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	495140	A. BUILDING ______ B. WING ______	C 03/10/2020

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/08/2020 through 03/10/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(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 facilities]. 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.	E 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/02/2020

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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*[For Inpatient Hospice at §418.113(b)(6)(iii):]
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 document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation that the emergency plan included policies and procedures for waste disposal.

The findings include:

On 03/10/2020 at 9:50 a.m., a review of the facility's emergency preparedness plan and interview was conducted with OSM (other staff member) # 9, maintenance director. Review of the facility's emergency preparedness plan failed

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E 015	Continued From page 2 to evidence documentation that the emergency plan included policies and procedures for waste disposal. OSM # 9 stated, "We don't have the documentation." No further information was provided prior to exit.	E 015		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [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 at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency	E 026		

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E 026	Continued From page 3 management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 03/10/19 at 9:50 a.m., a review of the facility's emergency preparedness plan and interview was conducted with OSM (other staff member) # 9, maintenance director. Review of the facility's emergency preparedness plan failed to evidence policies and procedures that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. OSM # 9 stated, "We don't have it." No further information was provided prior to exit.	E 026		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/8/20 through 3/10/20. A complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 43 current record reviews and seven	F 000		

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F 000	Continued From page 4 closed record reviews.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		

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F 580	Continued From page 5 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician and/or responsible party of resident to resident incidents or the need to alter treatment for one of 50 residents in the survey sample, Residents #18. The facility staff failed to notify the physician and/or the nurse practitioner when Resident #18's medications were not administered on 12/31/19. The findings include: Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to dementia, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired. Review of Resident #18's clinical record revealed a physician's order dated 12/14/18 for simvastatin (1) 40 mg (milligrams) by mouth at bedtime, a	F 580		

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physician's order dated 1/3/19 for donepezil (2) 10 mg by mouth once a day, and a physician's order dated 11/7/19 for trazodone (3) 25 mg (milligrams) by mouth at bedtime. The medications were scheduled for 8:00 p.m. on Resident #18's December 2019 MAR (medication administration record).

On 12/31/19, LPN (licensed practical nurse) #11 failed to document simvastatin, donepezil and trazodone was administered to Resident #18 on the MAR. LPN #11 documented the code, "7= Other/ See Nurse Notes." An eMAR (electronic medication administration record) note regarding simvastatin, dated 12/31/19 documented, "Waiting to be sent from pharmacy." An eMAR note regarding donepezil, dated 12/31/19 documented, "Waiting for pharmacy." An eMAR (electronic medication administration record) note regarding trazodone, dated 12/31/19 documented, "Waiting to be sent from pharmacy." There was no further documentation regarding the administration of simvastatin, donepezil or trazodone on 12/31/19 and no documentation that Resident #18's physician and/or nurse practitioner were notified.

Resident #18's comprehensive care plan dated 12/18/19 and 12/19/18 documented, "Impaired Cardiovascular status related to: HDL (high density lipoproteins [cholesterol])...Medications as ordered by physician..." The care plan further documented, "Impaired neurological status related to: Dementia...Medication as ordered by physician...Potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication...Provide medications as ordered by physician..."

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On 3/9/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding physician/nurse practitioner notification if medications are not administered. LPN #5 stated the physician and/or nurse practitioner should be notified if medications are not administered because the resident is missing a needed dose and staff needs to see what the physician/nurse practitioner recommends and what actions they would like for staff to take.

On 3/9/20 at 5:57 p.m., a telephone interview was conducted with LPN #11 regarding Resident #18's medication administration on 12/31/19. LPN #11 stated it had been a while since 12/31/19 and he could not recall if he administered simvastatin, donepezil or trazodone to Resident #18 on that date or if he notified the physician and/or nurse practitioner.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility pharmacy policy titled, "Medication Administration- General Guidelines" documented, "If two consecutive doses of a vital medication are withheld or refused, the physician is notified..."

No further information was presented prior to exit.

References:
(1) Simvastatin is used to treat high cholesterol. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692030.h

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(2) "Donepezil is used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality)." This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a697032.html

(3) Trazodone is used to treat depression. This information was obtained from the website:
https://medlineplus.gov/ency/article/002559.htm

F 584 SS=D — Safe/Clean/Comfortable/Homelike Environment
CFR(s): 483.10(i)(1)-(7) — F 584

§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,

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F 584	Continued From page 9 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, 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, staff interview and clinical record review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 50 residents in the survey sample, Resident #18. Multiple brown stains were observed on the resident's privacy curtain. The findings include: Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to repeated falls, diabetes and major depressive disorder. Resident #18's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.	F 584		

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On 3/8/20 at 1:09 p.m., and 3/9/20 at 8:21 a.m., observation of Resident #18's room was conducted. The resident was lying in bed. Approximately 15 brown stains were observed on the privacy curtain. All of the stains were approximately the size of a penny or smaller.

On 3/9/20 at approximately 2:15 p.m., an interview was conducted with OSM (other staff member) #6 (the housekeeping manager) regarding the facility process for maintaining clean privacy curtains. OSM #6 stated privacy curtains are removed and washed once a month during the room deep cleaning and when a resident is discharged and when the housekeeping staff notices a torn area or stain. Resident #18's privacy curtain was observed with OSM #6. The brown stains remained on the curtain. OSM #6 was unable to identify the cause of the stains and stated the stains may have come from food, drink or feces. OSM #6 stated the stained privacy curtain was not homelike.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. A policy regarding privacy curtains was requested via a list given to ASM #1.

No further information was presented prior to exit.

F 600 SS=E Free from Abuse and Neglect F 600
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,

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and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain the resident right to be free from abuse for nine of 50 residents in the survey sample, Residents #69, #67, #650, #652, #7, #651, #22, #41, and #39.
- On 1/22/19, facility staff failed to ensure that Resident #69 and Resident #67 were free from abuse from each other. Resident #67 hit Resident #69, and then Resident #69 hit Resident #67 back.
- On 2/26/19, facility staff failed to ensure that Resident #650 was free from abuse, when Resident #69 hit Resident #650 in the face on the nose and forehead.
- On 2/15/19, facility staff failed to ensure that Resident #652 was free from abuse, when Resident #69 grabbed Resident #652 by the neck.
- On 3/18/19, facility staff failed to ensure that Resident #7 was free from abuse, when Resident #69 hit Resident #7 in the face without injury.
- On 6/20/19, facility staff failed to ensure that Resident #651 was free from abuse, when Resident #69 hit Resident #651 in the chest and eye, causing a small laceration treated by staff

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F 600	Continued From page 12 with first aide. - On 10/17/19, facility staff failed to ensure that Resident #22 was free from abuse, when Resident #69 hit Resident #22 on the left arm with a closed fist. - On 1/12/20, facility staff failed to ensure that Resident #41 was free from abuse from, when Resident #69 hit Resident #41 in the right side of her face with a closed fist. - On 3/6/20, facility staff failed to ensure that Resident #39 was free from abuse, when Resident #69 pulled Resident #39 out of his chair to the floor. The findings include: A review of the facility policy, "Resident Abuse" dated February 2017 and revised January 2020, documented, "Policy: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse...Procedure:....c. Questions may arise as to what actions constitute abuse of a resident. Any action that may cause or causes actual physical, psychological, or emotional harm, which is not caused by simple negligence, constitutes abuse....Procedure for Reporting Abuse: A. All incidents of resident abuse are to be reported immediately to the Licensed Nurse in	F 600		

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Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. B. The facility shall report to the state agency and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. C. And if the events that caused the suspicion resulted in serious bodily injury the facility must report within 2 hours after forming the suspicion. If the events that caused the suspicion did not result in serious bodily injury the facility shall report within 24 hours....Investigation: a. The Abuse Coordinator and/or Director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...."

A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "....Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being. This includes verbal abuse, sexual abuse, physical abuse, mental

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F 600	Continued From page 14 abuse, involuntary seclusion, and misappropriation of resident property. Protocol: Resident to Resident Abuse: 1. Remove the residents from danger immediately. 2. If applicable, move the resident causing the danger to another room or unit, pending investigation of the incident. 3. Closely monitor and document the behavior and condition of the residents involved to evaluate for any injury and to prevent recurrence of the incident. 4. Notification must be made to the following of all residents involved in the incident: a. attending physician. b. responsible party. 5. A documented investigation by the Administrator, Director of Nursing, or their designee must be initiated within twenty-four (24) hours of our knowledge of the alleged incident. This investigation includes talking with all involved (directly or indirectly), any family involved, all residents involved and any visitors or volunteers involved. Obtain written statements as deemed necessary. 6. An Incident/Accident Report form must be completed by the nurse in charge. 7. The Administrator must notify the Regional Vice President or Operations and the Director of Clinical Services of alleged and/or actual incidences of abuse and the on-going investigation. 8. The Administrator, Director of Nursing, or their designee, must notify the Adult Protective Service Agency and the local Ombudsman of any alleged abuse per state specific protocols of our knowledge of the alleged incident. If no local Ombudsman is available, notify the state Ombudsman, APS usually works with the local Ombudsman to determine if a protected environment is needed for the residents involved. 9. The State Department of Health is to be notified by the Administrator, Director of Nursing, or their designee of the facility's knowledge of resident to resident altercations in	F 600		

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which a resident is injured to the extent that physical intervention and/or transfer or discharge to a hospital is required per state specific protocols. 10. The local law enforcement authorities are to be notified by the Administrator, Director of Nursing, or their designee of any instance of resident abuse, mistreatment, neglect, or misappropriation of personal property which is a "Criminal Act" and in accordance with Elder Justice Act. 11. If any injury has occurred to the resident, or there is potential for a lawsuit, the Administrator is to notify the Regional Vice President of Operations immediately, and a copy of the investigative report must be sent to the Regional Clinical Director. 12. The facility must develop measures to prevent reoccurrence and document these measures in the resident's medical record to include revision of the plan of care. 13. Other measures to be considered during this process include: a. Medication review and/or change; b. Obtaining orders for a psych consult to determine if there are organic reasons for the behavior, and if the resident can be treated with medication or other treatment modalities to alleviate the behavior."

1. On 1/22/19, facility staff failed to ensure that Resident #69 and Resident #67 were free from abuse from each other. Resident #67 hit Resident #69, and then Resident #69 hit Resident #67 back.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include, but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder,

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epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #67 was admitted to the facility on 11/21/12 with the diagnoses of but not limited to stroke, diabetes, hemiplegia, dysphagia, dementia with behaviors, adjustment disorder, insomnia, glaucoma, chronic obstructive pulmonary disease, depression, convulsions, high blood pressure, and bipolar disorder. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/3/20 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; and supervision for eating.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurse's note dated 1/22/19 that documented, "Resident [Resident #69] was arguing with another resident [Resident #67] when the other resident [Resident #67] began swearing at him. When approached by staff, the other resident [Resident #67] punched him [Resident #69] in the arm at which point he [Resident #69] punched back and exchanged

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punches until separated by staff."

Further review of the clinical record for Resident #69 revealed a physician psych eval (psychological evaluation) note dated 1/22/19 that documented, "Patient seen to evaluate mental status and to adjust medications....Treatment Plan / Recommendations....2. Continue current psychotropic medications as follows: seroquel (1) for psychosis related to dementia/BPSD (behavioral and psychological symptoms of dementia), Depakote (2) for mood stabilization, 3. monitor mood and behaviors....After careful consideration, the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia, hyperglycemia and stroke. They help in modifying the behavior such that normal care is possible while the patient is in the nursing facility. GDR (Gradual Dose Reduction) not indicated at this time. Resident has failed a previous gradual dose reduction and is not a candidate for another attempt because benefits of the medication outweigh risks of negative side effects."

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered,

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F 600	Continued From page 18 refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19.	F 600		

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"Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.

The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

Resident #67:

A review of the clinical record for Resident #67 revealed a nurse's note dated 1/22/19 that documented, "Resident [Resident #67] was arguing with another resident [Resident #69] swearing at the other resident [Resident #69].

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When approached by staff, this resident [Resident #67] punched the other resident in the arm, when the other resident [Resident #69] hit back, they began exchanging blows until they were separated."

Further review of the clinical record for Resident #67 failed to reveal any additional notes regarding this incident other than to document that the resident was status post aggressor of a resident-to-resident incident and did not display any further behaviors.

A review of the comprehensive care plan for Resident #67 failed to reveal any for behaviors; or any updates after this incident. The resident did have a care plan, dated 6/11/15, for "I have dxs (diagnoses) of Bipolar Disorder and Adjustment Disorder." This care plan included the following interventions: "Encourage me to get involved in activities related to my interests" dated 6/24/19. "Help me to keep in contact with family and friends" dated 6/11/15. "Introduce me to others with similar interests" dated 6/24/19. "Please give me my medications that help me with my depression and manage any side effects" dated 6/11/15. "Please tell my doctor if my symptoms are not improving to see if I need a change in my medication" dated 6/11/15. "Take the time to discuss my feelings when I'm feeling sad" dated 6/24/19.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested. None was

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provided.

On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych [psychiatric] is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated. ASM #1 stated due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

References:

(1) Seroquel is an antipsychotic used to treat symptoms of schizophrenia, or symptoms of mania or depression related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html

(2) Depakote is used to treat seizures or symptoms of mania related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html

2. On 2/26/19, facility staff failed to ensure that Resident #650 was free from abuse when Resident #69 hit Resident #650 in the face on the nose and forehead.

Resident #69 was admitted to the facility on

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1/17/13; diagnoses include, but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #650 was admitted to the facility on 3/14/18; diagnoses include but are not limited to femur fracture, depression, chronic obstructive sleep apnea, high blood pressure, heart disease, atrial fibrillation, congestive heart failure, acute respiratory failure, and cardiac pacemaker. The resident expired at the facility on 8/5/19 and therefore was not a current resident in the facility at the time of survey. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/28/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, eating and dressing; and extensive assistance for transfers.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurses note dated 2/26/19 that documented, "Resident to resident altercation with resident [#650] at 1730 (5:30 PM). Staff

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CNA (Certified Nursing Assistant) alerted this writer that resident (#650) bumped into residents [#69] w/c (wheel chair) in dining room. Resident [#69] turned around and hit resident [#650] twice in the face. Resident separated from area and was taken into restorative dining room with two staff LPN's (Licensed Practical Nurse) to eat his evening meal...Resident alert times one. When this writer questioned resident [#69] about incident he denied allegations. No further behaviors noted. Resident [#69] cooperative with staff and other residents. Resident [#69] monitored frequently for inappropriate behaviors. NP [nurse practitioner], DON [director of nursing] and POA [power of attorney] aware of incident. Care plan updated."

Further review of the clinical record for Resident #69 revealed a physician's note dated 2/26/19 that documented, "Called by the nurse to report an incident. Resident had hit a resident in her nose twice at the dining room and was witnessed by the staff. Found resident sitting in wheelchair in the hall way (Sic.) looking out the window. He is alert to him self (Sic.) and denied the episode. As per staff he does have a tendency to get violant (sic). 2/7/19 blood work with Valproic acid level 23.0, electrolytes WNL (within normal limits). Monitor resident closely. Will refer to the psych [psychological] for evaluation of his medications."

Further review of the clinical record for Resident #69 revealed a psych eval (psychological evaluation) note dated 3/4/19, that documented, "Patient seen to evaluate mental status and to adjust medications... Follow up requested by PCP-NP [primary care physician - nurse practitioner] for recent altercation with another resident in which he hit another resident in the

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face after she accidentally bumped into his WC....Treatment Plan / Recommendations....2. Continue current psychotropic medications as follows: seroquel (1) for psychosis related to dementia/BPSD (behavioral and psychological symptoms of dementia) - change to 50 mg oral BID (twice a day] due negative behaviors including physical aggression, Depakote (2) for mood stabilization, 3. monitor mood and behaviors....After careful consideration, the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia, hyperglycemia and stroke. They help in modifying the behavior such that normal care is possible while the patient is in the nursing facility."

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19.

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F 600	Continued From page 25 "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19. The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during	F 600		

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activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

Resident #650:

A review of the clinical record for Resident #650 revealed a physician note dated 2/26/19 that documented, "Called by the nurse to evaluate resident [#650] as she was assaulted. At the dining room she was punched in to her nose by another resident. She was tearful and anxious. No injuries. No bruising but mild erythema on dorsum of the nose noted.

Further review of the clinical record for Resident #650 revealed a nurse's note dated 2/26/19 that documented, "Assaulted by another resident during supper in the dining hall. No injuries noted. Resident tearful and upset. Slight

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redness on nose initially. Resident calmed down after consoling from staff. NP [Nurse Practitioner], POA [Power of Attorney], DON [Director of Nursing] notified. Resident remained calm and sociable through the rest of the evening. Will continue to monitor."

A review of the comprehensive care plan for Resident #650 failed to reveal any care plans for behaviors, potential for abuse, or any revisions, to address this incident.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/26/19. This form documented, "Resident (#69) hit Resident (#650) in face on nose and forehead in the dining room...Resident (#650) was close to his chair and hit w/c (wheel chair). Resident (#69) turned around and hit her (Resident #650)."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

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References:

(1) Seroquel is an antipsychotic used to treat symptoms of schizophrenia, or symptoms of mania or depression related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html

(2) Depakote is used to treat seizures or symptoms of mania related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html

3. On 2/15/19, facility staff failed to ensure that Resident #652 was free from abuse, Resident #69 grabbed Resident #652 by the neck

Resident #69 was admitted to the facility on 1/17/13; diagnoses include, but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #652 was admitted to the facility on

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1/14/19; diagnoses include but are not limited to heart failure, insomnia, dysphagia, dementia with behaviors, and high blood pressure. The resident expired on 2/19/19 and was not a current resident in the facility at the time of the survey. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/6/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; and supervision for eating.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurses note dated 2/15/19 that documented, "Resident [#69] grabbed another resident [#652] by the neck during supper in the dining room. Removed resident [#69] from dining room and kept him with nurse for supper. Resident [#69] has remained calm since removing. Other resident [#652] has no apparent injuries. Notified POA (Power of Attorney). Notified DON (Director of Nursing). Notified NP (Nurse Practitioner)."

Further review of the clinical record for Resident #69 revealed a physician psych eval (psychological evaluation) note dated 2/19/19 that documented, "Patient seen to evaluate mental status and to adjust medications....Recent incident in which resident was an aggressor in resident to resident altercation in which he grabbed other resident by the neck; no injuries sustained. Wanders unit in WC (wheel chair) independently. Previous failure to reduce seroquel (1)....Treatment Plan /

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F 600	Continued From page 30 Recommendations....2. Continue current psychotropic medications as follows: seroquel for psychosis related to dementia/BPSD (behavioral and psychological symptoms of dementia), Depakote (2) for mood stabilization, 3. monitor mood and behaviors....After careful consideration, the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia, hyperglycemia and stroke. They help in modifying the behavior such that normal care is possible while the patient is in the nursing facility." A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20.	F 600		

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"Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.

The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other

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residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

Resident #652:
A review of the clinical record for Resident #652 revealed a nurses note dated 2/15/19, which had also been crossed out, but documented, "Late Entry:...On 2.15.19 [Resident #652] was chocked (sic) by another resident in a dining room. Staff had been monitoring her skin in a neck area. No further abrasions had been noticed. No increased anxiety and distress had been noted. Family members had been notified."

A review of the comprehensive care plan for Resident #652 revealed one dated 2/5/19 and revised on 2/21/19 that documented, "I sometimes have behaviors which include Screaming/Yelling out, calls "help, help" constantly. This care plan included the following interventions: "Don not seat me around others who disturb me" dated 2/5/21 and revised

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2/21/19. "Help me to avoid situations or people that are upsetting to me" dated 2/5/19 and revised 2/21/19. "Offer me something I like as a diversion" dated 2/5/19 and revised 2/21/19.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/15/19. This form documented, "(Resident #69) was at dinner table, resident (#652) wheeled and spoke past (Resident #69) and (Resident #69) reached out and grabbed her (Resident #652) by the neck...."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

References:

(1) Seroquel is an antipsychotic used to treat symptoms of schizophrenia, or symptoms of mania or depression related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.h

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(2) Depakote is used to treat seizures or symptoms of mania related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html

4. On 3/18/19, facility staff failed to ensure that Resident #7 was free from abuse, when Resident #69 hit Resident #7 in the face without injury.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include, but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #7 was admitted to the facility on 2/19/19, diagnoses include but are not limited to stroke, hemiplegia, hemiparesis, diabetes, dysphagia, depression, high blood pressure, and chronic obstructive pulmonary disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/6/19 coded the resident as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and

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hygiene; and as requiring supervision for eating.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurses note dated 3/18/19 that documented, "Resident [Resident #69] was in dining room at 1730 (5:30 PM). He was going behind resident (#7) then [Resident #7] back into his w/c (wheel chair). Resident [Resident #69] became agitated and hit her [Resident #7] on the side of the face. No injuries noted. Residents separated and resident taken to restorative dining room to eat his meal. Resident (#7) nurse was notified. DON, POA, and NP [director of nursing, power of attorney, nurse practitioner] aware of incident. Care plan updated."

Further review of the clinical record for Resident #69 revealed a psych eval (psychological evaluation) note dated 4/4/19 that documented, "Patient seen to evaluate mental status and to adjust medications....Per chart, patient continues to have some periodic aggression with other residents. Seroquel (1) recently increased to 50 mg oral BID on 3/4/19....Treatment Plan / Recommendations....2. Continue current psychotropic medications as follows: seroquel for psychosis related to dementia/BPSD (behavioral and psychological symptoms of dementia) - change to 50 mg oral BID to due negative behaviors including physical aggression, Depakote (2) for mood stabilization, 3. monitor mood and behaviors....After careful consideration, the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia, hyperglycemia and stroke. They help in modifying the behavior such

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that normal care is possible while the patient is in the nursing facility."

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me

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to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.

The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me"

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dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

Resident #7:

A review of the clinical record for Resident #7 revealed a nurses note dated 3/18/19 that documented, "Resident [Resident #7] was smacked by another resident [Resident #69] during dinner. The other resident [Resident #69] was removed from the dining room. No injuries on the face [of Resident #7]. Resident [#7] was upset but remained in the dining room and had supper with others. Resident [#7] was upset later but no redness or injury noted."

There was no further documentation regarding this incident other than to document that the resident had exhibited no emotional distress.

A review of the comprehensive care plan for Resident #7 failed to reveal any care plans for behaviors, potential for abuse, or any revisions as a result of this incident.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

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Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/18/19. This form documented, "Resident (#69) hit Resident (#7) on face in dining room. (Resident #69) was behind (Resident #7) and she backed into his w/c (wheel chair)."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

References:

(1) Seroquel is an antipsychotic used to treat symptoms of schizophrenia, or symptoms of mania or depression related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html

(2) Depakote is used to treat seizures or symptoms of mania related to bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html

5. On 6/20/19, facility staff failed to ensure that Resident #651 was free from abuse, when Resident #69 hit Resident #651 in the chest and eye, resulting in a small laceration.

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Resident #69 was admitted to the facility on 1/17/13; diagnoses include, but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #651 was admitted to the facility on 11/3/17; diagnoses include, but are not limited to dementia with behaviors, depression, high blood pressure, and chronic kidney disease. The resident expired in the facility on 8/10/19 and therefore was not a current resident at the time of the survey. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/21/19 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for hygiene, toileting, dressing and transfers; and supervision for eating.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurse's note dated 6/20/19 that documented, "This resident [#69] and resident [#651] was sitting in the lobby beside each other. This resident [#69] hit [Resident #651] in the

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chest with a closed fist. The receptionist attempted to separate the 2 men and before they were separated this resident hit [Resident #651] in the left eye with a closed fist. Residents separated immediately."

Further review of the clinical record for Resident #69 revealed a social worker note dated 6/20/19 that documented, "Met with resident due to incident with resident [#651]. Resident [#69] shows no signs of emotional distress and is at baseline. Resident [#69] to be seen by psych services at next visit."

Further review revealed a physician note dated 6/20/19 that documented, "Reported by the nurse resident [#69] hit another resident [#651]. Witness by staff as he [#69] was sitting in wheelchair he hit the other resident [#651] for no apparent reason. First he [#69] swung his arm across the other resident [#651] and then swung his arm around the resident [#651] eyes. He is unable to give detail information due to aphasia. Able to babble some words with expressions. Stated he is having a headache....Assessment/Plan: Resident [#69] has a past history of assaulting residents. All medications reviewed. He is currently on Dementia with behavior: Divalporex ER (Depakote) (1) 250mg BID. Seroquel 25 mg BID. Psychology input appreciated. Give Tylenol (2) 650mg x1 for headache."

Further review of the clinical record for Resident #69 revealed a psychiatric progress note dated 6/25/19 that documented, "Altercation with another resident. History of Present Illness Follow up requested by nurse management for altercation with another resident that occurred on

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6/20/2019, in which he hit another resident who sustained a laceration to left eye....Patient does not recall altercation when this provider brings it up to discuss with him... History of labile moods and periodic physical aggression... Continue current meds [medications], Tapering meds is not indicated.... The patient will be continued on the current medications for now as the patient does not appear to require any immediate change in the medications due to no signs or symptoms of increased agitation today. Will continue to monitor closely for increased agitation as further adjustments in medications may be necessary.... After careful consideration, the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia, hyperglycemia and stroke. They help in modifying the behavior such that normal care is possible while the patient is in the nursing facility."

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19

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F 600	Continued From page 43 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.	F 600		

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The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

Resident #651:

A review of the clinical record for Resident #651 revealed a physician note dated 6/20/19 that documented, "Reported by nurse resident [#651] got assaulted by another resident [#69]. Resident [#651] was sitting in wheelchair while another resident [#69] repeatedly assaulted him twice by hitting his chest by swinging the arm across his chest, and next swinging the arm in his eyes. He [Resident #651] denies pain in eyes or chest area....small skin cut approximately 2cm

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(centimeters) close to outer canthus out side the Lt (left) eye area actively bleeding. Area skin color purple/blue. No visible damage to the eye...."

Further review of the clinical record for Resident #651 revealed a nurses note dated 6/20/19 that documented, "This resident [#651] and resident [#69] was sitting in the lobby. Resident [#69] hit this resident [#651] in the chest with a closed fist. The receptionist attempted to separate the 2 men and before she could move this resident, resident [#69] hit this resident [#651] again in the left eye. Residents separated immediately...Resident [#651] has a open area under his left eye with discoloration r/t (related to) the altercation. Response: NP (nurse practitioner), ED (Executive Director), DON (Director of Nursing), ADON (Assistant Director of Nursing), UM (Unit Manager), SS (Social Services) and RP (Responsible Party) notified...Regional Nurse Consultant notified."

Further review of the clinical record for Resident #651 revealed a social worker note dated 6/20/19 that documented, "Met with resident [#651] due to incident with resident [#69]. Resident could not recall incident that happened and exhibits no emotional distress."

A review of the comprehensive care plan for Resident #651 revealed one dated 11/6/17 and revised on 8/12/19 for "I sometimes have behaviors which include hitting during care, screaming, yelling during care, throwing things at hand, biting..." The interventions included the following: "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 8/12/19, "Do not seat me around others who

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disturb me" dated 6/20/19 and revised 8/12/19, "Help me maintain my favorite place to sit" dated 6/20/19 and revised 8/12/19, "Help me avoid situations or people that are upsetting to me" dated 6/20/19 and revised 8/12/19...."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 6/20/19. This form documented, "This resident (Resident #69) hit resident (#651) in the chest and the left eye with a closed fist."

A review of a Facility Reported Incident (FRI) dated 6/20/19 documented, "Two residents with primary diagnosis of dementia were seated in very close proximity of the other when (name of Resident #69) struck out at (name of Resident #651) hitting him in the chest and again on the face. Staff intervened to prevent further occurrence. Residents were assessed by nursing. Responsible parties and physician were notified. Initial assessment revealed a laceration to the left eye of (Resident #651) first aide was provided."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse.

On 3/10/20 at 2:30 PM, ASM #1 was made aware

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of the concern. No further information was provided.

References:

(1) Depakote is used to treat seizures or symptoms of mania related to bipolar disorder.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682412.html

(2) Tylenol is used to relieve mild to moderate pain.
Information obtained from
https://medlineplus.gov/druginfo/meds/a681004.html

6. On 10/17/19, facility staff failed to ensure that Resident #22 was free from abuse, when Resident #69 hit Resident #22 on the left arm with a closed fist.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

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Resident #22 was admitted to the facility on 9/28/18; diagnoses include but are not limited to dementia with behaviors, anxiety disorder, hallucinations, and dyspnea. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/10/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for dressing, eating, toileting and hygiene; and supervision for transfers.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurses note dated 10/17/19 that documented, "This resident [#69] and resident [#22] were passing each other in hall and this resident punched resident [#22] in the left arm with a closed fist. Residents separated. NP and RP [nurse practitioner and responsible party] notified."

Further review of the clinical record for Resident #69 revealed a psychiatric progress note dated 11/19/19, which documented, "Follow up for use of psychotropic and antipsychotic medications.... History of labile moods and periodic physical aggression.... Reviewed SE [side effects] and Risk/Benefits analysis, Continue current meds [medications], Tapering meds is not indicated, Monitor mood behavior.... The patient will be continued on the current medications for now as the patient does not appear to require any immediate change in the medications. Will continue to monitor closely for increased agitation as further adjustments in medications may be necessary...After careful consideration, the

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benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia, hyperglycemia and stroke. They help in modifying the behavior such that normal care is possible while the patient is in the nursing facility."

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised

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6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.

The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help

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me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

Resident #22:

A review of the clinical record for Resident #22 revealed a nurse note dated 10/17/19 that documented, "This resident [#22] walking in hallway near north nurses station. Not behaving in a provocative manner. Encountered resident [#69] who, for no apparent reason, punched her in upper right arm. The two residents were quickly separated and no further conflict ensued. The resident suffered no injuries as a result of this incident. Appropriate notifications done in a timely manner."

A review of the comprehensive care plan for Resident #22 revealed one dated 10/5/18 for "I sometimes have behavior which include visual and auditory hallucinations, esp (especially) about seeing and hearing family members, refuses care, easily agitated. Resident places herself on the floor intentionally and is acting out behavior but has no injuries these falls. Will get into bed with male rt's (residents) thinks they are her husband, altercation with another rt. She leaves walker at different places and at times undresses self and takes off brief." This care plan included

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the following interventions: "Attempt interventions before my behaviors begin" dated 10/5/18 and revised 6/18/19. "Do not seat me around others who disturb me" dated 10/5/18. "Help me maintain my favorite place to sit" dated 10/5/18. "Help me to avoid situations or people that are upsetting to me" dated 10/5/18 and revised 6/18/19. "Keep me separated from people that may become agitated from my behaviors" dated 10/17/19 and revised 10/20/19.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 10/17/19. This form documented, "This resident (Resident #69) was passing resident (#22) in hall and this resident punched resident (#22) in left arm with closed fist."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

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7. On 1/12/20, facility staff failed to ensure that Resident #41 was free from abuse, when Resident #69 hit Resident #41 in the right side of her face with a closed fist.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include, but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #41 was admitted to the facility on 4/21/18; diagnoses include but are not limited to congestive heart failure, dysphagia, depression, dementia with behaviors, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/15/20 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; and supervision for eating.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurses note dated 1/12/20 that

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documented, "On 3-11 shift 1/11/20 around dinner time. It was told this writer that, resident [#69] was sitting at the nurses station in his wheel chair. Staff/CAN [certified nursing assistant] was passing by resident with meal cart and resident in room [Resident #41] was behind her (the staff member) and tried kicking at the CNA who was in front of her to move out of her way. When this resident (#69) saw this take place he landed his closed fist on the right side of her [Resident #41] face. [Resident #41] hollered out and was holding the right side of her face. NP [nurse practitioner] was made aware."

Further review of the clinical record for Resident #69 revealed a psychiatric progress note dated 1/14/20 that documented, "Follow up requested by ED (Executive Director) due to recent altercation with another resident in which he was the aggressor. No injury sustained by other resident....History of labile moods and periodic physical aggression....Reviewed SE and Risk/Benefits analysis, Continue current meds [medications], Tapering meds is not indicated, Monitor mood behavior....The patient will be continued on the current medications for now as the patient does not appear to require any immediate change in the medications. Will continue to monitor closely for increased agitation as further adjustments in medications may be necessary....Will continue to monitor closely for increased agitation as further adjustments in medications may be necessary....."

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my

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F 600	Continued From page 55 things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a	F 600		

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diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.

The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

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Resident #41:

A review of the clinical record for Resident #41 revealed a nurses note dated 1/12/20 that documented, "Alert, s/p (status post) being the recipient in a res to res (resident to resident) altercation. Denied pain or discomfort. No apparent injuries noted to right eye area s/p episode. OOB (out of bed) in w/c (wheelchair) as tolerated. Needs to be re-directed from time to time to her room and away from other res [resident] doorway...."

A review of the comprehensive care plan for Resident #41 revealed one dated 5/22/18 for "I sometimes have behaviors which include yelling during activities, yelling during care, cursing, hitting others and attempting to take things that belong to others, wandering." This care plan included the following interventions: "Attempt interventions before my behaviors begin. Resident may need to be separated from other residents at times when her behavior escalates" dated 7/4/19 and revised 12/18/19. "Do not seat me around others who disturb me" dated 7/4/19. "Help me maintain my favorite place to sit" dated 5/22/18. "Help me to avoid situations or people that are upsetting to me" dated 7/4/19 and revised 9/19/19. "Staff will key into precursors to violent outburst behaviors and attempt to de-escalate me before any adverse behaviors are manifested" dated 1/5/20.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of

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the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 1/11/20 (misdated?). This form documented, "Resident (#69) in front of nurses station sitting beside resident (#41). Saw this resident (#41) kicking at her (a staff member that was pushing a food cart). Took his (Resident #69) right fist and connected with the other resident (#41) right cheek....he (Resident #69) was defending aide's honor."

On 3/09/20 at 3:20 PM, in an interview, ASM #1 stated, "There was a lady pushing the meal cart, she was trying to get down the hall by the residents sitting in the area. (Resident #41) reached out attempting to kick the lady from kitchen. (Resident #69) interceded to defend a staff member. ASM #1 also stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

8. On 3/6/20, facility staff failed to ensure that Resident #39 was free from abuse, when Resident #69 pulled Resident #39 out of his chair to the floor.

Resident #69 was admitted to the facility on 1/17/13, diagnoses include but are not limited to

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stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #39 was admitted to the facility on 6/15/18; diagnoses include but are not limited to brain disorders, dementia without behaviors, alcohol dependence, depression, post-traumatic stress disorder, epilepsy, high blood pressure and dystonia. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/20 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and extensive assistance for all other areas of activities of daily living.

Resident #69:

A review of the clinical record for Resident #69 revealed a nurses note dated 3/6/20 that documented, "Resident [#39] grabbed silverware off of this residents [#69] meal tray. This resident [#69] grabbed his [Resident #39] arm and pulled him to the floor. Residents separated. No further behaviors."

As of this review on 3/9/10, no physician or

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psychiatric documentation had yet occurred.

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to

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F 600	Continued From page 61 me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19. The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I	F 600		

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am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

Resident #39:

A review of the clinical record for Resident #39 revealed a nurses note dated 3/6/20 that documented, "This resident [#39] grabbed silverware of resident [#69] tray and he [Resident #69] grabbed this resident's [#39] arm and pulled him to the floor. No injury noted. Offers no c/o (complaints of) pain or discomfort. RP (responsible party) present. NP (nurse practitioner) notified."

The comprehensive care plan for Resident #39 revealed one dated 11/5/19 for "Sometimes I show behavior symptoms/risks, refusing personal care and picking nose until it bleeds." This care plan included the following interventions: "Attempt interventions before my behavior escalates" dated 11/5/19. "During episodes of inappropriate behaviors, please re-direct me by approaching slowly and speaking to me in a calm and steady voice - trying to redirect me to an alternative activity or topic of discuss" dated 11/5/19. "Please help me avoid situations and people that trigger inappropriate behaviors" dated 11/5/19 and revised 11/22/19.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical

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Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/6/20. This form documented, "Resident (#39) reached for the silverware on this resident's (#69) tray and this resident (#69) grabbed (#39) by the arm and pulled him out of his chair."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not conduct an initial report to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. ASM #1 was asked if an initial report had been sent to the required state agency. She stated it had not been as it was the facility's position that due to the cognitive status of the residents, it was not abuse. No further information was provided.

F 607 SS=E — Develop/Implement Abuse/Neglect Policies — F 607
CFR(s): 483.12(b)(1)-(3)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

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§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy to report and investigate allegations of abuse to the required State agency for eight of 50 residents in the survey sample, (Residents #69, #67, #7, #41, #22, #39, #650, and #652). On 1/22/19, Resident #67 hit Resident #69, and then Resident #69 hit Resident #67 back. On 3/18/19, Resident #69 hit Resident #7 in the face. On 1/12/20, Resident #69 hit Resident #41 in the right side of her face with a closed fist. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency and failed to notify Resident #67's, #7's and #41's physicians and responsible parties per the policy. On 10/17/19, Resident #69 hit Resident #22 in the left arm with a closed fist. On 3/6/20, Resident #69 pulled Resident #39 out of his chair to the floor. On 2/26/19, Resident #69 hit Resident #650 in the face. On 2/15/19, Resident #69 grabbed Resident #652 by the neck. The facility staff failed to implement the facility abuse policy to investigate and report the allegations of abuse for Resident #22, #39, #650, and #652, to the required state agency.

The findings include:

A review of the facility policy, "Resident Abuse" dated February 2017 and revised January 2020, documented, "Policy: It is inherent in the nature

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F 607	Continued From page 65 and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse...Procedure:....c. Questions may arise as to what actions constitute abuse of a resident. Any action that may cause or causes actual physical, psychological, or emotional harm, which is not caused by simple negligence, constitutes abuse...Procedure for Reporting Abuse: A. All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. B. The facility shall report to the state agency and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. C. And if the events that caused the suspicion resulted in serious bodily injury the facility must report within 2 hours after forming the suspicion. If the events that caused the suspicion did not result in serious bodily injury the facility shall report within 24 hours...Investigation: a. The Abuse Coordinator and/or Director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a	F 607		

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F 607	Continued From page 66 detailed report shall be prepared...." A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "....Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being. This includes verbal abuse, sexual abuse, physical abuse, mental abuse, involuntary seclusion, and misappropriation of resident property. Protocol: Resident to Resident Abuse: 1. Remove the residents from danger immediately...4. Notification must be made to the following of all residents involved in the incident: a. attending physician. b. responsible party. 5. A documented investigation by the Administrator, Director of Nursing, or their designee must be initiated within twenty-four (24) hours of our knowledge of the alleged incident. This investigation includes talking with all involved (directly or indirectly), any family involved, all residents involved and any visitors or volunteers involved. Obtain written statements as deemed necessary. 6. An Incident/Accident Report form must be completed by the nurse in charge...8. The Administrator, Director of Nursing, or their designee, must notify the Adult Protective Service Agency and the local Ombudsman of any alleged abuse per state specific protocols of our	F 607		

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knowledge of the alleged incident...9. The State Department of Health is to be notified by the Administrator, Director of Nursing, or their designee of the facility's knowledge of resident to resident altercations in which a resident is injured to the extent that physical intervention and/or transfer or discharge to a hospital is required per state specific protocols. 10. The local law enforcement authorities are to be notified by the Administrator, Director of Nursing, or their designee of any instance of resident abuse, mistreatment, neglect, or misappropriation of personal property which is a "Criminal Act" and in accordance with Elder Justice Act...."

1. On 1/22/19, Resident #67 hit Resident #69, and then Resident #69 hit Resident #67 back. Punches were exchanged until separated by staff. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency and failed to notify Resident #67's physician and responsible party.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and

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locomotion; and was frequently incontinent of bowel and bladder.

Resident #67 was admitted to the facility on 11/21/12; diagnoses include but are not limited to stroke, diabetes, hemiplegia, dysphagia, dementia with behaviors, adjustment disorder, insomnia, glaucoma, chronic obstructive pulmonary disease, depression, convulsions, high blood pressure, and bipolar disorder. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/3/20 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurse's note dated 1/22/19 that documented, "Resident [#69] was arguing with another resident [#67] when the other resident began swearing at him. When approached by staff, the other resident [#67] punched him [Resident #69] in the arm at which point he punched back and exchanged punches until separated by staff."

A review of the clinical record for Resident #67 revealed a nurse's note dated 1/22/19 that documented, "Resident [Resident #67] was arguing with another resident [Resident #69] swearing at the other resident [Resident #69]. When approached by staff, this resident [Resident #67] punched the other resident in the arm, when the other resident [Resident #69] hit back, they began exchanging blows until they were separated." This note, and follow up documentation, regarding this incident, did not

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document that Resident #67's responsible party and physician were notified of the incident.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested. None was provided.

On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated. ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.

2. On 3/18/19, Resident #69 hit Resident #7 in the face. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency and failed to notify Resident #7's physician and responsible party, per the abuse policy.

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Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #7 was admitted to the facility on 2/19/19; diagnoses include but are not limited to stroke, hemiplegia, hemiparesis, diabetes, dysphagia, depression, high blood pressure, and chronic obstructive pulmonary disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/6/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurses note dated 3/18/19 that documented, "Resident [#69] was in dining room at 1730 (5:30 PM). He was going behind resident [#7] then [Resident #7] back into his w/c (wheel chair). Resident [#69] became agitated and hit her [Resident #7] on the side of the face. No injuries noted. Residents separated and resident taken to restorative dining room to eat his meal. Resident [#7] nurse was notified. DON, POA,

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and NP [director of nursing, power of attorney, and nurse practitioner] aware of incident. Care plan updated."

A review of the clinical record for Resident #7 revealed a nurses note dated 3/18/19 that documented, "Resident [#7] was smacked by another resident [#69] during dinner. The other resident [#69] was removed from the dining room. No injuries on the face. Resident [#7] was upset but remained in the dining room and had supper with others. Resident [#7] was upset later but no redness or injury noted." This note, and follow up documentation, regarding this incident, did not identify that Resident #7's responsible party or the physician were notified of the incident.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/18/19. This form documented, "Resident (#69) hit Resident (#7) on face in dining room. (Resident #69) was behind (Resident #7) and she backed into his w/c (wheel chair)."

On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated. ASM #1 stated that due to the cognitive status of the residents, the facility did

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not consider this as abuse, or reportable, and did not complete an investigation on the incident or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.

3. On 1/12/20, Resident #69 hit Resident #41 in the right side of her face with a closed fist. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency, and failed to notify Resident #41's physician and responsible party per the abuse policy.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #41 was admitted to the facility on 4/21/18; diagnoses include but are not limited to congestive heart failure, dysphagia, depression, dementia with behaviors, and high blood

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pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/15/20 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurses note dated 1/12/20 that documented, "On 3-11 shift 1/11/20 around dinner time. It was told this writer that, resident [#69] was sitting at the nurses station in his wheel chair. Staff/CNA was passing by resident with meal cart and resident in room [Resident #41] was behind her (the staff member) and tried kicking at the CNA who was in front of her to move out of her way. When this resident [#69] saw this take place he landed his closed fist on the right side of her [Resident #41] face. [Resident #41] hollered out and was holding the right side of her face. NP [nurse practitioner] was made aware."

A review of the clinical record for Resident #41 revealed a nurses note dated 1/12/20 that documented, "Alert, s/p (status post) being the recipient in a res to res (resident to resident) altercation. Denied pain or discomfort. No apparent injuries noted to right eye area s/p episode. OOB (out of bed) in w/c (wheelchair) as tolerated. Needs to be re-directed from time to time to her room and away from other res [resident] doorway...." This note, and follow up documentation regarding this incident did not identify that the responsible party for Resident #41 was notified of the incident.

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On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 1/11/20 (misdated?). This form documented, "Resident (#69) in front of nurses station sitting beside resident (#41). Saw this resident (#41) kicking at her (a staff member that was pushing a food cart). Took his (Resident #69) right fist and connected with the other resident (#41) right cheek....he (Resident #69) was defending aide's honor."

On 3/09/20 at 3:20 PM, ASM #1 stated, "There was a lady pushing the meal cart, she was trying to get down the hall by the residents sitting in the area. (Resident #41) reached out attempting to kick the lady from kitchen. (Resident #69) interceded to defend a staff member. She stated that part of the process is to notify the doctor and the responsible party, and if psych is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated. ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was

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provided.

4. On 10/17/19, Resident #69 hit Resident #22 in the left arm with a closed fist. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #22 was admitted to the facility on 9/28/18; diagnoses include but are not limited to dementia with behaviors, anxiety disorder, hallucinations, and dyspnea. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/10/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for dressing, eating, toileting and hygiene; and supervision for transfers.

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A review of the clinical record for Resident #69 revealed a nurses note dated 10/17/19 that documented, "This resident [#69] and resident [#22] were passing each other in hall and this resident punched resident [#22] in the left arm with a closed fist. Residents separated. NP and RP [nurse practitioner and responsible party] notified."

A review of the clinical record for Resident #22 revealed a nurse note dated 10/17/19 that documented, "This resident walking in hallway near north nurses station. Not behaving in a provocative manner. Encountered resident [#69] who, for no apparent reason, punched her [Resident #22] in upper right arm. The two residents were quickly separated and no further conflict ensued. The resident suffered no injuries as a result of this incident. Appropriate notifications done in a timely manner."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 10/17/19. This form documented, "This resident (Resident #69) was passing resident (#22) in hall and this resident punched resident (#22) in left arm with closed fist."

On 3/09/20 at 3:20 PM, ASM #1 stated that due

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to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.

5. On 3/6/20, Resident #69 pulled Resident #39 out of his chair to the floor. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #39 was admitted to the facility on 6/15/18; diagnoses include but are not limited to

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brain disorders, dementia without behaviors, alcohol dependence, depression, post-traumatic stress disorder, epilepsy, high blood pressure and dystonia. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and extensive assistance for all other areas of activities of daily living.

A review of the clinical record for Resident #69 revealed a nurses note dated 3/6/20 that documented, "Resident [#39] grabbed silverware off of this residents meal tray. This resident [#69] grabbed his arm and pulled him to the floor. Residents separated. No further behaviors."

A review of the clinical record for Resident #39 revealed a nurses note dated 3/6/20 that documented, "This resident [#39] grabbed silverware of resident [#69] tray and he [Resident #69] grabbed this resident's arm and pulled him to the floor. No injury noted. Offers no c/o (complaints of) pain or discomfort. RP (responsible party) present. NP (nurse practitioner) notified."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/6/20. This form documented, "Resident (#39) reached for the

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silverware on this resident's (#69) tray and this resident (#69) grabbed (#39) by the arm and pulled him out of his chair."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not conduct an initial report to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. ASM #1 was asked if an initial report had been sent to the required state agency. She stated it had not been as it was the facility's position that due to the cognitive status of the residents, it was not abuse. No further information was provided.

6. On 2/26/19, Resident #69 hit Resident #650 in the face. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and

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locomotion; and was frequently incontinent of bowel and bladder.

Resident #650 was admitted to the facility on 3/14/18; diagnoses include but are not limited to femur fracture, depression, chronic obstructive sleep apnea, high blood pressure, heart disease, atrial fibrillation, congestive heart failure, acute respiratory failure, and cardiac pacemaker. The resident expired at the facility on 8/5/19 and therefore was not a current resident in the facility at the time of survey. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/28/19 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, eating and dressing; and extensive assistance for transfers.

A review of the clinical record for Resident #69 revealed a nurses note dated 2/26/19 that documented, "Resident to resident altercation with resident [#650] at 1730 (5:30 PM). Staff CNA (Certified Nursing Assistant) alerted this writer that resident [#650] bumped into residents w/c (wheel chair) in dining room. Resident [#69] turned around and hit resident [#650] twice in the face. Resident [#69] separated from area and was taken into restorative dining room with two staff LPN's (Licensed Practical Nurse) to eat his evening meal.... Resident alert times one. When this writer questioned resident about incident he denied allegations. No further behaviors noted. Resident [#69] cooperative with staff and other residents. Resident [#69] monitored frequently for inappropriate behaviors. NP, DON and POA, [nurse practitioner, director of nursing, power of

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attorney] aware of incident. Care plan updated."

A review of the clinical record for Resident #650 revealed a physician note dated 2/26/19 that documented, "Called by the nurse to evaluate resident as she was assaulted. At the dining room she was punched in to her nose by another resident [#69]. She was tearful and anxious. No injuries. No bruising but mild erythema on dorsum of the nose noted.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/26/19. This form documented, "Resident (#69) hit Resident (#650) in face on nose and forehead in the dining room.... Resident (#650) was close to his chair and hit w/c (wheel chair). Resident (#69) turned around and hit her (Resident #650)."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was

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provided.

7. On 2/15/19, Resident #69 grabbed Resident #652 by the neck. The facility staff failed to implement the facility abuse policy to investigate and report the incident to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #652 was admitted to the facility on 1/14/19; diagnoses include but are not limited to heart failure, insomnia, dysphagia, dementia with behaviors, and high blood pressure. The resident expired on 2/19/19 and was not a current resident in the facility at the time of the survey. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/6/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; and supervision for eating.

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A review of the clinical record for Resident #69 revealed a nurses note dated 2/15/19 that documented, "Resident [#69] grabbed another resident [#652] by the neck during supper in the dining room. Removed resident [#69] from dining room and kept him with nurse for supper. Resident has remained calm since removing. Other resident [#652] has no apparent injuries. Notified POA (Power of Attorney). Notified DON (Director of Nursing). Notified NP (Nurse Practitioner)."

A review of the clinical record for Resident #652 revealed a nurses note dated 2/15/19, which had also been crossed out, but documented, "Late Entry:...On 2.15.19 [Resident #652] was chocked (sic) by another resident [#69] in a dining room. Staff had been monitoring her skin in a neck area. No further abrasions had been noticed. No increased anxiety and distress had been noted. Family members had been notified."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/15/19. This form documented, "(Resident #69) was at dinner table, resident (#652) wheeled and spoke past (Resident #69) and (Resident #69) reached out

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and grabbed her (Resident #652) by the neck...."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.

F 608 SS=C

Reporting of Reasonable Suspicion of a Crime
CFR(s): 483.12(b)(5)(i)-(iii)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.
(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.
(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.
(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the

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suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.
(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.
(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post notice of employee rights regarding the reporting of suspicious crimes.

The findings include:

On 3/9/20 at 1:19 p.m., observation of the facility halls, lobby and employee only hall containing the employee break room and time clock was conducted. No posted notice of employee rights regarding the reporting of suspicious crimes was observed. On 3/9/20 at 1:29 p.m., observation of those same areas was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 could not locate the posted notice. ASM #1 stated she thought the posted notice had been on the same board as the federal and state employment laws in the employee only hall but the notice may have torn and fallen off. ASM #1 stated information regarding employee rights for the reporting of suspicious crimes is reviewed during employee orientation and training.

On 3/9/20 at 7:07 p.m., ASM #1, ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of

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F 608	Continued From page 86 the above concern. The facility policy for reporting suspected crimes under the federal elder justice act documented, "Specifically, it is the Facility policy to: c. post a notice in a conspicuous location that informs all 'covered individuals' (including staff) of -their reporting obligation under the EJA (elder justice act) to report a suspicion of a crime to the SSA (state survey agency) and local law enforcement; and -their right to file a complaint with the state survey agency if they feel the Facility has retaliated against an employee who reported a suspected crime under this statute..." No further information was presented prior to exit.	F 608		
F 609 SS=E	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	F 609		

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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.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report allegations of abuse, for eight of 50 residents in the survey sample, (Residents #69, #67, #7, #41, #22, #39, #650, and #652). On 1/22/19, Resident #67 hit by Resident #69 and then Resident #69 hit Resident #67 back. On 3/18/19, Resident #69 hit Resident #7 in the face. On 1/12/20, Resident #69 hit Resident #41 in the right side of her face with a closed fist. On 10/17/19, Resident #69 hit Resident #22 in the left arm with a closed fist. On 3/6/20, Resident #69 pulled Resident #39 out of his chair to the floor. On 2/26/19, Resident #69 hit Resident #650 in the face. On 2/15/19, Resident #69 grabbed Resident #652 by the neck. The facility staff failed to report immediately the allegations of abuse for Resident # 69, #67, #7, #41, #22, #39, #650 and #652 to the required state agency.

The findings include:

A review of the facility policy, "Resident Abuse" dated February 2017 and revised January 2020, documented, "Policy: It is inherent in the nature

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and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse...Procedure for Reporting Abuse: A. All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. B. The facility shall report to the state agency and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. C. And if the events that caused the suspicion resulted in serious bodily injury the facility must report within 2 hours after forming the suspicion. If the events that caused the suspicion did not result in serious bodily injury the facility shall report within 24 hours....Investigation: a. The Abuse Coordinator and/or Director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...."

A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "....Residents must

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not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals....6. An Incident/Accident Report form must be completed by the nurse in charge....9. The State Department of Health is to be notified by the Administrator, Director of Nursing, or their designee of the facility's knowledge of resident to resident altercations in which a resident is injured to the extent that physical intervention and/or transfer or discharge to a hospital is required per state specific protocols. 10. The local law enforcement authorities are to be notified by the Administrator, Director of Nursing, or their designee of any instance of resident abuse, mistreatment, neglect, or misappropriation of personal property which is a "Criminal Act" and in accordance with Elder Justice Act...."

1. The facility staff failed to report immediately to the required state agency an allegation of abuse for Residents #69 and #67. On 1/22/19, Resident #67 hit by Resident #69 and then Resident #69 hit Resident #67 back.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing;

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extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #67 was admitted to the facility on 11/21/12; diagnoses include but are not limited to stroke, diabetes, hemiplegia, dysphagia, dementia with behaviors, adjustment disorder, insomnia, glaucoma, chronic obstructive pulmonary disease, depression, convulsions, high blood pressure, and bipolar disorder. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/3/20 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurse's note dated 1/22/19 that documented, "Resident [#69] was arguing with another resident [#67] when the other resident began swearing at him. When approached by staff, the other resident [#67] punched him [Resident #69] in the arm at which point he punched back and exchanged punches until separated by staff."

A review of the clinical record for Resident #67 revealed a nurse's note dated 1/22/19 that documented, "Resident [Resident #67] was arguing with another resident [Resident #69] swearing at the other resident [Resident #69]. When approached by staff, this resident [Resident #67] punched the other resident in the arm, when the other resident [Resident #69] hit back, they began exchanging blows until they

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were separated."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested. None was provided.

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

2. On 3/18/19, Resident #69 hit Resident #7 in the face and the facility staff failed to report immediately the allegation of abuse for Resident #7 to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and

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locomotion; and was frequently incontinent of bowel and bladder.

Resident #7 was admitted to the facility on 2/19/19; diagnoses include but are not limited to stroke, hemiplegia, hemiparesis, diabetes, dysphagia, depression, high blood pressure, and chronic obstructive pulmonary disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/6/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurses note dated 3/18/19 that documented, "Resident [#69] was in dining room at 1730 (5:30 PM). He was going behind resident [#7] then [Resident #7] back into his w/c (wheel chair). Resident [#69] became agitated and hit her [Resident #7] on the side of the face. No injuries noted. Residents separated and resident taken to restorative dining room to eat his meal. Resident [#7] nurse was notified. DON, POA, and NP [director of nursing, power of attorney, and nurse practitioner] aware of incident. Care plan updated."

A review of the clinical record for Resident #7 revealed a nurses note dated 3/18/19 that documented, "Resident [#7] was smacked by another resident [#69] during dinner. The other resident [#69] was removed from the dining room. No injuries on the face. Resident [#7] was upset but remained in the dining room and had supper with others. Resident [#7] was upset later but no redness or injury noted."

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On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/18/19. This form documented, "Resident (#69) hit Resident (#7) on face in dining room. (Resident #69) was behind (Resident #7) and she backed into his w/c (wheel chair)."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

3. Resident #41 was hit in the right side of her face with a closed fist by Resident #69, on 1/12/20. The facility staff failed to report immediately the allegation of abuse for Resident #41to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder,

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epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #41 was admitted to the facility on 4/21/18; diagnoses include but are not limited to congestive heart failure, dysphagia, depression, dementia with behaviors, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/15/20 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurses note dated 1/12/20 that documented, "On 3-11 shift 1/11/20 around dinner time. It was told this writer that, resident [#69] was sitting at the nurses station in his wheel chair. Staff/CNA was passing by resident with meal cart and resident in room [Resident #41] was behind her (the staff member) and tried kicking at the CNA who was in front of her to move out of her way. When this resident [#69] saw this take place he landed his closed fist on the right side of her [Resident #41] face. [Resident #41] hollered out and was holding the right side of her face. NP [nurse practitioner] was made aware."

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A review of the clinical record for Resident #41 revealed a nurses note dated 1/12/20 that documented, "Alert, s/p (status post) being the recipient in a res to res (resident to resident) altercation. Denied pain or discomfort. No apparent injuries noted to right eye area s/p episode. OOB (out of bed) in w/c (wheelchair) as tolerated. Needs to be re-directed from time to time to her room and away from other res [resident] doorway...."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 1/11/20 (misdated?). This form documented, "Resident (#69) in front of nurses station sitting beside resident (#41). Saw this resident (#41) kicking at her (a staff member that was pushing a food cart). Took his (Resident #69) right fist and connected with the other resident (#41) right cheek....he (Resident #69) was defending aide's honor."

On 3/09/20 at 3:20 PM, ASM #1 stated, "There was a lady pushing the meal cart, she was trying to get down the hall by the residents sitting in the area. (Resident #41) reached out attempting to kick the lady from kitchen. (Resident #69) interceded to defend a staff member. ASM #1 also stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above

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identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

4. Resident #22 was hit in the left arm with a closed fist by Resident #69, on 10/17/19. The facility staff failed to report immediately an allegation of abuse for Resident #22 to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #22 was admitted to the facility on 9/28/18; diagnoses include but are not limited to dementia with behaviors, anxiety disorder, hallucinations, and dyspnea. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/10/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as

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requiring total care for bathing; limited assistance for dressing, eating, toileting and hygiene; and supervision for transfers.

A review of the clinical record for Resident #69 revealed a nurses note dated 10/17/19 that documented, "This resident [#69] and resident [#22] were passing each other in hall and this resident punched resident [#22] in the left arm with a closed fist. Residents separated. NP and RP [nurse practitioner and responsible party] notified."

A review of the clinical record for Resident #22 revealed a nurse note dated 10/17/19 that documented, "This resident walking in hallway near north nurses station. Not behaving in a provocative manner. Encountered resident [#69] who, for no apparent reason, punched her [Resident #22] in upper right arm. The two residents were quickly separated and no further conflict ensued. The resident suffered no injuries as a result of this incident. Appropriate notifications done in a timely manner."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 10/17/19. This form documented, "This resident (Resident #69) was passing resident (#22) in hall and this resident

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punched resident (#22) in left arm with closed fist."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

5. Resident #39 was pulled out of his chair to the floor by Resident #69 on 3/6/20. The facility staff failed to report immediately an allegation of abuse for Resident #39 to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #39 was admitted to the facility on 6/15/18; diagnoses include but are not limited to

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brain disorders, dementia without behaviors, alcohol dependence, depression, post-traumatic stress disorder, epilepsy, high blood pressure and dystonia. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and extensive assistance for all other areas of activities of daily living.

A review of the clinical record for Resident #69 revealed a nurses note dated 3/6/20 that documented, "Resident [#39] grabbed silverware off of this residents meal tray. This resident [#69] grabbed his arm and pulled him to the floor. Residents separated. No further behaviors."

A review of the clinical record for Resident #39 revealed a nurses note dated 3/6/20 that documented, "This resident [#39] grabbed silverware of resident [#69] tray and he [Resident #69] grabbed this resident's arm and pulled him to the floor. No injury noted. Offers no c/o (complaints of) pain or discomfort. RP (responsible party) present. NP (nurse practitioner) notified."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/6/20. This form documented, "Resident (#39) reached for the

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silverware on this resident's (#69) tray and this resident (#69) grabbed (#39) by the arm and pulled him out of his chair."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not conduct an initial report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. ASM #1 was asked if an initial report had been sent to the required state agency. ASM #1 stated it had not been as it was the facility's position that due to the cognitive status of the residents, it was not abuse. No further information was provided.

6. Resident #650 was hit in the face by Resident #69 on 2/26/19. The facility staff failed to report immediately an allegation of abuse for Resident #650 to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

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Resident #650 was admitted to the facility on 3/14/18; diagnoses include but are not limited to femur fracture, depression, chronic obstructive sleep apnea, high blood pressure, heart disease, atrial fibrillation, congestive heart failure, acute respiratory failure, and cardiac pacemaker. The resident expired at the facility on 8/5/19 and therefore was not a current resident in the facility at the time of survey. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/28/19 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, eating and dressing; and extensive assistance for transfers.

A review of the clinical record for Resident #69 revealed a nurses note dated 2/26/19 that documented, "Resident to resident altercation with resident [#650] at 1730 (5:30 PM). Staff CNA (Certified Nursing Assistant) alerted this writer that resident [#650] bumped into residents w/c (wheel chair) in dining room. Resident [#69] turned around and hit resident [#650] twice in the face. Resident [#69] separated from area and was taken into restorative dining room with two staff LPN's (Licensed Practical Nurse) to eat his evening meal.... Resident alert times one. When this writer questioned resident about incident he denied allegations. No further behaviors noted. Resident [#69] cooperative with staff and other residents. Resident [#69] monitored frequently for inappropriate behaviors. NP, DON and POA, [nurse practitioner, director of nursing, power of attorney] aware of incident. Care plan updated."

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A review of the clinical record for Resident #650 revealed a physician note dated 2/26/19 that documented, "Called by the nurse to evaluate resident as she was assaulted. At the dining room she was punched in to her nose by another resident [#69]. She was tearful and anxious. No injuries. No bruising but mild erythema on dorsum of the nose noted.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/26/19. This form documented, "Resident (#69) hit Resident (#650) in face on nose and forehead in the dining room.... Resident (#650) was close to his chair and hit w/c (wheel chair). Resident (#69) turned around and hit her (Resident #650)."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

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7. Resident #652 was grabbed by the neck by Resident #69 on 2/15/19. The facility staff failed to report immediately an allegation of abuse for Resident #652 to the required state agency.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #652 was admitted to the facility on 1/14/19; diagnoses include but are not limited to heart failure, insomnia, dysphagia, dementia with behaviors, and high blood pressure. The resident expired on 2/19/19 and was not a current resident in the facility at the time of the survey. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/6/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurses note dated 2/15/19 that documented, "Resident [#69] grabbed another

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resident [#652] by the neck during supper in the dining room. Removed resident [#69] from dining room and kept him with nurse for supper. Resident has remained calm since removing. Other resident [#652] has no apparent injuries. Notified POA (Power of Attorney). Notified DON (Director of Nursing). Notified NP (Nurse Practitioner)."

A review of the clinical record for Resident #652 revealed a nurses note dated 2/15/19, which had also been crossed out, but documented, "Late Entry:...On 2.15.19 [Resident #652] was chocked (sic) by another resident [#69] in a dining room. Staff had been monitoring her skin in a neck area. No further abrasions had been noticed. No increased anxiety and distress had been noted. Family members had been notified."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/15/19. This form documented, "(Resident #69) was at dinner table, resident (#652) wheeled and spoke past (Resident #69) and (Resident #69) reached out and grabbed her (Resident #652) by the neck...." On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident

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beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

F 610 SS=E

Investigate/Prevent/Correct Alleged Violation
CFR(s): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§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.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to investigate allegations of abuse, for seven of 50 residents in the survey sample, Residents #69, #67, #7, #41, #22, #650, and #652. On 1/22/19, Resident #67 hit by Resident #69 and then Resident #69 hit Resident #67 back. On 3/18/19, Resident #69 hit Resident

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#7 in the face. On 1/12/20, Resident #69 hit Resident #41 in the right side of her face with a closed fist. On 10/17/19, Resident #69 hit Resident #22 in the left arm with a closed fist. On 2/26/19, Resident #69 hit Resident #650 in the face. On 2/15/19, Resident #69 grabbed Resident #652 by the neck. The facility staff failed to investigate the allegations of abuse for Residents# 69, #67, #7, #41, #22, #650 and #652.

The findings include:

A review of the facility policy, "Resident Abuse" dated February 2017 and revised January 2020, documented, "Policy: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse...Procedure for Reporting Abuse: A. All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. B. The facility shall report to the state agency and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.

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C. And if the events that caused the suspicion resulted in serious bodily injury the facility must report within 2 hours after forming the suspicion. If the events that caused the suspicion did not result in serious bodily injury the facility shall report within 24 hours....Investigation: a. The Abuse Coordinator and/or Director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...."

A review of the facility policy, Resident Abuse - Resident to Resident" dated February 2017, no revision dates, documented, "....Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals....6. An Incident/Accident Report form must be completed by the nurse in charge....9. The State Department of Health is to be notified by the Administrator, Director of Nursing, or their designee of the facility's knowledge of resident to resident altercations in which a resident is injured to the extent that physical intervention and/or transfer or discharge to a hospital is required per state specific protocols. 10. The local law enforcement authorities are to be notified by the Administrator, Director of Nursing, or their designee of any instance of resident abuse, mistreatment, neglect, or misappropriation of personal property which is a "Criminal Act" and in accordance with Elder Justice Act...."

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1. On 1/22/19, Resident #67 hit by Resident #69 and then Resident #69 hit Resident #67 back. The facility staff failed to investigate the allegation of abuse for Residents #69 and #67.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #67 was admitted to the facility on 11/21/12; diagnoses include but are not limited to stroke, diabetes, hemiplegia, dysphagia, dementia with behaviors, adjustment disorder, insomnia, glaucoma, chronic obstructive pulmonary disease, depression, convulsions, high blood pressure, and bipolar disorder. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/3/20 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurse's note dated 1/22/19 that documented, "Resident [#69] was arguing with

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another resident [#67] when the other resident began swearing at him. When approached by staff, the other resident [#67] punched him [Resident #69] in the arm at which point he punched back and exchanged punches until separated by staff."

A review of the clinical record for Resident #67 revealed a nurse's note dated 1/22/19 that documented, "Resident [Resident #67] was arguing with another resident [Resident #69] swearing at the other resident [Resident #69]. When approached by staff, this resident [Resident #67] punched the other resident in the arm, when the other resident [Resident #69] hit back, they began exchanging blows until they were separated."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested. None was provided.

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

2. On 3/18/19, Resident #69 hit Resident #7 in the face. The facility staff failed to investigate the

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allegation of abuse for Resident #7.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #7 was admitted to the facility on 2/19/19; diagnoses include but are not limited to stroke, hemiplegia, hemiparesis, diabetes, dysphagia, depression, high blood pressure, and chronic obstructive pulmonary disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/6/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurses note dated 3/18/19 that documented, "Resident [#69] was in dining room at 1730 (5:30 PM). He was going behind resident [#7] then [Resident #7] back into his w/c (wheel chair). Resident [#69] became agitated and hit her [Resident #7] on the side of the face. No injuries noted. Residents separated and resident

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taken to restorative dining room to eat his meal. Resident [#7] nurse was notified. DON, POA, and NP [director of nursing, power of attorney, and nurse practitioner] aware of incident. Care plan updated."

A review of the clinical record for Resident #7 revealed a nurses note dated 3/18/19 that documented, "Resident [#7] was smacked by another resident [#69] during dinner. The other resident [#69] was removed from the dining room. No injuries on the face. Resident [#7] was upset but remained in the dining room and had supper with others. Resident [#7] was upset later but no redness or injury noted."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/18/19. This form documented, "Resident (#69) hit Resident (#7) on face in dining room. (Resident #69) was behind (Resident #7) and she backed into his w/c (wheel chair)."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware

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of the concern. No further information was provided.

3. Resident #41 was hit in the right side of her face with a closed fist by Resident #69, on 1/12/20. The facility staff failed to investigate the allegation of abuse for Resident #41.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #41 was admitted to the facility on 4/21/18; diagnoses include but are not limited to congestive heart failure, dysphagia, depression, dementia with behaviors, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/15/20 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; and supervision for eating.

A review of the clinical record for Resident #69

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revealed a nurses note dated 1/12/20 that documented, "On 3-11 shift 1/11/20 around dinner time. It was told this writer that, resident [#69] was sitting at the nurses station in his wheel chair. Staff/CNA was passing by resident with meal cart and resident in room [Resident #41] was behind her (the staff member) and tried kicking at the CNA who was in front of her to move out of her way. When this resident [#69] saw this take place he landed his closed fist on the right side of her [Resident #41] face. [Resident #41] hollered out and was holding the right side of her face. NP [nurse practitioner] was made aware."

A review of the clinical record for Resident #41 revealed a nurses note dated 1/12/20 that documented, "Alert, s/p (status post) being the recipient in a res to res (resident to resident) altercation. Denied pain or discomfort. No apparent injuries noted to right eye area s/p episode. OOB (out of bed) in w/c (wheelchair) as tolerated. Needs to be re-directed from time to time to her room and away from other res [resident] doorway...."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 1/11/20 (misdated?). This form documented, "Resident (#69) in front of nurses station sitting beside resident (#41). Saw this resident (#41) kicking at her (a staff member that was pushing a food cart). Took his (Resident

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#69) right fist and connected with the other resident (#41) right cheek....he (Resident #69) was defending aide's honor."

On 3/09/20 at 3:20 PM, ASM #1 stated, "There was a lady pushing the meal cart, she was trying to get down the hall by the residents sitting in the area. (Resident #41) reached out attempting to kick the lady from kitchen. (Resident #69) interceded to defend a staff member. ASM #1 also stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

4. Resident #22 was hit in the left arm with a closed fist by Resident #69, on 10/17/19. The facility staff failed to investigate the allegation of abuse for Resident #22.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing;

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extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #22 was admitted to the facility on 9/28/18; diagnoses include but are not limited to dementia with behaviors, anxiety disorder, hallucinations, and dyspnea. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/10/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for dressing, eating, toileting and hygiene; and supervision for transfers.

A review of the clinical record for Resident #69 revealed a nurses note dated 10/17/19 that documented, "This resident [#69] and resident [#22] were passing each other in hall and this resident punched resident [#22] in the left arm with a closed fist. Residents separated. NP and RP [nurse practitioner and responsible party] notified."

A review of the clinical record for Resident #22 revealed a nurse note dated 10/17/19 that documented, "This resident walking in hallway near north nurses station. Not behaving in a provocative manner. Encountered resident [#69] who, for no apparent reason, punched her [Resident #22] in upper right arm. The two residents were quickly separated and no further conflict ensued. The resident suffered no injuries as a result of this incident. Appropriate notifications done in a timely manner."

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On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 10/17/19. This form documented, "This resident (Resident #69) was passing resident (#22) in hall and this resident punched resident (#22) in left arm with closed fist."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

5. Resident #650 was hit in the face by Resident #69 on 2/26/19. The facility staff failed to investigate the allgation of abuse for Resident #650.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder,

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epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #650 was admitted to the facility on 3/14/18; diagnoses include but are not limited to femur fracture, depression, chronic obstructive sleep apnea, high blood pressure, heart disease, atrial fibrillation, congestive heart failure, acute respiratory failure, and cardiac pacemaker. The resident expired at the facility on 8/5/19 and therefore was not a current resident in the facility at the time of survey. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/28/19 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, eating and dressing; and extensive assistance for transfers.

A review of the clinical record for Resident #69 revealed a nurses note dated 2/26/19 that documented, "Resident to resident altercation with resident [#650] at 1730 (5:30 PM). Staff CNA (Certified Nursing Assistant) alerted this writer that resident [#650] bumped into residents w/c (wheel chair) in dining room. Resident [#69] turned around and hit resident [#650] twice in the face. Resident [#69] separated from area and was taken into restorative dining room with two

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staff LPN's (Licensed Practical Nurse) to eat his evening meal.... Resident alert times one. When this writer questioned resident about incident he denied allegations. No further behaviors noted. Resident [#69] cooperative with staff and other residents. Resident [#69] monitored frequently for inappropriate behaviors. NP, DON and POA, [nurse practitioner, director of nursing, power of attorney] aware of incident. Care plan updated."

A review of the clinical record for Resident #650 revealed a physician note dated 2/26/19 that documented, "Called by the nurse to evaluate resident as she was assaulted. At the dining room she was punched in to her nose by another resident [#69]. She was tearful and anxious. No injuries. No bruising but mild erythema on dorsum of the nose noted.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/26/19. This form documented, "Resident (#69) hit Resident (#650) in face on nose and forehead in the dining room.... Resident (#650) was close to his chair and hit w/c (wheel chair). Resident (#69) turned around and hit her (Resident #650)."

On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and

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did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency.

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

6. Resident #652 was grabbed by the neck by Resident #69 on 2/15/19. The facility staff failed to invetsigate the allegation of abuse for Resident #652.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #652 was admitted to the facility on 1/14/19; diagnoses include but are not limited to heart failure, insomnia, dysphagia, dementia with behaviors, and high blood pressure. The resident expired on 2/19/19 and was not a current resident in the facility at the time of the survey. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/6/19 coded

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the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurses note dated 2/15/19 that documented, "Resident [#69] grabbed another resident [#652] by the neck during supper in the dining room. Removed resident [#69] from dining room and kept him with nurse for supper. Resident has remained calm since removing. Other resident [#652] has no apparent injuries. Notified POA (Power of Attorney). Notified DON (Director of Nursing). Notified NP (Nurse Practitioner)."

A review of the clinical record for Resident #652 revealed a nurses note dated 2/15/19, which had also been crossed out, but documented, "Late Entry:...On 2.15.19 [Resident #652] was chocked (sic) by another resident [#69] in a dining room. Staff had been monitoring her skin in a neck area. No further abrasions had been noticed. No increased anxiety and distress had been noted. Family members had been notified."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a

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F 610	Continued From page 121 "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/15/19. This form documented, "(Resident #69) was at dinner table, resident (#652) wheeled and spoke past (Resident #69) and (Resident #69) reached out and grabbed her (Resident #652) by the neck...." On 3/09/20 at 3:20 PM, ASM #1 stated that due to the cognitive status of the residents, the facility did not consider this as abuse, or reportable, and did not complete an investigation on the incident beyond the above identified incident report, which was not a complete and thorough investigation or report it to the required state agency. On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and	F 622		

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appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot

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F 622	Continued From page 123 be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide the required information to the receiving facility at the time of facility initiated transfers for six of 50 residents in the survey sample, Residents #114, #60, #36, #7, #59 and #40. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving facility for: Resident # 114 transferred on 01/03/2020; Resident # 60 transferred on 02/27/2020 and for	F 622		

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Resident # 36 transferred on 01/09/2020. For Resident #7's transfer on 1/3/2020, for Resident #59's hospital transfer on 1/13/20 and for Resident #40's hospital transfer on 12/29/19.

The findings include:

1. Resident # 114 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, sepsis [1], and diabetes mellitus [2]. Resident # 114's MDS [minimum data set], was not due at the time of survey. The facility's "Admission Assessment" for Resident # 114 dated 01/03/2020 documented in part, "Moderately impaired for daily decision making."

The nurse's note for Resident # 114 dated 01/03/2020 documented, "At 1835 [6:45 p.m.] res [resident] was noted to be on the floor in her room on left side and was in severe pain. NP [nurse practitioner] was notified and ordered XRAY of left hip via [by] [Name of Radiology Company]. All appropriate parties notified of incident immediately. At 1855 [6:55 p.m.] [Name of Radiology Company] arrived and obtained xray. At 2030 [8:30 p.m.] res family came into facility and demanded she be sent to ED [emergency department] now because it was taking to long. Received order to send res to ED for eval [evaluation]. Called 911 and they transported to ED."

The physician's order for Resident # 114 dated "1/3/2020 1910 [7:10 p.m.] documented, "Sent to ED for left hip eval."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 114 failed to evidence that the comprehensive care plan

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goals were sent to the receiving facility at the time of Resident # 114's hospital transfer.

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding transfers of residents. When asked to describe the paperwork that is sent to the receiving facility, LPN # 5 stated that they send demographic information, a copy of the face sheet, nurse's notes, SBAR [Situation, Background, Assessment, Response form], medication list, and any blood work that was done. When asked if they send the resident's comprehensive care plan goals or care plan summary, LPN # 5 stated no.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

[2]A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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2. Resident # 60 was admitted to the facility with diagnoses that included but were not limited to: pain, muscle weakness and low iron. Resident # 60's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 01/27/2020, coded Resident # 60 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The nurse's note for Resident # 60 dated 02/27/2020 documented, "Resident observed with fall and AMS [altered mental status] at 1850 [6:30 p.m.]. Bruise to top right of scalp and forehead. Background: Resident alert an oriented, has upcoming apt [appointment] for cardiac cath [catheter] next month. Assessment: 92/56 [ninety-two over fifty-six blood pressure], 97.5 [temperature], 93% [percent] RA [room air], 20 [respiration]. Response: NP [nurse practitioner] updated with new orders to send out non emergent transfer. [Name of Responsible Party] called and updated of pending transfer."

The physician's order for Resident # 60 dated "2/27/20 1910 [7:10 p.m.] documented, "Sent to ER [emergency room] for eval [evaluation] + [and] tx [treatment] due to fall + AMS [altered mental status]."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 60 failed to evidence that the comprehensive care plan goals were sent to the receiving facility at the time of Resident # 60's facility initiated transfer.

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding facility initiated transfers of residents.

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When asked to describe the paperwork that is sent to the receiving facility for a facility initiated transfer, LPN # 5 stated that they send demographic information, a copy of the face sheet, nurse's notes, SBAR [Situation, Background, Assessment, Response form], medication list, and any blood work that was done. When asked if they send the resident's comprehensive care plan goals or care plan summary, LPN # 5stated no.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

3. Resident # 36 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, muscle weakness, and high cholesterol. Resident # 36's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 01/08/2020, coded Resident # 36 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The nurse's note for Resident # 36 dated 01/09/2020 documented in part, "Situation: resident found on the floor in the bathroom. Background: resident slept in the evening. Surroundings free of hazard material, call light is not on. His [sic] not witnessed. Assessment: resident alert/oriented and diaphoresis diastolic BP [blood pressure] was low 105/38 [one hundred five over thirty-eight] then went up to 120/78 after

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15 min [minutes]. Complain [sic] neck pain, stabled the neck until the EMS [emergency medical service] arrived, he mentioned he was depressed today and yesterday. Called on call NP [nurse practitioner] and [sic] get the order to send him to the hospital."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 36 failed to evidence that the comprehensive care plan goals were sent to the receiving facility at the time of Resident # 36's facility initiated transfer.

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding facility initiated transfers of residents. When asked to describe the paperwork that is sent to the receiving facility for a facility initiated transfer, LPN # 5 stated that they send demographic information, a copy of the face sheet, nurse's notes, SBAR [Situation, Background, Assessment, Response form], medication list, and any blood work that was done. When asked if they send the resident's comprehensive care plan goals or care plan summary, LPN # 5 stated no.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.
4. Resident #7 was admitted to the facility on 02/19/2019, with a readmission on 01/07/2020 with diagnoses that included but were not limited to cerebral infarction (1) and pneumonia (2). Resident #7's most recent MDS (minimum data

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set), a quarterly assessment with an ARD (assessment reference date) of 12/06/2019, coded Resident #7 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The "Progress Notes" dated "1/3/2020 16:18 (4:18 p.m.)" for Resident #7 documented, "Resident had low O2 (oxygen) sat (saturation) and put on 2L (two liters) of oxygen. VS (vital signs) have been stable, but resident did not seem like herself. Family came in and also had noticed that she was not herself. Spoke to DON (director of nursing) about my concerns about resident. Need to speak to Doctor. Left message, NP (nurse practitioner) called and notified her of concerns. Orders were given, then changed as residents condition worsened. Decision was made to send her to hospital for further evaluation ..."

The "Progress Notes" dated "1/4/2020 01:11 (1:11 a.m.)" for Resident #7 documented, "Patient admitted to [Name of Hospital] with diagnosis of pneumonia."

Review of the clinical record and the EHR (electronic health record) for Resident #7 failed to evidence documentation of the information provided to the receiving provider for the facility-initiated transfer on 1/3/2020.

On 3/8/20 at approximately 4:30 p.m., a request was made via a list provided to ASM (administrative staff member) #1, the executive director for evidence that all required documentation and information was provided to the receiving provider for the facility-initiated

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transfer of Resident #7 on 1/3/2020.

On 3/9/20 at approximately 9:00 a.m., ASM #1 provided the bed hold notice provided to Resident #7's representative and the notice of discharge sent to the ombudsman for the facility-initiated transfer on 1/3/2020. The documentation failed to evidence any resident information provided to the receiving provider for the facility-initiated transfer on 1/3/2020.

On 3/9/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding facility-initiated transfers of residents. LPN #5 stated that the facility sends demographic information, a copy of the face sheet (an information document with basic resident information), nurse's notes, SBAR (communication document containing situation, background, assessment and recommendation), medication list, and any blood work that was done with the resident for a facility-initiated transfer. LPN #5 stated that the resident's care plan goals or care plan summary are not sent with the resident to the receiving facility.

On 3/9/2020 at approximately 6:55 p.m., ASM (administrative staff member) #3, the regional director of clinical services, stated that they did not have any additional evidence to provide for the required information being provided to the receiving provider for a facility-initiated transfer of Resident #7 on 1/3/2020.

On 3/9/20 at approximately 7:00 p.m., ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings.

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No further information was presented prior to exit.

References:

1. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

2. Pneumonia: An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.

5. Resident #59 was admitted to the facility on 12/6/19; diagnoses include but are not limited to congestive heart failure, chronic kidney disease, atrial fibrillation, peripheral vascular disease, anxiety disorder, diabetes, sleep apnea, high blood pressure, dementia, and dyspnea. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/24/20 coded the resident as being mildly impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurses note dated 1/13/20 that documented, "Resident laying (Sic.) in bed crying "please help me, oh God please help me" while holding her stomach....Resident has slow bowel sounds to right upper quad (quadrant) and no bowel sounds to the other 3 quads....NP notified and gave N.O,

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(new order) to send to ER (emergency room) for eval (evaluation). RP (responsible party) notified."

Further review revealed a Physician's note dated 1/13/20 that documented, "Nurse reported c/o (complaints of) severe abdominal pain. She is crying and asking for help with her abdominal pain. Stated she did had a bowel movement yesterday, denies nausea but stated does not feel like eating. On 1/11/20 she did c/o abdominal discomfort and constipation for two days. At the time with good bowel sounds and pain level was very mild. Bowel regiment started and MiraLax (1) was given and nurses reported her having a large past bowel movement....abdomen soft, NT (non-tender), bowel sounds positive on right upper quadrants, rest of three abdomen very hypoactive bowel sounds. None distended. Not rigid or board like....Send to ER for evaluation..."

Further review of the clinical record failed to reveal any evidence of what, if any, required documentation was provided to the hospital upon transfer.

On 3/09/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding facility initiated transfers of residents. When asked to describe the paperwork that is sent to the receiving facility for a facility initiated transfer of a resident, LPN #5 stated that they send demographic information, a copy of the face sheet, nurse's notes, SBAR, medication list, and any blood work that was done. When asked if they send the resident's comprehensive care plan goals or care plan summary, LPN #5 stated no. When asked where staff document the information sent to the hospital for a resident

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transfer, LPN #5 stated that the facility has envelopes that has what information to send. A copy of this information was requested for Resident #59's hospital transfer. LPN stated, "I was informed today that we are supposed to do that (make copies). I was never told that we had to retain the copies of what was sent." A copy of the transfer packet was requested at this time from LPN #5. None was provided.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.

(1) MiraLax - is used to treat occasional constipation.
Information obtained from https://medlineplus.gov/druginfo/meds/a603032.html

6. Resident #40 was admitted to the facility on 11/4/11; diagnoses include but are not limited to stroke, dysphagia, hemiplegia, diabetes, depression, high blood pressure, and contractures. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/20 coded the resident as being severely impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurses note dated 12/29/19 that documented, "Called to resident room for patient not responding...Hx (history of) stroke and has dementia...Resident with AMS (altered mental status) responsive only after sternum rub completed, non-verbal to staff, not responding to painful stimuli...Send to ER

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(emergency room) for eval (evaluation) and tx (treatment)."

Further review revealed a physician's note dated 12/30/19 that documented, "Reason for visit: c/o (complaint of) acute change in mental status...he was sent out to ER last night...blood work and chest x-ray completed and send him back to facility....there is definitely change in his mental status from his base line...."

Further review of the clinical record failed to reveal any evidence of what, if any, required documentation was provided to the hospital upon transfer.

On 3/09/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding facility initiated transfers of residents. When asked to describe the paperwork that is sent to the receiving facility for a facility initiated transfer LPN #5 stated that they send demographic information, a copy of the face sheet, nurse's notes, SBAR, medication list, and any blood work that was done. When asked if they send the resident's care plan goals or care plan summary LPN #5 stated no. When asked where staff documented what information was sent to the hospital, LPN #5 stated that the facility has envelopes that have what to information send. A copy of this information was requested for Resident #40's hospital transfer. LPN #5 stated, "I was informed today that we are supposed to do that (make copies). I was never told that we had to retain the copies of what was sent." A copy of the transfer packet was requested at this time from LPN #5. None was provided.

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F 622	Continued From page 135 On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		

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(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the

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agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notification to the ombudsman and/or the resident and the resident's representative of a facility/resident-initiated transfer for six of 50 residents in the survey sample, Residents #114, #60, #36, #7, #59 and #40. The facility staff failed to evidence that written notification of the reason for transfer was provided to resident # 114 and Resident # 114's responsible party for the resident hospital transfer on 01/03/2020. To Resident # 60, Resident # 60's representative and /or the ombudsman for the facility-initiated transfer of Resident # 60 on 02/27/2020, and to

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Resident # 36, Resident # 36's representative and the ombudsman for the facility-initiated transfer of Resident # 36 on 01/09/2020. The facility staff failed to evidence written notification was provided to the responsible party for a facility-initiated transfer of Resident #7, and to Resident #59's responsible party for Resident #59's hospital transfer on 1/13/20. The facility staff failed to evidence that written notification of a hospital transfer was provided to the Resident #40's representative and the Ombudsman for the residents hospital transfer on 12/29/19.

The findings include:

1. Resident # 114 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, sepsis [1], and diabetes mellitus [2]. Resident # 114's MDS [minimum data set], was not due at the time of survey. The facility's "Admission Assessment" for Resident # 114 dated 01/03/2020 documented in part, "Moderately impaired for daily decision making."

The nurse's note for Resident # 114 dated 01/03/2020 documented, "At 1835 [6:45 p.m.] res [resident] was noted to be on the floor in her room on left side and was in severe pain. NP [nurse practitioner] was notified and ordered XRAY of left hip via [by] [Name of Radiology Company]. All appropriate parties notified of incident immediately. At 1855 [6:55 p.m.] [Name of Radiology Company] arrived and obtained xray. At 2030 [8:30 p.m.] res family came into facility and demanded she be sent to ED [emergency department] now because it was taking to long. Received order to send res to ED for eval [evaluation]. Called 911 and they transported to ED."

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The physician's order for Resident # 114 dated "1/3/2020 1910 documented, "Sent to ED for left hip eval."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 114 failed to evidence written notification of the transfer on 01/03/2020, to Resident # 114 and Resident # 114's representative.

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding transfers of residents. When asked to describe the procedure LPN # 5 stated that they contact the responsible party [RP] to let them know the resident is being sent to the hospital. When asked how the responsible party is contacted, LPN # 5 stated that they contact the RP by phone. When asked if the RP and the resident are provided with a written notification of the reason for transfer, LPN # 5 stated no.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

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[2]A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

2. Resident # 60 was admitted to the facility with diagnoses that included but were not limited to: pain, muscle weakness and low iron. Resident # 60's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 01/27/2020, coded Resident # 60 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The nurse's note for Resident # 60 dated 02/27/2020, documented, "Resident observed with fall and AMS [altered mental status] at 1850 [6:30 p.m.]. Bruise to top right of scalp and forehead. Background: Resident alert an oriented, has upcoming apt [appointment] for cardiac cath [catheter] next month. Assessment: 92/56 [ninety-two over fifty-six blood pressure], 97.5 [temperature], 93% [percent] RA [room air], 20 [respiration]. Response: NP [nurse practitioner] updated with new orders to send out non emergent transfer. [Name of Responsible Party] called and updated of pending transfer."

The physician's order dated "2/27/20 1910 [7:10 p.m.] documented, "Sent to ER [emergency room] for eval [evaluation] + [and] tx [treatment] due to fall + AMS [altered mental status]."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 60 failed

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to evidence Resident # 60's representative and /or the ombudsman were provided written notification of a facility-initiated transfer on 02/27/2020 for Resident # 60.

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding facility initiated transfers of residents. When asked to describe the procedure LPN # 5 stated that they contact the responsible party [RP] to let them know the resident is being sent to the hospital. When asked how the responsible part is contacted, LPN # 5 stated that they contact the RP by phone. When asked if the send the RP and the resident a written notification of the transfer, LPN # 5 stated no.

On 03/09/2020 at 5:55 p.m., an interview was conducted with OSM [other staff member] # 4, the director of social services, regarding written notification to the resident's responsible party and the ombudsman. When asked to describe the procedure, OSM # 4 stated that when a resident is discharged/transferred for more than 24 hours, their name appears on a discharge report and the ombudsman is notified of the names on the report. OSM # 4's further stated that if the resident was not gone more than 24 hours their name would not appear on the report and therefore the ombudsman would not be notified of their transfer. When asked about Resident # 60's transfer and notification to the ombudsman, OSM # 4 stated that they were not gone more than 24 hours so notification to the ombudsman was not sent.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM #

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3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

3. Resident # 36 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, muscle weakness, and high cholesterol. Resident # 36's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 01/08/2020, coded Resident # 36 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The nurse's note for Resident # 36 dated 01/09/2020 documented in part, "Situation: resident found on the floor in the bathroom. Background: resident slept in the evening. Surroundings free of hazard material, call light is not on. His [sic] not witnessed. Assessment: resident alert/oriented and diaphoresis diastolic BP [blood pressure] was low 105/38 [one hundred five over thirty-eight] then went up to 120/78 after 15 min [minutes]. Complain [sic] neck pain , stabled the neck until the EMS [emergency medical service] arrived, he mentioned he was depressed today and yesterday. Called on call NP [nurse practitioner] and [sic] get the order to send him to the hospital."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 36 failed to evidence that Resident # 36, Resident # 36's representative and the ombudsman were provided with a written notification of the reason for the facility-initiated transfer on 01/09/2020.

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On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding facility initiated transfers of residents. When asked to describe the procedure LPN # 5 stated that they contact the responsible party [RP] to let them know the resident is being sent to the hospital. When asked how the responsible party is contacted, LPN # 5 stated that they contact the RP by phone. When asked if the staff send the RP and the resident a written notification of the reason for transfer, LPN # 5 stated no.

On 03/09/2020 at 5:55 p.m., an interview was conducted with OSM [other staff member] # 4, the director of social services, regarding written notification to the resident's responsible party and the ombudsman. When asked to describe the procedure, OSM # 4 stated that when a resident is discharged/transferred for more than 24 hours, their name appears on a discharge report and the ombudsman is notified of the names on the report. OSM # 4's further stated that if the resident was not gone more than 24 hours their name would not appear on the report and therefore the ombudsman would not be notified of their transfer. When asked about Resident # 36's transfer on 1/9/2020 and notification to the ombudsman, OSM # 4 stated that they were not gone more than 24 hours so notification to the ombudsman was not sent.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

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4. Resident #7 was admitted to the facility on 02/19/2019, with a readmission on 01/07/2020 with diagnoses that included but were not limited to cerebral infarction (1) and pneumonia (2). Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/06/2019, coded Resident #7 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The "Progress Notes" dated "1/3/2020 16:18 (4:18 p.m.)" for Resident #7 documented, "Resident had low O2 (oxygen) sat (saturation) and put on 2L (two liters) of oxygen. VS (vital signs) have been stable, but resident did not seem like herself. Family came in and also had noticed that she was not herself. Spoke to DON (director of nursing) about my concerns about resident. Need to speak to Doctor. Left message, NP (nurse practitioner) called and notified her of concerns. Orders were given, then changed as residents condition worsened. Decision was made to send her to hospital for further evaluation ..."

The "Progress Notes" dated "1/4/2020 01:11 (1:11 a.m.)" for Resident #7 documented, "Patient admitted to [Name of Hospital] with diagnosis of pneumonia."

Review of the clinical record and the EHR (electronic health record) for Resident #7 failed to evidence documentation of written notice of the reason for transfer was provided to Resident #7 or the resident responsible party, for the facility-initiated transfer on 1/3/2020.

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On 3/8/20 at approximately 4:30 p.m., a request was made via a list provided to ASM (administrative staff member) #1, the executive director for evidence that written notification was provided to the resident and or the responsible party for the facility-initiated transfer of Resident #7 on 1/3/2020.

On 3/9/20 at approximately 9:00 a.m., ASM #1 provided the bed hold notice provided to Resident #7's representative and the notice of discharge sent to the ombudsman for the facility-initiated transfer on 1/3/2020. The documentation failed to evidence a written notification to the Resident #7 and or the responsible party for the facility-initiated transfer on 1/3/2020.

On 3/9/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding facility-initiated transfers of residents. LPN #5 stated that they contact the responsible party by telephone to let them know the resident is being sent to the hospital. LPN #5 stated that a written notification to the responsible party is not sent by nursing.

On 3/9/20 at 5:55 p.m., an interview was conducted with OSM (other staff member) #4, the director of social services, regarding written notification to the resident and or resident's responsible party. OSM #4 stated that she does not send written notification to the responsible party, that the nursing staff notifies them.

On 3/9/2020 at approximately 6:55 p.m., ASM (administrative staff member) #3, the regional director of clinical services, stated that they did not have any additional evidence to provide for a

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written notification of the reason for transfer being provided to Resident #7 and or the responsible party for a facility-initiated transfer on 1/3/2020.

On 3/9/20 at approximately 7:00 p.m., ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was presented prior to exit.

References:

1. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

2. Pneumonia: An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.
5. Resident #59 was admitted to the facility on 12/6/19; diagnoses include but are not limited to congestive heart failure, chronic kidney disease, atrial fibrillation, peripheral vascular disease, anxiety disorder, diabetes, sleep apnea, high blood pressure, dementia, and dyspnea. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/24/20 coded the resident as being mildly impaired in ability to make daily life decisions.

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A review of the clinical record revealed a nurses note dated 1/13/20 that documented, "Resident laying (Sic.) in bed crying "please help me, oh God please help me" while holding her stomach....Resident has slow bowel sounds to right upper quad (quadrant) and no bowel sounds to the other 3 quads....NP notified and gave N.O, (new order) to send to ER (emergency room) for eval (evaluation). RP (responsible party) notified."

Further review revealed a Physician's note dated 1/13/20 that documented in part "....Send to ER for evaluation..."

Further review of the clinical record failed to reveal any evidence that written notification of the reason for transfer was provided to the responsible party.

On 3/09/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding facility initiated transfers of residents. When asked to describe the procedure, LPN #5 stated that they contact the responsible party (RP) to let them know the resident is being sent to the hospital. When asked how the responsible party is contacted, LPN #5 stated that they contact the RP by phone. When asked if the send the RP a written notification of the transfer, LPN #5 stated no.

On 03/09/2020 at 5:55 p.m., an interview was conducted with OSM (other staff member) #4 (Social Services Director) regarding written notification to the resident's responsible party. When asked if they notify the responsible party in writing, OSM #4 stated no, nursing notifies them.

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On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.

(1) MiraLax - is used to treat occasional constipation.
Information obtained from
https://medlineplus.gov/druginfo/meds/a603032.html

6. Resident #40 was admitted to the facility on 11/4/11; diagnoses include but are not limited to stroke, dysphagia, hemiplegia, diabetes, depression, high blood pressure, and contractures. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/20 coded the resident as severely impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurses note dated 12/29/19 that documented, "Called to resident room for patient not responding...Hx (history of) stroke and has dementia...Resident with AMS (altered mental status) responsive only after sternum rub completed, non-verbal to staff, not responding to painful stimuli...Send to ER (emergency room) for eval (evaluation) and tx (treatment)."

Further review revealed the resident returned to the facility that night.

Further review revealed a physician's note dated 12/30/19 that documented, "Reason for visit: c/o acute change in mental status...he was sent out

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to ER last night...blood work and chest x-ray completed and send him back to facility....there is definitely change in his mental status from his base line...."

Further review of the clinical record failed to reveal any evidence that written notification of the reason for the transfer was provided to the responsible party and Ombudsman.

On 3/09/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding facility initiated transfers of residents. When asked to describe the procedure LPN #5 stated that they contact the responsible party (RP) to let them know the resident is being sent to the hospital. When asked how the responsible party is notified, LPN #5 stated that they contact the RP by phone. When asked if the send the RP a written notification of the transfer, LPN #5 stated no.

On 03/09/2020 at 5:55 p.m., an interview was conducted with OSM (other staff member) #4 (Social Services Director) regarding written notification to the resident's responsible party and the ombudsman. When asked to describe the procedure, OSM #4 stated that when a resident is discharged/transferred for more than 24 hours, their name appears on a discharge report and she notifies the ombudsman of the names on the report. OSM #4 further stated that if the resident was not gone more than 24 hours their name would not appear on the report and therefore the ombudsman would not be notified of their transfer. When asked about Resident # 40's transfer and notification to the ombudsman, OSM stated that they were not gone more than 24 hours so notification to the ombudsman was not

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sent. When asked if they notify the responsible party in writing, OSM #4 stated no, nursing notifies them.

On 3/10/20 at 2:30 PM, ASM #1 (Administrative Staff Member, the Executive Director) was made aware of the concern. No further information was provided.

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 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

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F 656	Continued From page 151 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, staff interview, clinical record review and facility document review it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for five of 50 residents in the survey sample, (Residents #313, 18, 11, 87, and 61). The facility staff failed to develop and implement a comprehensive care plan to address Resident #313's fall risk. The facility staff failed to implement Resident #18's comprehensive care plan for medication administration, failed to implement Resident #11's comprehensive care plan for oxygen administration, and failed to implement Resident # 87's comprehensive care plan for the use of oxygen. The facility staff failed to develop a comprehensive care plan to address Resident # 61's use of a C-PAP [Continuous Positive Airway Pressure]. The findings include: 1. The facility staff failed to develop and implement a comprehensive care plan to address Resident #313's fall risk.	F 656		

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Resident #313 was admitted to the facility 3/2/2020 with diagnoses that included but were not limited to myocardial infarction (1), dementia (2) and muscle weakness. The most recent MDS (minimum data set), for Resident #313 was not due at the time of the survey. The facility's nursing admission assessment dated 3/2/2020 coded Resident #313 as being "disoriented x 3 (person, place and time) at all times."

On 3/8/20 at approximately 1:00 p.m., an observation was conducted of Resident #313 in her room. Resident #313 was observed asleep in her bed. Resident #313's bed was observed in the lowest position to the floor with the call bell in reach.

Review of the "Admission Data Collection Form" dated "03/02/2020 1400 (2:00 p.m.)" for Resident #313 documented the resident was non-ambulatory (not walking), having poor bed mobility or difficulty moving to a sitting position on the side of the bed, having difficulty with balance or poor trunk control and on medication that would require safety precautions in Section N. Section O documented Resident #313 had poor decision-making skills. Section I documented Resident #313 was always incontinent of bowel and bladder. Section "L. Risk for Falls" documented Resident #313 was disoriented x 3 at all times, ambulatory and continent and having adequate vision. Documentation areas for gait/balance, systolic blood pressure, medications, predisposing diseases and the total score for the fall assessment were not completed in Section L.

The "Baseline Care Plan Summary" dated

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"3/2/20" for Resident #313 documented in part "This is a written summary of the Baseline Care Plan developed on admission for [Blank Line] on 3/2/20. This temporary care plan is based on your needs, preferences and goals. It will be used until your overall assessment is completed and a comprehensive care plan is developed to reflect your ongoing needs, preferences and goals. This facility will also notify you in writing of any changes to this Baseline Care Plan." The Baseline care plan failed to evidence documentation of risk of falls for Resident #313 or fall precautions.

The comprehensive care plan for Resident #313 dated "3/4/2020" failed to evidence documentation for a focus on falls.

The "Progress Notes" dated "3/6/2020 02:35 (2:35 a.m.)" documented, "Res (resident) alert and oriented with periods of confusion. Resident was yelling out and upon CNA (certified nursing assistant) entering the room found resident on half on the bed with knees on the floor. Bed was in the lowest position. Resident stated she was just sitting there and she had not fallen or rolled out of the bed. VSS (vital signs stable) with no c/o (complaints of) pain. Resident did not hit anything when sitting. This nurse did an assessment and no injuries noted. Redirection provided to the resident about the importance of not trying to get out of bed on her own and reassurance that we would assist her if she used the call bell. Upon Neuro (neurological) checks (to check level of consciousness) resident was found to be sleeping quietly and no longer yelling out. Upon waking resident up she voiced she was not in pain and that she wanted to sleep but allowed me to take her vitals (vital signs).

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Resident sleeping at this time with no other incidents."

Further review of the "Progress Notes" dated "3/9/2020 09:51 (9:51 a.m.)" documented in part," ...She is not lethargic now. She is alert and conversant. She denies any pain. Nurses stated she still not sleep [sic] all night, talking to herself and at times crying. Not crying this morning but awake and talking to herself, half her body (lower legs dangling down from the bed). Limited input from her due to dementia ..."

On 3/10/20 at 8:05 a.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding care planning residents at risk for falling. LPN #6 stated that the purpose of the care plan was to accommodate the care of the resident. LPN #6 stated that multiple factors were used in assessing residents including orientation status, transfer status and history of falling and diagnosis. LPN #6 stated that if a resident is at risk for falls, interventions were put into place such as putting the bed in the lowest position and placing a star on the door and a care plan was put into place. When asked when the care plan would be put into place, LPN #6 stated that it would be put into place within the first 24 hours after admission, if the resident was not assessed as a fall risk, they would be reassessed after a fall and the care plan would be updated then. When asked about Resident #313, LPN #6 stated that she had been a fall risk since admission and had fall risk interventions in place. LPN #6 stated that Resident #313 was checked every two hours and had her bed in the lowest position at all times. LPN #6 stated that Resident #6 should have had a care plan that addressed risk of falls. LPN #6 reviewed the progress note

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dated 3/6/2020, and stated that they did not consider the incident a fall because Resident #313 did not completely come out of the bed. LPN #6 stated that it would be considered a near fall and interventions that Resident #313 was observed closely after the incident for any further incidents. LPN #6 reviewed the baseline and comprehensive care plans for Resident #313 and stated that there was not a care plan that addressed Resident #313's risk of falls.

On 3/9/20 at approximately 6:55 p.m., a request was made by written list to ASM (administrative staff member) #1, the executive director for the facility policy on developing and implementing the comprehensive care plan.

On 3/10/20 at 10:40 a.m., ASM #3, the regional director of clinical services stated that the facility did not have a policy on developing, implementing the care plan, and that they follow Lippincott as their standard of practice. ASM #3 provided a copy of the document "Lippincott Nursing Procedures, 8th Edition, Wolters Kluwer; pages 130-132 Care Plan Preparation."

According to Lippincott Nursing Procedures, 8th Edition, Wolters Kluwer, pages 130-132 documented in part, "A nursing care plan should be written for each patient, preferably within 24 hours of admission. It is usually started by the patient's primary nurse or the nurse who admits the patient. If the care plan contains more than one nursing diagnosis, assign priority to each diagnosis and implement those with the highest priority to each diagnosis and implement those with the highest priority first. Update and revise the plan throughout the patient's stay, based on the patient's response ...Elements of a nursing

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diagnosis, Risk diagnosis; a risk-related nursing diagnosis contains two components: the identified risk and the risk factors. Identified risk- After assessing the patient's condition, choose a diagnostic label from a facility-approved list, or create a specific label for the patient that describes the condition for which the patient is at risk ...Risk factors- For a risk diagnosis there are no etiological (cause) factors. You're identifying a patient's vulnerability for a potential problem, so the problem isn't yet present. List the risk factors that predispose the patient to the identified risk ..."

On 3/10/20 at approximately 1:25 p.m., ASM #1, the executive director and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Myocardial infarction - Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm.

2. Dementia- A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.
2. The facility staff failed to implement Resident #18's comprehensive care plan for medication

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administration.

Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to dementia, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.

Resident #18's comprehensive care plan dated 12/18/19 and 12/19/18 documented, "Impaired Cardiovascular status related to: HDL (high density lipoproteins [cholesterol])...Medications as ordered by physician..." The care plan further documented, "Impaired neurological status related to: Dementia...Medication as ordered by physician...Potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication...Provide medications as ordered by physician..."

Review of Resident #18's clinical record revealed a physician's order dated 12/14/18 for simvastatin (1) 40 mg (milligrams) by mouth at bedtime, a physician's order dated 1/3/19 for donepezil (2) 10 mg by mouth once a day, and a physician's order dated 11/7/19 for trazodone (3) 25 mg (milligrams) by mouth at bedtime. The medications were scheduled for 8:00 p.m., on Resident #18's December 2019 MAR (medication administration record).

On 12/31/19, LPN (licensed practical nurse) #11 failed to document simvastatin, donepezil and trazodone was administered to Resident #18 on the MAR. LPN #11 documented the code, "7=

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Other/ See Nurse Notes." An eMAR (electronic medication administration record) note regarding simvastatin dated 12/31/19, documented, "Waiting to be sent from pharmacy." An eMAR note regarding donepezil dated 12/31/19, documented, "Waiting for pharmacy." An eMAR (electronic medication administration record) note regarding trazodone dated 12/31/19, documented, "Waiting to be sent from pharmacy." There was no further documentation regarding the administration of simvastatin, donepezil or trazodone to Resident #18 on 12/31/19.

On 3/9/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding comprehensive care plans. LPN #5 stated the purpose of the care plan was, "To be able to make all needs known, to be able to make sure all the nurses see it and know what's going on. To know residents' needs and we have to implement what it says; how are we going to do this." In regards to the facility process for ensuring medications are available for administration, LPN #5 stated she re-orders medications from the pharmacy when ten tablets are left available for administration. LPN #5 stated if a medication is scheduled for administration and she cannot find the medication, she contacts the pharmacy and if possible, obtains the medication from the "back up" box (a box in the facility containing various medications available for administration). LPN #5 stated if the needed medication is not available in the "back up" box then she contacts the pharmacy and asks for the medication to be immediately sent or asks the nurse practitioner to call in an order to the local pharmacy. LPN #5 stated that after she obtains and administers the medication, she documents a follow up note that

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the medication was given.

On 3/9/20 at 5:57 p.m., a telephone interview was conducted with LPN #11 regarding Resident #18's medication administration on 12/31/19. LPN #11 stated it had been a while since 12/31/19 and he could not recall if he contacted the pharmacy or if he administered simvastatin, donepezil or trazodone to Resident #18 on that date.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

References:
(1) Simvastatin is used to treat high cholesterol. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692030.html

(2) "Donepezil is used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697032.html

(3) Trazodone is used to treat depression. This information was obtained from the website: https://medlineplus.gov/ency/article/002559.htm

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3. The facility staff failed to implement Resident #11's comprehensive plan of care for oxygen administration.

Resident #11 was admitted to the facility on 12/22/16. Resident #11's diagnoses included but were not limited to diabetes, heart failure and high blood pressure. Resident #11's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognition as moderately impaired. Section G coded Resident #11 as requiring extensive assistance of two or more staff with bed mobility and transfers. Section O coded the resident as having received oxygen therapy.

Resident #11's comprehensive care plan dated 1/11/17 documented, "Impaired Cardiovascular status related to Congestive Heart Failure (CHF), Hypertension (high blood pressure)...Oxygen 3L/NC (three liters via nasal cannula)..."

Review of Resident #11's clinical record revealed a physician's order dated 2/5/20 for continuous oxygen at two liters per minute.

On 3/9/20 at 8:12 a.m., Resident #11 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the ball in the oxygen concentrator flow meter positioned between the two and a half and three-liter lines. This observation of the flow meter was conducted at eye level.

On 3/9/20 at 4:38 p.m., an interview was

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conducted with LPN (licensed practical nurse) #5 regarding care plans. LPN #5 stated the purpose of the care plan was, "To be able to make all needs known, to be able to make sure all the nurses see it and know what's going on. To know residents' needs and we have to implement what it says; how are we going to do this." LPN #5 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for two liters. LPN #5 stated the two-liter line should pass through the middle of the ball at eye level. LPN #5 stated it was important to set oxygen at the correct rate because if too low, the resident could become hypoxic (an inadequate oxygen level) and if too high, the resident could become over oxygenated and experience bad side effects including hallucinations.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

4. The facility staff failed to implement Resident # 87's comprehensive care plan for the use of oxygen.

Resident # 87 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease [1].

Resident # 87's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/13/2020, coded Resident # 87 as scoring a 12 on the staff

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assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. In Section O "Special Treatments, Procedures and Programs" Resident # 87 was coded for the use of oxygen.

On 03/08/20 at 1:35 p.m., an observation of Resident # 87 revealed they were sitting in their wheelchair in their room watching television receiving oxygen by nasal cannula. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between one-and -a half and two liters per minute.

On 03/08/20 at 4:42 p.m., an observation of Resident # 87 revealed they were sitting in their wheelchair in their room watching television receiving oxygen by nasal cannula. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between one-and -a half and two liters per minute.

On 03/09/20 at 8:06 a.m., an observation of Resident # 87 revealed they were sitting in their wheelchair in their room watching television receiving oxygen by nasal cannula. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between one-and -a half and two liters per minute.

The POS [physician's order sheet] dated 03/2020 for Resident # 87 documented, "Oxygen Concentrator at 2 [two] liters NC [nasal cannula] every shift. Order Date 10/25/2019."

The comprehensive care plan for Resident # 87 dated of 11/20/2019 documented, "Focus: I have alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease, Congestive

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Heart Failure. Date Initiated 11/20/2019." Under "Interventions", it documented in part, "Administer medications as ordered. Observe labs, response to medication and treatments. Date Initiated 11/20/2019."

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding how to read the flow rate on a resident's oxygen concentrator. LPN # 5 stated that the liter line on the flow meter of the oxygen concentrator should pass through the middle of the float ball at the appropriate flow rate.

On 03/09/2020 at approximately 4:55 p.m., an observation of Resident # 87's flow meter on the oxygen concentrator was conducted with LPN # 5. When asked to observe the flow and read the oxygen flow rate LPN stated that the flow rate was set between one-and -a half and two liters per minute. When asked what flow rate of oxygen the physician ordered for Resident #87, LPN # 5 stated, "Two liters per minute." LPN # 5 immediately adjusted the oxygen flow rate for Resident # 87. When asked to describe the purpose of a resident's care plan, LPN # 5 stated (the care plan) was to make all the resident care needs known and to implement what it says. When asked if Resident # 87's care plan was implemented for two liters of oxygen per minute based on the observations, LPN # 5 stated no.

On 03/09/2020 at 5:07 p.m., an interview was conducted with ASM [administrative staff member] # 3, regional director of clinical services. When asked what standard the nursing staff follow ASM # 3 stated, "Our policies and procedures and Lippincott."

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According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

5. The facility staff failed to develop a comprehensive care plan for Resident # 61's use of a C-PAP [Continuous Positive Airway Pressure] [1].

Resident # 61 was admitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [2]. Resident # 61's most

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recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/10/2019, coded Resident # 61 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. In Section O "Special Treatments, Procedures and Programs" Resident # 61 was coded as having a C-PAP.

On 03/08/20 at 3:20 p.m., and 4:44 p.m., observations of Resident # 61's room revealed a C-PAP mask lying on top of the bedside table uncovered.

On 03/09/20 at 8:29 a.m., an observation of Resident # 61's room revealed a C-PAP mask lying on top of the bedside table uncovered.

The POS [physician's order sheet] dated 03/2020 for Resident # 61 failed to evidence an order for the use of the C-PAP machine.

The comprehensive care plan for Resident # 61 dated of 11/26/2019 failed to address the use of the C-PAP machine.

On 03/09/2020 at approximately 8:30 a.m., an interview was conducted with Resident # 61. When asked how often they use the C-PAP mask, Resident #61 stated every night. When asked how long they had been using the C-PAP, Resident # 61 stated, "I've been using it for the past 15 years."

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding the storage of a C-PAP mask when not in use. LPN # 5 stated, "It has to be cleaned

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should be covered to prevent bacteria on it."
When asked to describe the purpose of a resident's comprehensive care plan, LPN # 5 stated was to make all the resident care needs known and to implement what it says.

On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 2 regarding a physician's order for Resident # 61's use of a C-PAP. After reviewing all of Resident # 61's discontinued and active physician orders, LPN # 2 stated that there was not an order for the use of a C-PAP.

On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 3, MDS coordinator regarding the missing documentation for Resident # 61's use of a C-PAP. LPN # 3 stated that a respiratory/C-PAP care plan was developed on 03/09/2020. When asked how they developed the care plan when there was no evidence of a physician's order for the use of a C-PAP, LPN # 3 stated, "I knew she used one."

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep

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F 656	Continued From page 167 apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. [2] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined 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	F 657		

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comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for eight of 50 residents in the survey sample, (Residents #69, #7, #41, #22, #650, #39, #43 and #99). The facility staff failed to revise the comprehensive care plans to address allegations of abuse for Resident #69, #67, #22, and #650. The facility staff failed to review and revise Resident #39's and Resident # 43's comprehensive care plans to address the use of halo assist bar bed rails. The facility staff failed to review and revise Resident #99's comprehensive care plan to address the administration of physician ordered oxygen to Resident #99.

The findings include:

1. The facility staff failed to review and revise the comprehensive care plans for Resident #69 and Resident #67 to address a resident-to-resident incident on 1/22/19, when Resident #67 hit Resident #69 and then Resident #69 hit Resident #67 back.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD

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(Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #67 was admitted to the facility on 11/21/12; diagnoses include but are not limited to stroke, diabetes, hemiplegia, dysphagia, dementia with behaviors, adjustment disorder, insomnia, glaucoma, chronic obstructive pulmonary disease, depression, convulsions, high blood pressure, and bipolar disorder. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/3/20 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; and supervision for eating.

A review of the clinical record for Resident #69 revealed a nurse's note dated 1/22/19 that documented, "Resident was arguing with another resident when the other resident began swearing at him. When approached by staff, the other resident punched him in the arm at which point he punched back and exchanged punches until separated by staff."

A review of the comprehensive care plan for Resident #69 revealed one dated 6/24/15 for "I have a hx (history) of the following behaviors which include following and cursing at staff, wheeling behind staff desk and packing up my

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F 657	Continued From page 170 things, claiming I am going home with a staff member. I can become attached to certain staff and believe that they are my partner and are going to take me home with them. I have a hx of sexual inappropriate behavior, I have a hx of being aggressive towards staff/others rt's (residents) by grabbing, hitting and squeezing arm, calling out when care needs have been addressed, and rejecting care when offered, refuses therapy prn (as needed), At times I will refuse rest periods when encouraged/offered." This care plan included the following interventions: "Aggressor of Resident to altercation, residents separated" dated 10/17/19 and revised 1/14/20. "Ask me if I would like a cup of coffee and see if I would like to go to the activities room and watch TV. Or if there is any other activity I would enjoy" dated 6/26/19. "Assist with moving others out of the way to clear a path so that I can move freely up and down the hall way" dated 6/20/19 and revised 1/14/20. "Attempt interventions before my behaviors begin" dated 6/20/19 and revised 6/26/19. "Complete an activity referral" dated 9/5/17. "Do not seat me around others who disturb me such as people who yell out" dated 6/20/19 and revised 6/26/19. "Enc (encourage) smaller groups to avoid over stimulation" dated 6/20/19 and revised 6/26/19. "Give me my medications as my doctor has ordered" dated 2/1/17. "Help me maintain my favorite place to sit" dated 2/1/17. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Keep me separated from other residents who are too close to me" dated 6/20/19 and revised 6/26/19. "Let my physician know if I (sic) my behaviors are interfering with my daily living" dated 6/24/15. "Make sure I am not in pain or uncomfortable" dated 2/1/17. "Offer me something I like as a	F 657		

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diversion" dated 6/20/19 and revised 6/26/19. "Offer rt (resident) his own sugar packs" dated 2/1/17. "Please refer me to my psychologist/psychiatrist as needed refer back to psych for eval" dated 6/24/15 and revised 1/14/20. "Please tell me what you are going to do before you begin" dated 6/24/15. "Re-approach me if I become upset/combative, explain what you want/need me to do first" dated 12/30/19. "Resident requires a great distance from other residents. Feels crowded when people get too close to his space" dated 6/20/19 and revised 6/26/19. "Speak to me unhurriedly and in a calm voice" dated 6/26/19.

The comprehensive care plan for Resident #69 also included one dated 3/12/17 for "I sometimes have behaviors which include hitting during activities." This care plan included the following interventions: "Assess dining room seating set-up. Sit me where I am not too close to other residents" dated 6/20/19 and revised 6/26/19. "Attempt interventions before my behavior begin. Offer me my favorite drink (coffee) or food" dated 6/20//19 and revised 6/26/19. "Do not seat me around others who disturb me" dated 10/17/19 and revised 10/20/19. "Give me my medications as my doctor has ordered" dated 8/1/18. "Help me maintain my favorite place to sit" dated 6/20/19 and revised 6/26/19. "Help me to avoid situations or people that are upsetting to me" dated 6/20/19 and revised 6/26/19. "Make sure I am not in pain or uncomfortable" dated 8/1/18. "Pharmacy medication review" dated 3/13/17. "Please refer me to my psychologist/psychiatrist as needed" dated 3/12/17. "Separate me from another (sic) residents if they sit to (sic) close within my space" dated 6/20/19 and revised 6/26/19.

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A review of the comprehensive care plan for Resident #69 failed to reveal any revisions to address this incident.

A review of the clinical record for Resident #67 revealed a nurse's note dated 1/22/19 that documented, "Resident was arguing with another resident swearing at the other resident. When approached by staff, this resident punched the other resident in the arm, when the other resident hit back, they began exchanging blows until they were separated."

Further review of the clinical record for Resident #67 revealed a social services note dated 1/23/19 that documented, "Care plan meeting held with IDT (Interdisciplinary team) and resident. Responsible party invited but did not attend....Resident had an altercation with another resident on 1/22/19 and has no emotional distress from incident....Plan of care reviewed and appropriate."
A review of the comprehensive care plan for Resident #67 failed to reveal any for behaviors or any revision after this incident. The resident did have a care plan, dated 6/11/15, for "I have dxs (diagnoses) of Bipolar Disorder and Adjustment Disorder." This care plan included the following interventions: "Encourage me to get involved in activities related to my interests" dated 6/24/19. "Help me to keep in contact with family and friends" dated 6/11/15. "Introduce me to others with similar interests" dated 6/24/19. "Please give me my medications that help me with my depression and manage any side effects" dated 6/11/15. "Please tell my doctor if my symptoms are not improving to see if I need a change in my

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medication" dated 6/11/15. "Take the time to discuss my feelings when I'm feeling sad" dated 6/24/19.

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested. None was provided.

On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated.

The facility document regarding care plans, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "CARE PLAN PREPARATION- A care plan directs the patient's nursing care from admission to discharge...Update and revise the plan throughout the patient's stay, based on the patient's response..."

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

2. The facility staff failed to review and revise the comprehensive care plan for Resident #7 to address an allegation of abuse on 3/18/19, when Resident #69 hit Resident #7 in the face.

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Resident #7 was admitted to the facility on 2/19/19; diagnoses include but are not limited to stroke, hemiplegia, hemiparesis, diabetes, dysphagia, depression, high blood pressure, and chronic obstructive pulmonary disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/6/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; and supervision for eating, requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

A review of the clinical record for Resident #7 revealed a nurses note dated 3/18/19 that documented, "Resident was smacked by another resident during dinner. The other resident was

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removed from the dining room. No injuries on the face. Resident was upset but remained in the dining room and had supper with others. Resident was upset later but no redness or injury noted."

A review of the comprehensive care plan for Resident #7 failed to reveal any revisions as a result of this incident.

A review of the clinical record for Resident #69 revealed a nurses note dated 3/18/19 that documented, "Resident was in dining room at 1730 (5:30 PM). He was going behind resident (#7) then (Resident #7) back into his w/c (wheel chair). Resident became agitated and hit her on the side of the face. No injuries noted. Residents separated and resident taken to restorative dining room to eat his meal. Resident (#7) nurse was notified. DON, POA, and NP [director of nursing, power of attorney, nurse practitioner] aware of incident. Care plan updated."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 3/18/19. This form documented, "Resident (#69) hit Resident (#7) on face in dining room. (Resident #69) was behind (Resident #7) and she backed into his w/c (wheel chair)." This form was specific to Resident #69 and did not address any care plan reviews for Resident #7.

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On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych [psychiatric] is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated.

The facility document regarding care plans, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "CARE PLAN PREPARATION- A care plan directs the patient's nursing care from admission to discharge...Update and revise the plan throughout the patient's stay, based on the patient's response..."

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

3. The facility staff failed to ensure that Resident #41's comprehensive care plan was reviewed, revised to address an incident of alleged abuse when on 1/12/20, Resident #69 hit Resident #41 in the right side of her face with a closed fist.

Resident #41 was admitted to the facility on 4/21/18; diagnoses include but are not limited to congestive heart failure, dysphagia, depression, dementia with behaviors, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/15/20 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; and

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supervision for eating.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

A review of the clinical record for Resident #41 revealed a nurses note dated 1/12/20 that documented, "Alert, s/p (status post) being the recipient in a res to res (resident to resident) altercation. Denied pain or discomfort. No apparent injuries noted to right eye area s/p episode. OOB (out of bed) in w/c (wheelchair) as tolerated. Needs to be re-directed from time to time to her room and away from other res doorway...."

A review of the comprehensive care plan for Resident #41 revealed one dated 5/22/18 for "I sometimes have behaviors which include yelling during activities, yelling during care, cursing, hitting others and attempting to take things that belong to others, wandering." This care plan included the following interventions: "Attempt interventions before my behaviors begin. Resident may need to be separated from other

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residents at times when her behavior escalates" dated 7/4/19 and revised 12/18/19. "Do not seat me around others who disturb me" dated 7/4/19. "Help me maintain my favorite place to sit" dated 5/22/18. "Help me to avoid situations or people that are upsetting to me" dated 7/4/19 and revised 9/19/19. "Staff will key into precursors to violent outburst behaviors and attempt to de-escalate me before any adverse behaviors are manifested" dated 1/5/20.

A review of the comprehensive care plan for Resident #41 failed to reveal any revisions to address this incident.

A review of the clinical record for Resident #69 revealed a nurses note dated 1/12/20 that documented, "On 3-11 shift 1/11/20 around dinner time. It was told this writer that, resident was sitting at the nurses station in his wheel chair. Staff/CNA was passing by resident with meal cart and resident in room (Resident #41) was behind her (the staff member) and tried kicking at the CNA who was in front of her to move out of her way. When this resident (#69) saw this take place he landed his closed fist on the right side of her (Resident #41) face. (Resident #41) hollered out and was holding the right side of her face. NP was made aware."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Administrator and Regional Clinical Nurse) were made aware of the identified incident and additional information was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 1/11/20 (misdated?).

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This form documented, "Resident (#69) in front of nurses station sitting beside resident (#41). Saw this resident (#41) kicking at her (a staff member that was pushing a food cart). Took his (Resident #69) right fist and connected with the other resident (#41) right cheek....he (Resident #69) was defending aide's honor."

On 3/09/20 at 3:20 PM, ASM #1 stated, "There was a lady pushing the meal cart, she was trying to get down the hall by the residents sitting in the area. (Resident #41) reached out attempting to kick the lady from kitchen. (Resident #69) interceded to defend a staff member. This form was specific to Resident #69 and did not address any care plan reviews for Resident #41.

On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated.

The facility document regarding care plans, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "CARE PLAN PREPARATION- A care plan directs the patient's nursing care from admission to discharge...Update and revise the plan throughout the patient's stay, based on the patient's response..."

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

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4. The facility staff failed to ensure that Resident #22's comprehensive care plan was reviewed and revised to address an allegation of abuse incident, on 10/17/19, Resident #22 was hit by Resident #69, in the left arm with a closed fist.

Resident #22 was admitted to the facility on 9/28/18; diagnoses include but are not limited to dementia with behaviors, anxiety disorder, hallucinations, and dyspnea. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/10/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for dressing, eating, toileting and hygiene; and supervision for transfers.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of bowel and bladder.

A review of the clinical record for Resident #22 revealed a nurse note dated 10/17/19 that documented, "This resident walking in hallway near north nurses station. Not behaving in a provocative manner. Encountered resident (#69)

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who, for no apparent reason, punched her in upper right arm. The two residents were quickly separated and no further conflict ensued. The resident suffered no injuries as a result of this incident. Appropriate notifications done in a timely manner."

A review of the comprehensive care plan for Resident #22 revealed one dated 10/5/18 for "I sometimes have behavior which include visual and auditory hallucinations, esp (especially) about seeing and hearing family members, refuses care, easily agitated. Resident places herself on the floor intentionally and is acting out behavior but has no injuries these falls. Will get into bed with male rt's (residents) thinks they are her husband, altercation with another rt. She leaves walker at different places and at times undresses self and takes off brief." This care plan included the following interventions: "Attempt interventions before my behaviors begin" dated 10/5/18 and revised 6/18/19. "Do not seat me around others who disturb me" dated 10/5/18. "Help me maintain my favorite place to sit" dated 10/5/18. "Help me to avoid situations or people that are upsetting to me" dated 10/5/18 and revised 6/18/19. "Keep me separated from people that may become agitated from my behaviors" dated 10/17/19 and revised 10/20/19.

A review of the comprehensive care plan for Resident #22 failed to reveal any revisions to address this incident.

A review of the clinical record for Resident #69 revealed a nurses note dated 10/17/19 that documented, "This resident and resident (#22) were passing each other in hall and this resident punched resident (#22) in the left arm with a

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closed fist. Residents separated. NP and RP notified."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 10/17/19. This form documented, "This resident (Resident #69) was passing resident (#22) in hall and this resident punched resident (#22) in left arm with closed fist." This form was specific to Resident #69 and did not address any care plan reviews for Resident #22.

On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated.

The facility document regarding care plans, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "CARE PLAN PREPARATION- A care plan directs the patient's nursing care from admission to discharge...Update and revise the plan throughout the patient's stay, based on the patient's response..."

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.

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5. facility staff failed to review and revise the comprehensive care plan for Resident #650 after an allegation of abuse between Resident #69 and Resident #650, when on 2/26/19, Resident #650 was hit in the face by Resident #69.

Resident #650 was admitted to the facility on 3/14/18; diagnoses include but are not limited to femur fracture, depression, chronic obstructive sleep apnea, high blood pressure, heart disease, atrial fibrillation, congestive heart failure, acute respiratory failure, and cardiac pacemaker. The resident expired at the facility on 8/5/19 and therefore was not a current resident in the facility at the time of survey. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/28/19 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, eating and dressing; and extensive assistance for transfers.

Resident #69 was admitted to the facility on 1/17/13; diagnoses include but are not limited to stroke, dementia with behaviors, hemiplegia and hemiparesis, depression, pain in leg and shoulder, dysphagia, adjustment disorder, epilepsy, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating and locomotion; and was frequently incontinent of

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bowel and bladder.

A review of the clinical record for Resident #650 revealed a physician note dated 2/26/19 that documented, "Called by the nurse to evaluate resident as she was assaulted. At the dining room she was punched in to her nose by another resident. She was tearful and anxious. No injuries. No brusing but mild erythema on dorsum of the nose noted.

Further review of the clinical record for Resident #650 revealed a nurse's note dated 2/26/19 that documented, "Assaulted by another resident during supper in the dining hall. No injuries noted. Resident tearful and upset. Slight redness on nose initially. Resident calmed down after consoling from staff. NP (Nurse Practitioner), POA (Power of Attorney), DON (Director of Nursing) notified. Resident remained calm and sociable through the rest of the evening. Will continue to monitor."

A review of the comprehensive care plan for Resident #650 failed to reveal any revisions to address of this incident.

A review of the clinical record for Resident #69 revealed a nurses note dated 2/26/19 that documented, "Resident to resident altercation with resident (#650) at 1730 (5:30 PM). Staff CNA (Certified Nursing Assistant) alerted this writer that resident (#650) bumped into residents w/c (wheel chair) in dining room. Resident turned around and hit resident (#650) twice in the face. Resident separated from area and was taken into restorative dining room with two staff LPN's (Licensed Practical Nurse) to eat his evening meal....Resident alert times one. When this

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writer questioned resident about incident he denied allegations. No further behaviors noted. Resident cooperative with staff and other residents. Resident monitored frequently for inappropriate behaviors. NP, DON and POA [nurse practitioner, director of nursing, and power of attorney], aware of incident. Care plan updated."

Further review of the clinical record for Resident #69 revealed a physician's note dated 2/26/19 that documented, "Called by the nurse to report an incident. Resident had hit a resident in her nose twice at the dining room and was witnessed by the staff. Found resident sitting in wheelchair in the hall way looking out the window. He is alert to him self and denied the episode. As per staff he does have a tendency to get violant (sic). 2/7/19 blood work with Valproic acid level 23.0, electrolytes WNL (within normal limits). Monitor resident closely. Will refer to the psych for evaluation of his medications."

On 3/9/20 at 10:10 AM, ASM #1 and ASM #3 (Administrative Staff Members, the Executive Director and Regional Director of Clinical Services) were made aware of the identified incident. Additional information such as an incident report was requested.

Per this request, the facility provided a "Behavioral Outburst Assault of Another Resident or Staff Member" form dated 2/26/19. This form documented, "Resident (#69) hit Resident (#650) in face on nose and forehead in the dining room....Resident (#650) was close to his chair and hit w/c (wheel chair). Resident (#69) turned around and hit her (Resident #650)." This form was specific to Resident #69 and did not address

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any care plan reviews for Resident #650.

On 3/09/20 at 3:20 PM, ASM #1 stated that part of the process is to notify the doctor and the responsible party, and if psych is following the resident, identify if any new interventions are needed, and the care plan should be looked at and updated.

The facility document regarding care plans, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "CARE PLAN PREPARATION- A care plan directs the patient's nursing care from admission to discharge...Update and revise the plan throughout the patient's stay, based on the patient's response..."

On 3/10/20 at 2:30 PM, ASM #1 was made aware of the concern. No further information was provided.
6. The facility staff failed to review and revise Resident #39's comprehensive care plan for the use of halo assist bar bed rails.

Resident #39 was admitted to the facility on 6/15/18. Resident #39's diagnoses included but were not limited to seizures, high blood pressure and muscle weakness. Resident #39's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/14/20, coded the resident's cognition as severely impaired. Section G coded Resident #39 as requiring extensive assistance of two or more staff with bed mobility.

Resident #39's comprehensive care plan dated 11/5/19 failed to document information regarding the resident's use of halo assist bar bed rails.

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On 3/9/20 at 8:21 a.m., Resident #39 was observed in bed with bilateral halo assist bars up.

On 3/9/20 at 5:20 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding comprehensive care plan revisions for halo assist bars. LPN #1 stated the nurses obtain a recommendation from the therapy staff for residents who need halo assist bars, obtain a physician's order for the halo assist bars, then the residents' care plans are reviewed and revised for the use of halo assist bars.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility document regarding care plans, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "CARE PLAN PREPARATION- A care plan directs the patient's nursing care from admission to discharge...Update and revise the plan throughout the patient's stay, based on the patient's response..."

No further information was presented prior to exit.

7. The facility staff failed to revise Resident # 43's comprehensive care plan to address the use of bedrails.

Resident # 43 was admitted to the facility with diagnoses that included but were not limited to: muscle weakness, swallowing difficulties and pain. Resident # 43's most recent MDS (minimum

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data set), a quarterly assessment with an ARD (assessment reference date) of 01/15/2020, coded Resident # 43 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being severely impaired of cognition for making daily decisions. Section G coded Resident # 43 as requiring extensive assistance of two staff members for bed mobility.

On 03/08/20 at 3:15 p.m., an observation revealed Resident # 43 lying in bed with right and left upper bed rails/Halos raised.

On 03/09/20 at 8:05 a.m., an observation revealed Resident # 43 lying in bed with right and left upper bed rails/Halos raised.

The comprehensive care plan for Resident # 43 dated 09/10/2019 failed to address the use of bed rails.

On 3/9/20 at 5:20 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding comprehensive care plan revisions to address the use of halo assist bars. LPN #1 stated the nurses obtain a recommendation from the therapy staff for residents who need halo assist bars, obtain a physician's order for the halo assist bars, then the residents' care plans are reviewed and then revised for the use of halo assist bars.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

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8. The facility staff failed to review and revise Resident #99's comprehensive care plan to address the administartion of physician orderd oxygen to Resident #99.

Resident # 99 was admitted to the facility with diagnoses that included but were not limited to: history of pulmonary embolism [1]. Resident # 99's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/19/2020, coded Resident # 99 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Section O "Special Treatments, Procedures and Programs" coded Resident # 99 for the use of oxygen.

On 03/08/20 at 1:48 p.m., an observation of Resident # 99 revealed the resident sitting in their wheelchair in their room watching television receiving oxygen by nasal cannula connected to any oxygen concentrator that was running. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between three-and-a half and four liters per minute.

On 03/08/20 at 4:43 p.m., an observation of Resident # 99 revealed the resident sitting in their wheelchair in their room watching television receiving oxygen by nasal cannula connected to any oxygen concentrator that was running. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between three-and-a half and four liters per minute.

The POS [physician's order sheet] dated 03/2020

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for Resident # 99 documented, "O2 [oxygen] via nasal cannula 2L/min [two liters per minute]. Order Date 12/08/2019."

The comprehensive care plan for Resident # 99 dated of 11/26/2019 failed to evidence documentation for respiratory care or the administration of oxygen.

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding how to read the flow rate on a resident's oxygen concentrator. LPN # 5 stated that the liter line on the flow meter of the oxygen concentrator should pass through the middle of the float ball at the appropriate flow rate. When informed of the above observations of Resident # 99 oxygen flow rate, LPN # 5 stated that it was set incorrectly and that the physician ordered oxygen flow rate was to be set at two liters per minute. When asked to describe the purpose of a resident's comprehensive care plan, LPN # 5 stated was to make all the resident care needs known and to implement what it says.

On 03/10/2020 at 8:05 a.m., an interview was conducted with LPN [licensed practical nurse] # 3, MDS coordinator regarding the missing documentation of Resident # 99's use of oxygen. After reviewing Resident # 99's comprehensive care plan dated 11/26/2019, LPN # 3 stated that the care plan was not updated for Resident # 99's use of oxygen. LPN # 3 further stated that nursing should have updated the care plan and that they, MDS, would have revised the care plan.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM #

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3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] A blockage of an artery in the lungs. This information was obtained from the website: https://medlineplus.gov/ency/article/000132.htm.

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Services Provided Meet Professional Standards
CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review it was determined facility staff failed to follow professional standards of practice for two of 50 residents in the survey sample, Resident #99 and Resident #61. The facility staff failed to follow medication administration standards of practice during the administration of Protonix delayed release tablet on 3/9/20. RN (registered nurse) #1 crushed, opened and mixed the contents of one 40 mg (milligram) Protonix delayed release capsule with pudding and administered the medication to Resident #99. The facility staff failed to obtain an order for Resident #61 use of a CPAP [continuous positive airway pressure].

The findings include:

1. Resident #99 was admitted to the facility on

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11/25/2019 with diagnoses that included but were not limited to pulmonary embolism (2) and major depressive disorder (3). Resident #99's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 2/19/2020 coded Resident #99 as scoring an 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions.

On 3/9/20 at approximately 8:20 a.m., an observation of medication administration for Resident #99 was conducted with RN (registered nurse) #1. RN #1 prepared medications to administer to Resident #99 including Protonix 40 mg (milligram) one tablet. Prior to administration of the Protonix tablet RN #1 used the plastic sleeve and pill crusher to crush the tablet and empty the contents into a medication cup. RN #1 then mixed the medication contents with pudding. RN #1 then proceeded to crush or open up the other capsules and mixed the pill contents with pudding. RN #1 was observed leaving one single tablet intact and placed it in pudding. When asked about the tablet, RN #1 stated that Resident #99 takes all of her medications crushed or opened up into pudding except for the Xarelto (blood thinner) which was left intact and placed in the pudding. RN #1 administered the medications to Resident #99.

Review of the "Order Summary Report" dated "Mar (March) 9, 2020" documented in part, "Protonix Tablet Delayed Release 40 mg (Pantoprazole Sodium) (generic name for Protonix) Give 1 (one) tablet by mouth one time a day for GERD (gastroesophageal reflux disease) (4). Order Date: 11/26/2019. Start Date: 11/27/2019."

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The comprehensive care plan failed to evidence a care plan regarding administering medications as ordered.

The "Medication Administration Record" dated "3/1/2020-3/31/2020" documented Resident #99 receiving the Protonix Tablet delayed release as documented above each day at 9:00 a.m.

On 3/9/20 at approximately 4:45 p.m., a request was made to LPN (licensed practical nurse) #2, to interview RN #1. LPN #2 stated that RN #1 had already left for the day and RN #1 was not scheduled to work on 3/10/20.

On 3/9/20 at approximately 5:00 p.m., an interview was conducted with LPN #1. LPN #1 stated that delayed release medications should not be crushed or opened. LPN #1 stated that delayed released means the medication is to be released over an extended period of time. LPN #1 stated that they needed to get an order for something that they could crush or a liquid medication for Resident #99 if she could not swallow the delayed release medication.

On 3/9/20 at approximately 6:55 p.m., a request was made by written list to ASM (administrative staff member) #1, the executive director for the facility policy on medication administration.

On 3/10/20 at 10:40 a.m., ASM #3, the regional director of clinical services stated that the facility followed their policies, the regulations and Lippincott as their standard of practice. ASM #3 provided a copy of the document "Lippincott Nursing Procedures, 8th Edition, Wolters Kluwer; pages 678-680, Safe Medication Administration

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Practices, General."

According to "Lippincott Nursing Procedures, 8th Edition, Wolters Kluwer; pages 678-680, Safe medication administration practices, general" failed to evidence guidance in the administration of delayed release medications.

The facility policy "Medication Administration Guidelines" dated "12/12 (December 2012)" documented in part, "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication ...5. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from prescriber ...b. Long-acting, extended release or enteric-coated (coating to prevent dissolving in the stomach) dosage forms should generally not be crushed; an alternative should be sought."

"PROTONIX Delayed-Release Tablets should be swallowed whole, with or without food in the stomach.... should not be split, chewed, or crushed." [4]

On 3/9/20 at 6:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was presented prior to exit.

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References:

1. Protonix- (pantoprazole) is a proton pump inhibitor that decreases the amount of acid produced in the stomach. Protonix is used to treat erosive esophagitis (damage to the esophagus from stomach acid caused by gastroesophageal reflux disease, or GERD) in adults and children who are at least 5 years old. Pantoprazole is usually given for up to 8 weeks at a time while your esophagus heals. This information was obtained from the website: https://www.drugs.com/protonix.html

2. Pulmonary embolus- (PE) is a sudden blockage in a lung artery. It usually happens when a when a blood clot breaks loose and travels through the bloodstream to the lungs. PE is a serious condition that can cause: Permanent damage to the lungs, Low oxygen levels in your blood, Damage to other organs in your body from not getting enough oxygen, PE can be life-threatening, especially if a clot is large, or if there are many clots. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=pulmonary+embolism

3. Major depressive disorder- is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.

4. This information was taken formt the website:

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cfeacb5c-8b1b-48f6-9acf-00044a8179b4
2. Resident # 61 was admitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [2]. Resident # 61's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/10/2019, coded Resident # 61 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. In Section O "Special Treatments, Procedures and Programs" Resident # 61 was coded as having a C-PAP [continuous positive airway pressure] [1].

On 03/08/20 at 3:20 p.m., and at 4:44 p.m., observations of Resident # 61's room revealed a C-PAP mask laying on top of the bedside table uncovered.

On 03/09/20 at 8:29 a.m., an observation of Resident # 61's room revealed a C-PAP mask laying on top of the bedside table uncovered.

The POS [physician's order sheet] dated 03/2020 for Resident # 61 failed to evidence an order for the use of the C-PAP machine.

The comprehensive care plan for Resident # 61 dated of 11/26/2019 failed to evidence an order for the use of the C-PAP machine.

On 03/09/2020 at approximately 8:30 a.m., an interview was conducted with Resident # 61. When asked how often they use the C-PAP mask, Resident #61 stated every night. When asked how long they had been using the C-PAP,

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Resident # 61 stated, "I've been using it for the past 15 years."

On 03/10/2020 at 10:05 a.m., an interview was conducted with LPN # 2 regarding a physician's order for Resident # 61's use of a C-PAP. After reviewing, all of Resident # 61's discontinued and active physician orders LPN # 2 stated that there was not an order for the use of a C-PAP. When asked to describe the procedure for the use of a C-PAP, LPN # 2 stated, "Nursing should check for a physician's order, and set the machine according to the setting on the order. If there is no order, they need to notify the nurse practitioner and a respiratory company to verify the settings and notify the resident's responsible party." When asked if there could be any negative outcomes for the resident if they did not have the correct settings, LPN # 2 stated, "The patient would not get the proper oxygen level and could have respiratory distress or hypoxia [not enough oxygen]." When asked if Resident # 61 was receiving respiratory treatment without a physician's order, LPN # 2 stated yes.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure)

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F 658	Continued From page 198 prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. [2] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services in accordance with professional standards of practice and the comprehensive plan of care for two of 50 residents in the survey sample, (Residents #18 and #40). The facility staff failed to administer physician prescribed medications to Resident #18 on 12/31/19. The facility staff failed to maintain a current physician's order for Resident #4 to received Hospice care and services.	F 684		

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The findings include:

1. Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to dementia, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision making as moderately impaired.

Review of Resident #18's clinical record revealed a physician's order dated 12/14/18 for simvastatin (1) 40 mg (milligrams) by mouth at bedtime and a physician's order dated 1/3/19 for donepezil (2) 10 mg by mouth once a day.

The medications were scheduled for 8:00 p.m. on Resident #18's December 2019 MAR (medication administration record). On 12/31/19, LPN (licensed practical nurse) #11 failed to document simvastatin and donepezil was administered to Resident #18 on the MAR. LPN #11 documented the code, "7= Other/ See Nurse Notes." An eMAR (electronic medication administration record) note regarding simvastatin and dated 12/31/19 documented, "Waiting to be sent from pharmacy." An eMAR note regarding donepezil and dated 12/31/19 documented, "Waiting for pharmacy." There was no further documentation regarding the administration of simvastatin or donepezil on 12/31/19.

Resident #18's comprehensive care plan dated 12/19/18 documented, "Impaired Cardiovascular status related to: HDL (high density lipoproteins [cholesterol])...Medications as ordered by physician..." The care plan further documented,

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"Impaired neurological status related to: Dementia...Medication as ordered by physician..."

Review of a pharmacy manifest dated 12/5/19 revealed a quantity of 30- 40 mg tablets of simvastatin and a quantity of 30- 10 mg tablets of donepezil for Resident #18 was delivered to the facility on that date. Review of the facility medication "back up" box list (a box containing various medications that are available for administration to residents) revealed ten 20 mg tablets of simvastatin was contained in the box.

On 3/9/20 at 4:38 p.m., an interview was conducted with LPN #5 regarding the facility process for ensuring, physician prescribed medications are available for administration. LPN #5 stated she re-orders medications from the pharmacy when ten tablets are left available for administration. LPN #5 stated if a medication is scheduled for administration and she cannot find the medication, she contacts the pharmacy and if possible, obtains the medication from the "back up" box. LPN #5 stated that after she obtains and administers the medication, she documents a follow up note that the medication was given.

On 3/9/20 at 5:57 p.m., a telephone interview was conducted with LPN #11 regarding Resident #18's medication administration on 12/31/19. LPN #11 stated it had been a while since 12/31/19 and he could not recall if he contacted the pharmacy or if he administered simvastatin or donepezil to Resident #18 on that date.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of

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the above concern. ASM #2 and ASM #3 stated the facility staff follows Lippincott and policies as the facility standard of practice.

The facility pharmacy policy titled, "Medication Administration- General Guidelines" documented, "1. Medications are administered in accordance with written orders of the prescriber..."

The facility document regarding safe medication administration practices, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "Follow a written or typed order or an order entered into a computer order-entry system..."

No further information was presented prior to exit.

References:

(1) Simvastatin is used to treat high cholesterol. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692030.html

(2) "Donepezil is used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697032.html

2. Resident #40 was admitted to the facility on 11/4/11; diagnoses include but are not limited to stroke, dysphagia, hemiplegia, diabetes, depression, high blood pressure, and contractures. The significant change MDS (Minimum Data Set) with an ARD (Assessment

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Reference Date) of 1/14/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, transfers, and hygiene; extensive assistance for dressing, eating, and toileting; and was incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 12/30/19 for a hospice consult.

Further review revealed the order was discontinued in the electronic clinical record system on 1/20/20.

A review of the monthly POS (Physician's Order Sheets) printed on 1/26/20 and signed by the nurse practitioner on 1/29/20; and the POS printed on 2/27/20 and signed by the Nurse Practitioner on 2/27/20, revealed no current hospice orders were listed.

A review of the nurses' notes revealed that on 1/20/20, 1/23/20, and on 3/2/20, documented the resident was seen by Hospice.

A review of the comprehensive care plan revealed one dated 1/15/20 for "Patient is on Hospice Care..." This care plan included the intervention, dated 1/15/20, for "Obtain Physician order and appropriate Referral."

On 3/9/20 at 7:07 PM, ASM #1 (Administrative Staff Member, the Executive Director), ASM #2 (the Director of Nursing) and ASM #3 (the Regional Director of Clinical Services) were made aware of the findings.

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On 3/10/20 at 12:50 PM, an interview was conducted with ASM #3. She stated that for some reason the order was discontinued when it shouldn't have been. ASM #3 stated that an order is needed for hospice and that the resident was currently receiving hospice without an order from 1/20/20 up to the time when the facility was notified that there was not an order for hospice, on 3/9/20 at 7:07 PM.

On 3/10/20 at 12:50 PM, ASM #3 stated that there wasn't a policy for hospice. No further information was provided.

F 690 SS=D Bowel/Bladder Incontinence, Catheter, UTI F 690
CFR(s): 483.25(e)(1)-(3)

§483.25(e) Incontinence.
§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and

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(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to provide treatment and services to maintain and/or restore a resident's bladder function for one of 50 residents in the survey sample, Resident #78. The facility staff failed to identify and address Resident #8's decline in urinary continence between a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/9/19 and a quarterly MDS assessment with an ARD of 2/12/20.

The findings include:

Resident #78 was admitted to the facility on 10/15/19. Resident #78's diagnoses included but were not limited to diabetes, urinary incontinence and high blood pressure. Resident #78's quarterly MDS assessment with an ARD of 12/9/19 coded the resident as being cognitively intact, scoring a 14 out of 15 on the brief interview for mental status. Section H coded Resident #78 as occasionally incontinent of urine (less than seven episodes of incontinence during the

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seven-day look back period). Resident #78's quarterly MDS assessment with an ARD of 2/12/20 coded the resident's cognition as moderately impaired, scoring 12 out of 15 on the brief interview for mental status. Section H coded Resident #78 as frequently incontinent of urine (seven or more episodes of urinary incontinence during the seven-day look back period).

Review of Resident #78's ADL (activities of daily living) records revealed the resident presented with four episodes of urinary incontinence from 12/3/19 through 12/9/19 and seven episodes of urinary incontinence from 2/6/20 through 2/12/20.

Resident #78's comprehensive care plan dated 11/11/19 documented, "Alteration in elimination of bowel and bladder Stress incontinence...Discuss medications with physician which may be contributing to incontinence; evaluate timing of medications which may cause increased urination; use of briefs/pads for incontinence protection..."

Review of Resident #78's clinical record, including nurses' notes and physical therapy notes, failed to reveal evidence that the facility staff identified and addressed the decline in the resident's urinary continence between the 12/9/19 MDS assessment and the 2/12/20 MDS assessment.

On 3/10/20 at 8:35 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (MDS coordinator) and LPN #3 (unit manager), regarding the decline in Resident #78's urinary continence from the 12/9/19 MDS assessment and the 2/12/20 MDS assessment. LPN #1 stated she does look at urinary changes including

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improvements and declines when coding MDS assessments but she probably did not do so when Resident #78's MDS assessments were completed because she (LPN #1) was new. The MDS assessments were reviewed with LPN #1. LPN #1 stated she now knows that Resident #78 "cycles" depending on what is going on with her oxygen level and her anxiety. When asked if "frequently incontinent" is a decline from "occasionally incontinent," LPN #1 stated, "Yeah, a little one." LPN #1 stated she did not remember if she identified the decline in Resident #78's continence because she was new. LPN #1 stated therapy referrals, toileting programs and physician notification should be implemented when a resident's continence level declines. LPN #1 and LPN #3 were asked if any interventions were implemented to address the decline in Resident #78's continence level. LPN #1 and LPN #3 both stated, "No."

On 3/10/20 at 1:04 p.m., an interview was conducted with OSM (other staff member) #10 (the rehabilitation director). OSM #10 stated Resident #78 received physical therapy for improved activity intolerance and walking distance in February 2020, but the resident was not evaluated or treated for bladder incontinence.

On 3/10/20 at 1:32 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual, used for coding MDS assessments documented,
"SECTION H: BLADDER AND BOWEL

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F 690	Continued From page 207 Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible." No further information was presented prior to exit.	F 690		
F 695 SS=E	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, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services for four of 50 residents in the survey sample, Residents #11, #87, #99 and #61. The facility staff failed to administer oxygen to Resident #11, #87 and #99, at flow rate prescribed by the physician. The facility staff failed to store Resident # 61's C-PAP [Continuous Positive Airway Pressure] mask in a	F 695		

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sanitary manner.

The findings include:

1. The facility staff failed to administer oxygen to Resident #11 at the physician prescribed rate of two liters per minute.

Resident #11 was admitted to the facility on 12/22/16. Resident #11's diagnoses included but were not limited to diabetes, heart failure and high blood pressure. Resident #11's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognition as moderately impaired. Section G coded Resident #11 as requiring extensive assistance of two or more staff with bed mobility and transfers. Section O coded the resident as having received oxygen therapy.

Resident #11's comprehensive care plan dated 1/11/17 documented, "Impaired Cardiovascular status related to Congestive Heart Failure (CHF), Hypertension (high blood pressure)...Oxygen 3L/NC (three liters via nasal cannula)..."

Review of Resident #11's clinical record revealed a physician's order dated 2/5/20 for continuous oxygen at two liters per minute.

On 3/9/20 at 8:12 a.m., Resident #11 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the ball in the concentrator flow meter positioned between the two and a half and three-liter lines. This

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observation of the flow meter was conducted at eye level.

On 3/9/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for two liters. LPN #5 stated the two-liter line should pass through the middle of the ball at eye level. LPN #5 stated it was important to set oxygen at the correct rate because if too low, the resident could become hypoxic (an inadequate oxygen level) and if too high, the resident could become over oxygenated and experience bad side effects including hallucinations.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The oxygen concentrator manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed."

The facility document regarding oxygen, an excerpt from Lippincott Nursing Procedures Eight Edition documented, "Oxygen administration helps relieve hypoxemia (low level of oxygen) and maintain adequate oxygenation of tissues and vital organs...Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed..."

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No further information was presented prior to exit.

2. The facility staff failed to administer Resident # 87's oxygen according to the physician's orders.

Resident # 87 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease [1]. Resident # 87's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/13/2020, coded Resident # 87 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. In Section O "Special Treatments, Procedures and Programs" Resident # 87was coded for the use of oxygen.

On 03/08/20 at 1:35 p.m., an observation revealed Resident # 87 sitting in their room in a wheelchair watching television and receiving oxygen by nasal cannula connected to any oxygen concentrator that was running. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between one-and -a half and two liters per minute.

On 03/08/20 at 4:42 p.m., an observation of revealed Resident # 87 sitting in their wheelchair in their room watching television receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between one-and -a half and two liters per minute.

On 03/09/20 at 8:06 a.m., an observation of Resident # 87 revealed they were sitting in their

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wheelchair in their room watching television receiving oxygen by nasal cannula. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between one-and -a half and two liters per minute.

The POS [physician's order sheet] dated 03/2020 for Resident # 87 documented, "Oxygen Concentrator at 2 [two] liters NC [nasal cannula] every shift. Order Date 10/25/2019."

The comprehensive care plan for Resident # 87 dated of 11/20/2019 documented, "Focus: I have alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease, Congestive Heart Failure. Date Initiated 11/20/2019." Under "Interventions", it documented in part, "Administer medications as ordered. Observe labs [laboratory tests], response to medication and treatments. Date Initiated 11/20/2019."

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding how to read the flow rate on a resident's oxygen concentrator. LPN # 5 stated that the liter line on the flow meter of the oxygen concentrator should pass through the middle of the float ball at the appropriate flow rate.

On 03/09/2020 at approximately 4:55 p.m., an observation of Resident # 87's flow meter on the oxygen concentrator was conducted with LPN # 5. When asked to observe the flow and read the oxygen flow rate, LPN stated that the flow rate was set between one-and -a half and two liters per minute. When asked what the physician prescribed oxygen flow rate was for Resident #87, LPN # 5 stated, "two liters per minute." LPN # 5 immediately adjusted the oxygen flow rate for

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Resident # 87.

The "[Name of Manufacturer] User Manual" for Resident # 87's oxygen concentrator documented in part, "6.3.4 Flowrate. To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min [liter per minute] line prescribed."

On 03/09/2020 at 5:07 p.m., an interview was conducted with ASM [administrative staff member] # 3, regional director of clinical services. When asked what standard practice the facility follows, ASM # 3 stated, "Our policies and procedures and Lippincott."

According to Lippincott, page 242, read in part: "Nursing Assessment and Interventions: 3. Administer oxygen in the appropriate concentration.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

3. The facility staff failed to administer Resident # 99's oxygen according to the physician's orders.

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Resident # 99 was admitted to the facility with diagnoses that included but were not limited to: history of pulmonary embolism [1].

Resident # 99's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/19/2020, coded Resident # 99 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. In Section O "Special Treatments, Procedures and Programs" Resident # 99 was coded for the use of oxygen.

On 03/08/20 at 1:48 p.m., an observation revealed Resident # 99 sitting in their wheelchair, in their room watching television, receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between three-and-a half and four liters per minute.

On 03/08/20 at 4:43 p.m., an observation revealed Resident # 99 sitting in their wheelchair in their room watching television, receiving oxygen by nasal cannula, connected to an oxygen concentrator that was running. Observation of the oxygen flow rate revealed the flow rate of the oxygen was between three-and-a half and four liters per minute.

The POS [physician's order sheet] dated 03/2020 for Resident # 99 documented, "O2 [oxygen] via nasal cannula 2L/min [two liters per minute]. Order Date 12/08/2019."

The comprehensive care plan for Resident # 99 dated of 11/26/2019 failed to evidence

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documentation for respiratory care or the administration of oxygen.

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding how to read the flow rate on a resident's oxygen concentrator. LPN # 5 stated that the liter line on the flow meter of the oxygen concentrator should pass through the middle of the float ball at the appropriate flow rate. When informed of the above observations for Resident # 99's oxygen flow rate, LPN # 5 stated that it was set incorrectly and that the physician ordered oxygen flow rate was to be set at two liters per minute.

The "[Name of Manufacturer] User Manual" for Resident # 87's oxygen concentrator documented in part, "6.3.4 Flowrate. To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min [liter per minute] line prescribed."

On 03/09/2020 at 5:07 p.m., an interview was conducted with ASM [administrative staff member] # 3, regional director of clinical services. When asked what standard of practice the facility follows, ASM # 3 stated, "Our policies and procedures and Lippincott."

According to Lippincott, page 242, read in part: "Nursing Assessment and Interventions: 3. Administer oxygen in the appropriate concentration.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM #

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3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] A blockage of an artery in the lungs. This information was obtained from the website: https://medlineplus.gov/ency/article/000132.htm.

4. The facility staff failed to store Resident # 61's C-PAP [Continuous Positive Airway Pressure] mask in a sanitary manner.

Resident # 61 was admitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [2]. Resident # 61's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/10/2019, coded Resident # 61 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. In Section O "Special Treatments, Procedures and Programs" Resident # 3 was coded as having a C-PAP [Continuous Positive Airway Pressure] [1].

On 03/08/20 at 3:20 p.m., and at 4:44 p.m., observations of Resident # 61's room revealed a C-PAP mask laying on top of the bedside table uncovered.

On 03/09/20 at 8:29 a.m., an observation of Resident # 61's room revealed a C-PAP mask laying on top of the bedside table uncovered.

The POS [physician's order sheet] dated 03/2020

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for Resident # 61 failed to evidence an order for the use of the C-PAP machine.

The comprehensive care plan for Resident # 61 dated of 11/26/2019 failed to evidence an order for the use of the C-PAP machine.

On 03/09/2020 at approximately 8:30 a.m., an interview was conducted with Resident # 61. When asked how often they use the C-PAP mask, Resident #61 stated every night. When asked how long they had been using the C-PAP, Resident # 61 stated, "I've been using it for the past 15 years."

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding the storage of a C-PAP mask when not in use. LPN # 5 stated, "It has to be cleaned should be covered to prevent bacteria on it."

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website:

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https://medlineplus.gov/ency/article/001916.htm.

[2] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

F 700 SS=D — F 700

Bedrails
CFR(s): 483.25(n)(1)-(4)

§483.25(n) Bed Rails.
The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to

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implement bed rail requirements for three of 50 residents in the survey sample, (Residents #39, #107 and #43). The facility staff failed to assess Resident #39, #107 and #43 for the use of halo assist bar bed rails, failed to review risks and benefits with the residents (or the resident's representative) and failed to obtain informed consent for the use of halo assist bar bed rails.

The findings include:

1. Resident #39 was admitted to the facility on 6/15/18. Resident #39's diagnoses included but were not limited to seizures, high blood pressure and muscle weakness. Resident #39's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/14/20, coded the resident's cognition as severely impaired. Section G coded Resident #39 as requiring extensive assistance of two or more staff with bed mobility.

Review of Resident #39's clinical record revealed a quarterly data collection tool dated 1/5/20 that documented, "Side Rails do not Appear to be indicated at this Time." Further review of Resident #39's clinical record failed to reveal the facility staff assessed Resident #39 for the use of halo assist bar bed rails. There was no documentation that staff reviewed the risks and benefits for the use of bed rails with Resident #39 (or the resident's representative), prior to use and there was evidence an informed consent was obtained.

Resident #39's comprehensive care plan dated 11/5/19 failed to document information regarding the resident's use of bed rails.

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On 3/9/20 at 8:21 a.m., Resident #39 was observed in bed with bilateral halo assist bars up.

On 3/9/20 at 11:05 a.m., bed rail assessments, evidence that the risks and benefits for bed rails was provided and a bed rail informed consent for Resident #39 was requested via a list provided to ASM (administrative staff member) #1 (the executive director).

On 3/9/20 at 4:59 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding bed rails. LPN #1 stated the facility is a "no rail" facility with the exception of a few residents who have halo assist bars. LPN #1 stated the therapy staff completes assessments and recommendations for residents who need halo assist bars to turn and maneuver in bed. LPN #1 stated side rail assessments are completed by nurses upon admission, quarterly and as needed but these assessments are for longer side rails and not halo assist bars. LPN #1 stated the side rail assessment for Resident #39 was not an assessment for the halo assist bars and that is why the assessment documented side rails were not indicated. LPN #1 stated risks and benefits of the halo assist bars should be explained to residents and this should be documented but consent forms are not provided or signed by residents or their representatives.

On 3/9/20 at 7:07 p.m., ASM #1, ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility policy titled, "Side Rail Screening" documented, "It is the policy of the Facility that on admission and quarterly, all residents will be

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screened for the use of side rails as an enabler vs. restraint." The policy did not document information regarding halo assist bar bed rails.

No further information was presented prior to exit.
2. Resident # 107 was admitted to the facility with diagnoses that included but were not limited to: muscle weakness, high blood pressure and history of falls. Resident # 107's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/25/2020, coded Resident # 107 as scoring an 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section G coded Resident # 107 as requiring extensive assistance of two staff members for bed mobility.

On 03/08/20 at 1:32 p.m., an observation revealed Resident # 107 lying in bed with right and left upper bed rails/Halos raised.

On 03/09/20 at 8:04 a.m., an observation revealed Resident # 107 lying in bed with right and left upper bed rails/Halos raised.

The comprehensive care plan for Resident # 107 dated 02/21/2020 documented in part, "Focus. At risk for falls related to: Fell in the past 30 days, Fell in the past 31-180 days. History of falls. New environment. Date initiated: 02/21/2020." Under "Interventions", it documented in part, "Halo to assist resident with turning/repositioning due to CVA [cerebral vascular accident (stroke)]/Hemi [hemiparesis] left side. Date Initiated: 02/21/2020."

Review of the EHR (electronic health record) for

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Resident # 107 failed to evidence a physical device evaluation. Further review of EHR (electronic health record) for Resident # 107 failed to evidence informed consent was obtained, the risks, benefits, and for bed rail use was provided.

On 3/9/20 at 4:59 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding bed rails. LPN #1 stated the facility is a "no rail" facility with the exception for a few residents who have halo assist bars. LPN #1 stated the therapy staff completes assessments and recommendations for residents who need halo assist bars to turn and maneuver in bed. LPN #1 stated side rail assessments are completed by nurses upon admission, quarterly and as needed but these assessments are for longer side rails and not halo assist bars. LPN #1 stated the side rail assessment for Resident # 107 was not an assessment for the halo assist bars and that is why the assessment documented side rails were not indicated. LPN #1 stated risks and benefits of the halo assist bars should be explained to residents and this should be documented but consent forms are not provided or signed by residents or their representatives.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

3. Resident # 43 was admitted to the facility with diagnoses that included but were not limited to:

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muscle weakness, swallowing difficulties and pain. Resident # 43's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/15/2020, coded Resident # 43 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being severely impaired of cognition for making daily decisions. Section G coded Resident # 43 as requiring extensive assistance of two staff members for bed mobility.

On 03/08/20 at 3:15 p.m., an observation revealed Resident # 43 lying in bed with right and left upper bed rails/Halos raised.

On 03/09/20 at 8:05 a.m., an observation revealed Resident # 43 lying in bed with right and left upper bed rails/Halos raised.

The comprehensive care plan for Resident # 43 dated 09/10/2019 failed to evidence the use of bed rails.

Review of the EHR (electronic health record) for Resident # 43 failed to evidence a physical device evaluation. Further review of EHR (electronic health record) for Resident # 107 failed to evidence informed consent was obtained, the risks, benefits, and for bed rail use was provided.

On 3/9/20 at 4:59 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding bed rails. LPN #1 stated the facility is a "no rail" facility with the exception for a few residents who have halo assist bars. LPN #1 stated the therapy staff completes assessments and recommendations for residents who need halo assist bars to turn and maneuver in bed. LPN #1 stated side rail assessments are

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completed by nurses upon admission, quarterly and as needed but these assessments are for longer side rails and not halo assist bars. LPN #1 stated the side rail assessment for Resident # 43 was not an assessment for the halo assist bars and that is why the assessment documented side rails were not indicated. LPN #1 stated risks and benefits of the halo assist bars should be explained to residents and this should be documented but consent forms are not provided or signed by residents or their representatives.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.No further information was provided prior to exit.

F 732 SS=C Posted Nurse Staffing Information
CFR(s): 483.35(g)(1)-(4) F 732

§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.

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(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to post the current nurse staffing information. Nurse staffing information for 3/8/20 was not posted on 3/8/20. Instead, nurse staffing information for 3/7/20 was posted.

The findings include:

On 3/8/20 at 11:45 a.m. and 12:30 p.m., observation of the nurse staffing information posted in the facility lobby was conducted. Observation revealed nurse staffing information dated 3/7/20 and contained staffing information for that date, and not information regarding staffing for 3/8/2020.

On 3/9/20 at 5:34 p.m., an interview was

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F 732	Continued From page 225 conducted with OSM (other staff member) #7 (the staffing coordinator), regarding the nurse staffing information posting. OSM #7 stated she is present in the facility Monday through Friday and sometimes on weekends. OSM #7 stated she generates the staffing report and posts the information in the lobby as soon as she arrives in the morning. OSM #7 stated on Fridays, she places nurse staffing information for weekend days in the posting sleeve, in the lobby for someone to post the current date when she is not in the facility. OSM #7 stated she was not sure who was responsible for posting the information when she was not present during the weekends but she assumed the receptionist did. On 3/9/20 at 5:38 p.m., an interview was conducted with OSM #8 (the receptionist who works from 5:00 p.m. to 8:00 p.m. during weekdays and 9:00 a.m. to 3:00 p.m. every other weekend). OSM #8 stated she had no responsibilities regarding the nurse staffing information posting. On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 3/10/20 at 10:40 a.m., ASM #1 and ASM #3 stated the facility did not have a policy regarding the nurse staffing information posting and staff follows the regulations. No further information was presented prior to exit.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure physician prescribed medication were available for administration as ordered for one of 50 residents

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in the survey sample, Resident #18. On 12/31/19, the facility staff failed to administer the medication trazadone (1) to Resident #18 because the medication was on order from the pharmacy.

The findings include:

Resident #18 was admitted to the facility on 12/14/18. Resident #18's diagnoses included but were not limited to dementia, high cholesterol and major depressive disorder. Resident #18's annual MDS (minimum data set), assessment with an ARD (assessment reference date) of 12/10/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.

Review of Resident #18's clinical record revealed a physician's order dated 11/7/19 for trazodone 25 mg (milligrams) by mouth at bedtime. The medication was scheduled for 8:00 p.m. on Resident #18's December 2019 MAR (medication administration record). On 12/31/19, LPN (licensed practical nurse) #11 failed to document trazodone was administered to Resident #18 on the MAR. LPN #11 documented the code, "7= Other/ See Nurse Notes." An eMAR (electronic medication administration record) note regarding trazodone and dated 12/31/19 documented, "Waiting to be sent from pharmacy." There was no further documentation regarding the administration of trazodone on 12/31/19.

Resident #18's comprehensive care plan dated 12/18/18 documented, "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication...Provide medications as ordered by physician..."

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Review of the facility medication "back up" box list (a box containing various medications that are available for administration to residents) revealed that only 50 mg tablets of trazodone were available in the box.

On 3/9/20 at 4:38 p.m., an interview was conducted with LPN #5 regarding the facility process for ensuring medication is available for administration as prescribed. LPN #5 stated she re-orders medications from the pharmacy when ten tablets are left available for administration. LPN #5 stated if a medication is scheduled for administration and she cannot find the medication, she contacts the pharmacy and if possible, obtains the medication from the "back up" box. LPN #5 stated if the needed medication is not available in the "back up" box then she contacts the pharmacy and asks for the medication to be immediately sent or asks the nurse practitioner to call in an order to the local pharmacy. LPN #5 stated that after she obtains and administers the medication, she documents a follow up note that the medication was given.

On 3/9/20 at 5:57 p.m., a telephone interview was conducted with LPN #11 regarding Resident #18's medication administration on 12/31/19. LPN #11 stated it had been a while since 12/31/19 and he could not recall if he contacted the pharmacy or if he administered trazodone to Resident #18 on that date.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

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The facility pharmacy policy titled, "Medication Administration- General Guidelines" documented, "1. Medications are administered in accordance with written orders of the prescriber..."

The facility pharmacy policy titled, "ORDER AND RECEIVING NON-CONTROLLED MEDICATIONS" documented, "Medications and related products are received from the provider pharmacy on a timely basis..."

No further information was presented prior to exit.

Reference:

(1) Trazodone is used to treat depression. This information was obtained from the website: https://medlineplus.gov/ency/article/002559.htm

F 761 SS=E | Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2) | F 761

§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.

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F 761	Continued From page 230 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined facility staff failed to ensure expired medications and biological's were not available for use in two of four medication carts observed, (North Unit yellow and North Unit one medication cart), and one of one medication rooms observed, (South Unit medication room). On the North Unit yellow medication cart 2 bottles of medication expired were observed available for use a bottle of zinc sulfate (mineral supplement) 220mg (milligram) with "Best by 12/19" labeled on the bottle, and a 10 (ten) oz. (ounce) bottle of Geri-mucil fiber laxative and dietary supplement with "09/19" printed on the bottle. On the North Unit Medication cart 1 (one) eleven plastic vials of "Albuterol Sulfate inhalation solution 0.083% (percent) 2.5mg (milligram)/3ml (milliliter), labeled, "Exp [expire]: Sep 2019, were available for resident use. In the medication room located on the South Unit of the facility, nine containers of expired Nepro with Carb steady 1.8cal (calorie) (ready to hang tube feeding) with "use before 1 Dec 2019" were located on the top shelf of the storage cabinet. The findings include:	F 761		

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On 3/9/20 at 4:20 p.m., an observation was made with LPN (licensed practical nurse) #1 of the medication room located on the South Unit of the facility. Observation of the medication room revealed 9 (nine) 1000 ml (milliliter) containers of Nepro with Carb steady 1.8cal (calorie) (ready to hang tube feeding) located on the top shelf of the storage cabinet. The package was observed to contain "use before 1 Dec 2019" on the neck of the bottle. When asked what the date on the bottle meant, LPN #1 stated that it meant that the feeding expired on 12/1/2019 and should have been discarded. LPN #1 stated that they do not have any residents using this type of feeding so it had been overlooked. LPN #1 stated that it was available for use in the medication room and that central supply stocks the room and nursing double checks all supplies and medications they pull out prior to taking them out of the room to ensure they are in date.

On 3/9/20 at 4:35 p.m., an observation was made with LPN (license practical nurse) #7 of the medication carts located on the North Unit of the facility. Observation of the medication cart yellow revealed a bottle of 100 tablets of zinc sulfate (mineral supplement) 220mg with "Best by 12/19" labeled on the bottle. When asked what the date on the bottle meant, LPN #7 stated that the tablets expired in December of 2019 and should have been thrown away. When asked who maintained the supplies on the medication carts LPN #7 stated that the nurses on the 11-7 (11:00 p.m. - 7:00 a.m.) shift check the cart each night and she checked it each week as well, but it must have been overlooked. Further observation of the yellow medication cart revealed a 10 (ten) oz. (ounce) bottle of Geri-mucil fiber laxative and dietary supplement with "09/19" printed on the

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bottle. The bottle was observed to contain a hand written dated of "11-2-19" on the top lid of the bottle. When asked about the dates, LPN #7 stated that the "11-2-19" meant that the bottle had been opened by the facility staff on November 2, 2019 and that the "09/19" was the manufacturer's expiration date which meant that the medication had expired on September 2019. LPN #7 stated that it had been overlooked in the medication cart checks.

On 3/9/20 at 4:45 p.m. further observation of the medication carts located on the North Unit of the facility were conducted with LPN #7. Observation of the medication cart 1 (one) revealed 11 (eleven) plastic vials (small container holding liquid medication) in a box labeled "Albuterol Sulfate inhalation solution (medication used to increase air flow to lungs) 0.083% (percent) 2.5mg (milligram)/3ml (milliliter)." The box was observed to be labeled "Exp: Sep 2019." When asked what the date meant, LPN #7 stated that it meant that the medication expired in September of 2019 and should have been discarded. LPN #7 stated that it must have been overlooked during the cart checks.

On 3/9/20 at approximately 6:55 p.m., a request was made by written list to ASM (administrative staff member) #1, the executive director for the facility policy on maintaining and stocking medication carts and medication rooms.

On 3/10/20 at 10:40 a.m., ASM #3, the regional director of clinical services stated that the facility did not have a policy on maintaining and stocking the medication carts and medication rooms. ASM #3 stated that the facility uses their policies, the regulations and Lippincott as their standard of

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practice.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007, Lippincot Company, page 174, "Always note a drug's expiration date - the date after which it loses some amount of potency. Never administer an outdated drug...discard any drug that has reached its expiration date..."

On 3/9/20 at approximately 6:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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 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

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standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review it was determined facility staff failed to prepare food in the facility's kitchen in a sanitary manner and store food in a sanitary manner in two of two nutritional rooms.

The findings include:

On 03/08/2020 at 11:45 a.m., an observation of the facility's kitchen was conducted with OSM [other staff member] # 1, dietary manager with the following results:

An observation of OSM # 3, dietary aide, revealed they were preparing resident lunch trays in the kitchen without their mustache covered.

An observation of OSM # 2, cook, revealed they were handling dinner rolls with gloved hands after handling packages of salad dressings that had been stored facility's dry storage room without changing their gloves.

Observation on 03/08/2020 of the south unit's nutritional room with OSM # 1, fine dining coordinator at 4:00p.m., revealed a plastic container containing eight slices of cheesecake in the refrigerator. Further observation revealed two slices of cheesecake wrapped in a napkin sitting on top of the cheesecake container. Observation of these food items failed to evidence a name or date on the items. OSM # 1 stated that when food is placed in the nutritional room refrigerators that it should be dated and have a name on it. OSM # 1 immediately removed the cheesecake and placed it in a trashcan.

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Observation on 03/08/2020 of the north unit's nutritional room with OSM # 1, fine dining coordinator at 4:05 p.m., revealed sliced peaches a 15 ounce can, without a name or date in the refrigerator. Observation of the freezer revealed six flavored ice-pops and a popsicle without a name or date on the food items. OSM # 1 stated that when food is placed in the nutritional room refrigerators that it should be dated and have a name on it. OSM # 1 immediately removed the six flavored ice-pops and a popsicle and placed it in a trashcan.

On 03/08/2020 at 2:40 p.m., an interview was conducted with OSM # 1, fine dining coordinator and OSM # 2, cook. When asked about OSM # 3's mustache not being covered OSM # 1 stated that all facial hair should be covered. When asked why gloves were worn when plating the residents' food, OSM # 2 stated that it was to prevent cross contamination. At this time, OSM #1 was informed of the observation of OSM # 2 handling the dinner rolls with their hands after handling the packets of salad dressing OSM # 2 stated that they should have used a pair of tong to serve the rolls or had them individually wrapped.

The facility's policy "Staff Attire" documented in part, "1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained."

The facility policy, "Food Preparation" documented in part, "15. All staff will use serving utensils appropriately to prevent cross contamination."

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F 812	Continued From page 236 The facility policy "Snacks" documented in part, "3. Snacks will be assembled, labeled, and dated in accordance with the individual plan or care for each resident and those items will be delivered to patient care areas in a timely manner." On 03/09/2020 at approximately 6:55 p.m., ASM [administrative staff member] # 1, the executive director, ASM # 2, director of nursing, and ASM # 3, clinical services specialist were made aware of the findings. No further information was provided prior to exit.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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§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 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.

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§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement infection control practices for the storage of a C-PAP mask for one of 50 residents in the survey sample, Residents # 61; in the laundry room and in one of two dining rooms, (the facility's main dining room). The facility staff failed to store Resident #61's CPAP [continuous positive airway pressure] mask in a manner to prevent infection. The facility staff failed to maintain the clean laundry area in a clean and sanitary manner. Dust, dirt and lint were observed on the metal overhead conduit piping, vents and support beams. During the lunch meal service in the main dining room on 3/8/20 at approximately 12:10 p.m., CNA (certified nursing assistant) #1 was observed touching resident food items, without changing gloves that were worn while touching multiple other items, such as serving trays, and stands.

The findings include:

1. Resident # 61 was admitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [2]. Resident # 61's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/10/2019, coded Resident # 61 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. In Section O "Special

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Treatments, Procedures and Programs" Resident # 61 was coded as having a C-PAP.

On 03/08/20 at 3:20 p.m., an observation of Resident # 61's room revealed a C-PAP mask laying on top of the bedside table uncovered.

On 03/08/20 at 4:44 p.m., an observation of Resident # 61's room revealed a C-PAP mask laying on top of the bedside table uncovered.

On 03/09/20 at 8:29 a.m., an observation of Resident # 61's room revealed a C-PAP mask laying on top of the bedside table uncovered.

The POS [physician's order sheet] dated 03/2020 for Resident # 61 failed to evidence an order for the use of the C-PAP machine.

The comprehensive care plan for Resident # 61 dated of 11/26/2019 failed to evidence an order for the use of the C-PAP machine.

On 03/09/2020 at approximately 8:30 a.m., an interview was conducted with Resident # 61. When asked how often they use the C-PAP mask, Resident # 61 stated every night. When asked how long they had been using the C-PAP, Resident # 61 stated, "I've been using it for the past 15 years."

On 03/09/20 at 4:38 p.m., an interview was conducted with LPN [licensed practical nurse] # 5 regarding the storage of a C-PAP mask when not in use. LPN # 5 stated, "It has to be cleaned should be covered to prevent bacteria on it."

On 03/09/2020 at approximately 4:55 p.m., an observation of Resident # 61's C-PAP mask was

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conducted with LPN # 5. LPN #5 stated that it [CPAP mask] should have been placed in a bag.

On 03/09/2020 at approximately 6:55 p.m. ASM [administrative staff member] # 1, executive director, ASM # 2, director of nursing, and ASM # 3, regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm.

[2] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.
2. On 3/9/20 at 1:12 p.m., observation of the clean laundry area was conducted with OSM (other staff member) #6 (the housekeeping manager). Staff was folding clean clothes. Dust, dirt and lint was observed on the metal overhead conduit piping, vents and support beams in the clean laundry area. OSM #6 stated there was potential for the dust, dirt and lint to fall onto the clean clothes and she had tried to clean the pipes and beams but she would probably have to get a

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ladder. OSM #6 stated the amount of dust, dirt and lint was really bad.

On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

On 3/10/20 at 10:40 a.m., ASM #1 and ASM #3 stated the facility did not have a policy regarding the clean laundry area.

No further information was presented prior to exit.
3. On 3/8/20 at approximately 12:10 p.m., an observation of the lunch dining service was conducted in the main dining room of the facility. Twenty-two residents were observed seated at tables consisting of two to four table settings in the dining room. CNA (certified nursing assistant) #1 was observed serving residents drinks table-to-table wearing disposable gloves. At 12:25 p.m., after serving all residents drinks, CNA #1 was observed removing the gloves, washing her hands and dinning a new pair of disposable gloves.

CNA #1 was then observed obtaining a large brown serving tray containing two lunch plates from the dining service door located in the dining room. CNA #1 placed the large serving tray containing the plates onto a folding serving tray stand and served the two residents their pates wearing the disposable gloves. CNA #1 assisted the first resident at the table with set up of their plate, including opening the roll on the plate using her gloved fingers and applying the butter with the knife. CNA #1 then assisted the second resident with set up of their plate, including opening the

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roll on the plate using her gloved fingers and applying the butter with a knife. CNA #1 then picked up the empty serving tray with the gloved hands, and carried it back to the kitchen service door and returned the tray to a kitchen staff member.

CNA #1 then moved the folding serving tray stand to the next table to be served. CNA #1 then retrieved a second serving tray containing three plates of food with the gloved hands and placed it on the folding serving tray stand. CNA #1 continued to serve the three residents seated at the table using her gloved fingers to open the rolls and butter them with a knife. CNA #1 then picked up the empty serving tray with the gloved hands and carried it back to the kitchen service door, and returned the tray to a kitchen staff member.

CNA #1 then moved the folding serving tray stand to the next table to be served. CNA #1 then retrieved a third serving tray containing two plates of food with the gloved hands and placed it on the folding serving tray stand. CNA #1 continued to serve the two residents seated at the table using her gloved fingers to open the rolls and butter them with a knife. CNA #1 then picked up the serving tray with the gloved hands, and carried it back to the kitchen service door and returned the tray to a kitchen staff member.

The last resident was served their lunch at 12:49 p.m. CNA #1 did not change the gloves donned after serving resident drinks. CNA #1 touched serving trays, folded and moved the serving tray stand and touched multiple resident food items, including dinner rolls, wearing the same pair of gloves

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On 3/8/20 at 2:40 p.m., an interview was conducted with CNA #1 regarding the lunch observation in the dining room. When asked how resident food is handled, CNA #1 stated that gloves are worn when handling things like rolls. When asked what else the gloves have touched prior to touching the rolls, CNA #1 stated that the gloves have touched the plates, trays and tray holder. CNA #1 stated that they have been taught to use gloves when serving food and she had never thought about touching the trays and then touching the rolls but that they would be contaminated from the trays. CNA #1 stated that the kitchen cleans the trays on the inside between uses but she would use a fork in the future to open the rolls and apply the butter rather than using her fingers to open the rolls to prevent any cross contamination.

On 3/9/20 at approximately 6:55 p.m., a request was made by written list to ASM (administrative staff member) #1, the executive director for the facility policy on serving residents in the dining room.

On 3/10/20 at 10:40 a.m., ASM #3, the regional director of clinical services stated that the facility did not have a policy on serving food in the dining room and that the facility follows the regulations in serving food to residents in the dining room.

On 3/9/20 at approximately 6:45 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

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(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer the pneumococcal immunization for one of five influenza and pneumococcal resident reviews, Resident #7. Consent for Resident #7 to receive the pneumococcal immunization was obtained on 10/5/19 and the facility staff failed to administer the immunization.

The findings include:

Resident #7 was admitted to the facility on 2/19/19. Resident #7's diagnoses included but were not limited to stroke, diabetes and muscle weakness. Resident #7's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/6/19 coded the resident as being cognitively intact. Section O0300 documented Resident #7's pneumococcal

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F 883	Continued From page 246 vaccination was not up to date. Review of Resident #7's clinical record revealed a pneumococcal vaccine consent form dated 10/5/19, that was signed by two nurses and documented Resident #7 did wish to receive the pneumococcal vaccine (immunization). Further review of Resident #7's clinical record, including the October 2019 medication administration record, October 2019 nurses' notes and Resident #7's immunization record failed to reveal evidence that the pneumococcal immunization was provided to the resident. On 3/9/20 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5, regarding the facility process for administering the pneumococcal immunization. LPN #5 stated upon admission, residents are provided a consent form for the immunization. LPN #5 stated if a resident does wish to receive the immunization, the nurses make sure the resident is not allergic to the immunization, obtains an order for the immunization, administers the immunization, documents the immunization administration in the clinical record and monitors the resident for side effects. Review of Resident #7's clinical record revealed Resident #7's only documented allergies was penicillin (antibiotics). On 3/9/20 at 7:07 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING ______ B. WING ______	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

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F 883	Continued From page 247	F 883		

Continued From page 247

On 3/10/20 at 9:47 a.m., an interview was conducted with LPN #1, one of the nurses who signed Resident #7's pneumococcal vaccine consent form on 10/5/19. LPN #1 stated she could not provide any information regarding Resident #7 and the pneumococcal immunization.

The facility policy titled, "Pneumococcal Vaccinations" documented, "All residents admitted to the facility will be given the opportunity to receive to receive the pneumococcal vaccine per physician's order...9. The vaccine should be documented on the MAR (medication administration record)..."

No further information was presented prior to exit.