printed out another document from the care tracker that showed that Resident #2 was supposed to have showers on Mondays and Thursdays. These showers were not signed off as being given. She then provided surveyor with a hand written (not generated by the ERH) "CNA Shower Documentation Sheet" dated 11/14/20.<br><br>On 11/17/20 at approximately 1:30 PM, an interview was conducted with Employee D who stated she knew there was a problem with the CNAs (Certified Nursing Assistants) documenting in PCC (Point Click Care electronic health record). She stated that they have had a lot of "agency staff" because of the Covid-19 crisis. She stated they aren't as "invested" as regular staff would be and don't always do the documentation correctly.<br><br>On 11/18/20 during the end of the day conference, the Administrator was made aware of the concerns with the ADL documentation. No further information was provided. | F 842 | | |