STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495319	A. BUILDING _____ B. WING _____	02/27/2020

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THE VIRGINIAN	9229 ARLINGTON BLVD FAIRFAX, VA 22031

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/25/2020 through 02/27/2020. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E 015		4/17/20

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

Electronically Signed | 03/19/2020

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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E 015	Continued From page 1 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to have policies and procedures for the provision of food and water, sewage management, and waste disposal. The Findings included: On 2/27/2020, the facility's Emergency Preparedness Plan was reviewed with the Facility Administrator (Employee A) and the Director of Plant Operations (Employee C). The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures for how food and water will be obtained or how sewage and waste will be disposed.	E 015	We have reached out to several vendors to receive documented evidence of support for sewage and waste disposal during an emergency situation. This new agreement will become incorporated into our Annual Assessment in addition to our Emergency Policies and procedures, which we will be updating. These will both be reviewed annually by the Administrator and Director of Plant Operations.	

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E 015	Continued From page 2 During the review, Employee A stated, "An Emergency Preparedness Plan should be proactive, that is the whole reason for being prepared". When asked about policies and procedures with regard to obtaining food and water during activation of the facility's Emergency Preparedness Plan, Employee A stated, "I see that we do not have anything specific in place, but I would just make it happen". Employee C stated, "There is no defined, specific plan for waste management--sewer or trash--we do not have arrangements for these services in the event of an emergency, I will definitely be looking into this moving forward". No further information was provided by the facility staff.	E 015		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/25/20 through 2/27/20. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated. The census in this 81 certified bed facility was 77 at the time of the survey. The survey sample consisted of 26 resident reviews.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		4/17/20

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F 561	Continued From page 3 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to facilitate resident self-determination for one resident (Resident #65) in a sample size of 26 residents. The findings included: For Resident #65, the facility failed to administer her sleeping pill at her preferred time of 8:30 PM for 7 administrations out of 22 opportunities. Resident #65, a 75-year old female, was admitted	F 561	This Resident□s medication administration schedule was immediately changed to 2030 per Resident request. The Care Plan was updated to reflect the Resident□s preferred time of administration. The Unit Manager will initiate this same question about medication time preference at each Resident□s upcoming care conference. Nurses will obtain the MD order if Resident requests a time different time of administration. Audits have been initiated to determine if other Residents are	

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F 561	Continued From page 4 to the facility most recently on 02/03/2020. Diagnoses included but not limited to insomnia and legal blindness. Resident #65's Minimum Data Set with an Assessment Reference Date of 02/09/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for bed mobility, transfers, and eating were coded as requiring extensive assistance from staff. On 02/25/20 at approximately 12:30 PM, Resident #65 was observed awake in her bed. When asked if she had any concerns about the care she received at the facility, Resident #65 stated that her evening medications were "not delivered in a timely fashion." When asked what medications she receives, Resident #65 stated it was her sleeping pills. Resident #65 stated that she would like to get them around 8:30 every evening but and sometimes she doesn't get it until after 9 or 10 PM. Resident #65 also stated that she cannot sleep without that medication and she has to "lay around waiting for those things." The Medication Administration Record was reviewed. There was a one-time dose of zolpidem [a sedative] 5 milligrams with a scheduled date of 02/04/2020 and a scheduled time of 9:00 PM. Under the header "Charted Date", it was documented, "02/04/2020 22:36 [10:36 PM]." Under the header, "Reasons/Comments", it was documented, "Late Administration: Administered late" and signed off as administered by a licensed practical nurse. Another entry on the Medication Administration Record [MAR] for zolpidem scheduled at 9:00 PM	F 561	satisfied with the timing of their medication. The Unit Managers will document current Resident medication time preferences, and do the same for every new admission. Nursing will be in-serviced to be more sensitive to individualized Resident requests, and Residents rights will be fully reviewed.	

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F 561	Continued From page 5	F 561		

documented as follows: "Zolpidem - Schedule IV tablet; 5 mg [milligrams]; Amount to Administer: ½ tablet; oral" and "Zolpidem - Schedule IV tablet; 5 mg; Amount to administer: 1 tablet; oral." Under the header "Frequency", it was documented, "At bedtime." Under the header, "Special Instructions" it was documented, "Administer 0.5 tab = 2.5 mg with one tab of 5 mg = total 7.5 mg QHS [every evening at bedtime]." It was signed off as administered every evening from 02/05/2020 through 02/24/2020 at the scheduled time of 2100 [9:00 PM]. Specific administration times could not be viewed on the MAR and there were no comments associated with the entries.

On 02/27/2020, a copy of the medication administration history for zolpidem was requested and the facility staff provided a copy of a document entitled, "Administration History" with the sub-header "zolpidem - Schedule IV tablet ...". Of the 22 administrations of zolpidem with a date range of 02/05/2020 through 02/26/2020, there were 7 encounters where zolpidem was administered between 9:00 PM and 10:00 PM.

On 02/27/2020 at approximately 12:30 PM, an interview with Licensed Practical Nurse G (LPN G) was conducted. When asked about the policy for medication administration timing, LPN G stated that they can give a medication up to one hour before or after that scheduled time. When asked about the process if a resident requests a specific time, LPN G stated that then the physician should be notified and "rearrange the order" and time it according the resident's preference.

On 02/27/2020 at approximately 2:30 PM, the administrator and DON notified of concerns and

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F 561	Continued From page 6 they offered no further documentation or information.	F 561		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property	F 574		4/17/20

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F 574	Continued From page 7 in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: The facility staff failed to provide all residents with a written description of legal rights that included email addresses of all pertinent agencies. The Findings included:	F 574	Email addresses have been added to the Grievance handouts. No Residents were affected negatively by this deficient practice. The facility will create an annual update reminder to review grievance handouts for updated information	

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F 574	Continued From page 8 The facility staff failed to ensure that their Grievance Procedure included email addresses for the Virginia Dept. of Health Office of Licensure and Certification, State Ombudsman Northern Virginia Long-Term Care, Adult Protective Services, and The Center for Quality Health Care. The facility submitted the Explanation of Grievance Procedure letter that they give to each resident upon admission. The email addresses were not included for the Virginia Dept. of Health-Office of Licensure and Certification, State Ombudsman Northern Virginia Long-Term Care, Adult Protective Services, and The Center for Quality Health Care. On 2/27/20 at 3:00 P.M., the Administrator (Employee A) was notified of the findings. No further information was received.	F 574	regarding email addresses. Executive Assistant and Administrator will be responsible for checking handouts in November 2020, when The Virginian conducts its annual assessment.	
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency	F 575		4/17/20

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F 575	Continued From page 9 concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: The facility staff failed, for all residents, to post a written description of legal rights that included email addresses of all pertinent agencies. The Findings included: The facility staff failed to post the email addresses for the Virginia Dept. of Health Office of Licensure and Certification, State Ombudsman Northern Virginia Long-Term Care, Adult Protective Services, and The Center for Quality Health Care. On 2/25/20 at 11:30 A.M., a tour was conducted of the facility, revealing a grievance procedure posted on the wall on Level B-1. The grievance procedure did not include email addresses for the Virginia Dept. of Health-Office of Licensure and Certification. On 2/27/20 at 1:00 P.M., a second tour of the facility was conducted, revealing that the above-mentioned poster had not been corrected to include the email address. The Director of Acute Care Services (Registered Nurse B) conducted the tour along with the surveyor. When asked why the email addresses had not been included, she said, "This is an old	F 575	Email addresses have been added to the posted Grievance procedures. No Residents were affected negatively by this deficient practice. The facility will create an annual update reminder to review all email addresses with these entities. Executive Assistant and Administrator will be responsible for checking these posters to ensure the email addresses are updated in November 2020, when The Virginian conducts its annual assessment.	

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F 575	Continued From page 10 poster, the Director of Nursing has changed. The poster has not been updated. The email addresses should be on it." On 2/27/20 at 3:00 P.M., the Administrator (Employee A) was notified of the findings. No further information was received.	F 575		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		4/17/20

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F 609	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed, for 1 resident (Resident #3) in the survey sample of 26 residents, to report an injury of unknown injury within 2 hours of the allegation and failed to submit a follow-up report within 5 working days. The Findings included: Resident #3 was a 101 year old. Resident #3's diagnoses included Dementia, and Generalized Muscle Weakness. Quarterly Minimum Data Set dated 11/23/19 was reviewed. Resident #3 was coded with a Brief Interview of Mental Status Score of 0, indication severe cognitive impairment. Resident #3 was also coded as requiring the extensive physical assistance of 1 person for eating, mobility, and dressing. Resident #3 utilized a wheelchair for mobility. On 2/27/20 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 1/22/20. The incident occurred on 1/21/20. An excerpt read, "Resident was noted with a dark blue bruise on a tiny .0.2 cm. [centimeters] to the bridge of her nose this morning. Interviewed resident. Stated that she was hit on the nose by a male after dinner." Investigation statements from one nurse and three aides, including 1 male aide were reviewed. None of the staff recalled seeing a bruise on Resident #3's face. The follow-up report was submitted to the State Agency on 2/10/20. An	F 609	Policies regarding submission of the final 5 day report were updated to highlight the importance of this regulation. No other cases were affected. The Administrator and Director of Nursing will work in tandem to ensure the final report is submitted to the appropriate agencies within a 5 day timeframe. All FYI□s will be submitted to the QA Committee for the next 2 quarters for assurance of compliance.	

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excerpt read, "Resident, age 101, contends she was hit in the face. This resident is frequently confused, and we strongly believe it is her glasses that caused the bruise and small scratch. He daughter told us she has always bruised easily and our staff reports that her skin is extremely frail. This Resident has not had any incidents since this on 1/21/20."

On 2/27/20 a review was conducted of Resident #3's clinical record, revealing a care plan. An excerpt read, "2/22/20. Resident has a bruise and scratches on her nose. Dress resident in long sleeve pants and shirts. Protect extremities. File fingernails on bath days. Weekly shin assessments were reviewed. There were no other bruising of unknown origin either before or after the incident.

On 2/27/20 at 10:00 A.M., an observation was conducted of Resident #3 in her bed. She appeared clean, and dressed in a long-sleeve shirt and long pants appropriately. Resident #3's face was free of any signs of bruising or injury. The Director of Nursing (Employee -B) was interviewed. She stated that Resident #3 did not like to wear her glasses, and had a history of pushing them across her face in a rough manner, causing a bruise on the bridge of her nose. The staff no longer put her glasses on, in conjunction with her wish. When asked why Resident #3's incident report was not submitter within 2 hours of the allegation, and the follow up was not submitted within 5 working days, the DON stated that she didn't know why they were submitted late.

The facility Abuse Reporting policy dated February, 2020 was reviewed. An excerpt read,

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F 609	Continued From page 13 "...ensure that all allegation s of abuse, neglect...injuries of unknown source...are reported immediately, but no later that 2 hours after the allegation is made if the events that cause the allegation involve abuse...the facility must investigate the incident, implement corrective action, and file a written report...within 5 working days of the incident." On 2/27/20 at approximately 4:30 P.M., the Administrator (Employee A) was informed of the findings. The Administrator was unable to recall why the follow up report to the Facility Reported Incident was not submitted to the State Agency within 5 working days of Resident #3's injury. No further information was submitted.	F 609		
F 656 SS=E	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	F 656		4/17/20

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F 656	Continued From page 14 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed, for 3 residents of 26 residents (Resident #60, Resident #65, Resident #61) to implement the care plan. The Findings included: 1. For Resident #60, the facility staff failed to implement the fall prevention care plan, by ensuring that her call bell was placed within a safe reaching distance. This resulted in Resident #60 lurching to reach it, falling out of the wheelchair and sustaining a fracture of the left arm.	F 656	#60 The fall prevention care plan was updated to ensure her call bell will be placed within a safe reaching distance. The Resident□s call light was also exchanged for a pancake style call light. The DON/ADON will conduct a house-wide audit of Residents with high fall risk/ history of falls and implement care plans if required. Nurses will be in-serviced to update care plans for Residents with high fall risk or history of falls. Unit Managers/ADON will audit new admissions within 24 hours to ensure care plan addresses risk for falls, if required and diagnosis of dementia/psychotropic medications. ADON will audit five fall	

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F 656	Continued From page 15 Resident #60 was a 76 year old. Resident #60's diagnoses included Aftercare following Joint Replacement surgery Right Shoulder, Primary Osteoarthritis-Right Shoulder, Bicipital tendonitis, Right Shoulder, Abnormalities of Gait and Mobility, Generalized Muscle Weakness, and Glaucoma. The Admission Minimum Data Set, dated 1/24/20 was reviewed. Resident #60 had a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. Resident #60 was coded as requiring the physical assistance of 1 person for eating, transfers, dressing and ambulation. On 2/25/20 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 1/30/20. An excerpt read, "Acute, Non-displaced fracture of the proximal Humerus. Resident pushed her bedside table after breakfast & fell forward with the table. Staff heard her calling for help. She was found on the floor in a prone position." On 2/25/20 at 11:02 A.M., an interview was conducted of Resident #60 in her room. She stated that there was no staff person in her room to assist her with her meal on the morning of her fall. She said that her right shoulder was inoperable due to a recent surgery. She said that during breakfast a staff member put her wheelchair near the bottom left of her bed, with her right shoulder closest to the bed. After she was put into her wheelchair by a staff member, The call bell was never moved from it's position on the right side of the bed near the outer edge, halfway down the mattress. The call bell was approximately 3 feet away from her left hand,	F 656	risk/prevention care plans each week for two months. The Social Services designee will audit five dementia care plans dated within five days of admission. #65 The Care plan was updated to include diagnosis of insomnia and preferred time of administration. Social Services will conduct an audit of Residents who receive psychotropic medications and implement care plans. Social Services Coordinator will audit new admissions with 24 hours to ensure compliance. #61This care plan was immediately updated to reflect this Resident□s interests and preferences. The Life Enrichment Director will conduct an audit to ensure every Resident□s plan of care reflects each Resident□s preferences and interests. The Director of Life Enrichment and Administrator will be responsible for conducting future spot-checks each week, for 3 months. The Life Enrichment staff will receive in-services to ensure understanding of the importance of this regulation.	

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which was her only working hand. She had to reach across her body and lurch toward the call bell. As she grabbed it, she fell out of the wheelchair onto the floor, with a force that pulled the call bell cord out of the wall. Resident #60 said that she fell and broke her left arm, and experienced a high level of pain. Resident #60 stated that she was subsequently given a pad-type call bell, which was easier to use. She originally had a standard plunger-type of call bell. She stated that she was on the floor screaming for a couple of minutes before staff came in to assist her. She subsequently was hospitalize.

On 2/27 a review was conducted of Resident #60's clinical record, revealing a care plan. An excerpt read, "ADL [Activities of Daily Living]. Resident needs assistance with daily ADL care...need setup with eating. At risk for impaired nutrition...Staff to provide cut-up assistance at meal times as needed...potential for falls... Keep personal items within reach. 1/31/20 Regular call bell was changed to easy touch call."

On 2/27/20 at approximately 4:30 P.M., the Administrator (Employee A) was informed of the findings. No further information was submitted.

2. For Resident #65, the facility staff failed include her diagnosis of insomnia on the care plan and preferred time for medications.

Resident #65, a 75-year old female, was admitted to the facility most recently on 02/03/2020. Diagnoses included but not limited to insomnia and legal blindness.

Resident #65's Minimum Data Set with an

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Assessment Reference Date of 02/09/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for bed mobility, transfers, and eating were coded as requiring extensive assistance from staff.

On 02/25/20 at approximately 12:30 PM, Resident #65 was observed awake in her bed. When asked if she had any concerns about the care she received at the facility, Resident #65 stated that her evening medications were "not delivered in a timely fashion." When asked what medications she receives, Resident #65 stated it was her sleeping pills. Resident #65 stated that she would like to get them around 8:30 every evening but and sometimes she doesn't get it until after 9 or 10 PM. Resident #65 also stated that she cannot sleep without that medication and she has to "lay around waiting for those things."

On 02/27/2020, a copy of the medication administration history for zolpidem was requested and the facility staff provided a copy of a document entitled, "Administration History" with the sub-header "zolpidem - Schedule IV tablet ...". Of the 22 administrations of zolpidem with a date range of 02/05/2020 through 02/26/2020, there were 7 encounters where zolpidem was administered between 9:00 PM and 10:00 PM.

The care plan was reviewed. There were no goals, interventions, or resident preferences addressed associated with the problem of insomnia.

On 02/27/2020 at approximately 2:30 PM, the administrator and DON notified of concerns and

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they offered no further documentation or information.

3. For Resident #61, the facility staff did not assess, plan, or implement in-room activities.

Resident #61, a 77-year old female, was admitted to the facility on 01/31/2020. Diagnoses included but not limited to debility, pressure wounds, heart failure, muscle weakness, and depression.

Resident #61's Minimum Data Set with an Assessment Reference Date of 02/06/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff.

On 02/25/2020 at approximately 1:15 PM, Resident #61 was observed in her room awake, watching TV. When asked if she was able to participate in activities, Resident #61 stated that her physician didn't want her out of bed much until her wound healed and added that "in-room activities would be nice." When asked what interested her, Resident #61 stated that she likes to play cards, dominoes, and board games. Resident #61 also stated it was boring watching TV reruns over and over.

On 02/26/2020, the care plan was reviewed. An activity plan, goals, measures, or preferences were not addressed in the care plan.

On 02/27/2020 at 12:35 PM, an interview with

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F 656	Continued From page 19 Employee D, the Activities Leader, was conducted. When asked about Resident #61's activity preferences, Employee D stated that Resident #61 "watches TV, she reads sometimes, she eats ice cream." When asked about Resident #61's plan for activities, Employee D stated that "we do one-on-one in her room when she's up but most of the time she's sleeping." Employee D also stated "I'm on that unit every day and I see about her [Resident #61] twice a week." When asked about documentation regarding those visits, Employee D stated, "I haven't documented my visits - she's usually sleeping." Employee D also stated that she has seen Resident #61 reading the newspaper and "her TV is always on." When informed Resident #61 stated she likes cards, dominoes, and board games, Employee D stated she would "see if I can get her some board games" and also locate a volunteer to be with [Resident #61]." When asked about the importance of activity services, Employee D stated it was important to "keep their mind going" and to "avoid isolation and depression." On 02/27/2020 at approximately 2:30 PM, the administrator and DON were notified of concerns. The administrator stated her expectation is that activity assessment would be completed within 5 days of admission to learn preferences and verified that there were no activity service notes for Resident #61. The administrator and DON confirmed the expectation is to include activity services on the care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		4/17/20

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F 657	Continued From page 20 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure a therapeutic diet was care planned for one resident (Resident #28) in a survey sample of 26 residents. The findings included: Resident #28 had a therapeutic diet and need for avoidance of certain foods. The diet and the recommendations were not care planned.	F 657	This Resident□s diet has been reviewed by the registered dietitian and speech language pathologist to ensure the diet ordered in the Physician's order sheet matches the Care Plan documentation. To ensure all Residents' diets are care planned, the registered dietitian will do a weekly review of all diet orders, for two months, and will confirm orders are accurate and up to date in the care plan. This will be discussed and reviewed at	

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F 657	Continued From page 21 Resident #28 was admitted to the facility on 12-25-19. Diagnoses included; Stroke with dysphagia, aneurysm of the brain, heart failure, and history of pneumonia. Resident #28's most recent Minimum Data Set assessment was an admission assessment with an assessment reference date of 12-31-19. The Resident was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. The Resident required extensive assistance from staff with all activities of daily living, including being fed all meals. Resident #28's lunch meals were observed on 2-25-2020, and 2-26-2020 at 11:30 a.m. The meal tray ticket read "Regular Mechanical Soft (level 3) no allergies, no preferences, dislikes oatmeal, regular coffee & iced tea, Staff to provide feeding assistance as needed. The Resident had thin consistency iced tea on both trays. Resident #28's clinical record was reviewed. Included was a physician's order dated 12-27-19, which read ST (Speech Therapist) clarification; "mechanical soft diet with nectar thick liquids." This order was current and had not been changed as of the time of survey. On 2-25-2020, and 2-26-2020 the Resident was observed with thin consistency liquids consumption at lunch. Speech Language Pathologist (SLP) notes were reviewed and revealed that from 12-27-19 through discharge of SLP treatment on 2-14-2020, the SLP had been evaluating and treating Resident #28. On 2-10-2020 the SLP notes revealed the following entry; "Patient may	F 657	weekly IDT meetings.	

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be at increased choking risk with certain regular PO (by mouth) textures. SLP plans for discharge next session; however, SLP to create a list of foods that patient may consume and provide to dietician and dietary prior to discharge."

On 2-26-2020 the Dining Services Manager, and nursing staff on the memory care unit where Resident #28 resided were asked to provide the dietary foods that the Resident could safely eat. The dietary manager for the unit, and the Licensed Practical Nursing staff (LPN D, and LPN E) all answered that they were not aware of any safe or unsafe list of foods for the Resident. The tray ticket also did not list safe or unsafe foods for the Resident.

RD notes were reviewed and revealed that nursing staff had reported to her that the Resident had experienced coughing when swallowing during meals.

On 2-27-2020 at 11:00 a.m., The RD, and SLP were interviewed together in the conference room with all surveyors. They were asked how the diet orders were communicated to the nursing staff and to the kitchen. They stated that they would call and tell them about the changes. In addition, they went on to say they were more worried about the Resident being laid down with cheeks full of food, and that staff needed to make sure there was no food in the Residents mouth after a meal. They stated that the Resident had a habit of "pocketing" food, and they did not want her to aspirate it into her lungs during or after eating. They were asked why none of the baseline staff who delivered meals and fed residents were aware of her specific needs. They stated changes needed to be made in communicating

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F 657	Continued From page 23 that information. They were asked if they took part in the interdisciplinary care planning process for the Resident, and both stated "Sometimes, but that their recommendations were documented in their notes and could be accessed at any time by staff." The SLP was asked for the list of safe foods for the Resident, and she stated "I don't have one, I need to make some changes, I see that now." The care plan was reviewed, and revealed a nutrition care plan, however, no interventions for the following: No notation of need for staff to feed the Resident, no specified type of diet or liquid consistency, no specified safe foods for the Resident, no specified sips of fluids between bites to rinse food out of the cheeks/pocketing, no checks to assess if the Resident had pocketed food in the cheeks, and no assessment of, nor reporting of, coughing during or after feeding as a sign that the diet may not be tolerated by the Resident. All areas of concern which were documented in the RD and SLP notes. The Administrator, and Director of Nursing were notified of the failure to supply the correct therapeutic diet for Resident #28 at the end of day meetings on 2-26-2020, and 2-27-2020. No further information was available to be supplied by the facility.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		4/17/20

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F 679	Continued From page 24 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide individualized activity services for one resident (Resident #61) in a sample size of 26 residents. The findings included: For Resident #61, the facility staff did not assess, plan, or implement in-room activities. Resident #61, a 77-year old female, was admitted to the facility on 01/31/2020. Diagnoses included but not limited to debility, pressure wounds, heart failure, muscle weakness, and depression. Resident #61's Minimum Data Set with an Assessment Reference Date of 02/06/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff. On 02/25/2020 at approximately 1:15 PM, Resident #61 was observed in her room awake, watching TV. When asked if she was able to participate in activities, Resident #61 stated that	F 679	This Resident was immediately visited by our Life Enrichment staff, who reported she was happy to receive word searches and crosswords. Rt. refused our offer of an iPad, which she knows how to use. Her initial assessment was documented The Care Plan has been updated. An audit is being conducted by the Life Enrichment Director /designee to determine if other Residents are affected. The Life Enrichment staff will create a new system for highlighting new admissions, and care plan due dates. This deficiency will be marked for review at our next QA meeting to ensure compliance. Audits will be completed to ensure all new and current Residents have Activities care plans and assessments dated within 5 days of admission.	

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her physician didn't want her out of bed much until her wound healed and added that "in-room activities would be nice." When asked what interested her, Resident #61 stated that she likes to play cards, dominoes, and board games. Resident #61 also stated it was boring watching TV reruns over and over.

On 02/25/2020 at approximately 4:05 PM, Resident #61 was observed awake in bed watching TV.

On 02/26/2020 at approximately 10:00 AM, Resident #61 was awake in bed. The TV was on in her room.

On 02/27/2020 at 12:35 PM, an interview with Employee D, the Activities Leader, was conducted. When asked about Resident #61's activity preferences, Employee D stated that Resident #61 "watches TV, she reads sometimes, she eats ice cream." When asked about Resident #61's plan for activities, Employee D stated that "we do one-on-one in her room when she's up but most of the time she's sleeping." Employee D also stated "I'm on that unit every day and I see about her [Resident #61] twice a week." When asked about documentation regarding those visits, Employee D stated, "I haven't documented my visits - she's usually sleeping." Employee D also stated that she has seen Resident #61 reading the newspaper and "her TV is always on." When informed Resident #61 stated she likes cards, dominoes, and board games, Employee D stated she would "see if I can get her some board games" and also locate a volunteer to be with [Resident #61]." When asked about the importance of activity services, Employee D stated it was important to "keep their

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F 679	Continued From page 26 mind going" and to "avoid isolation and depression." On 02/27/2020 at approximately 2:30 PM, the administrator and DON were notified of concerns.	F 679		
F 689 SS=G	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, clinical record review, and facility documentation review, the facility staff failed to ensure that 2 residents. (Resident #60) and (Resident #8) in the survey sample of 26 residents were free of accidents hazards. This resulted in harm for Resident #60. The Findings included: 1. For Resident #60, the facility staff failed to ensure that her call bell was placed within a safe reaching distance, resulting in her leaning to reach it, losing her balance, and pulling the call bell cord out of the wall as she fell forward. This resulted in a left arm fracture. This is harm. Resident #60 was a 76 year old. Resident #60's diagnoses included Aftercare following Joint Replacement surgery Right Shoulder, Primary	F 689	Staff immediately confirmed that the Resident□s call bell was placed within a safe reaching distance. The Resident□s call light was also exchanged for a pancake style call light. The DON/ADON will conduct a house-wide audit of Residents with high fall risk/ history of falls and implement care plans if required. Unit Managers will round daily to ensure call lights are placed within Resident□s reach. Unit Managers will round five Residents□ rooms per week for two months.	4/17/20

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F 689	Continued From page 27	F 689		

Osteoarthritis-Right Shoulder, Bicipital tendonitis, Right Shoulder, Abnormalities of Gait and Mobility, Generalized Muscle Weakness, and Glaucoma.

The Admission Minimum Data Set, dated 1/24/20 was reviewed. Resident #60 had a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. Resident #60 was coded as requiring the physical assistance of 1 person for eating, transfers, dressing and ambulation.

On 2/25/20 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 1/30/20. An excerpt read, "Acute, Non-displaced fracture of the proximal Humerus. Resident pushed her bedside table after breakfast & fell forward with the table. Staff heard her calling for help. She was found on the floor in a prone position." The Follow-up report was not submitted by the Administrator (Employee A) until 2/10/20. An excerpt read, "Resident, age 75 is recuperating from the results of her fall, which occurred as she pushed away her bedside tray from her bed after breakfast. We do not believe there was anything unusual about this incident, and certainly no suspicion of abuse was considered."

On 2/25/20 at 11:02 A.M., an interview was conducted of Resident #60 in her room. She stated that there was no staff person in her room to assist her with her meal on the morning of her fall. She said that her right shoulder was inoperable due to a recent surgery. She said that during breakfast a staff member put her wheelchair near the bottom left of her bed, with her right shoulder closest to the bed. After she was put into her wheelchair by a staff member,

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The call bell was never moved from it's position on the right side of the bed near the outer edge, halfway down the mattress. The call bell was approximately 3 feet away from her left hand, which was her only working hand. She had to reach across her body and lurch toward the call bell. As she grabbed it, she fell out of the wheelchair onto the floor, with a force that pulled the call bell cord out of the wall. Resident #60 said that she fell and broke her left arm, and experienced a high level of pain. Resident #60 stated that she was subsequently given a pad-type call bell, which was easier to use. She originally had a standard plunger-type of call bell. She stated that she was on the floor screaming for a couple of minutes before staff came in to assist her. She subsequently was hospital.

On 2/26/20 the second day of the survey, the facility obtained a written statement from Resident #60. An excerpt read, "I sat in the wheelchair by the left side of the bed for breakfast. I finished my breakfast and the tray was on the table that was in front of the wheelchair, then I tried to reach the call light on top of the bed that was far away from me. I lost my balance and fell onto my left side facing the wall. The table moved forward in front of me."

The incident report signed by LPN-J was reviewed. An excerpt read, "...she pushed away the bedside table that was in front of the chair and she went forward with the table. This writer went to the resident's room and observed resident in a prone position, the bedside table in front of her and the call light hanging by the left side of the bed close to her." LPN-J did not state in the report that the call light had been pulled out of the wall by Resident #60."

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On 2/27/20 at approximately 4:00 P.M., an interview was conducted with Licensed Practical Nurse J (LPN -J). LPN-J was the staff person who wrote the incident report, because she responded to Resident #60's call for help after the fall. LPN-J stated, "The call light was on She was yelling. I was busy passing meds. I can't tell how long the call light was on, the yelling alerted me. When asked why there was no Certified Nursing Assistant assisting Resident #60, LPN-J said, "They were all busy helping other residents who needed assistance. She told me I want the tray to be taken out. She told me at the time that the call bell was out of reach. The new one is much better, it is more sensitive to the touch." When asked why she didn't document Resident #60's statement about the call bell being far away from her, LPN-J did not state the reason.

On 2/27/20 the call bell Zone Activity Report was reviewed. It documented that on 1/30/20 from 8:54:28 A.M., until over 2 minutes later at 8:57:54 the call bell experienced "Circuit Trouble", indicating that it had been abruptly disconnected from the wall. This was at the time of the fall. Prior to the fall, the call bell was working and had been rung at 7:54:05 A.M. and responded to at 7:54:33 A.M.

On 2/27 a review was conducted of Resident #60's clinical record, revealing a care plan. An excerpt read, "ADL [Activities of Daily Living]. Resident needs assistance with daily ADL care...need setup with eating. At risk for impaired nutrition...Staff to provide cut-up assistance at meal times as needed...potential for falls... Keep personal items within reach. 1/31/20 Regular call bell was changed to easy touch call."

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The x-ray report dated 1/30/20 was reviewed. An excerpt read, "Acute, Non-Displaced Fracture of the Proximal Left Humerus." Resident #60 was sent to the hospital, and returned that day with her arm in a sling. The physician order was reviewed. An excerpt read, "Sling to left upper arm at all times except for hygiene or the routine ROM [Range of Motion]."

The facility staff conducted an inservice during the survey on 2/26/20 -2/27/20 regarding placing the call bell within reach.

On 2/27/20, a review of facility documentation was conducted, revealing a Call Light Answering policy dated November, 2018. An excerpt read, "When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident."

On 2/27/20 at approximately 4:30 P.M., the Administrator (Employee A) was informed of the findings. No further information was submitted.

2. For Resident #8, the facility staff failed to ensure that his call bell was within reach for two consecutive days during the survey.

Resident #8 was a 90 year old. Resident #8's diagnoses included Heart Failure, Wheezing, and Acute Bronchitis.

The Quarterly Minimum Data Set dated 11/21/19 was reviewed. Resident #8 had a Brief Interview of Mental Status Score of 14, indicating no cognitive impairment. Resident #8 was coded as requiring the extensive physical assistance of 1

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person for toileting, transfers, Wheelchair locomotion, and toileting. In addition to also having impaired range of motion in the upper and lower extremities on both sides.

On 2/25/20 at 11:29 A.M., an observation was conducted of Resident #8 in his wheelchair, sitting in his room. The Call bell was on the floor between his bed and the night stand. The resident stated that the call light is often on the floor, and he has to bend down while in his wheelchair to pick it up. On 2/26/20 at approximately 1:00 P.M., a second observation was made of Resident #8's call bell on the floor between the bed and the nightstand. It was in that same position on the first day of the survey. Licensed Practical Nurse I was immediately interviewed inside of Resident #8's room. She was asked where Resident #8's call bell was located. She stated, "I don't see it." When asked about the importance of the call bell being within Resident #8's reach, LPN-I stated, "So that when he's calling for help, the CNA [Certified Nursing Assistant] can come in quickly."

On 2/26/20 a review was conducted of Resident #8's care plan. An excerpt read, "ADL [Activities of Daily Living] Functional/Rehabilitation. Resident requires limited assistance from one person for upper body dressing, and extensive assistance from one person for personal hygiene, lower body dressing and transfers.

On 2/27/20, a review of facility documentation was conducted, revealing a Call Light Answering policy dated November, 2018. An excerpt read, "When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident."

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F 689	Continued From page 32 On 2/27/20 at approximately 4:30 P.M., the Administrator (Employee A) was informed of the findings. No further information was submitted.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 store respiratory equipment according to professional standards of practice, for one resident (Resident # 18) in a survey sample of 26 residents. The Findings Included: 1. For Resident # 18, the facility staff failed to store the sterile water for oxygen concentrator in a sanitary manner. During the initial tour of the facility on 2/25/2020, Resident #18's oxygen concentrator was observed with an opened bottle of sterile water dated 12/12/2019 attached to the oxygen concentrator. Resident # 18 was a 94 year old admitted to the facility in 2019 with the diagnoses of, but not limited to, History of Pelvic Fracture, Dementia	F 695	#18 Sterile water on concentrator was removed from room. A walk through of all Resident rooms where respiratory equipment is present was conducted, and all equipment checked for any expired water. The DON/ADON/ in tandem with the Unit Manager will conduct weekly rounding of rooms, for two months, specifically to check respiratory equipment for sterile water expiration dates.	4/17/20

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with Behavioral Disturbances, Congestive Heart Failure, Major depressive Disorder, Chronic Kidney Disease, Dysphagia, Hypertension and Paroxysmal Atrial Fibrillation.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/17/2019. The MDS coded Resident # 18 with a BIMS (Brief Interview for Mental Status) of 5/15 indicating severe cognitive impairment; Resident # 18 required extensive assistance of one staff person to two staff persons with activities of daily living. Resident # 18 was also coded as always incontinent of bowel and bladder. Resident # 18 was not coded as requiring oxygen therapy.

During the initial tour of the facility on 2/25/2020 at 1:39 PM, Resident #18's oxygen concentrator was observed with an opened bottle of sterile water dated 12/12/2019 attached to the oxygen concentrator.

Resident #18's room was observed during initial tour of the facility on 02/25/2020 at 1:39 p.m. At that time, it was noted that Resident #18 had an oxygen concentrator located on the right side of the bed near the head of the bed (if facing the bed). The sterile water container attachment was observed to be open and dated 12/12/2019.

On 2/25/2020 at 1:40 p.m., an interview was conducted with LPN (Licensed Practical Nurse) A stated that oxygen equipment should always be changed once a week on the night shift. LPN #A also stated that the order for oxygen was on a PRN (As Needed) basis for Resident # 18. LPN A stated Resident # 18 had not used the oxygen in a long time. LPN A stated she would remove

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the oxygen concentrator from the room. Observed LPN A removed the oxygen concentrator from the room immediately.

On 2/25/2020 during the end of day debriefing, the facility administrator and Director of Nursing were informed of the findings of the opened sterile water container attached to the oxygen concentrator and dated 12/12/2019. The Director of Nursing stated she had been informed by the nursing staff that the sterile water container had not been changed since December 2019. Copies of the care plan, facility policy on Respiratory Therapy, were requested.

The next day, 02/26/2020, it was noted that the oxygen concentrator was not in the room any longer.

Review of the electronic clinical record was conducted on 2/25/2020 and 2/26/2020.

Review of the Physicians Orders revealed an order -Start date 12/6/2019 "Oxygen Special Instructions: Give 3 liters via nasal cannula if oxygen saturation is below 90% Every Shift-PRN [As Needed] Day, Evening, Night"

A review of the facility policy on "Respiratory Therapy" revealed the following under the heading "Procedure- Oxygen Administration": "2. Oxygen flow is routinely humidified except for emergently used tanks.

3. Use pre-filled, disposable sterile water oxygen humidifiers, dispose when empty if used continuously.

4. Partially empty humidifiers may remain

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F 695	Continued From page 35 connected to the tank or concentrator for up to 7 days before disposal. " The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 02/25/2020. On 2/26/2020 at 8:25 AM, the Director of Nursing presented copies of the Medication Administration Records for December 2019- February 2020 and stated that Resident # 18 did not receive oxygen during that period of time. The Director of Nursing stated the opened bottle of sterile water should not have been in the room and available for use since December 2019. No further documentation was provided.	F 695		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, the facility staff failed to establish a dementia care plan for one resident (Resident # 18) in the survey of sample of 26 residents. The Findings Include: For Resident # 18, the facility staff failed to have a dementia care plan. Resident # 18 was a 94 year old admitted to the	F 744	The Care plan was updated to address cognitive deficits. Social Services will conduct an audit of Residents with cognitive deficits, and ensure individualized care plans are written and implemented. The Director of Social Services will conduct weekly audits to ensure all new residents with cognitive deficits have an appropriate plan of care, to include any psychotropic medications they may be taking. Nurses will be	4/17/20

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F 744	Continued From page 36 facility in 2019 with the diagnoses of, but not limited to, Dementia with Behavioral Disturbances, Congestive Heart Failure, Major depressive Disorder, Chronic Kidney Disease, Dysphagia, Hypertension and Paroxysmal Atrial Fibrillation. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/17/2019. The MDS coded Resident # 18 with a BIMS (Brief Interview for Mental Status) of 5/15 indicating severe cognitive impairment; Resident # 18 required extensive assistance of one staff person to two staff persons with activities of daily living. Resident # 18 was also coded as always incontinent of bowel and bladder. Review of the clinical record was conducted on 2/25/2020 and 2/26/2020. Review of the 19 pages of the care plan revealed no care plan for dementia. On Page 2 of 19 was Category: Drug Therapy-Antipsychotic Drug Therapy: Potential for complications related to Antipsychotic medication use. On Page 4 of 19 was Category: Psychosocial Well-being The choice has been made by the resident/family to continue to resident at this community in a long term care setting. On Page 7 of 19 was Category: Drug Therapy Antidepressant Drug Therapy: Potential for complications related to antidepressant medication use. On Page 8 of 19 was Category:	F 744	in-serviced to update care plans for Residents with high fall risk or history of falls. Unit Managers/ADON will audit new admissions within 24 hours to ensure care plan addresses risk for falls, if required and diagnosis of dementia/psychotropic medications. ADON will audit five fall risk/prevention care plans each week for two months. The Social Services designee will audit five dementia care plans dated within five days of admission.	

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Psychosocial/Behavioral Antianxiety Drug Therapy: Potential for complications related to Antianxiety medication use

On Page 12 was Category: Psychosocial well-being. Safety: Resident is at risk for altered mood, impaired adjustment ability to new environment.
O
Drug Therapy, Code Status, Nutritional Status, Falls, ADL Functioning/Rehab Potential Activities, Integumentary System -Risk for pressure ulcers, Integumentary System-Skin tear.

During the end of day debriefing on 2/26/2020, the administrator and Director of Nursing were informed of the finding of no care plan for dementia.

On 2/26/2020 at approximately 5 PM, an interview was conducted with the Director of Nursing who stated there was a care plan for use of Antipsychotic medications that addressed the behaviors. When asked if use of Antipsychotic medications was synonymous with a plan for dementia diagnosis, the Director of Nursing stated "No, but it addresses the behaviors."

Further review of the care plan revealed no documentation of a dementia care plan. There was no mention of altered cognition.

On 2/27/2020 at 10:10 AM, the Director of Nursing stated there was no Dementia Care Plan for Resident # 18. The Director of Nursing stated the care plans should be tailored for each resident.

No further information was provided.

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F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure an SLP (Speech Language Pathologist), Registered Dietician (RD), and physician ordered therapeutic diet recommendations were provided for one resident (Resident #28) of the 26 residents in the survey sample. The findings included: Resident #28 had an SLP, physician, and RD ordered dysphagia diet plan for avoidance of certain foods which caused the Resident choking. The foods were not provided. Resident #28 was admitted to the facility on 12-25-19. Diagnoses included; Stroke with dysphagia, aneurysm of the brain, heart failure, and history of pneumonia. Resident #28's most recent Minimum Data Set assessment was an admission assessment with an assessment reference date of 12-31-19. The Resident was coded with a Brief Interview of Mental Status score of 3 indicating severe	F 808	This Resident□s diet has been reviewed by the registered dietitian and speech language pathologist to ensure the diet ordered in the Physician's order sheet matches what she has received at meal time, a regular, mechanical soft, thin liquid diet, which she has been receiving. To ensure the Residents continue to receive the proper diets, the registered dietitian has conducted an audit of all diets to ensure the EMR orders match the dietary tray card system. To ensure that the diets will continue to be accurate, the registered dietitian will conduct this audit weekly for two months, and will be discussed and reviewed at weekly IDT meetings.	4/17/20

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F 808	Continued From page 39	F 808		

cognitive impairment. The Resident required extensive assistance from staff with all activities of daily living, including being fed all meals.

Resident #28's lunch meals were observed on 2-25-2020, and 2-26-2020 at 11:30 a.m. The meal tray ticket read "Regular Mechanical Soft (level 3) no allergies, no preferences, dislikes oatmeal, regular coffee & iced tea, Staff to provide feeding assistance as needed. The Resident had thin consistency iced tea on both trays.

Resident #28's clinical record was reviewed. Included was a physician's order dated 12-27-19, which read ST (Speech Therapist) clarification; "mechanical soft diet with nectar thick liquids." This order was current and had not been changed as of the time of survey. On 2-25-2020, and 2-26-2020 the Resident was observed with thin consistency liquids consumption at lunch.

Speech Language Pathologist (SLP) notes were reviewed and revealed that from 12-27-19 through discharge of SLP treatment on 2-14-2020, the SLP had been evaluating and treating Resident #28. On 2-10-2020 the SLP notes revealed the following entry; "Patient may be at increased choking risk with certain regular PO (by mouth) textures. SLP plans for discharge next session; however, SLP to create a list of foods that patient may consume and provide to dietician and dietary prior to discharge."

On 2-26-2020 the Dining Services Manager, and nursing staff on the memory care unit where Resident #28 resided were asked to provide the dietary foods that the Resident could safely eat. The dietary manager for the unit, and the

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F 808	Continued From page 40 Licensed Practical Nursing staff (LPN D, and LPN E) all answered that they were not aware of any safe or unsafe list of foods for the Resident. The tray ticket also did not list safe or unsafe foods for the Resident. RD notes were reviewed and revealed that nursing staff had reported to her that the Resident had experienced coughing when swallowing during meals. On 2-27-2020 at 11:00 a.m., The RD, and SLP were interviewed together in the conference room with all surveyors. They were asked how the diet orders were communicated to the nursing staff and to the kitchen. They stated that they would call and tell them about the changes. The Administrator, and Director of Nursing were notified of the failure to supply the correct therapeutic diet for Resident #28 at the end of day meetings on 2-26-2020, and 2-27-2020. No further information was available to be supplied by the facility.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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	F 812		4/17/20

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F 812	Continued From page 41 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 documentation review, the facility staff failed to store food in accordance with standards for food service safety. The Findings included: 1. Facility staff failed to obtain temperatures for 2 days out of 31 in January 2020 to ensure safe food storage for the "Walk In Refrigerator in Loading" and "Walk In Freezer in Loading", located in the back of the main kitchen. On 02/25/2020 at approximately 12:15 PM, a tour of the kitchen took place with the facility Director of Food and Beverage (Employee F) and a review of temperature logs for January 2020 located on the front of a walk-in refrigerator and walk-in freezer revealed no temperature documentation for January 18th and 19th for both units. Employee F stated, "I would expect to see these logs filled out in its entirety as that is the only way to know the temperatures were checked on that day and to check that the units [refrigerator and freezer] were cooling correctly, I do not know why they were not filled out on those days". On 02/26/2020, a facility policy entitled, "Food Safety Requirements", dated 11-2018, was	F 812	An immediate in-service has been conducted to review the importance of recording daily refrigerator log temperatures. Undated food was discarded. No Residents have been adversely affected. In-services on maintaining the temperature logs and food storage requirements have been conducted across all food and beverage employee shifts. The Director of Food and Beverage or designee, will monitor these logs and check refrigerators for labelled and dated stored food, on a daily basis for 2 weeks, then once a week for 2 months. Any anomalies will be reported to the Administrator and developed into a performance improvement plan.	

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F 812	Continued From page 42	F 812		

received and reviewed. Excerpts include, "All refrigerators will be at or below 41 degrees F" and "Document the temperature of external and internal refrigerator gauges. Refrigerators must be 41 degrees or less". The Facility Administrator (Employee A) was informed of the findings on 02/26/2020 at approximately 3:30 PM and no additional information was received during the remainder of the survey.

2. Facility staff failed to properly label and date food items stored in the refrigerator identified as "Cook's Under the Grill" located in the main kitchen.

2a) On 02/25/2020 at approximately 12:15 PM, a tour of the kitchen took place with the facility Director of Food and Beverage (Employee F). During visual inspection of the contents located in the refrigerator unit identified as "Cook's Under the Grill", a plastic container labeled "Tuna" was observed without a date. Employee F confirmed that it was tuna salad, a mixture containing tuna fish and mayonnaise, and that this tuna salad had been made at the facility. Employee F stated, "I would definitely expect to see a date on this, there is no other way to know when it was made, it needs to be thrown out now" and confirmed this practice posed a food safety issue for the residents.

2b) A metal pan containing approximately 13 hard boiled eggs with intact shells and 5 hard boiled eggs which were cracked open with missing shell pieces exposing the surface of the cooked egg, was also observed in the same refrigerator. The pan of eggs was uncovered and had no date.

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F 812	Continued From page 43 Employee F stated that he expected to see a date to indicate when the eggs were hard boiled and they should have been covered. Employee F confirmed the uncovered, exposed hard boiled eggs which were not dated provided food safety concerns. The Facility Administrator (Employee A) was informed of the findings on 02/26/2020 at approximately 3:30 PM and no additional information was received during the remainder of the survey.	F 812		