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	495085	A. BUILDING _____ B. WING _____	C 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	201 EPPS STREET HOPEWELL, VA 23860

(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 02/04/2020 through 02/06/2020. 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 2/4/20 through 2/6/20. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 124 certified bed facility was 117 at the time of the survey. The survey sample consisted of 43 resident reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to determine if it was safe for one Resident to self-administer nebulized respiratory medication (Resident #110) in a sample of 43 residents. The findings include:	F 554	1. The Medication Nurse administering the nebulizer to Resident #110 has resigned and is no longer employed. Resident #110 has been assessed for self- administration of medications. 2. Any resident has the potential to be affected if they are not supervised during medication administration. An audit of current residents will be conducted to	3/11/20

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

Electronically Signed | 02/27/2020

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F 554	Continued From page 1 Resident #110's Diagnoses included; Chronic respiratory failure with hypoxia & hypercapnia, congestive heart failure, cardiac pacemaker, pulmonary heart disease, dementia without behavioral disturbance, and diabetes. On 2-5-2020 at 9:30 a.m., during morning interviews with residents, Resident #110 was visited and found to be in her room with a face mask covering her nose and mouth, receiving an aerosol medication. The medication was being administered through a nebulizer machine. The Resident was talking to the television, or her room mate, it is unknown which, and not inhaling the medication. As the surveyor entered, the Resident began immediately talking to the surveyor and not inhaling her medication. The medication nurse was found by the surveyor in another Resident room administering medications, and had left Resident #110 to self administer the Pulmicort (Budesonide) respiratory medication. The nurse (Registered Nurse) RN C was asked if Resident #110 had been assessed as able to self administer inhaled medications, and she stated "I'm not sure." On 2-5-2020, the Resident's clinical record was reviewed and there was no assessment found for self administration of medications. There was no physician's order for self administration of medications. Further, the nurse's notes did not address medication self-administration. On 2-5-2020 at 4:30 p.m., at the end of day debrief, the Administrator and Director of Nursing (DON) were asked if the Resident had a medication self-administration assessment. The DON stated the Resident "doesn't have a self-administration assessment." No further	F 554	identify those residents who wish to exercise their right to self- administer their medication/s and to ensure an assessment has been completed to verify competency, a physician order obtained and a care plan to reflect the self –administration of medications per the Center's policy on Self Administration of Medications. 3. RN's and LPN's will be educated on observing residents during medication administration unless the resident has been assessed and deemed competent in self-administration per the Center's policy and procedure on Self Administration of Medications. 4. Rounds will be conducted during med pass times by the Unit Manager or designee to ensure nurses are following the Center's Policy and Procedure on Self-Administration of Medication randomly 2 x week x 4 weeks then monthly x 2 months, any variances will be addressed promptly with the medication nurse . The Director of Nursing or designee will review the findings of the rounds and will report to the QAPI committee monthly x 3 months for any further recommendations.	

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F 554	Continued From page 2 information was provided by the facility.	F 554		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		3/11/20

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F 584	Continued From page 3 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, resident interview and staff interview, the facility staff failed for 1 resident (Resident # 37) of 43 residents to provide a clean, comfortable, home-like environment. The findings included: 1. For Resident # 37, the facility staff failed to maintain a clean and homelike environment as evidenced by two large bags of empty soda cans stored at the entrance into the room. Resident # 37 was admitted to the facility in 2016. Resident # 37's diagnoses included but were not limited to: dementia, hemiplegia and hemiparesis, Cardiovascular Accident (stroke), Diabetes and Major Depressive Disorder. On 2/4/2020 at approximately 7:20 PM during the initial tour, two large trash bags filled with empty soda cans were observed at the entrance in the room shared with roommate. On 2/4/2020 at 7:22 PM, an interview was conducted with a family member of Resident # 37 who stated they were upset that trash bags full of empty soda cans were stored at the entrance into the room. The family member stated Resident # 37 complained to them about the bags. Resident # 37 family member stated they had complained to administrative staff on behalf Resident # 37	F 584	1. The bags of empty soda cans have been removed from Resident #37's room. 2. Any resident has the potential to be affected if staff fail to maintain a clean, comfortable, home-like environment. Room rounds will be conducted to ensure residents are provided with a clean, comfortable and home-like environment including but not limited to free of bags of empty soda cans. 3. Staff will be educated on their role and the importance of maintaining clean, comfortable and home-like environment for Center residents. Department managers will be educated on their responsibility in conducting environmental room rounds to ensure a clean, comfortable and home-like environment. 4. Random room rounds will be conducted 2 times a week x 4 weeks then monthly x 2 months to ensure clean, comfortable and home-like environment, any variances will be addressed promptly. The Administrator or designee will review findings and report to the QAPI committee monthly x 3 months for any further recommendations.	

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F 584	Continued From page 4	F 584		

because they noticed flying insects in the room several times. Resident # 37's family member stated they were told that the roommate (Resident # 15) had a right to keep the empty cans in the room because the room was where he resided as well. Resident # 37's family member stated they did not want to infringe on the roommate's rights but felt the cans were like trash being kept in the room and increased the risk of insects or pests. The family member stated they knew the roommate collected money for recycling the cans but wished they did not have to be kept in the room.

When Resident # 37 was asked if the bags of cans bothered him, he said "yes".

On 2/5/2020 at 9:00 AM, observed two Large clear trash bags full of empty soda cans in the entrance to the room. There were also two small plastic grocery bags with empty soda cans inside on top of the large bags.

ON 2/5/2020 at 5:45 PM, observed the large trash bags and two small trash bags with empty soda cans at the entrance to the room. Resident # 37's family member was observed visiting. Resident # 37's family member stated it looked like more cans were stored at the doorway.

On 2/6/2020 at 1 PM, an interview was conducted with the maintenance director (Employee B) who stated he was asked to remove the bags of empty cans from the room on the late evening of 2/5/2020. The maintenance director stated he placed the cans in the shed outside the facility.

On 2/6/2020 at 1:30 PM, an interview was conducted with the Director of Nursing who stated

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F 584	Continued From page 5 she had the bags of soda cans removed from Resident # 15's room after she discussed the concerns with keeping them in the room shared with a roommate. The Director of Nursing stated Resident # 15 gave consent for the cans to be removed and they discussed a couple of places for the cans to be stored until taken to the recycling center. On 2/6/2020 at 5:55 PM, Resident # 37's family member stated they were glad to see the bags removed from the entry way. During the end of day debriefing on 2/6/2020, the facility Administrator, Director of Nursing, and two Corporate Consultants were informed of the findings. No further information was provided.	F 584		
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	F 600		3/11/20

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F 600	Continued From page 6 by: Based on observation, staff interview, clinical record review, facility documentation review, and the facility failed to prevent physical abuse by staff for one resident (Resident #169) in a survey sample of 43 residents. The Findings included: The facility staff pushed Resident #169's back while putting him to bed. Resident #169 was an 77 year old. Resident #169's diagnoses included Heart Failure, and Unspecified Dementia without Behavioral Disturbance Resident #169 was sometimes able to understand and be understood by others. Resident #169 expired at the facility on 10/27/19. The Minimum Data Set, which was a Quarterly Assessment, with an Assessment Reference Date of 8/17/19 was reviewed. Resident #169 was coded as requiring the physical assistance of 2 persons for transfers, and utilized a wheelchair for mobility. On 2/4/20 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 10/16/18. An excerpt read, "On October 20, 2018 it was reported to me [Administrator - Administration A] that the acting 7 to 3 supervisor that Resident #169 complained to his wife... that he had been punched in the back when he was being transferred to bed... she informed me that her husband was punched in the back when he could not help the CNA [Certified Nursing Assistant I] transfer him to bed because his legs had buckled...she stated that she was on the phone when the incident occurred	F 600	1) The C.N.A's employment was terminated upon completion of the investigation. Resident #169 expired at the Center on 10/27/19, he was receiving Hospice Services. 2. Any resident has the potential to be affected if staff fail to provide services in a compassionate, caring manner. An audit of employee HR files will be completed to ensure proper screening. 3. Staff will be re-educated on the Center's Abuse Prevention Policy and Procedure and Service Excellence Standards. 4. Random resident/family interviews will be conducted by Department Managers or designees weekly x 4 weeks then monthly x 2 months to ensure resident/family satisfaction in care/services, any variances will be addressed promptly. The Administrator or designee will review the findings and will ensure that any concerns identified have been addressed; and will report summary of findings to the QAPI Committee monthly x 3 months for further recommendations.	

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F 600	Continued From page 7	F 600		

and could not make out what was going on... [Resident #169 stated he asked the lady is she would help him to bed and she got behind him and started pushing on him and punched him in the back with 2 opened hands...Conclusion of the investigation it was identified and determined that [CNA I] did not meet the centers service excellence standards of care. The employee file revealed previous care concerns resulting in termination of employment."

On 2/5/20 at approximately 11:00 A.M. an interview was conducted in the conference room with the facility Director of Nursing (Administration B). She stated that there were no other residents who were abused by facility staff after 10/8/18. She submitted a written statement. An excerpt read, "An investigation was initiated...[Resident 169] was in his normal state of mind and body showed no signs of bruising. [Resident #169 is a poor historian but was able to recall the staff member's names and that fact that she was working a double shift. [CNA I] was suspending completion of the investigation. MD was notified, and on 10/22/18 MD was in to visit."

A document dated 10/22/18 was reviewed. It was an interview with Resident #169. An excerpt read, "I was in my room and wanted to go to bed, so I asked the lady is she would mind helping me to get in the bed...She got behind me and started pushing on me. She started hitting me in the back with her 2 opened hands...She got another girl to help her because she couldn't do it. Both of them finally got me in the bed...I believe she was mad because she was working a double shift."

A document dated 10/22/18 was reviewed. It was an interview with Resident #169's roommate. An

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excerpt read, "The CNA came in and pulled the curtain to put [Resident #169] in the bed and she began hollering at him. She picked him up out of the wheelchair...she threw him on the bed wit his face in the pillow. I think she pushed him. I was listening and [Resident #169's wife] was on the phone. I heard her yelling come on I know you can do it. I heard her hitting him in the back about 3 or 4 times...I didn't see it but I heard it. I could see a shadow of her railing her hand through the curtain and heard [Resident #169] yelling you hit me and she said no I did not and he said yes you did. [Resident #169] was screaming and she kind of threw him on the bed like a pretzel because he could not use his legs another CNA had to come and straighten him out in the bed. I pulled the curtain back to tell her that there were somethings [Resident #169] could do and some things he could not do. I called his wife back and she wanted to know who the CNA was and I told her...I told her it was [CNA I]."

A letter dated 11/7/18 from Adult Protective Services to the Administrator was reviewed. An excerpt read, "The investigation has been completed. Although there is a preponderance of evidence that [Resident #169] was a victim of abuse, neglect or exploitation, the need for protective services no longer exists because [Resident #169] is no longer at risk for further abuse..."

On 2/6/20 a review was conducted of facility documentation, revealing an Abuse Policy dated January, 2017. An excerpt read, "The facility is committed to maintaining a safe and abuse-free environment for all residents...Physical Abuse - causing physical pain or injury...Hitting, biting, kicking, holding, etc."

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F 600	Continued From page 9 No further information was received.	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 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	F 656		3/11/20

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F 656	Continued From page 10 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, clinical record review, and facility documentation review, the facility staff failed to implement a care plan for bowel management and incontinence care for 1 resident (Resident #23) in a survey sample of 43 residents. The Findings included: For Resident #23, the facility staff failed to provide toileting in a timely manner for bowel management and incontinence care. Resident #23 was a 63 year old. Resident #63's diagnoses included Cerebral Palsy, Congenital Malformations of Musculoskeletal System, Idiopathic Scoliosis, Osteoporosis, Age-Related Nuclear Cataract, Unspecified Eye, Depression and Anxiety. The Quarterly Minimum Data Set dated 11/15/19 was reviewed. Resident #23 was coded as having a Brief Interview of Mental Status Score of 15, indicating intact cognition. Resident #23 was also coded as requiring the physical assistance of 2 persons for toileting. Resident #23 was also coded as having range of motion impairment on both of her upper and lower limbs. Resident #23 was coded as being frequently incontinent of bowel and occasionally incontinent of urine.	F 656	1. Resident #23's care plan has been updated to reflect her individualized interventions for bowel management and incontinence care and is communicated to the C.N.A's via the Kardex. 2. Any resident who is dependent upon staff for toileting needs has the potential to be affected if staff fail to provide toileting in a timely manner. An audit of current residents who are dependent on staff for bowel management and incontinence care will be completed to ensure toileting needs are being met and their care plans reflect individualized interventions. 3. Nursing staff will be educated on the importance of developing and following care plans to reflect individualized interventions for bowel management and incontinence care. 4. Random rounds will be conducted by the Unit Manager or designee 2 x weekly x 4 weeks then monthly x 2 months to ensure staff are responding in a timely manner for bowel management and incontinence care, any variances will be addressed promptly. The Director of Nursing or designee will review the findings and report summary of findings to the QAPI committee monthly x 3 months	

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Resident #23 used a motorized wheelchair for mobility.

On 2/6/20 at 3:30 P.M., Resident #23 came to the conference room and stated that she had concerns about short staffing. She said that every night she is given Milk of Magnesia for bowel management. She said that a staff member from the 11-7 shift but her on a bedpan just before leaving at 7:00 A.M. She stated that she remained on the bedpan until 10 A.M. During that time, an Auxiliary staff member who was not a Certified Nursing Assistant came in response to her call bell and stated that she go and get a CNA for me. Then the Director of Nursing came in and left without helping her. At 10 A.M. the Director of Activities came in, removed the bedpan, and cleaned her. Resident #23 stated, "I want an aide who gets me up on time. I don't ask for much. Today they didn't get me up in my chair until 3:00 P.M. This happens nearly every day." Resident #23 stated that every morning her toileting is delayed due to staffing shortages.

On 2/6/20 at 4:00 P.M. an interview was conducted with the Unit Manager (RN A). When asked about Resident #23's bowel management routine, the Unit Manager stated that Resident #23 receives 30 cc of Milk of Magnesia at bedtime every night. She stated, "They should check before the end of the shift. They should check back within 15 to 30 minutes. We don't have a system to monitor call bell response times. [CNA L] is not as fast as the other CNA's. The nurse's and I pitch in. We are supposed to have 7 CNA's, today and yesterday we had 4, we usually have 4."

The Director of Nursing (Administration B) and for further recommendations.

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F 656	Continued From page 12 Administrator (Administration B) were also present during the interview. The DON stated, "She should have been gotten off the bedpan when she put on her light by a licensed clinical staff. Someone should monitor. Skin breakdown can happen if she if left on too long. We will have staff education." On 2/6/20 a review was conducted of Resident #23's clinical record, revealing a care plan. An excerpt read, "at risk for constipation r/t [related to] decreased mobility, medication side effects...incontinence episodes r/t cerebral palsy...bowel and bladder incontinence r/t impaired mobility and self care deficit." The physician's order read, "2/1/20. Milk of Magnesia Suspension. Give 30 ml by mouth at bedtime for Bowel Management." On 2/6/20, a review was conducted of facility documentation, submitted by the DON. It was an undated Incontinent Management Policy. An excerpt read, "Determine if resident is capable of toileting self; if not, determine toileting schedule. Attempt to determine cause of incontinence and, if treatable, a plan will be developed and implemented by the Interdisciplinary Treatment Team." No further information was received.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		3/11/20

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F 658	Continued From page 13 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to ensure Residents were provided care and services according to professional standards of practice for 2 Residents (#7 and #75) in a survey sample of 43 Residents. The findings included: 1. For Resident # 7 the CNA failed to report possible injury and increased in pain to the nurse after patient care. Resident #7, a 71 year old woman admitted to the facility on 10/4/2017 with diagnoses of but not limited to hypertensive heart disease, bilateral Osteoarthritis of the hip, Type 2 diabetes, polyneuropathy, and polyarthritis. The Resident's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/22/2019 coded as a Quarterly Assessment, codes Resident #7 as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. The MDS also coded Resident as requiring extensive assistance of 2 + physical assistance for bed mobility and transfers, extensive assistance of 1 person physical assistance for toileting, hygiene and dressing. On 2/5/2020 during the course of a complaint investigation it was reported that on 5/11/2019 while the resident was receiving ADL care Resident #7 told CNA F she was in pain and that she felt her shoulder "pop." On 2/5/2020, A review of the progress notes	F 658	1)C.N.A F is no longer employed at the Center. RN A has received education on her responsibility for the safety and security of medications by not leaving meds unattended on top of the med cart and on the process to obtain and document retrieval/administration of medications from Interim kits2. 2) Any resident has the potential to be affected if direct staff fail to promptly report possible injury and increased pain to the nurse for assessment. An audit of the 24 hour report will be completed to verify if any reports of possible injury or increase in pain expressed by residents; any identified will be followed up to verify appropriate interventions in place. Any resident has the potential to be affected if nurses fail to ensure the safety and security of medications. Rounds will be conducted to ensure meds are not left unattended by the nurse. 3) C.N.A. and Licensed Nursing staff will be educated on standards of practice to identify, report, assess and manage resident pain and Clinical team to be educated on reviewing 24 hour report for any reports of new, increase in or unmanaged pain. RN's and LPN's will be educated on their responsibility to ensure the safety and security of medications. 4. Random resident interviews will be conducted by the QAPI nurse or designee weekly x 4 weeks then monthly x 2	

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F 658	Continued From page 14 revealed no entries for 5/11/2019 or 5/12/2019. A review of the progress notes revealed that on 5/13/2019 at 2:03 PM LPN B documented as follows: "Resident brought to the nurses station by therapist with a c/o [complaint of] 'feeling like a pimple burst under my left breast' with some pain going down left arm. The left breast was assessed, no opening or desensitized skin noted. Resident left arm movable and resident voiced no complaint of pain." "5/14/2019 7:55 AM NP [nurse practitioner] gave new order to obtain chest x-ray and left shoulder x-ray due to pain. RP updated." "5/14/2019 1:26 PM - X-ray results show anterior dislocation with possible humeral fracture. Orthopedic evaluation recommended. Resident is own RP and has been updated. MD updated also." On 2/5/2020 the facility provided the witness statements from the investigation into the incident the statement read as follows: (Witness Statement from CNA F not dated) "I [CNA F name redacted] was giving [Resident name redacted] her bath like normal she was stating that to touch her body it hurts so I was gentle. She had to roll side to side a few time the last roll she said oww. I said what's wrong she said she things something popped so I continued to dress her and when I was done she stated she was ok. And felt fine. I went on with my day and at round time asked again was she fine she said yes." "5/15/2019 - Interview with [CNA G name	F 658	months to verify resident's needs are being addressed promptly. Random audit of Medication Administration Records (MARs) will be completed 2 x weekly x 4 weeks then monthly x 2 months by the QAPI nurse or designee to reconcile MARs to Control Drug Records and/or Control Charge Slips from the Interim Kits to verify administration of medications and documentation. Random rounds will be conducted by the Unit Manager or designee 2 x weekly x 4 weeks then monthly x 2 months to ensure medications are not left unattended. The Director of Nursing or designee will review findings and report summary of findings to QAPI committee for further recommendations monthly x 3 months.	

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redacted] - RE: [Resident name redacted] During AM care with [Resident name redacted] she complained of pain to her shoulders. [Resident name redacted] always complain [sic] of shoulder pain and her left arm pain. I reported that [Resident name redacted] was in pain to the charge nurse [LPN B name redacted]."

"5/15/2019 - Interview with [LPN B name redacted] - RE: [Resident name redacted] - I went in the room to give [Resident name redacted] her morning medication and she told me that over the weekend the aid was turning her and she felt a pop. I asked her did she tell anybody and she said the aid knew, but she never told the nurse. I asked her was she in pain and [Resident name redacted] said yes. I tiger tested the MD for an X-Ray. The Dr. ordered and x-ray, she gets schedule [sic] Tylenol with her medication. Once the x-ray resulted the MD ordered an orthopedic consult and N.O. [new order] for Motrin."

Lippincott Textbook for Nursing Assistants Chapter 17 page 387 reads:
"Tell The Nurse - Tell the nurse immediately if you observe any of the following signs or symptoms while assisting a person with his or her bath."
"New rashes, bruises, broken skin, bleeding or unusual odors"
"Areas that are red, pale or have a bluish cast"
"Areas that are swollen or tender."

On 2/6/2020 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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2. For Resident #75 the facility staff failed to document medications when they are given and left medications on top of the cart unattended.

Resident # 75, a 55 year old woman admitted to the facility on 10/25/2019 with diagnoses of but not limited to chronic hematogenous osteomyelitis, diabetes type 2, diabetic neuropathy, major depressive disorder anxiety disorder, and chronic pain syndrome.

The Resident's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/28/2019 coded as a Quarterly Assessment, codes Resident #75 as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment.

On 2/5/2020 at 9:50 AM during "Medication Administration Task" Resident #75 requested Tramadol for pain rated 6/10 on pain scale. RN A looked for the pain medication and could not find it in the narcotics box on the cart. She pulled the on narcotic medications and placed them on top the medication cart. She pulled the last medication out of the narcotic box, a bottle of liquid methadone and was unable to open the top. After several unsuccessful tries she then left the medication cart to enter the patient room and use the sink to run hot water over the bottle to aid in opening it. When she left the cart the previously pulled medications were on the top of the cart unsecured.

When RN A returned to cart and was told she left the medications on top of the cart unsecured, she stated "Oh yes I did." When asked what could happen if medications are left unsecured on top of the cart she stated "Other residents or visitors

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could get hold of them and take them."

When asked the process to follow when a resident is out of medication such as pain medication she stated "I will have to call the pharmacy and get a code to use the stat box."

On 2/5/2020 at 3:00 PM a review of the MAR revealed the Tramadol had not been signed out on the MAR. On 2/5/2020 a review of the MAR revealed the Tramadol still had not been signed out. On 2/6/2020 at 1:21 PM a review of the progress notes do not reflect the administration of Tramadol on 2/5/2020.

On 2/5/2020 at 1:00 PM an interview was conducted with the DON who stated that the Medication had been ordered and given she produced a "Control Substance Medication Usage Form" signed by RN A for Resident #75 for Tramadol 50 mg. the form was dated 2/5/2020 but time was not listed.

When asked if the time should have been written on the form the DON responded that is should. When asked if it is usual practice to also sign the medication out in the MAR she stated that it should have been recorded on the MAR so that there is a record of the patient receiving the medication.

The facility submitted the Medication Administration Policy which read:
Page 2 -Paragraph C
"9. If a medication is unavailable, contact the pharmacy and document accordingly."

The facility staff stated the facility utilized "Lippincott" as their professional nursing

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F 658	Continued From page 18 standard. Guidance for nursing standards for the administration of medication is provided by "Lippincott", Professional standards, such as the American Nurses Association's nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. Medications and treatments are given in accordance with physician's orders. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation. On 2/6/2020 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. complaint-related deficiency	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation	F 677	1. Resident #23's care plan has been revised to reflect her individualized bowel	3/11/20

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F 677	Continued From page 19 review, the facility staff failed to provide timely personal care after episodes of incontinence for 1 resident (Resident #23) in a survey sample of 43 residents. The Findings included: For Resident #23, the facility staff failed to provide personal cleaning in a timely manner after episodes of incontinence. Resident #23 was a 63 year old. Resident #63's diagnoses included Cerebral Palsy, Congenital Malformations of Musculoskeletal System, Idiopathic Scoliosis, Osteoporosis, Age-Related Nuclear Cataract, Unspecified Eye, Depression and Anxiety. The Quarterly Minimum Data Set dated 11/15/19 was reviewed. Resident #23 was coded as having a Brief Interview of Mental Status Score of 15, indicating intact cognition. Resident #23 was also coded as requiring the physical assistance of 2 persons for toileting. Resident #23 was also coded as having range of motion impairment on both of her upper and lower limbs. Resident #23 was coded as being frequently incontinent of bowel and occasionally incontinent of urine. Resident #23 used a motorized wheelchair for mobility. On 2/6/20 at 3:30 P.M. Resident #23 came to the conference room and stated that she had concerns about short staffing. She said that every night she is given Milk of Magnesia for bowel management. She said that a staff member from the 11-7 shift but her on a bedpan just before leaving at 7:00 A.M. She stated that she remained on the bedpan until 10 A.M. During that	F 677	management plan and incontinence care needs. The Director of Nursing has visited with Resident #23 to follow up on her concerns and she expressed that her needs were now being addressed by staff. 2. Any resident who is dependent on staff for ADL care has the potential to be affected if staff fail to timely provide personal care needs. An audit of residents who are dependent in ADL needs will be conducted to ensure incontinence care is provided timely. 3. Nursing staff will be educated on timely response in providing ADL care to residents. 4. Rounds will be conducted by Unit Manager or designee 2 x week x 4 weeks then monthly x 2 months to ensure resident's needs are being addressed timely. Random resident interviews will be conducted by the QAPI nurse or designee weekly x 4 weeks then monthly x 2 months to verify resident's needs are being addressed promptly. The Director of Nursing or designee will review findings and report summary of findings to the QAPI committee monthly x 3 months for further recommendation.	

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F 677	Continued From page 20	F 677		

time, an Auxiliary staff member who was not a Certified Nursing Assistant came in response to her call bell and stated that she go and get a CNA for me. Then the Director of Nursing came in and left without helping her. At 10 A.M. the Director of Activities came in, removed the bedpan, and cleaned her. Resident #23 stated, "I want an aide who gets me up on time. I don's ask for much. Today they didn't get me up in my chair until 3:00 P.M. This happens nearly every day." Resident #23 stated that every morning her personal cleaning is delayed after using a bedpan due to staffing shortages.

On 2/6/20 at 4:00 P.M. an interview was conducted with the Unit Manager (RN A). When asked about Resident #23's bowel management routine, the Unit Manager stated that Resident #23 receives 30 cc of Milk of Magnesia at bedtime every night. She stated, "They should check before the end of the shift. They should check back within 15 to 30 minutes. We don't have a system to monitor call bell response times. [CNA L] is not as fast as the other CNA's. The nurse's and I pitch in. We are supposed to have 7 CNA's, today and yesterday we had 4, we usually have 4."

The Director of Nursing (Administration B) and Administrator (Administration B) were also present during the interview. The DON stated, "She should have been gotten off the bedpan when she put on her light by a licensed clinical staff. Someone should monitor. Skin breakdown can happen if she if left on too long. We will have staff education."

On 2/6/20 a review was conducted of Resident #23's clinical record, revealing a care plan. An

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F 677	Continued From page 21 excerpt read, "at risk for constipation r/t [related to] decreased mobility, medication side effects...incontinence episodes r/t cerebral palsy...bowel and bladder incontinence r/t impaired mobility and self care deficit." The physician's order read, "2/1/20. Milk of Magnesia Suspension. Give 30 ml by mouth at bedtime for Bowel Management." On 2/6/20, a review was conducted of facility documentation, submitted by the DON. It was an undated Incontinent Management Policy. An excerpt read, "The resident will be at risk for...skin breakdown. To help decrease incidents of this type, the facility will...Change resident as soon as possible when soiled. Residents who are incontinent shall have a partial bath, clean clothing and linens each time their clothing or bed lined is soiled." No further information was received.	F 677		
F 688 SS=D	complaint-related deficiency Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		3/11/20

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F 688	Continued From page 22 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed for one resident (Resident #80) of 43 residents to administer splints to the upper extremities and hands as ordered. The findings include: Resident # 80, a 72 year old, was admitted to the facility in 2016. Resident 80's diagnoses included but were not limited to : Gastrostomy, Dysphagia, Dementia, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/5/2020. Resident # 80 was coded with a Brief Interview of Mental Status score of 00 indicating severe cognitive impairment and required total assistance of one staff person with activities of daily living including bed mobility except for transfers. The assessment coded Resident # 80 as requiring total assistance of two staff persons for transfers. Resident # 80 was also coded as always incontinent of bowel and bladder. The following observations occurred during the survey.	F 688	1. Resident #80 has been re-screened by Occupational Therapy for splinting and has the WHO splints in place. The communication card for Nursing and Restorative aides has been updated 2. Any resident with limited range of motion (ROM) has the potential to be affected if appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM is not provided. An audit of current residents will be completed to identify residents with orders for splints and rounds will be conducted to ensure splints are in place per orders/care plans. 3. Nursing staff will be educated on the Center's policy on Contracture Prevention. 4. Rounds will be conducted 2 x weekly x 4 weeks, then monthly x 2months by the Unit Manager or designee to verify splints/devices are in place per orders/care plan, any variances will be addressed promptly. The Assistant Director of Nursing or designee will review the findings and will report to the QAPI Committee monthly x 3 for any further recommendations.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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02/04/20 07:00 PM Observation- No splints noted in hands. Fingers of both hands curled closed. Top drawer of nightstand has label with the word "SPLINTS". Resident lying on her back.

02/04/20 08:15 PM Observation- No splints noted in hands. Resident lying on her back. No splints on upper extremities.

02/05/20 9:00 AM Observation- No splints noted in hands. No splints on upper extremities.

02/05/20 11:20 AM Observation-No splints noted in hands. No splints on upper extremities.

02/05/20 05:43 PM No splints in hands. Opened top drawer- several orthotics were noted in top drawer.

No orthotics were noted on the upper extremities of Resident # 80 on either observation on 2/4/2020 or 2/5/2020.

Review of the clinical record was conducted on 2/5/2020. Review of the Orders revealed an order dated 10/17/2017 for a "Cock-up" splint to the left and right upper extremity "to reduce contracture and promote functional alignment."

During the end of day debriefing on 2/5/2020, the facility Administrator, Director of Nursing and two Corporate Consultants were advised of the findings. The Director of Nursing stated Resident # 80 was enrolled in the Restorative Nursing Program and she would check on the orders for when to use splints.

On 2/6/2020 at 8:15 AM, this surveyor observed Resident # 80 lying in bed, no splints or orthotics

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were in Resident # 80's hands. There was a black splint on the right elbow. There was nothing on the left upper extremity. The "Splints" sign was removed from the top drawer of the night stand.

On 2/6/2020 at 9:00 AM, an interview was conducted with CNA (Certified Nursing Assistant) D who stated Residents who need splints should be noted on the CNA Kardex. CNA D stated the Kardex informed the CNAs of the type of care each resident needed. CNA D stated Resident # 80 was in the Restorative Nursing Program. CNA D stated Resident # 80 could not move extremities without help from the staff. CNA D stated there were different splints for Resident # 80. CNA D stated palm guards should be used in both hands when Resident # 80 was put back in bed.

On 2/6/2020 at 9:15 AM, an interview was conducted with the Assistant Director of Nursing who stated Resident # 80 was in the Restorative Nursing Program and had splints that were used 6 hours a day. The Assistant Director of Nursing stated the facility staff did provide the splints for Resident # 80 each day. The Assistant Director of Nursing stated the staff should document the use of the splints each day when used as tolerated. The Assistant Director of Nursing stated the facility staff did provide Range of Motion exercises daily for Resident # 80 since she was in the Restorative Nursing Program.

On 2/6/2020 at 3 PM, an interview was conducted with the Director of Nursing who stated Resident # 80 should have her splints applied as ordered.. The Director of Nursing reviewed the clinical record including the Physicians Orders with the

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Surveyor. The Director of Nursing stated Resident # 80 was a part of the Restorative Nursing Program. Review of the Order Summary revealed an Occupation Therapy order for Pt (patient) to benefit from cock-up splint on L and R UR (left and Right Upper Extremity) to reduce contracture and promote functional alignment. Order date: 10/17/2017.

Review of the Restorative Clinical Reviews Progress Notes revealed documentation on 1/31/2020 at 12 noon stated Resident # 80 "continues to participate in the Restorative Nursing Program. "Resident tolerating splinting and PROM (Passive Range of Motion) without difficulty per treatment plans. The note was authored by the Assistant Director of Nursing.

Review of the care plan revealed documentation of a Focus concern: "_____ (Resident # 80) is enrolled in the RNP (Restorative Nursing Program) for splinting of her bilateral arms using a WHO and right elbow posey to prevent contractures. Date initiated 8/2/2019.

Goal: "____ will not experience an avoidable loss of functional ROM (Range of Motion) through the next review date.

Interventions: " Follow restorative ROM program outlined by the supervising nurse Date initiated 8/12/2019
Notify nurse of decline in abilities. Date initiated 8/12/2019."

Another Focus Concern: "is enrolled in the restorative program to Maintain ROM passive to neck extension and bilateral upper extremity extension of elbow wrists, digits and thumb for

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F 688	Continued From page 26 contracture management. Date initiated 8/12/2019. Goal: "____ will not experience an avoidable loss of functional ROM (Range of Motion) through the next review date. Interventions: " Follow restorative ROM program outlined by the supervising nurse Date initiated 8/12/2019 Notify nurse of decline in abilities. Date initiated 8/12/2019." Review of the Facility Policy on Contractures, Prevention revealed statements that the purpose of the policy was to set guidelines to prevent contracture of extremities for residents who no longer had full use of their extremities. Under Procedures:" 5. Hand rolls should be in any hand that the resident cannot move. These can be commercial rolls or wash cloths rolled up...." Also stated "*Handrolls prevent skin problems and help to maintain natural position of the hands." 6. Some residents may have braces or splints to prevent to help release contractures-be sure to follow the physician's order regarding the schedule of when to put these on and when to remove them." During the end of day debriefing on 2/6/2020, the facility Administrator, Director of Nursing and two Corporate Consultants were advised of the findings. No further information was provided.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		3/11/20

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F 689	Continued From page 27 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to provide adequate supervision to prevent elopement for 1 of 43 residents (Resident #168). The Findings included: Resident #168 eloped from the facility after a staff member (the Social Worker - Administration G) held the door open for him to exit the building to sit outside unattended near a driveway and parking lot. Resident #168 was a 62 year old who no longer resided at the facility at the time of the survey. Resident #168's diagnoses included Generalized Muscle Weakness, Lack of Coordination, and Cerebral Infarction. Resident #168's niece was his Responsible Party. He did not make independent decisions. The Discharge Minimum Data Set dated 8/30/19 was reviewed. Resident #168 was coded as having a Brief Interview of Mental Status Score of 10, indicating moderately impaired cognition. Resident #168 utilized a wheelchair for mobility.	F 689	1. Resident #168 no longer resides in the Center. Employee Administration G has received education on the Center's Elopement Prevention policy. 2. Any resident who is cognitively impaired may be at risk if allowed outside unsupervised. An audit of current residents will be completed to identify residents who are cognitively impaired, demonstrate poor judgment or is at risk for wandering outside facility unattended and care plans will be reviewed to verify care plan reflects resident risk/interventions. 3. Staff will be re-educated on the Center's policy on elopement prevention and to notify the nurse of any resident wishing to exercise their right to go outside to ensure resident is competent to be outside unattended or supervision will be provided. 4. Rounds will be conducted by the Unit Manager or designee 2 x weekly x 4 weeks then monthly x 2 months to ensure Center Policy on Elopement Prevention is being followed. The Director of Nursing or designee will review the findings and	

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F 689	Continued From page 28 On 2/5/20 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 3/1/19. An excerpt read, "[Resident #168] wanted to sit outside under our porch [the porch is a few steps away from the driveway in front of the building- about the width of a sidewalk]. Staff complied, but around 15 minutes later he was found at the top of our hill, [in the parking lot, near the street] near our facility van. Staff brought him back to the facility and he was asked where he was going and he stated that he 'was going home to bed'. [Resident #168] was assessed by nursing, had no visible signs or symptoms of hypothermia noted with no harm...it was determined that a Wander Guard was needed and placed on his person...The associate who brought [Resident #168] outside has been educated, and staff education has started on the potential for persons who are cognitively impaired from sitting outside unattended, and that indicated poor judgement to being outside or near lobby should not be left unattended." On 2/5/20 at 2:15 P.M. an interview was conducted with the social worker (Administration G) in the conference room. She stated, "I am the one who let him out. I held the door open for him. I signed an education counseling. Honestly I didn't understand why I was counseled. I didn't see any reason for him not going out." She stated that the receptionist could see the residents while they sat outside in front of the building. The surveyor conducted a tour of the lobby with the social worker. From the receptionist's desk, which is in a room in the lobby with a window, it was impossible to see (outside in front of the building) where the residents sit near the	F 689	report a summary of the findings to the QAPI committee monthly x 3 months for any further recommendations.	

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F 689	Continued From page 29 benches. It was only possible to see whatever was directly in front of the front door. The facility Director of Nursing (Administration B) submitted a written statement. An excerpt read, "I was approached by [CNA M] stating that [Resident #168] was up on the hill headed towards [the hospital next door to the facility]. [CNA M] stated I ran and got him and brought him back. I asked (CNA M) if she saw him leaving the building she stated 'no'. She proceeded to say when I got him, he had on no shoes only gripper socks. I instructed [CNA M] to place a wander guard on [Resident #168] and a wandering assessment was completed...as well as the Care Plan updated." On 3/1/19 the facility conducted a training in-service education on elopement. Five months later, on 8/17/19 another resident eloped from the facility and went to the hospital next door. The resident had already been scheduled for discharge on 8/19/19. He was returned to the facility unharmed, and discharged home on 8/19/19. On 2/4/20 a tour of the facility was conducted with the Director of Nursing to review the safety measures that were put in place after the 8/19/19 elopement. The DON demonstrated how the front door would lock automatically once someone wearing a wander guard became within 20 feet of the door. The alarm also sounded. The front door also prevented anyone from entering the building, or exiting the building. No further information was received.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		3/11/20

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F 761	Continued From page 30 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 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 interview the facility staff failed to appropriately label and store medications and biologicals for 1 of 4 units The findings include: For Medication room on the 300 Hall the facility staff failed to lock the narcotic box inside of the medication refrigerator and inside of the refrigerator was an opened half used multi-use	F 761	1. The vial of tuberculin solution used for tuberculosis testing in the 300 Unit medication refrigerator noted to be open without an open date was discarded and the refrigerator narc box securely locked upon discovery. The contents of the refrigerator narc box have been audited and verified to be accurate with the Control Drug Records for the Marinol gel capsules and liquid Lorazepam. The	

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F 761	Continued From page 31 vial of Tubersol (a biological used to test for Tuberculosis) with no date opened or date to discard on label. On 2/5/2020 at 12:45 PM during Medication Storage Task, the medication room on the 300 hallway was inspected. Accompanying the Surveyor was LPN A. The medication room door was properly locked and the LPN used her keys to enter the room. The refrigerator was not locked but there was a narcotic box attached to the inside the refrigerator that had a lock on it. However, the narcotic box that was attached inside the refrigerator was left unlocked. The surveyor was able to open the narcotic box unassisted. Inside the Narcotic box was Marinol (gel capsule of THC the man-made form of the active substance in cannabis) and Lorazepam liquid (an anti-anxiety medication). Also found in the refrigerator was a half empty multi-use vial of Tubersol (injectable biologic used for Tuberculin Testing). The multi-use vial contained a sticker that read "Date Opened" and a space was provided for the date, however, the space was left blank. At 12:45 PM an interview was conducted with LPN A and she was asked how the narcotics should be stored she replied they should be locked in the narcotics box inside the refrigerator. When asked about the storage and labeling of the Tubersol she stated it should have been dated by the person who first opened the vial.	F 761	Medication Nurse LPN A at the time of discovery is no longer employed at the Center. 2. Any resident is at risk of receiving outdated drugs/biologicals if multiple dose vials are not dated upon opening. Security of control substances is the responsibility of the nurse to ensure control substances are double locked. An inspection of all med room refrigerators and med carts will be completed to ensure medications are securely locked per center policy and regulations. 3. Nurses will be educated on the Center's policy for dating open drug/biologicals vials and ensuring control medications are securely locked. 4. Random rounds will be conducted by the Unit Manager or designee 2 x weekly x 4 weeks, then monthly x 2 months to ensure multiple dose vials are dated upon opening and control medication storage compartments are double locked, any variance will be addressed promptly. The Director of Nursing or designee will review findings and report summary of findings to the QAPI Committee monthly x 3 months for any further recommendations. Date of compliance	

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F 761	Continued From page 32 On 2/5/2020 at 1:00 PM an interview with the DON was conducted and she stated that the narcotics box in the refrigerator should be locked at all times. She was questioned about the Tubersol not being dated and she said that any multi-use vial should be dated when it is opened. Multi-use vials are only good for 30 days and if it is not dated we do not know when it should be thrown out. On 2/6/2020 the Administrator was made aware of the concerns with the medications and no further information was provided.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, Resident Council meeting, and two Resident interviews, the facility failed to ensure food was served at a palatable temperature for 2 of 43 residents (Resident #32 and #49). The findings included: On 2-4-2020 during the initial tour of the facility, Resident's #32, and #49 were interviewed. They were room mates, and both stated the only	F 804	1. Residents #32 and #49 were visited by the Dietary Manager and Director of Food & Nutrition Services during a recent dinner meal and both residents confirmed food served was at a palatable temperature. 2. Any resident has the potential to be affected if food is not served at palatable temperatures. An audit will be completed to identify residents needing assistance and their trays will be assigned to the last	3/11/20

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F 804	Continued From page 33	F 804		

complaint they had regarding their care was that meals were served after they had become cold.

Clinical records were reviewed for both Residents and they were both found to have a "Brief Interview for Mental Status" (BIMS) score of 15 points, out of a possible 15 points, indicating, no cognitive impairment.

On 2-5-2020, the breakfast meal observation was conducted at 9:15 a.m. Residents #32, and #49 were observed and interviewed. Both Residents were in their rooms and both had eggs delivered to them while the surveyor was in the hallway just minutes before entering the room. Both Residents complained of "cold food", and neither of them ate the meal. They stated that this had happened "a lot lately", and getting the food reheated was "almost impossible", as the staff was "busy handing out trays, and feeding other Residents." Resident #49 requested "just feel this, no one wants cold eggs, I am not eating this," and requested the surveyor touch the eggs. Both Residents plates were cool/room temperature to the touch.

On 2-5-2020 during the Resident council interview, Residents almost unanimously complained of the food being cold the majority of the time when delivered to their rooms. Complaints about the food being served cold were made by residents representing all of the units.

The Administrator and Director of Nursing were notified of the food temperature issues at the end of day meeting on 2-5-2020. No further information was submitted by the facility.

delivery cart to allow nursing staff additional time to pass trays to those residents who are independent with eating.
3. Dietary and Nursing staff will be educated on changes in meal service delivery times and order of tray delivery. Staff task assignments will be adjusted to complete tray pass within 20 minutes.
4. The Dietary Manager/Registered Dietitian or designee will conduct Test Tray Audits including point of service temperatures, delivery times and # staff assisting for each meal weekly x 4 weeks, then monthly x 2 to ensure food is served at a safe and palatable temperature. The Administrator or designee will review Resident Council Meeting Minutes monthly to identify areas of opportunity for improvement including but not limited to food temperatures/meal service and develop plan of action and monitor resolution. The Registered Dietitian/Dietary Manager or designee will report audit findings to the Director of Nursing and Administrator. The Administrator will report a summary of the findings to the QAPI committee monthly x 3 months for any further recommendations where applicable.

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F 806	Continued From page 34	F 806		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on Resident interview, facility documentation, and clinical record review the facility staff failed to ensure the resident received food that accommodates resident preferences, for 1 Resident (#32) in a survey sample of 43 Residents. The findings include: On 2-4-2020 during the initial tour of the facility, Resident's #32, and #49 were interviewed. They were room mates. Resident #32 stated that she would request soup at meal time, and the staff always told her there was no soup, even when her room mate received it. Resident #49 supported that statement. Resident #49 went on to say that her room mate loved all soups, and that just the day before she had received tomato soup and her room mate Resident #32 had requested the same, and staff told her there was no more soup. Both Residents stated this happened on almost every occasion, and Resident #32 stated that she could not understand how they would not let her have soup.	F 806	1. Resident #32 was revisited by the Dietary Manager and Director of Food & Nutrition Services to review her specific food preferences. Resident indicated she would like soup daily. Resident #32's tray card was updated to include soup daily as a standing order. Observation of Resident #32 during a recent dinner meal confirmed she did receive soup per her request. 2. Any resident has the potential to be affected if their food preferences are not honored. An audit will be completed to identify residents who have expressed concerns with food preferences not being honored and will be visited by the Registered Dietician, Dietary Manager or designee to identify additional dietary preferences and their tray card will be updated. 3. Nursing staff will be re-educated on Resident #32's desire to have soup daily. All Dietary and Nursing staff will be re-educated on alternative menu options	3/11/20

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F 806	Continued From page 35 The facility listed soups on their posted and reviewed menus frequently. Clinical records were reviewed for both Residents and they were both found to have a "Brief Interview for Mental Status" (BIMS) score of 15 points, out of a possible 15 points, indicating, no cognitive impairment. On 2-5-2020 Resident #32's clinical record was reviewed and revealed that she was ordered to have a regular diet with mechanically ground meats because of her lack of teeth, and promoted soft substances that would be easy for her to chew. There was no prohibition in her care plan, nor dietary restrictions, for soup. The Resident had a significant weight loss previously with updates to her care plan and new orders for dietary supplements, and in her dietary evaluation, her preferences listed among them "soup." The Administrator and Director of Nursing were notified of the staff refusal to honor Resident #32's food preference at the end of day meeting on 2-5-2020. No further information was submitted by the facility.	F 806	and procedures for handling resident meal requests in a timely manner. A copy of the alternative menu options will be provided to each resident and posted in each Nourishment Pantry. 4. Registered Dietitian or designee, will conduct a random Dietary Preference/Tray Accuracy audit and re-visit Resident #32 weekly x 4 weeks, then monthly x 3 to verify resident requests are being honored. The audit findings will be reviewed by the Dietary Manager or designee and he/she will ensure any variances are addressed promptly. The Dietary Manager or designee will report audit findings to the QAPI committee monthly x 3 months for any further recommendations where applicable.	
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.	F 880		3/11/20

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F 880	Continued From page 36 §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: (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	F 880		

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F 880	Continued From page 37 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, facility document review, clinical record review, and staff interview, the facility staff failed to implement an effective infection control program for two Residents (Resident #36, & #80) in a survey sample of 43 residents. The findings included: 1. For Resident #36 the facility failed to keep an enteral feeding pump clean, which was encrusted with a tan substance resembling dried enteral feeding liquid, and failed to remove and discard a visibly soiled clear plastic bag with brown watery liquid in it, and a tan smeared dried substance on the outside of the bag. On 2-5-2020 at 10:30 a.m. Resident #36 was observed, and his enteral feeding pump was	F 880	1. Resident #36's enteral pump was cleaned. Resident # 80's enteral feed supplies were replaced. 2. Any resident has the potential to be affected if enteral feed pumps and supplies are not cleaned and supplies replaced per Center's Enteral Feed/Pump policy on cleaning and maintenance. An audit of current residents with orders for enteral nutrition will be completed to ensure pumps are clean and supplies are labeled/dated and stored per Center policy. 3. Nurses will be educated on the Center's Enteral Feed/Pump policy for cleaning and maintenance of enteral pumps and replacement of supplies. 4. Random rounds will be conducted by the Unit Manager or designee 2 x weekly	

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F 880	Continued From page 38 observed on and infusing. The feeding pump was encrusted on the top and sides with a tan substance resembling dried enteral feeding liquid. Hanging from the pole, which the pump was affixed to, was a visibly soiled gallon sized clear plastic bag. The bag was hanging behind, and touching, the graduated bag containing the feeding formula. The clear bag had no closure on top, and only contained approximately 30 milliliters of a brown watery liquid substance in it. The liquid resembled watered down tea, and a tan smeared dried substance on the outside of the bag, which looked like finger prints sliding down the bag. The Resident's clinical record was reviewed and revealed a current physician's order for the enteral feeding for Resident #36. On 2-5-2020 The observations of the dirty feeding pump and dirty fluid filled bag were observed 3 times, at 10:30 a.m., 1:30 p.m., and 3:30 p.m.. No one cleaned the pump, nor removed the soiled bag. On 2-6-2020 An interview was conducted with the infection control nurse, and policies were reviewed. The infection control nurse stated that all machines to include feeding pumps were to be kept clean, in order that bacteria would not grow on them and cause an infection for residents. The policy review agreed with that statement. On 2-6-2020 at the end of day debrief an interview was held with the Director of Nursing (DON), and the Administrator. The DON was informed of the findings. No further information was provided by the facility.	F 880	x 4 weeks then monthly x 2 months to verify enteral pumps are clean and supplies replaced per Center policy, any variances will be addressed promptly. The Director of Nursing or designee will review findings and report summary of findings to the QAPI committee monthly x 3 months for any further recommendations.	

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For Resident # 80, the facility staff failed to change the graduate cylinder since 11/23/2019.

Resident # 80, a 72 year old, was admitted to the facility in 2016. Resident 80's diagnoses included but were not limited to : Gastrostomy, Dysphagia, Dementia, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/5/2020. Resident # 80 was coded with a Brief Interview of Mental Status score of 00 indicating severe cognitive impairment and required total assistance of one to two staff person with activities of daily living.

On 2/4/2020 Resident at 7:15 PM during the initial tour, a plastic bag with a graduate cylinder inside were noted on the pole. The date written on both the bag and graduate cylinder was 11/3/2019.

On 2/5/2020 at 2:45 PM, an interview was conducted with LPN A (Licensed Practical Nurse) who stated she was not scheduled to work with Resident # 80 today but had worked with her in the past few months. LPN A stated she had administered tube feedings to the resident as ordered. LPN A stated she typically used medicine cups to flush between medications. LPN A stated she had not noticed the date on the bag and graduate cylinder were dated in November 2019.

On 2/5/2020, a copy of the policy on "Feeding Tube Pump Feedings" was presented to the surveyor. Under policy was written "4. All

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supplies (tubing, syringe, feeding sets, bags) must be labeled with resident's name, and date and time hung/replaced, and must be changed every 24 hours." footnote from Perry and Potter, Clinical Nursing Skills and Techniques. Mosby, 2004, p. 675

On 2/5/2020, an interview was conducted with the Director of Nursing who stated the graduate cylinder and bag dated 11/23/2019 should not have been still hanging at Resident # 80's bedside. The Director of Nursing stated the cylinder should have been changed every 24 hours. The Director of Nursing stated there was a concern of infection control issues due to the graduate cylinder being available for use since November 23, 2019. The Director of Nursing stated the facility staff should change the graduate cylinders every 24 hours as per policy. The Director of Nursing removed the bag and cylinder.

On 2/5/2020 at 4:45 PM, observed a new bag and graduate cylinder hanging on the tube feeding stand. The bag and cylinder were dated 2/5/2020.

On 2/6/2020 at 8:30 AM, observed no graduate cylinder or plastic bag hanging on the feeding pump stand.

On 2/6/2020 at 9 AM, an interview was conducted with the Assistant Director of Nursing who stated she was in charge of Infection Control Program at the facility. When the Assistant Director of Nursing was asked if it was acceptable for the graduate cylinder and bag to have been hanging at the bedside since 11/23/2019, she responded "No." The Assistant Director of Nursing stated the

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graduate cylinder and bag should have been changed every 24 hours as per the policy. The Assistant Director of Nursing stated she had removed the graduate cylinder and bag after discussions with the Administrative staff, Director of Nursing, and corporate nurses on 2/5/2020. The Assistant Director of Nursing stated the nursing staff would retrieve a graduate cylinder when they were ready to use it for flushes and they would be dated on that day.

On 2/6/2020 at 5:50 PM, review of a copy of the Physicians Order Summary Report revealed orders for Enteral Feed Order two times a day "Nocturnal H2O (water) flush at 50 cc/hr (cubic centimeters/per hour) from 6 pm-8 am (total of 700 cc/day)

Under was written: Dietary Supplements-Sugar free ProStat one time a day 30 cc followed by 240 cc H2O through PEG (Percutaneous Gastrostomy Tube) Order date- 9/11/2018, Start Date 9/12/2018.

Under "Other" was written
Flush feeding tube before and after med administration with 30-60 ml (milliliters) of water. Flush tube with 5-10 milliliters of water between meads every shift for Facility Protocol." Ordered 7/25/2019 and start 7/25/2019.

On 2/6/2020 during the end of day debriefing, the facility Administrator and Director of Nursing were made aware of the findings.

No further information was provided.