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	495372	A. BUILDING ______ B. WING ______	08/30/2018

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/28/18 through 08/30/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/28/18 through 8/30/18. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 216 certified bed facility was 194 at the time of the survey. The survey sample consisted of 34 current Resident reviews and three closed record reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		10/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/20/2018

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

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 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 and staff interview, the facility failed to ensure a homelike environment. In rooms 310 and 231, the drywall behind the beds was in ill repair. The residents' day room on unit 2 had a television mounted in an unsafe manner with medication carts and mechanical lifts stored in the room during resident use. The Findings include: 1. On 08/28/18 at 10:15 AM, during a Resident interview, an unpainted drywall patch behind bed 1 and bed 2 was observed. Resident #14, who	F 584	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that:	

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F 584 Continued From page 2

was being interviewed, was unable to verbalize when or what caused the disrepair to the wall.

On 08/30/18 at 10:14 AM, an interview was conducted with the facility manager (other staff, OS #2) regarding dry wall in ill repair. OS #2 verbalized that all staff can email repair requests, a work order is then generated and when the work is completed OS #2 will close out the work order and mark as completed. OS #2 was asked for a work order and close date for the drywall repair to room 310. OS #2 verbalized that the drywall has been repaired several times and the facility has an outside contractor that comes in about twice a month to do wall and paint repair.

A work order was presented with an open date of 3/1/18 (no other work orders were presented for drywall repair). OS #2 was then asked for documentation of a completed date for drywall repair, OS #2 was unable to provide documentation of a completed date for drywall repair, although was able to present completed work orders for other repairs in room 310.

On 8/30/18 at 3:30 PM, the above information was presented to the director of nursing and administrator

No other information was presented prior to exit on 8/30/18.
2. On 08/28/18 at 9:30 a.m., during the initial tour, the drywall in room 231-2 was observed in disrepair. The wall behind the bed had a section of drywall torn and with an uneven surface.

On 8/28/18 at 10 a.m., the resident who resides in room 231-2 stated the wall had been in disrepair since she had been admitted to this

F 584

Corrective Action:

Room 310 (beds 1 and 2) drywall has been repaired.

Room 231 (bed 2) drywall has been repaired.

TV in dayroom on affected unit was mounted in safe manner.

Medication carts and mechanical lifts were removed from dayroom on affected unit

Identification:

Affected units will be assessed for drywall damage (behind bed) and repaired accordingly.

Unsecured TV in dayroom on affected unit was found to be an isolated concern.

Storage of medication carts and mechanical lifts in dayroom on affected unit was found to be an isolated concern.

Changes:

Managers and designee(s) will be educated on conducting environmental rounds, specifically identifying damaged drywall behind bed(s) in resident rooms and safe mounting of TV in affected dayroom.

Nurse Manager, Supervisor and

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room. The resident stated "the staff comes in here and does nothing about it."

On 8/29/18 at 10:41 a.m., the facilities manager (FM) was interviewed about the wall being in disrepair in room 231-2. The FM stated the maintenance staff does a monthly walk-through to identify maintenance issues and or items needing repairs. The FM stated they also depended on nursing to enter work orders for items needing maintenance or repair. The FM checked the electronic system and stated she did not have a work order for room 231-2. She continued and stated she would check the monthly walk through sheets for maintenance or repairs for room 231-2.

On 8/29/18 at approximately 11:15 a.m., the FM presented copies of the July 9, 2018 and August 3, 2018 facility walk-through sheets which did not list 231-2 as needing maintenance or repair.

These findings were reviewed with the administrator and director of nursing (DON) during a meeting on 08/29/18 at 2:30 p.m.
3. On 8/28/18 at 12:34 p.m., the television day room on unit 2 was inspected. A television was mounted on the wall next to the window. The television was not level with the top of the television angled down toward the floor. The television was loose when manipulated and the top mounting bracket was pulled from the wall several inches with the bracket bolt visible. This top bracket bolt was not mounted in a wall stud but was pulled out of the drywall surface. In addition, two mechanical lifts were stored in the room in front of the television area.

On 8/29/18 at 10:24 a.m., a resident from unit 2

F 584

designee(s) will be educated on keeping medication carts and mechanical lifts out of affected unit dayroom. When not in use, medication carts and mechanical lifts will be stored in the hallway.

Monitoring:

Managers and designee(s) will round affected units twice monthly to assess drywall damage (behind bed) and assess TV to ensure it is secured to wall in affected dayroom and record results via use of Environmental Rounds Inspection forms.

Nurse Manager, Supervisor, or designee will monitor and record storage location of medical carts and mechanical lifts weekly.

Audit findings will be reported to the Quality Assurance & Performance Improvement(QAPI)Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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was in the day room watching television. A medication cart and mechanical lift were stored in the room at the time directly in front of the television.

On 8/29/18 at 2:01 p.m., a licensed practical nurse (LPN #9) was in the day room working at a medication cart stored in the room. LPN #9 was interviewed at this time about the use of the room. LPN #9 stated the medications carts for the unit were routinely stored in the day room because they had no other available storage area. LPN #9 stated the mechanical lifts were also stored in the room at times because the designated areas for lifts did not have enough space. LPN #9 stated residents used the room at times when watching television.

On 8/29/18 at 2:22 p.m., two medication carts were stored in the unit 2 day room. On 8/29/18 at 3:59 p.m., a resident was in the unit 2 day room watching television with two medication carts stored in front of the television.

On 8/30/18 at 8:05 a.m., the registered nurse unit manager (RN #2) was interviewed about the unit 2 day room. RN #2 stated residents and their families used the room as desired. Concerning the facility equipment stored in the room, RN #2 stated they tried to keep carts and equipment out of the hallway for safety reasons. RN #2 stated they had no other space available for storage of the medication carts. RN #2 stated she was not aware of the loose television mounting bracket.

These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/18 at 2:30 p.m.

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F 657	Continued From page 5	F 657		
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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for three of 37 residents in the survey sample. 1. Resident #9's care plan was not revised with	F 657	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction	10/12/18

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interventions for injury prevention related to bruising.

2. Resident #164's care plan was not revised regarding bathing preferences.

3. Resident #154's plan of care was not revised regarding pain management.

The findings include:

1. Resident #9 was admitted to the facility on 2/20/18 with diagnoses that included knee replacement, arthritis, hypothyroidism, high cholesterol, high blood pressure, insomnia, depression and overactive bladder. The minimum data set (MDS) dated 5/23/18 assessed Resident #9 with moderately impaired cognitive skills and as requiring the extensive assistance of two people for transfers, bed mobility and toileting.

On 8/28/18 at 9:23 a.m., Resident #9 was observed with bruised areas on both of her forearms. The areas were dark purple, irregularly shaped discolorations on the top area of her forearms below the elbows. Resident #9 was interviewed at this time about the bruised looking areas. Resident #9 stated she was not sure exactly how she was bruised. Resident #9 denied any rough handling by staff but stated aides manually assisted her when transferring her from the bed to her wheelchair. The resident stated she used a mechanical lift when going to the bathroom. Resident #9 stated she had tender skin and bruised easy but stated she was not on a blood thinner. Resident #9 stated she had bruises before in the same areas on her arms.

F 657

prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that:

Corrective Action:

Resident #9's care plan was revised to include interventions for injury prevention related to bruising, specifically the use of Geri sleeves.

Resident #164's care plan was revised to include bathing preferences.

Resident #154's care plan was revised regarding pain management.

Identification:

Nurse Managers will review residents with Geri sleeves to ensure that their associated care plans are updated appropriately with interventions for injury prevention.

Nurse Managers will interview residents to confirm bathing preferences and revise care plans as needed.

Nurse Managers will interview residents with moderate to severely rated pain (as confirmed on CASPER report) to ensure that their care plan is updated to include pain management interventions.

Changes:

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F 657	Continued From page 7 On 8/29/18 at 8:00 a.m., Resident #9 was observed with protective "geri" sleeves on both forearms. Resident #9's clinical record documented a history of bruises to the resident's forearms. Nursing notes documented the following regarding arm bruises. 3/27/18 - "CNA [certified nurses' aide] came and report to nurse...noticed to [two] bruises to resident L [left] wrist...Noted to L wrist is to [two] small bruise 1 is 1.5 cm [centimeters] x 1 cm and the other bruise is 1.5 cm x 1.5 cm...She [resident] also stated that one has been there for a week..." (Sic) 6/8/18 - "Recorder called to resident room by CNA...observed a 7.5 cm x 2.5 cm bruise on residents L arm just below her elbow on the lateral side resident states she 'must have bumped it on something' and that she 'bruises easily..." (Sic) 8/21/18 - "CNA reports resident has a bruise. 10 cm x 6 cm purple bruise noted to the R [right] forearm...States 'I keep a bruise easy. I must have bumped it last night..." Resident #9's plan of care (revised 8/15/18) listed on 3/1/18 that the resident had fragile skin and "skin bruises, tears easily" due to aspirin use. Interventions added on 3/1/18 included care with transfers, positioning and locomotion and notification of skin changes to family and physician as needed. The care plan made no mention of the use of "geri" sleeves and included no additional interventions to protect the resident from bruising since 3/1/18.	F 657	Nurse Managers and MDS Coordinators will be re-educated on facility's "Comprehensive Person-Centered Care Planning" policy. Monitoring: The interdisciplinary team will initiate and complete updates for the care plan for facility residents. The MDS Coordinator(s) will be responsible for monitoring compliance and will review resident care plans in conjunction with each MDS assessment. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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On 8/30/18 at 7:38 a.m., the registered nurse unit manager (RN #2) was interviewed about Resident #9's bruised forearms. RN #2 presented investigations regarding the bruises assessed on 3/27/18 and 8/21/18. RN #2 stated she did not find an incident report regarding the bruising assessed on 6/8/18.

The incident reports included interviews with the resident that ruled out any type of abuse or rough handling but included no evidence of attempts to locate the source of the bruising or of any additional interventions to prevent the bruising. RN #2 stated the resident was a manual "stand and pivot" transfer between the bed to the wheelchair but was a mechanical lift to the toilet. RN #2 stated they were supposed to use a draw sheet for movement in bed and they were now using "geri" sleeves for protection. RN #2 stated the care plan listed the bruising issue but did not include the interventions in use.

These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/18 at 2:30 p.m.
2. Resident # 164 was admitted to the facility on 03/06/12. Diagnoses for this resident included, but were not limited to: hypothyroidism, bilateral belpheritis, hypokalemia, high blood pressure, PVD (peripheral vascular disease), and dementia.

A quarterly MDS (minimum data set) dated 8/03/18 was reviewed and documented the resident's cognitive score as having long and short term memory impairment with severe impairment in daily decision makings skills. The resident was documented as requiring extensive assistance for most ADL's (activities of daily

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living) with at least one person physical assist, but was assessed as requiring total dependence of one person for personal hygiene and bathing. The resident was assessed as having inattention and disorganized thinking that comes and goes, and changes in severity and as being short tempered with the frequency being between 2-6 days (several days) during the look back period. The resident did not have any behaviors listed.

During clinical record review the resident's 'bath detail report' sheets were reviewed and documented that the resident only had one shower during the entire month of August. The resident's clinical record was reviewed and did not document that the resident had any refusals. No information and/or documentation was found regarding why the resident was not getting a bath.

The resident's CCP (comprehensive care plan) was reviewed and documented, "08/07/18...ADL function: [name of resident] needs set up to total assist for ADL needs...staff assist for ADL needs...dementia, episodes of increased confusion...or agitation...-severely impaired....03/15/12 tub/shower 2 times a week, hair/nail care with bath, PRN [as needed]..."

The resident's CCP above, had a revision date of 08/07/18 for ADL function with a hand written entry that documented, "severely impaired." The resident had an intervention of receiving a bath twice weekly, as documented above dated 03/15/12. The CCP did not provide specific intervention on how the resident would continue to receive a tub/shower 2 times weekly in relation to the resident's identified problem, i.e. dementia episodes of increased confusion and or agitation severally impaired.

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On 08/30/18 at 3:30 PM, The Unit 2 Coordinator (U2C) was interviewed regarding bathing for resident's on unit 2. The U2C stated that, "our goal for the resident's is to have a bath/shower twice a week." The U2C stated that bathing information and assistance provide for that should be included on the resident's CCP. The U2C was made aware that Resident # 164's CCP was updated with a date 08/07/18 and a hand written entry, but was not updated in response on how the resident was going to continue to receive baths/showers related to the "severely impaired" problem. The resident's interventions were not updated in response Resident # 164's ADL "problem" becoming worse.

The survey team held an end of day meeting with the DON and administrator on 08/30/18 at approximately 3:30 p.m. regarding the concerns surrounding Resident # 164 only having one bath for the entire month of August and the resident's CCP was updated with the date of 08/07/18 and a hand written entry of "severely impaired", but everything else was the same, including the interventions from 2012 for bathing. The administrator was asked how often resident's should get baths. The administrator stated that, "the expectation would be twice weekly" and went on to say that "the twice weekly is the minimum, if there is additional frequency, then that would have to individualized." The administrator was made aware that there seems to be an issue with residents not receiving the bare minimum and this resident had only received one for the entire month.

No further information and/or documentation was presented prior to the exit conference on

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F 657	Continued From page 11 08/30/18 at 5:00 p.m. 3. Resident #152 was readmitted to the facility on 10/13/17 with diagnoses including, but not limited to: Left Breast Cancer with Mastectomy, Left Humerus Fracture, Chronic Obstructive Pulmonary Disease with Continuous Oxygen Use, and Protein-Calorie Malnutrition. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 08/14/18. Resident #152 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #152's clinical record was reviewed on 08/29/18 at 8:00 a.m. Included in her August 2018 POS (physician order sheet) was: "...Duragesic 12MG/HR [milligrams per hour] Apply 1 patch to skin every 72 hours *Remove Old Patch*...Hydrocodone-Acetaminophen SOL 7.5-32 10 ML [milliliters] via J-tube every six hours as needed for pain..." Review of Resident #152's July and August 2018 MAR's (medication administration sheets) showed this resident was using her PRN pain medication on average, three times daily, every day, in conjunction with the Duragesic patch. Resident #152's comprehensive care plan (CCP) included the following regarding pain: "...09/20/17 Pain management as needed. Notify charge nurse of any changes in condition, c/o [complaints of] pain or discomfort. Reposition for comfort as needed. Rest periods as needed. Pain med as needed for pain or discomfort, ensure relief, go back in an hour to check for relief, not having any relief let charge nurse know. Notify MD/family [physician] of any complaints of	F 657		

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pain/discomfort. Need for routine pain med...08/15/18 Administer medications as ordered and monitor for adverse side effects-SEE MD ORDERS. Position for comfort...Provide rest periods as needed and after medication to facilitate relief. Observe for unrelieved pain, especially back pain, loss of height, kyphosis. Report abnormalities to MD with follow up as indicated..."

Resident #152 had several medication changes from 9/2017 through 7/2018 in relation to her pain level. She also had an antidepressant added during this timeframe. None of the changes in Resident #152's treatment plan were noted in her CCP. She had the original interventions from 9/2017 and then interventions that were added 8/15/18 that mirrored the interventions already in place for this resident.

Resident #152 was interviewed on 08/29/18 at 9:48 a.m. regarding her pain and treatment measures in place. Regarding the Duragesic patch Resident #152 stated, "It doesn't really help." When asked if she had notified anyone that the pain patch didn't work, Resident #152 stated, "I have been told by the nurses, you need to give it time to work." At 16:30 p.m. Resident #152 was interviewed regarding pain assessments. Resident #152 stated, "Some of the nurses ask and some don't. My arm is a 10. My mastectomy is a 7.5 to 8. After prn pain med, it decreases to a 3-4." Regarding whether that was an acceptable level for her, the resident stated, "I really don't have a choice. I have never rated my pain as a zero because it is never a zero."

The Administrator and DON (director of nursing)

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F 657	Continued From page 13 were informed of the above during a meeting with the survey team on 08/30/18 at approximately 3:10 p.m. No further information was received by the survey team prior to the exit conference on 08/30/18.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview and clinical record review, the facility staff failed to ensure three of 37 residents were provided a full bath/shower twice weekly per the resident's bath schedule, and per the resident's comprehensive care plan (CCP). 1. The facility staff failed to provide showers and/or tub baths to Resident # 104 per the resident's bath schedule and individual needs and preferences. 2. Facility staff failed to provide showers and/or tub baths to Resident # 119 per the resident's bath schedule and the resident's CCP and individual preferences 3. Facility staff failed to provide Resident # 164 with a bath and or shower twice weekly per the resident's CCP and bathing schedule. Findings include: 1. Resident # 104 was admitted to the facility	F 677	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action: Residents #104, 119 and 164 were offered full baths/showers with results recorded in their corresponding medical records. Identification: Nurse Managers will review medical	10/12/18

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originally on 05/27/15. Diagnoses for Resident # 104 included, but were not limited to: osteoporosis, macular degeneration, glaucoma, depressive disorder, DM (diabetes mellitus), history of TIA (transient ischemic attack) with weakness on left side, HTN (high blood pressure), drusen (degenerative) of macula (right eye) with blindness and moderate impairment in left eye, moderate impairment in hearing ability, weakness, periodic headaches, and anxiety.

The most current MDS (minimum data set) was a quarterly assessment dated 07/11/18. This MDS assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was assessed as requiring limited assistance with one person physical assist for mobility, transfers, dressing, toilet use, personal hygiene, and bathing.

On 08/28/18 at 8:39 AM, an interview was conducted with Resident # 104. The resident stated that she was worked up this morning due to a bathing issue. The resident stated that a CNA (certified nursing assistant, identified as CNA #13) she (the resident) had never seen before came to take her this morning to the shower room. The resident voiced being upset and stated that it is always something trying to get a shower around here. The resident stated that right away CNA # 13 kept telling her that she couldn't lift anything heavier than 25 lbs and stated, "If she didn't tell me that once she told me that 25 times. I said I am certainly more than 25 lbs, I can assure you that." The resident stated that the CNA went over to sit down and "(She) didn't even help me with my clothes, she didn't even move the chair [shower chair] over, she kept

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record documentation to ensure that residents were provided a full bath/shower twice weekly per the resident's bath schedule and individual needs and preferences.

Changes:

Nursing staff will receive re-education on providing residents with a full bath/shower twice weekly per the resident's bath schedule and individual needs and preferences with results recorded (including but not limited to resident refusal or medical contraindications).

Monitoring:

Nurse Managers will review Bath Detail Reports weekly. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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saying I can't push that." The resident stated, "I'm 90 years old, I'm blind and I'm deaf, and I need a little help." The resident stated that if she (the CNA) couldn't do anything she needs to be home. The resident stated that after she was in the shower chair, she had to get out of the shower chair and she had to push the chair herself back to where the water was running. The resident stated she didn't have any clothing on at this point. The resident stated, "Then all she [the CNA] did was walk around and complain about the shower room being flooded, I [the resident] said well this is a shower room." The resident stated, "I then asked her if she could pick up a wash cloth, and wash my back or is that too heavy." The resident stated that after all of that the CNA kept asking her if she was done, repeating it several times. The resident stated it takes her a little time because she can wash her self and again stated she is 90 years old. The resident stated that she washes herself in the sink/pan at times and stated that she will wash her head in the sink and she can get just as clean. The resident stated that she is an early riser and looks forward to bath/shower days, but most of the time you get up and get prepared to go and staff will come and say they aren't giving baths today, or someone called off.

The resident then stated that after the shower, the CNA wouldn't even pick up my clothes and stated, "You are in the shower stripped," and I finally said, "Just give my housecoat and let me get out of here." The resident stated that she didn't know the girls name, but if she can't do anything she needs to go home and she has no business working.

The resident stated that the CNA was pulled from

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Unit 1 due to call outs on Unit 2.

The DON (director of nursing) was interviewed on 08/28/18 at 11:27 PM and was asked about staff calling out on Unit 2. The DON stated that Unit 2 had two call outs today and CNA #13 was pulled from Unit 1 to Unit 2 to help out. The DON was asked about job duties for CNA's. The DON presented a job description for CNA's, which documented, "...performs basic and routine patient care, such as personal hygiene, toileting, ...assists in the delivery of activities of daily living...assists patient with transfer as required using assistive devices...facilitates safe transfer and mobility of patient and follows high risk precautions identified patients...utilizes safety precautions when caring for residents...physical demand strength: HEAVY...heavy - Exerting 50 -100 lbs of force occasionally...lift/carry 1-35 lbs...push/pull 50+ lbs..." The DON stated that CNA # 13 had a physician's note for a weight restriction of 25 lbs.

On 08/29/18 at 8:27 AM, the resident's care tracker documentation was reviewed for bathing. The report, "Bath type detail report" for this resident documented the resident got a whirlpool bath on 08/09, a shower on 08/13, a tub bath on 08/16, and a whirlpool bath on 08/23. The resident also received a shower on 08/28/18. The resident had a total of five baths/showers for the entire month of August. The resident stated that she likes a shower or tub bath, but often times when you prepare for one, they (staff) will tell you that they don't have enough people to give baths and stated that she feels the facility is short staffed.

On 08/30/18 at 2:34 PM, the U2C (unit 2

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coordinator) and the U2M (unit 2 manager), were interviewed regarding baths and how is it known when a resident is to receive a bath. The U2C stated that the information is in the computer when a resident gets a bath. The U2C was asked how does a CNA know when a resident gets a bath, or more specifically what days does the resident get a bath, such as a bath schedule. The U2C stated that the unit has a bath schedule for each resident and pulled out a small notebook with days of the week listed and a list of resident names and room numbers under the specific day of the week, and stated that the resident is supposed to get a bath according to the schedule. The U2C was asked, if a resident gets a bath on Monday then the next bath day would be on Thursday? The U2C stated that was correct. The U2M then stated, "A resident that gets a bath on Mondays and Thursdays, may not get a bath on Thursday." The U2M was asked why would that be and the U2M stated, "A resident may get a bath on Monday and then may get a bath on Wednesday, but not on Thursday." The U2M was asked again, why would that be. The U2M stated, "like if someone called off then the resident may not get a bath on the next scheduled day." The U2M stated that a resident might get a bath on Monday, but they don't always get a bath on Thursday. The U2M was asked again to clarify and the U2C stated, "Well, if someone calls out they may get a bath the next day."

The resident's current physician's orders were reviewed. The resident had an order for "activity as tolerated." No other care instructions and/or orders for bathing or hygiene were found for this resident.

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The resident's CCP (comprehensive care plan) was reviewed and documented, "...mobility devices/equipment...will receive assistance with walking to reduce the risk of falls...reminded to take extra care when walking outside due to uneven pavement...receive assist as needed daily with ADL's (activities of daily living) - the amount of amt [amount] of staff assist may vary...resident encouraged to be careful when bending over to pick up or reach things...encourage independence...Assist as needed when vision prohibits independence...may need to break down ADL tasks into smaller segments to allow greater independence...assist as needed due to poor vision, HOH (hard of hearing)-will need increased staff assist with emergencies due to poor vision/hearing...provide assistance on resident request or as needed --may need more staff assist during episodes of hip/back/eye pain...more assist with choice of clothing/dressing due to decreased vision...remind [name of resident] to ask for assist with bathing, dressing, etc, as vision declines."

The resident's bath schedule documented the resident to have a bath or shower on Tuesdays and Saturdays.

This resident's nursing notes were reviewed and did not document that the resident had refused any baths or showers.

On 08/30/18 at 3:30 PM, the U2C was interviewed again regarding bathing for residents on unit 2. The U2C stated that, "Our goal for the resident's is to have a bath/shower twice a week." The U2C stated that bathing information and assistance should be included on the resident's CCP.

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The survey team held an end of day meeting with the DON and administrator on 08/30/18 at approximately 3:30 p.m. regarding the concerns surrounding Resident # 104's bathing experience, the lack of consistent bathing per the resident's interview and the lack of staff to assist with completing bathing for residents. The administrator stated that, "The expectation would be twice weekly," and went on to say that, "The twice weekly is the minimum, if there is additional frequency, then that would have to individualized." The administrator was made aware that the resident in question was not getting the minimum and had only had five baths or showers for the entire month of August. The administrator and DON were asked about staffing in relation to residents getting baths. The DON stated that staffing does have an effect, but the charge nurse will redirect staff on how the groups are set up and delegate staff to cover. The DON stated that the charge nurse should be adjusting the schedule to ensure baths and showers are completed. The DON was asked if the CNAs report that baths or showers are not completed. The DON stated that they (CNAs) should be informing the charge nurse, and the charge nurse should ensure they are completed and redirect staff as needed. The DON stated that the charge nurse gets direction and guidance from the U2C.

The DON and administrator was made aware of the bathing experience for Resident # 104 and was asked, if two staff members call off on Unit 2 and one staff member is pulled from Unit 1 (that staff member being CNA # 13, who is on a 25 lb weight restriction), how does that ensure that baths and showers are being done. The DON stated, "that is not a staffing problem, that is a

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person problem."

No further information and/or documentation was presented prior to the exit conference on 08/30/18 at 5:00 p.m.

2. Resident # 119 was admitted to the facility on 01/31/17. Diagnoses for this resident included, but were not limited to: high blood pressure, muscle weakness, hemiplegia on right side following a stroke, ETOH (alcohol) dependence, insomnia, and difficulty walking.

The most current MDS (minimum data set) was a quarterly assessment dated 07/18/18. This MDS assessed the resident's cognitive score of 12, indicating the resident had slight moderate impairment for daily decision making skills. The resident was also assessed as requiring limited assistance with one person physical assist for most ADL's (activities of daily living).

On 08/28/18 at 3:20 PM, Resident # 119 was interviewed about bathing and his bath days. The resident stated his bath days are on Monday and Thursday mornings. The resident was asked if he got a bath yesterday (Monday). The resident stated, "No, it seems every Monday, they [staff] come and say we [staff] are not giving baths today, we don't have enough help." The resident stated that he didn't think any residents got a bath on Monday, but he didn't know for sure. The resident stated that he was used to getting baths and he used to take a bath or shower every night when he was home. The resident stated that he can give himself a "bird bath" (in the sink), but stated that isn't like going back and getting in the tub or shower. The resident stated that sometimes they are short of help, and sometimes

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they will move people around to try to get things done. The resident stated they need more help than they got here. The resident was asked if there is ever anytime that staff come to get him for a bath or shower and he refuses, the resident stated, "No, I like my baths."

On 8/29/18 at 08:27 AM, Resident # 119's care tracker documentation for "Bath type detail report' was reviewed and documented the resident got a whirlpool bath on 08/09, got a shower on 08/13, a tub bath on 08/16, and a whirlpool bath on 08/23, for a total of four baths the entire month of August.

The resident's CCP was reviewed and documented, "....Provide assistance with ADL's as needed...assist as needed with dressing...assist with personal hygiene...tub/shower 2 times a week, hair/nail care with bath, PRN [as needed]..."

The resident's bath schedule was to have a bath or shower on Mondays and Thursdays.

On 08/30/18 at 2:34 PM, the U2C (unit 2 coordinator) and the U2M (unit 2 manager), were interviewed regarding baths and how is it known when a resident is to receive a bath. The U2C stated that the information is in the computer when a resident gets a bath. The U2C was asked how does a CNA know when a resident gets a bath, or more specifically what days does the resident get a bath, such as a bath schedule. The U2C stated that the unit has a bath schedule for each resident and pulled out a small notebook with days of the week listed and a list of resident names and room numbers under the specific day of the week, and stated that the resident is

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supposed to get a bath according to the schedule. The U2C was asked, if a resident gets a bath on Monday then the next bath day would be on Thursday? The U2C stated that was correct. The U2M then stated, "A resident that gets a bath on Mondays and Thursdays, may not get a bath on Thursday." The U2M was asked why would that be and the U2M stated, "A resident may get a bath on Monday and then may get a bath on Wednesday, but not on Thursday." The U2M was asked again, why would that be. The U2M stated, "like if someone called off then the resident may not get a bath on the next scheduled day." The U2M stated that a resident might get a bath on Monday, but they don't always get a bath on Thursday. The U2M was asked again to clarify and the U2C stated, "Well, if someone calls out they may get a bath the next day."

This resident's nursing notes were reviewed and did not evidence the resident had any refusals for any type of care, including bathing.

On 08/30/18 at 3:30 PM, the U2C was interviewed again regarding bathing for resident's on unit 2. The U2C stated that, "Our goal for the resident's is to have a bath/shower twice a week." The U2C stated that bathing information and assistance should be included on the resident's CCP.

The survey team held an end of day meeting with the DON and administrator on 08/30/18 at approximately 3:30 p.m. regarding the concerns surrounding Resident # 119's lack of bathing for the month of August and lack of staff to assist with completing bathing for residents. The administrator was asked how often residents

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should get baths. The administrator stated that, "the expectation would be twice weekly" and went on to say that "the twice weekly is the minimum, if there is additional frequency, then that would have to individualized." The administrator was made aware that the residents are not even receiving the bare minimum and this resident had only received four baths and did receive one this morning (08/30/18), which made five for the entire month. The administrator and DON were asked about staffing in relation to residents getting baths. The DON stated, that staffing does have an effect, but the charge nurse will redirect staff on how the groups are set up and delegate staff to cover. The DON stated that the charge nurse should be adjusting the schedule to ensure baths and showers are completed. The DON was asked do the CNAs report that baths or showers are not completed. The DON stated that they (CNAs) should be informing the charge nurse, and the charge nurse should ensure they are completed and redirect staff as needed. The DON stated that the charge nurse gets direction and guidance from the U2C. The DON and administrator were made aware that baths were not being completed on Unit 2 and residents feel like there is a staffing issue.

The DON and administrator were asked about the two staff members that called off on Unit 2 on Tuesday and one staff member was pulled from Unit 1 (that staff member being CNA # 13, who is on a 25 lb weight restriction), how does that ensure that baths and showers are being done. The DON stated, "that is not a staffing problem, that is a person problem." The DON and administrator were made aware that the residents are not getting baths regularly per the resident interviews and according to the documentation.

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No further information and/or documentation was presented prior to the exit conference on 08/30/18 at 5:00 p.m.

3. Resident # 164 was admitted to the facility on 03/06/12. Diagnoses for this resident included, but were not limited to: hypothyroidism, bilateral belpheritis, hypokalemia, high blood pressure, PVD (peripheral vascular disease), and dementia.

A quarterly MDS (minimum data set) dated 8/03/18 was reviewed and documented the resident's cognitive score as having long and short term memory impairment with severe impairment in daily decision makings skills. The resident was documented as requiring extensive assistance for most ADL's (activities of daily living) with at least one person physical assist, but was assessed as requiring total dependence of one person for personal hygiene and bathing. The resident was assessed as having inattention and disorganized thinking that comes and goes, and changes in severity.

During clinical record review the resident's "bath detail report" sheets were reviewed and documented that the resident only had one shower during the entire month of August. The resident's clinical record was reviewed and did not document that the resident had any refusals. No information and/or documentation was found regarding why the resident was not getting a bath.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...tub/shower 2 times a week, hair/nail care with bath, PRN [as needed]...use caution with transfers...staff to assist with locomotion..."

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The resident's bath schedule was to have a bath or shower on Mondays and Thursdays.

On 08/30/18 at 2:34 PM, the U2C (unit 2 coordinator) and the U2M (unit 2 manager), were interviewed regarding baths and how is it known when a resident is to receive a bath. The U2C stated that the information is in the computer when a resident gets a bath. The U2C was asked how does a CNA know when a resident gets a bath, or more specifically what days does the resident get a bath, such as a bath schedule. The U2C stated that the unit has a bath schedule for each resident and pulled out a small notebook with days of the week listed and a list of resident names and room numbers under the specific day of the week, and stated that the resident is supposed to get a bath according to the schedule. The U2C was asked, if a resident gets a bath on Monday then the next bath day would be on Thursday? The U2C stated that was correct. The U2M then stated, "A resident that gets a bath on Mondays and Thursdays, may not get a bath on Thursday." The U2M was asked why would that be and the U2M stated, "A resident may get a bath on Monday and then may get a bath on Wednesday, but not on Thursday." The U2M was asked again, why would that be. The U2M stated, "like if someone called off then the resident may not get a bath on the next scheduled day." The U2M stated that a resident might get a bath on Monday, but they don't always get a bath on Thursday. The U2M was asked again to clarify and the U2C stated, "Well, if someone calls out they may get a bath the next day."

This resident's nursing notes were reviewed and

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did not evidence the resident had any refusals for any type of care, including bathing.

On 08/30/18 at 3:30 PM, the U2C was interviewed again regarding bathing for resident's on unit 2. The U2C stated that, "Our goal for the resident's is to have a bath/shower twice a week." The U2C stated that bathing information and assistance should be included on the resident's CCP.

The survey team held an end of day meeting with the DON and administrator on 08/30/18 at approximately 3:30 p.m. regarding the concerns surrounding Resident # 164 only having one bath for the entire month of August. The administrator was asked how often residents should get baths. The administrator stated that, "The expectation would be twice weekly," and went on to say that, "The twice weekly is the minimum, if there is additional frequency, then that would have to individualized." The administrator was made aware that there seems to be an issue with residents not receiving the bare minimum and this resident had only received one for the entire month. The administrator and DON were asked about staffing in relation to residents getting baths. The DON stated, that staffing does have an effect, but the charge nurse will redirect staff on how the groups are set up and delegate staff to cover. The DON stated that the charge nurse should be adjusting the schedule to ensure baths and showers are completed. The DON was asked do the CNAs report that baths or showers are not completed. The DON stated that they (CNAs) should be informing the charge nurse, and the charge nurse should ensure they are completed and redirect staff as needed. The DON stated that the charge nurse gets direction

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F 677	Continued From page 27 and guidance from the U2C. The DON and administrator were made aware that baths were not being completed on Unit 2 and resident's feel like there is a staffing issue. The DON and administrator were asked about the two staff members that called off on Unit 2 on Tuesday and one staff member was pulled from Unit 1 (that staff member being CNA # 13, who is on a 25 lb weight restriction), how does that ensure that baths and showers are being done. The DON stated, "That is not a staffing problem, that is a person problem." The DON and administrator were made aware that the resident's are not getting baths regularly per the resident interviews and according to the documentation. No further information and/or documentation was presented prior to the exit conference on 08/30/18 at 5:00 p.m.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		10/12/18

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This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for treatment and care of skin integrity for two of 37 residents, Resident's #165 and #58.

1. Resident #165 did not have physician ordered heel protectors on while in bed.

2. Resident #58 did not have physician ordered heel protectors in place.

The Findings Include:

1. Resident #165 was admitted to the facility on 07/27/18. The most current MDS (minimum data set) was an initial assessment dated 8/3/18. Resident #165 was assessed with a cognitive score of 14, indicating cognitively intact. Diagnoses for included: Peripheral edema, diabetes, and congestive heart failure.

On 8/29/18 Resident #165 clinical record was reviewed. A physician's order dated 8/16/18 documented "Heel protectors while in bed." The treatment record was also reviewed and indicated that heel protectors were in place from 8/16/18 through 8/28/18.

On 08/29/18 at 09:13 AM, Resident #165 was interviewed. During the interview Resident #165 was laying in bed and without heel protectors. When asked, Resident #165 verbalized that no one has ever put any protectors on her feet and her feet hurt. The Resident's heels were observed and showed no evidence of skin break down. At this time, license practical nurse (LPN

F 686

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that:

Corrective Action:

Residents' #165 and #58 heel protectors were applied in accordance to physician order.

Identification:

Nurse Managers will review residents with physician ordered heel protectors to ensure their application is in accordance to physician's orders.

Changes:

Nursing staff will be re-educated on following physician orders and accurately recording of ordered treatments, specifically heel protectors.

Monitoring:

Nurse Managers, Supervisor, or designee will assess 25% of residents with heel

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F 686	Continued From page 29 #10) was asked to observe Resident #165 without heel protectors. LPN #10 looked around Resident #165's room and was unable to find the heel protectors. LPN #10 verbalized that she would get Resident #165 some heel protectors. On 08/29/18 03:00 PM the above information was provided to the director of nursing and administrator during a surveyor/staff meeting. No other information was provided prior to exit conference on 8/30/18. 2. Resident # 58 was admitted to the facility 1/13/14 with diagnoses to include, but not limited to: dementia, cancer, anemia, peripheral artery disease, coronary artery disease, and heart failure. The most recent MDS (minimum data set) was a significant change assessment. Resident # 58 was coded with moderate impairment in cognition with a total summary score of 09 out of 15. On 8/28/18 beginning at 8:30 a.m. during initial tour of the facility, Resident # 58 was observed in bed. He did not have any socks or other applications to his feet. On 8/29/18 at 7:50 a.m. Resident # 58 was observed in bed with bare feet. On 8/30/18 at 8:10 a.m. Resident # 58 was observed in bed, again with bare feet. The clinical record was then reviewed. The August 2018 POS (physician order summary) was noted to include an order for: "Treatment: Heel protectors while in bed for Decub (ulcer) prevention." LPN (licensed practical nurse) # 12	F 686	protectors weekly to ensure they are applied in accordance to physician's orders. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI)Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 686	Continued From page 30 was asked for assistance with Resident # 58. LPN # 12 stated "Let me get his treatment sheet; I give the medications, but another nurse does the treatments." LPN # 12 obtained the treatment sheet. The order for the heel protectors was on the treatment sheet, and was initialed by staff indicating the heel protectors were on while in bed. LPN # 12 and this writer then went to Resident # 58's room, and after given permission to enter, LPN # 12 observed the resident's feet. She stated to the resident "Where are the foam booties that are supposed to be on your feet?" Resident # 58 replied "Where are they?" LPN # 12 then asked the resident if she could look in his closet and drawers for the booties and he stated "yes." The booties were not located anywhere in the resident's room. LPN # 12 stated "I'll let [name of LPN # 13] know..." On 8/30/18 at 11:15 a.m. RN (registered nurse) # 4, who was the unit manager, stated "I think [name of LPN # 13] had to go get some new heel protectors; there were none in his room." She was also asked if the resident had any ulcers to the feet. She replied "No; the heel protectors are for prevention." RN # 4 was then informed Resident # 58 had been observed throughout the survey each morning without the heel protectors applied, yet staff had initialed the treatment sheet for that time frame as being on. RN # 4 did not reply. The administrator and DON (director of nursing) were informed of the the above findings during a meeting 8/30/18 at 3:05 p.m. No further information was provided prior to the exit conference.	F 686		

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F 688	Continued From page 31	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a splint was in place for one of 37 residents, Resident #131. Resident #131's left wrist/hand place was not in place per physician's order. Findings were: Resident # 131 was admitted to the facility on 12/03/2016 with the following diagnoses, but not limited to: intertrochanteric fracture, atrial fibrillation, hypertension, hemiparesis/hemiplegia of her left side related to CVA (cerebral vascular accident aka stroke), and major depressive disorder.	F 688	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action: Resident #131 left wrist/hand splint is	10/12/18

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The annual MDS (Minimum data set) with an ARD of 07/19/2018 assessed Resident #131 as cognitively intact with a summary score of "15".

On 08/28/2018 at approximately 9:15 a.m., Resident #131 was observed sitting up in bed eating breakfast. Observed above her bed was a diagram for the application of a splint. Resident #131 was asked if she had a splint. She stated, " Yes shug, I am suppose to wear it at night, but they can't get it to stay on...It falls off...they gave up on it..." She was asked if she had any problems with her left hand or any pain. She stated, "Sometimes, and sometimes it tingles a little bit." She was asked if the splint helped that. She stated, "Darling it's been so long since I've worn it I don't really know."

On 08/29/18 at approximately 8:30 a.m., Resident #131 was observed in bed eating breakfast. She was asked if she had worn her splint during the night. She stated, "No, honey, they just can't get it on there right."

The clinical record was reviewed at approximately 8:40 a.m. The POS (physician order sheet) contained the following order: "Resident to wear left hand/wrist splint at night as tolerated, remove in AM."

LPN (licensed practical nurse) #13 was interviewed at approximately 8:45 a.m. regarding Resident #131's splint. She looked at the TAR (treatment administration record) and stated, "They signed it off that they put it on last night...I haven't been in there this morning, I don't know who took it off...she can do it herself if she wants to." LPN #13 was told that per the resident no one had been putting it on at night for sometime. She

F 688

applied as resident tolerates. Resident is now receiving Occupational Therapy services.

Identification:

Nurse Managers will review residents with splints to ensure that they are in place per physician's orders.

Changes:

Nursing staff will be re-educated on proper signage of Treatment Administration Record (TAR)for the application and removal of physician ordered splint - to include documentation of resident preferences (refusals, modified schedules, etc.)

Monitoring:

Nurse Managers, Supervisor or designee will observe residents with splints weekly to ensure that they are applied in accordance to physician order with appropriate supportive documentation completed on the TAR. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI)Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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stated, "I don't know, it's signed off."

The care plan was reviewed and contained the following information: "Problem/Strengths: Resident has hemiparesis/hemiplegia of left side related to CVAs (potential for pain); Goals: Will maintain functional level within limitations of hemiparesis this qtr. [quarter] with review ongoing; Interventions: [including but not limited to] Adaptive equipment AS NEEDED." LPN #13 was asked if that intervention referred to Resident #131's splint. She stated, "Yes."

At approximately 9:00 a.m., the therapy director was interviewed regarding Resident #131. She looked a the computer and stated, "She was discharged from therapy about a year ago...according to the discharge summary the staff and the resident were educated on putting the splint on and they could do it." She was asked if she was aware the resident was not wearing the splint because, per the resident's report it wouldn't stay on. She stated that she was not aware of that and usually when there were problems with a splint the nurse's would notify them. She stated there had not been a referral regarding the splint but they would look at it.

On 08/29/2018 at approximately 3:00 p.m.,the therapy director presented a therapy screening form. She stated, "We screened her today...we are going to open her back up to occupational therapy so we can do some staff training on that splint...all the straps come off of that one and we need to do some training...she may need a different one."

The above information was discussed with the DON (director of nursing) and the administrator

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F 688	Continued From page 34 during a meeting on 08/29/2018 at approximately 2:25 p.m. On 08/30/2018 Resident #131 was sitting up in her bed eating breakfast. She was asked if she had worn her splint during the night. She stated, [Name] worked and worked on it last night but she couldn't get it to stay on...she gave up on it. [Name] came in yesterday and tried to adjust it...I think I am going to need something different. That one has too many straps and we can't get it to work." No further information was obtained prior to the exit conference on 08/30/2018.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure a safe bed environment for one of 37 residents in the survey sample (Resident #140), and failed to ensure a call bell was accessible for one of 37 residents (Resident # 142) as required in his plan of care for fall/injury prevention. 1. Resident #140, assessed as not using bed rails	F 689	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving	10/12/18

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due to safety risks, was observed in bed with a side rail in use.

2. Resident #142's call bell was not within reach of the resident when his plan of care included call bell accessibility and prompt call bell response among interventions for fall/injury prevention.

The findings include:

1. Resident #140 was admitted to the facility on 5/31/18 with diagnoses that included seizures, metabolic encephalopathy, sepsis, pneumonia and congestive heart failure. The minimum data set (MDS) dated 7/26/18 assessed Resident #140 with short and long-term memory problems and severely impaired cognitive skills and as totally dependent on two people for bed mobility and transfers.

On 8/29/18 at 7:28 a.m., Resident #140 was observed in bed with a 1/4 bed length side rail in the up position near the head of the bed. The bed was against the wall on the other side. Resident #140 was observed again in bed on 8/29/18 at 9:15 a.m. with the side rail in the raised position.

Resident #140's clinical record documented a bed rail assessment form dated 5/31/18 documenting "bed rails are not indicated at this time."

Resident #140's plan of care listed the resident as totally dependent upon two staff members for turning and repositioning in bed. The care plan listed the resident was at risk of falls and skin breakdown and included maintenance of a safe, clutter free environment among interventions for

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the foregoing statements, the facility states that:

Corrective Action:

Resident #140's bedside rails were discontinued.

Resident #142's call bell (tap bell) was placed within reach/accessibility.
Resident #142 has since been provided a soft touch call bell.

Identification:

Nurse Managers will review residents with side rails to ensure a safe bed environment, and confirm appropriate use of side rails.

Nurse Managers will review residents with tap bells to ensure that they are within reach, specifically when a change in location occurs such as bed to chair.

Changes:

Nursing staff will be re-educated on the appropriate use of bedside rails.

Nursing staff will be re-educated on ensuring call bell accessibility, specifically when a resident changes location such as bed to chair.

Monitoring:

Nurse Manager or designee will complete an "Evaluation for Use of Bed Rails" form

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fall/injury prevention.

On 8/29/18 at 8:44 a.m., the certified nurses' aide (CNA #1) caring for Resident #140 was interviewed about the resident's use of the bed rail. CNA #1 stated the bed rail was routinely used with Resident #140 when he was in bed. When asked how he knew which residents were safe to have bed rails, CNA #1 stated he went by what the residents told him. CNA #1 stated Resident #140 was "still alert" and let him know he wanted the bed rail. CNA #1 stated when Resident #140 was in bed, the bed rail was raised.

On 8/29/18 at 2:08 p.m., the licensed practical nurse (LPN #9) caring for Resident #140 was interviewed about the side rail use. LPN #9 stated she did not know whether Resident #140 was supposed to use side rails.

On 8/30/18 at 7:46 a.m., the registered nurse unit manager (RN #2) was interviewed about Resident #140's side rail use. RN #2 stated the resident was assessed in May 2018 and was not considered a candidate for side rail use. RN #2 stated the resident was not capable of using the rail and was unable to independently move or reposition in bed. RN #2 stated staff members were not supposed to use bed rails with Resident #140. RN #2 stated she thought there was still a mind-set with some of the aides that bed rails was always safe. RN #2 stated residents were assessed once per quarter regarding safe bed rail use.

These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/18 at 2:30 p.m.

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following a resident's admission to the facility and obtain a physician's order as needed. QA Coordinator or designee will conduct monthly rounds to ensure call bell accessibility for facility residents with tap bells. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI)Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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2. Resident #142 was admitted to the facility on 10/26/17 with diagnoses that included paraplegia, seizures, neurogenic bladder, diabetes, hyperlipidemia and depression. The minimum data set (MDS) dated 7/25/18 assessed Resident #142 as cognitively intact and as totally dependent on two people for bed mobility and transfers.

On 8/28/18 at 10:50 a.m., Resident #142 was observed in his room seated in a reclining chair beside his bed. The resident was in a private room and was unattended by staff members or family. A manual tap bell was observed on a table across the room and out of reach of the resident. Resident #142 was interviewed at this time about the call bell. Resident #142 stated he had limited movement of his arms and hands but was able to tap the manual type bell as long as it was within his reach. Resident #142 stated, "I can't reach it [bell] when it is across the room." Resident #142 stated he was unable to activate a standard push button call light due wearing hand splints for contractures of his fingers.

Resident #142 was observed in the reclining chair and/or in bed on 8/28/18 at 12:00 p.m. and 12:32 p.m. and again on 8/29/18 at 7:26 a.m. and 9:14 a.m. The tap call bell was on the table across the room out of the resident's reach during each of these observations.

Resident #142's plan of care (effective 7/31/18) stated the resident was at risk of falls due to a fall history, paraplegia, seizures, pain and periods of restlessness/agitation. Interventions listed to prevent falls/injury included, "Call light within reach, with prompt response to all requests..."

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F 689	Continued From page 38 On 8/30/18 at 7:54 a.m., the registered nurse unit manager (RN #2) was interviewed about Resident #142's call bell. RN #2 stated the call bell was supposed to be within the resident's reach. RN #2 stated Resident #142 was able to tap the manual bell if within his reach. These findings were reviewed with the administrator and director of nursing during a meeting on 8/30/18 at 2:30 p.m.	F 689		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, facility staff failed to ensure acceptable pain management and control for one of 37 residents in the survey sample, Resident #152. Facility staff failed to ensure Resident #152's pain was controlled and managed at an acceptable level for this resident. Findings included: Resident #152 was readmitted to the facility on 10/13/17 with diagnoses including, but not limited to: Left Breast Cancer with Mastectomy, Left Humerus Fracture, Chronic Obstructive Pulmonary Disease with Continuous Oxygen Use,	F 697	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action: Facility staff is working with Resident #152	10/12/18

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and Protein- Calorie Malnutrition.

The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 08/14/18. Resident #152 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

Resident #152's clinical record was reviewed on 08/29/18 at 8:00 a.m. Included in her August 2018 POS (physician order sheet) was: "...Duragesic 12MG/HR [milligrams per hour] Apply 1 patch to skin every 72 hours *Remove Old Patch*...Hydrocodone-Acetaminophen SOL 7.5-32 10 ML [milliliters] via J-tube every six hours as needed for pain..."

Review of Resident #152's July and August 2018 MAR's (medication administration sheets) showed this resident was using her PRN pain medication on average, three times daily, every day, in conjunction with the Duragesic patch. Documentation on the MAR's included Resident #152's pain was always a zero when assessed by the nursing staff.

Resident #152 had nine medication changes from 9/2017 through 7/2018 in relation to her pain status. This was noted from a medication timeline completed by RN #1 (registered nurse).

Resident #152's CCP included the following regarding pain: "...09/20/17 Pain management as needed. Notify charge nurse of any changes in condition, c/o [complaints of] pain or discomfort. Reposition for comfort as needed. Rest periods as needed. Pain med as needed for pain or discomfort, ensure relief, go back in an hour to check for relief, not having any relief let charge

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to ensure acceptable pain management and control. Resident has had changes to pain management regimen as prescribed by attending physician. Numeric pain scale rating has also been added to Resident #152's Medication Administration Record (MAR). Resident is also now receiving Occupational Therapy to assist with pain management.

Identification:

Nurse Mangers will interview residents with moderate to severely rated pain (as confirmed on CASPER report) to ensure acceptable pain management and control.

Changes:

Facility will review Pain Management policy and revise as/if needed. Nursing staff will be re-educated on such policy.

Monitoring:

Nurse Managers will interview residents who report moderate to severely rated pain weekly to ensure acceptable pain management and control. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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nurse know. Notify MD/family [physician] of any complaints of pain/discomfort. Need for routine pain med...08/15/18 Administer medications as ordered and monitor for adverse side effects-SEE MD ORDERS. Position for comfort...Provide rest periods as needed and after medication to facilitate relief. Observe for unrelieved pain, especially back pain, loss of height, kyphosis. Report abnormalities to MD with follow up as indicated..."

No documentation was located in nursing progress notes in relation to Resident #152's pain status. All pain documentation was documented on the MAR's only.

Resident #152 was interviewed on 08/29/18 at 9:48 a.m. regarding her pain and treatment measures in place. Regarding the Duragesic patch Resident #152 stated, "It doesn't really help." When asked if she had notified anyone that the pain patch didn't work, Resident #152 stated, "I have been told by the nurses, you need to give it time to work." During this interview Resident #152 further stated, "There are a couple of nurses I would rather not have...They have both told me, don't ring your call light for meds, I will bring it when I bring it. When they are working I do not ring my light for pain medicine. They will bring it eventually. It may be eight hours or nine, but they eventually bring it to me." When asked what she does if she is in pain and her six hours has elapsed she stated, "I just wait. I just stay in pain..." Resident #152 declined to name the two nurses.

At 10:50 a.m. Resident #152 was interviewed a second time. Resident #152 stated regarding Nurse #1, "She told me that when she first started

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working here. I just know not to call." Regarding Nurse #2, Resident #152 stated, "She said you don't understand what prn means. There is no early and no late. But, I do know what it means." Resident #152 continued to decline naming the two nurses.

At 16:30 p.m. Resident #152 was interviewed regarding pain assessments. Resident #152 stated, "Some of the nurses ask and some don't. My arm is a 10. My mastectomy is a 7.5 to 8. After prn pain med, it decreases to a 3-4." Regarding whether that was an acceptable level for her, the resident stated, "I really don't have a choice. I have never rated my pain as a zero because it is never a zero."

On 08/30/18 at 9:40 a.m., LPN #2 and #3 (licensed practical nurse) and RN #1 (registered nurse) were interviewed regarding when they assess a resident's pain level and document on the MAR. LPN #2 stated, "I assess when I first go in. I ask how they are feeling or how they slept. This is what I document on the front of the MAR. I document on the back of the MAR after a pain medicine has been given." LPN #3 and RN #1 both agreed with LPN #2.

LPN #1 was interviewed at 9:50 a.m., LPN #1 stated, "I ask when I go in to give their morning meds, but I rate their pain by the facial pain scale. I ask them, but what I document is from the facial pain scale. That is what it says on the MAR." The MAR for Resident #152 was reviewed by LPN #1 and this surveyor. This resident's MAR included, "...Assess for pain Q-shift [every] using facial pain scale 0-10..."

LPN #2 and #3 were interviewed a second time at

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1:10 p.m. regarding which pain scale was used to document on the MAR. LPN #2 and #3 both stated, "I document the pain number on a scale of 0-10. I do not use the facial pain scale." No one was able to answer why Resident #152 had received, on average, three prn doses of pain medication daily, but her pain level was always assessed and documented as zero.

The NP (nurse practitioner) was interviewed on 08/30/18 at 1:40 p.m. regarding why a pharmacy recommendation from 6/4/18 was not followed. The recommendation included: "...1. Increase in the Fentanyl to 25mcg q [every] 3 days...2. Consider trial of Lidocaine patch on the upper left arm...3. Addition of Cymbalta 30mg [milligrams] qd [everyday] x1 [times one] week, then increase to 60mg (for help with depression/chronic/neuropathic pain)."
The NP responded on 6/18/2018 to the pharmacy recommendation. The response included: "...I have written orders for #2 and #3. Will evaluate in one week and add #1, if needed." The NP stated, "She is so tiny. I didn't want to overload her. She was also seeing Psych and we were working on her depression. I just wanted to take it in steps. She is usually good about telling us if something isn't working."

The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 08/30/18 at approximately 3:10 p.m. No further information was received by the survey team prior to the exit conference on 08/30/18.

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		10/12/18

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§483.35(a) Sufficient Staff.
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, resident interviews, and staff interviews, the facility failed to ensure sufficient staffing on the Serenity Unit to allow the nurse passing medication to do so in a timely manner. On Unit 2, the facility failed to ensure sufficient staff to provide bathing and hygiene services according to the residents' plan of care, and personal preferences.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving

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The findings include:

1. On 08/28/2018 at approximately 8:30 a.m., the breakfast meal was observed on the Serenity unit. A staff member, later identified as LPN # 11 (Licensed Practical Nurse) was observed preparing breakfast plates for the residents. LPN # 11 plated food, served it on the table, and prepared juice for the residents to drink. At approximately 8:55 a.m. the unit manager, RN # 3 (Registered Nurse) was asked who would be giving morning medications on the unit. She pointed to LPN # 11 and stated, "[Name] is giving medications today."

LPN # 11 was still in the kitchen area, preparing cereal bowls, and pouring milk over the cereal. Asked if she would be doing the medication pass, she stated "Yes." LPN # 11 was then asked when she would be starting the medication pass. She stated, "They are due at 8 and 9, but by the time I get everyone fed it will probably be 10. I know it's suppose to be an hour before and after, but there are only two CNAs (Certified Nursing Assistant) back here, that's not enough. On most days, when we come in and they [the residents] are soaking wet, we have to do baths right away. There are 18 residents back here, all total care. While they [CNAs] are doing that, I am trying to get the food out to the ones who are down here and ready to eat." LPN # 11 was asked if she was the only nurse. She stated, "[Name of RN # 3] is back here, she's the unit manager and she's going back and forth between this unit and Seasons [adjacent locked unit]. LPN #11 was told that when medications were given this surveyor would like to do a medication pass observation.

F 725

the foregoing statements, the facility states that:

Corrective Action:

Sufficient staff was available on Serenity neighborhood. Medication pass was completed, no ill effect experienced by affected residents.

Resident's #104, 119, and 164 were offered bathing and hygiene services according to resident's plan of care and personal preference.

Identification:

Observations on Serenity neighborhood were isolated to affected unit.

Nurse Managers will review Bath Detail Reports to ensure bathing and hygiene services were provided in accordance to resident's plan of care and personal preferences.

Changes:

LPN involved in observation was re-educated on facility Medication Administration policy, specifically timely administration of medications.

Charge Nurse will be educated on monitoring staffing patterns to ensure sufficient staff to provide bathing, and hygiene services according to resident's plan of care, and personal preferences. Proof of bathing will be confirmed via the

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F 725	Continued From page 45 LPN # 11 continued to prepare food, and talk to the residents. Two CNAs came to the dining area and started passing out food and assisting with feeding. LPN # 11 then went to a cart of clean dishes and began putting them away. LPN # 11 completed her kitchen duties and started medication pass at approximately 9:30 a.m. LPN # 11 was asked if medications were usually started that late. She stated, "We don't have enough help back here. Sometimes it's later." On 8/28/18, at approximately 9:20 a.m., LPN # 1 was accompanied during the medication pass and pour observation on Unit 1. Medications were prepared and administered to two residents. Resident # 121 received her medications at 9:35 a.m. Resident # 103 received her medications at 9:50 a.m. All the medications given to the two residents were scheduled for administration at 8:00 a.m. At approximately 10:00 a.m. on 8/28/18, LPN # 1 was interviewed regarding the lateness of the medications. LPN # 1 stated, "I know their meds (medications) should have been given within one hour prior to or one hour after 8:00 a.m. The pharmacy assigns the administration times. It is impossible to give medications to all of these residents in a two hour period." The facility policy for medication administration was requested and received on 8/30/18 at 8:30 a.m. from the Administrator. The facility policy, "Administering Medications...Effective Date: 11-28-17" included the following: "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed.	F 725	Bath Detail Report. Monitoring: Nurse Manager, DON and/or Pharmacist consultant will conduct monthly medication pass observations on affected unit. Nurse Managers will review Bath Detail Reports weekly. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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Policy Interpretation and Implementation: ...3. Medications must be administered in accordance with the orders, including required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified."

2. The facility staff failed to ensure sufficient staffing to meet the needs of three residents, Resident # 104, Resident # 119 and Resident # 164.

During the survey process the clinical records of the following residents from Unit 2 were reviewed. Each of the residents required assistance for bathing and hygiene needs. Review of the residents' clinical records and bathing records revealed bathing and hygiene care was not provided according to the residents individual needs.

a. Resident # 104 was admitted to the facility originally on 05/27/15. Diagnoses for Resident # 104 included, but were not limited to: osteoporosis, macular degeneration, glaucoma, depressive disorder, DM (diabetes mellitus), history of TIA (transient ischemic attack) with weakness on left side, HTN (high blood pressure), Drusen (degeneration) of macula (right eye) with blindness and moderate impairment of vision in the left eye, moderate impairment in hearing ability, weakness, periodic headaches, and anxiety.

The most current MDS (minimum data set) is a quarterly assessment dated 07/11/18. This MDS assessed the resident as having a cognitive score of '15', indicating the resident was cognitively intact for daily decision making skills. The

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resident was assessed as requiring limited assistance with one person physical assist for mobility, transfers, dressing, toilet use, personal hygiene, and bathing.

b. Resident # 119 was admitted to the facility on 01/31/17. Diagnoses for this resident included, but were not limited to: high blood pressure, muscle weakness, hemiplegia on right side following a stroke, ETOH (alcohol) dependence, insomnia, and difficulty walking.

The most current MDS (minimum data set) was a quarterly assessment dated 07/18/18. This MDS assessed the resident's cognitive score of 12, indicating the resident had, slight moderate impairment for daily decision makings skills. The resident was also assessed as requiring limited assistance with one person physical assist for most ADL's (activities of daily living), including bathing and hygiene.

c. Resident # 164 was admitted to the facility on 03/06/12. Diagnoses for this resident included, but were not limited to: hypothyroidism, bilateral belpheritis, hypokalemia, high blood pressure, PVD (peripheral vascular disease), and dementia.

A quarterly MDS (minimum data set) dated 8/03/18 was reviewed and documented the resident's cognitive function as long and short term memory impairment with severe impairment in daily decision makings skills. The resident was assessed as requiring total dependence of one person for personal hygiene and bathing.

The bathing records for the above residents were reviewed for the entire month of August. According to the bathing records, Resident # 104

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had a total of five tub/shower baths for the entire month, Resident # 119 had a total of four tub/shower baths, and Resident # 164 had one tub/shower bath for the month of August 2018.

According to the bathing records, each of the three residents were scheduled to have two baths/showers per week.

Resident # 104 and Resident # 119 were both interviewed, and both stated that staff often come to them on their scheduled bath/shower days and tell them that they will not get a bath due to the fact there is not enough staff to give baths to the resident. The residents both stated that they feel the facility is short staffed, and that is why they are not getting their baths/showers.

Resident # 164 was not interviewable, but the resident's clinical record was reviewed, as well as the bath logs, which revealed the resident had one bath/shower for the month of August.

On 08/30/18 at 2:34 PM, the U2C (unit 2 coordinator) and the U2M (unit 2 manager) were interviewed regarding baths and how is it known when a resident is to receive a bath. The U2C stated that the information is in the computer when a resident gets a bath. The U2C was asked how does a CNA know when a resident gets a bath, or more specifically, on what days does the resident get a bath. The U2C stated that the unit has a bath schedule for each resident, and she produced a small notebook that listed the days of the week, with a correspondding list list of resident names and room numbers under the specific day of the week that the resident is supposed to get a bath. The U2C was asked if a resident gets a bath on

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Monday, then would the next bath day would be on Thursday. The U2C stated that was correct.

The U2M then stated, "A resident that gets a bath on Mondays and Thursdays, may not get a bath on Thursday." The U2M was asked why would that be, and the U2M stated, "A resident may get a bath on Monday and then may get a bath on Wednesday, but not on Thursday." The U2M was asked again, why would that be. The U2M stated, "Like if someone called off," then the resident may not get a bath on the next scheduled [bath] day." The U2M stated that, "A resident might get a bath on Monday, but they don't always get a bath on Thursday." The U2M was asked again to clarify and the U2C stated, "Well, if someone calls out they may not get a bath the next day."

Review of Nursing Notes for Resident # 104, Resident # 119, and Resident # 164, failed to reveal documentation that either of the three residents had any refusals of personal care and hygiene, including bathing.

On 08/30/18 at 3:30 PM, the U2C was interviewed again regarding bathing for residents on Unit 2. The U2C stated that, "Our goal for the resident's is to have a bath/shower twice a week." The U2C also stated that bathing information and assistance should be included on the resident's CCP.

The survey team held an end of day meeting with the DON (Director of Nursing) and administrator on 08/30/18 at approximately 3:30 p.m. regarding the concerns surrounding the three residents listed above. The administrator was asked how often residents should get baths. The

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administrator stated that, "The expectation would be twice weekly. Twice weekly is the minimum, if there is additional frequency requested, then that would have to individualized." The administrator was made aware that according to interviews with residents and staff, as well as review of bathing documentation, that the residents aren't getting bathed/showered twice weekly.

The administrator and DON were asked about staffing in relation to resident's getting baths. The DON stated, that staffing does have an effect, but the charge nurse will redirect staff on how the groups are set up and delegate staff to cover. The DON stated that the charge nurse should be adjusting the schedule to ensure baths and showers are completed. The DON was asked if the CNA's report that baths or showers are not completed. The DON stated that they (CNA's) should be informing the charge nurse, and the charge nurse should ensure they are completed and redirect staff as needed. The DON stated that the charge nurse gets direction and guidance from the U2C. The DON and administrator were made aware that baths were not being completed twice weekly on Unit 2, and the above residents were attributing the lack of bathing to short staffing.

The DON and administrator were asked how they ensured baths/showers were being done on Unit 2 when two staff members that called off (i.e., they would not be at work) on Unit 2 on Tuesday (08/28/18), and one staff member was pulled from Unit 1 (CNA # 13, who is on a 25 lb weight restriction) to replace them. The DON stated, "That is not a staffing problem that is a person problem." The DON and administrator were made aware that the residents are not getting

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F 725	Continued From page 51 baths regularly per the resident interviews, staff interviews and according to the documentation. The survey team's findings regarding the staffing on the Serenity Unit, the timely passing of medications on Unit 1, and the lack of staff to provide bathing and hygiene on Unit 2 were discussed during a meeting at 3:15 p.m. on 8/30/18 that included the Administrator and the Director of Nursing. No further information and/or documentation was presented prior to the exit conference on 08/30/18 at 5:00 p.m.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		10/12/18

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implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure accurate weight tracking for one of 37 residents in the survey sample, Resident # 81. Staff performing weights for Resident # 81 were subtracting weight for the resident's clothing.

Findings include:

Resident # 81 was admitted to the facility on 4/16/18 with diagnoses to include but were not limited to: cerebral palsy, mild mental retardation, and high blood pressure.

The most recent MDS (minimum data set) was a quarterly review dated 5/31/18 and had Resident # 81 assessed as having severe cognitive impairment with a total summary score of 03 out of 15.

On 8/29/18 at 8:00 a.m. during review of the clinical record it was noted Resident # 81 had experienced weight loss. Several interventions had been put in place, and the last recorded weight was documented on 8/6/18 as 164 pounds. LPN (licensed practical nurse) # 13 was asked when Resident # 81 would be weighed again. She stated "Today, it's his bath day, so

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The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that:

Corrective Action:

Resident #81's weight was obtained and recorded without subtracting weight for resident's clothing.

Identification:

Observed process of subtracting weight for resident's clothing was identified as an isolated practice on affected unit.

Changes:

Nursing staff on affected unit will be

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he'll get weighed then."

On 8/29/18 at 4:00 p.m. RN (registered nurse) # 4 was asked for Resident # 81's weight. She stated "I don't know, let's go down to the shower room and the sheet will be down there; nothing's recorded yet." This surveyor and RN #4 went to the shower room. A CNA (certified nursing assistant) was still there and was asked for the resident's weight. She looked at the sheet and stated "151 lbs." RN # 4 stated "I can't believe that's right; can we reweigh him?" RN # 4 and CNA (certified nurses' assistant) # 6 reweighed the resident. Resident # 81 had on a white tee shirt, pants, and white crew socks with sandals. CNA # 6 stated "Looks like it's 160 lbs; do you want to see?" This surveyor observed the scale reading 160 pounds. We always subtract 2 lbs for clothes and shoes, which he has on, so the weight is 158 lbs."

On 8/30/18 9:50 a.m. CNA # 6 was asked about subtracting weight for clothed residents. She stated "I always subtract 2 pounds when they have on clothes; no one told me to do that; I don't know if it's in the policy. That's what all of us (CNA staff) do...."

On 8/30/18 at 10:45 a.m. the dietary manager was asked if the weight policy included directions to subtract 2 pounds for clothing. She stated "The policy would be on the nursing side; however, I am not aware that anything should be subtracted for shoes or clothes..."

On 8/30/18 at 10:50 a.m., the CNA on unit 2 was asked if she weighed residents. She stated she did, and described how residents were weighed. She was then asked if she subtracted any weight

F 726

re-educated on facility's Weight Monitoring policy.

Monitoring:

Nurse Manager or designee on affected unit will review weights monthly and conduct staff interviews to ensure weights are recorded accurately, without subtraction for resident's clothing. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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F 726	Continued From page 54 if the resident was clothed. She stated "no." On 8/30/18 at 11:00 a.m. the unit manager, RN # 6 was asked about the technique used by the CNAs to weigh residents. She stated "I think the subtraction goes on just over here (on unit 3). After talking with the staff, they were told by the previous unit manager to do that; it's not in the policy and I have told them to stop doing that." The policy was then requested. The policy "Weight Monitoring" under "Procedure" included "2. All weights will be obtained by the Nursing Assistants... 9. Residents will be weighed without shoes and prosthesis when possible, if weighed with prosthesis, please note as such..." There were no directions to subtract weight for clothes or shoes. On 8/30/18 at 3:05 p.m. the administrator and DON (director of nursing) were informed of the above findings during a meeting with facility staff. No further information was provided prior to the exit conference.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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	F 755		10/12/18

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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, facility staff failed to ensure an accurate accountability of controlled medications for one of 37 residents in the survey sample, Resident #152. The Controlled Substance Count Sheet and medication administration record (MAR) for Resident #152 during the month of August 2018 did not include complete and accurate documentation for the use of PRN (as needed) Hydrocodone/APAP SOL 7.5-325.

Findings included:

Resident #152 was readmitted to the facility on 10/13/17 with diagnoses including, but not limited to: Left Breast Cancer with Mastectomy, Left

F 755

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that:

Corrective Action:

The Controlled Substance Count Sheet recorded an accurate accountability of

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Humerus Fracture, Chronic Obstructive Pulmonary Disease with Continuous Oxygen Use, and Protein- Calorie Malnutrition.

The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 08/14/18. Resident #152 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

Resident #152's clinical record was reviewed on 08/29/18 at 8:00 a.m. Included in her August 2018 POS (physician order sheet) was: "...Duragesic 12MG/HR [milligrams per hour] Apply 1 patch to skin every 72 hours *Remove Old Patch*...Hydrocodone-Acetaminophen SOL 7.5-32 10 ML [milliliters] via J-tube every six hours as needed for pain..."

Documentation for Resident #152's PRN Hydromorphone was not consistent on the Controlled Substance Count Sheet and front and back of the August 2018 MAR. From the time period of 08/02/2018 at 6:00 a.m. through 08/29/2018 at 3:50 p.m. there were 88 doses recorded on the Controlled Substance Count Sheet, 84 doses documented on the front of Resident #152's August MAR, and 77 doses recorded on the back of MAR.

On 08/30/18 at 10:45 a.m., LPN #5 (licensed practical nurse) was interviewed via phone regarding a dose of Hydromorphone signed out on 08/13/18 at 2:00 p.m. LPN #5 stated, "I did give her a dose at the end of my shift. She likes to get it before second shift comes on so she doesn't get caught up in change of shift. Did I sign it out on the back of the MAR? I just forgot to initial on the front of the MAR." Attempts were

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controlled medications for Resident #152. Associated nursing staff were interviewed with statements collected to verify accurate accountability of controlled substance.

Identification:

Nurse Managers will review Controlled Substance Count Sheets and Medication Administration Records for residents receiving PRN Hydrocodone.

Changes:

Nursing staff will be re-educated on Controlled Substances and Medication Administration policies.

Monitoring:

Nurse Manager, Pharmacist consultant and/or designee will audit Control Substance Count Sheets and Medication Administration Records for resident's receiving PRN Hydrocodone monthly. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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F 755	Continued From page 57 made to contact LPN #4 and #6 via phone at 10:40 a.m. and again at 12:30 p.m. without success. The DON (director of nursing stated), "They both worked last night. They are probably asleep." The DON stated regarding her expectation for recording narcotic usage, "The nurse should initial the front of the MAR, sign the back of the MAR, look at the bottle of liquid medication and sign it out on the narcotic count sheet." The consulting Pharmacist was interviewed on 08/30/18 at 1:55 p.m. via phone regarding reconciliation of narcotic medications with resident MAR's. The Pharmacist stated, "We look at the prn's. We look at the front and back of the MARs. We look at the count sheets for each shift, but we do not reconcile the Narcotic sheets to the MAR." The Administrator and DON were informed of the above findings during a meeting with the survey team on 08/30/18 at approximately 3:10 p.m.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, clinical record review, staff interview and facility document review, the facility staff failed to ensure a medication error rate of less than five percent.	F 759	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the	10/12/18

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Forty medication opportunities were observed with five identified errors, resulting in a medication error rate of 12.5%.

1. Resident #58 was administered Enteric Coated Aspirin in place of physician ordered chewable aspirin. The enteric coated aspirin and the extended release Metoprolol (labeled DO NOT CRUSH) were both crushed by LPN #11 and mixed with applesauce for administration. LPN # 11 also administered Enteric Coated Aspirin in place of physician ordered chewable aspirin to Resident #63.

2. LPN #1 (licensed practical nurse) failed to administer Pletal 100mg (milligrams) by mouth to Resident #103, on an empty stomach, as ordered by the physician.

Findings were:

1. A medication pass and pour observation was conducted on the Serenity unit on 08/28/2018 beginning at approximately 9:30 a.m. LPN #11 began preparing medications for Resident #58. She stated, "I have to crush her pills and put them in applesauce or she won't take them." LPN #11 prepared the following medications: Aspirin EC (enteric coated) 81 mg, Metoprolol ER 25 mg, Cozaar 100 mg, Norvasc 5 mg, Centrum, and Namenda 5 mg. The medications were placed in a plastic bag and crushed, mixed in applesauce and given to Resident #58.

The following medications were prepared for Resident #63: Norvasc 10 mg, Aspirin EC 81 mg, Zestoretic 20-12.5 mg, Kdur 20 meq, Tylenol 2 tabs 325 mg (650 mg), Zantac 150 mg, and 15 cc of Elder Tonic. The medications were given to

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facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that:

Corrective Action:

Residents #58 and #63 were free of any known ill effect. Chewable aspirin was obtained. Resident #58 Extended Release Metoprolol has been since discontinued with new orders in place.

Resident #103 was free of any known ill effect. Medication administration time was changed to ensure it is administered on an empty stomach.

Identification:

Nurse Managers will review residents with orders to crush medications who also have active orders for Aspirin and extended release Metoprolol.

Nurse Managers will review residents with orders for Pletal to ensure it is administered on an empty stomach.

Changes:

Nursing staff will be re-educated on Do Not Crush medication listing.

Nursing staff will be re-educated on

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Resident #63, she took all the medications but the Elder Tonic which she refused.

Medication reconciliation was completed following the medication pass. Both Resident #58 and Resident #63 were ordered Aspirin 81 mg chewable, not the enteric coated aspirin that was given. The Metoprolol order for Resident #58 on the POC (physician order sheet) was for "Metoprolol 25 mg ER 1 by mouth daily for hypertension **DO NOT CRUSH** *TAKE WITH FOOD*.

LPN #11 was interviewed at approximately 10:15 a.m., regarding the Aspirin ordered for the two residents and the aspirin given. She stated, "We can't get the chewable ones...I've told them but this is what I have." When asked about crushing the enteric coated aspirin and the Metoprolol for Resident #63, she stated, "If I don't crush it she won't take it."

The unit manager, RN (registered nurse) #3 was interviewed at approximately 10:20 a.m. regarding the unavailability of chewable aspirin. She stated, "We should have that on the cart as a stock medicine. I'll take care of it."

The administrator and the DON (director of nursing) were notified of the above information on 08/29/2018 at 2:25 p.m., during an end of the day meeting.

Per the facility policy "Administering Medications": "Medications must be administered in accordance with the orders...the individual administering the medications must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route)

Medication Administration policy.

Monitoring:

Nurse Manager, DON and/or Pharmacist consultant will conduct monthly medication pass observations. Nurse Manager, Pharmacist and/or designee will audit medication administration records for residents with orders for Pletal to ensure proper scheduling of administration, on an empty stomach. Audit findings will be reported to the Quality
Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.

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F 759	Continued From page 60 of administration before giving the medicine." No further information was obtained prior to the exit conference on 08/30/2018. 2. LPN #1 was observed preparing and administering medications to Resident #103 on 08/28/18 at 9:50 a.m. During this observation Resident #103 received Pletal 100mg by mouth along with her other morning medications. During reconciliation of the medication pass with the physician orders, it was noted the Pletal should be given on an empty stomach. The resident's MAR (medication administration sheet) was observed and in the box where the Pletal was listed it stated, "Take on an empty stomach." At 11:38 a.m. on 08/28/18, LPN #1 was interviewed regarding Resident #103's Pletal and was he aware this was ordered to give on an empty stomach. LPN #1 stated, "No, is it on the MAR that way? I will need to change the time. I will get a clarification order from [Name] [physician] to change the time to 6AM. They eat breakfast around 8, so that should be okay." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 08/29/18 at approximately 2:25 p.m. No further information was received by the survey team prior to the exit conference on 08/30/18.	F 759		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		10/12/18

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

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

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

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

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F 842	Continued From page 62 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure complete and accurate clinical records for two of 37 residents in the survey sample. 1. Resident #140's clinical record documented an inaccurate physician's order regarding side rail use. 2. Resident #150's clinical record inaccurately documented the resident as a tube feeder, when the resident was able to eat by mouth. The findings include:	F 842	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action:	

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1. Resident #140 was admitted to the facility on 5/31/18 with diagnoses that included seizures, metabolic encephalopathy, sepsis, pneumonia and congestive heart failure. The minimum data set (MDS) dated 7/26/18 assessed Resident#140 with short and long-term memory problems and severely impaired cognitive skills and as totally dependent on two people for bed mobility and transfers.

Resident #140's clinical record included a bed rail assessment form dated 5/31/18 documenting "bed rails are not indicated at this time." The record also documented a physician's order dated 8/27/18 stating, "May use upper (L) and (R) 1/4 bedrail for turning and repositioning in bed."

On 8/30/18 at 11:33 a.m., the registered nurse unit manager (RN #2) as interviewed about the conflicting order and assessment regarding bed rails. RN #2 stated the physician's order was inaccurate. RN #2 stated the resident was assessed and was not considered safe for bed rails. RN #2 stated she did not know how or why the order for the bed rails was listed on the current order summary sheet.

This finding was reviewed with the administrator and director of nursing during a meeting on 8/30/18 at 2:30 p.m.

2. Resident #150 was admitted to the facility on 04/13/13 with a readmission on 05/03/16. Diagnoses for Resident #150 included hypertension, arthritis, Alzheimer's Disease, dementia, macular degeneration, cerebral infraction, pain and dysphasia. The minimum data set (MDS) dated 7/31/18 assessed Resident #150 with severely impaired cognitive skills.

F 842

Physician order for Resident #140's side rails was discontinued.

Resident #150's referenced documentation was in error, no ill effect experienced by the resident. Resident has received appropriate physician ordered diet since facility admission.

Identification:

Nurse Managers will review resident results of "Evaluation for Use of Bed Rails" to ensure the accuracy of physician orders.

Nutrition Coordinator will review Dietary Preference documentation for new facility admissions for the past week.

Changes:

Nurse Manager or designee will complete an "Evaluation for Use of Bed Rails" following a resident's admission to the facility and obtain a physician order as needed.

Nutrition Coordinator will identify residents receiving tube feedings weekly to ensure accurate documentation is accurately referenced with Dietary Preferences worksheet(s) for new admissions.

Monitoring:

QA Coordinator or designee will review physician orders of residents who have been evaluated to not use bedside rails

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F 842	Continued From page 64 Resident #150's clinical record documented Resident #150 as a tube feeder on the facility's "Diet History/Food Preference List" dated 3/6/18. Resident #150's physician orders documented the diet as mechanical soft and EBC (every bite counts). Resident #150's Medical Nutritional Therapy Assessment documented the diet as mechanical soft and EBC and her eating ability as independent with set-up assistance. Resident #150's Geri-Menu documented the diet as mechanical soft. On 08/30/18 at 9:59 a.m., the nutrition coordinator (NC) responsible for completing the "Diet History/Food Preference List" was interviewed about the "tube feeder" status written the list. The NC stated she was new to her position at the time the preference list was completed. She continued and stated Resident #150 was mistakenly documented as a tube feeder on the "Diet History/Food Preference List" dated 3/6/18. On 08/30/18 at 10:49 a.m., the NC and the facilities manager (FM) were interviewed regarding the "tube feeder" status written the food preference list. The FM stated this was done in error and the dietary department communicates with Resident #150's family and responsible representative to determine Food Preferences for the resident. These findings were reviewed with the administrator and director of nursing (DON) during a meeting on 08/30/18 at 3 p.m.	F 842	monthly. Nutrition Coordinator or designee will audit 50% of monthly admissions to ensure accurate documentation is reflected on Dietary Preference worksheet. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		10/12/18

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§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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F 880	Continued From page 66 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, facility staff failed to follow infection control practices during a dressing change procedure for two of 37 residents in the survey sample, Residents # 43 and 113. 1. RN #1 (registered nurse) did not follow proper hand washing technique prior to measuring a sacral wound on Resident #43.	F 880	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility	

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2. Facility staff failed to follow infection control practices during a dressing change for Resident #113.

Findings included:

1. Resident #43 was admitted to the facility on 5/31/17 with diagnoses including, but not limited to: Dementia, Complete Heart Block with a Pacemaker, Congestive Heart Failure, Diabetes, and a Stage 3 Pressure Ulcer.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/26/18. Resident #43 was assessed as severely impaired in her cognitive status with a total cognitive score of three out of 15.

On 08/29/18 at 09:15 a.m., a dressing change to Resident #43's sacrum was observed. RN #1 (registered nurse) was observed washing her hands prior to measuring this resident's sacral wound. RN #1 washed and rinsed her hands, turned the faucet off with wet hands and then dried her hands with a paper towel. RN #1 was interviewed at 9:20 a.m. regarding turning the facet off with wet hands and then drying her hands. RN #1 stated, "I did. I'm sorry. I know I am supposed to use a paper towel."

A copy of the facility hand washing policy was requested and received on 08/30/18 at 8:30 a.m. from the Administrator. The policy, "Handwashing Requirements, Effective 11-28-17" included the following: "Policy: All staff are trained in proper technique upon hire, annually, and PRN [as needed], and are monitored for proper handwashing practices...Procedure: ...B.

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states that:

Corrective Action:

RN observed was re-educated on facility's Handwashing Requirements procedure following observation. Resident #43 was free of any known ill effect.

RN observed was re-educated on facility's Dressing Dry/Clean procedure. Resident #113 was free of any known ill effect.

Identification:

Nurse Managers and/or Wound Nurse will perform observations on sacral wound measurements to ensure proper handwashing technique.

Nurse Managers and/or Wound Nurse will perform observations on dry dressing changes for residents with arterial wounds to ensure adherence to infection control practices during a dressing change.

Changes:

Nursing staff re-educated on facility's Handwashing Requirements procedure.

Nursing staff re-educated on facility's Dressings, Dry/Clean procedure.

Monitoring:

Infection Control Nurse, Wound Nurse, or designee will conduct monthly observations to ensure proper hand

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Handwashing with Antimicrobial Soap and Water...2. Turn the water on, using gentle flow of water, throughout the entire procedure...3. Wet your hands and wrists...4. Work lather over hands and wrists...g. Rinse hands and wrist thoroughly under running water...5. Dry hands thoroughly with a disposable towel, turning off the faucet on the hand sink with the disposable paper towel. Discard the towel into the trash can..."

The Administrator and DON (director of nursing) was informed of the above observation during a meeting with the survey team on 08/30/18 at approximately 3:10 p.m. No further information was received by the survey team prior to the exit conference on 08/30/18.

2. Resident #113 was admitted to the facility on 03/14/2017. Her diagnoses included but were not limited to: Dementia, delusional disorder, anxiety, peripheral vascular disease, diabetes mellitus, Alzheimer's disease and history of DVT (deep vein thrombosis).

The annual MDS (minimum data set) with an ARD (assessment reference date) of 07/16/2018, assessed Resident #113 as severely impaired in her cognitive status with a summary score of "04."

The clinical record was reviewed on 08/28/2018 at approximately 10:30 a.m. Observed on the POS (physician order sheet) was the following order: "Tx (treatment): Clean R (right) lower leg lateral side venous ulcer and top of R foot venous ulcer with wound cleanser, apply hydrogel mixed with collagen powder and apply advance secondary dressing daily." The order was dated 08/08/2018.

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washing technique prior to measuring sacral wounds. Nurse Managers or designee will observe dressing changes on arterial wounds monthly. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendations. The QAPI Committee will determine when to discontinue this practice.

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LPN (licensed practical nurse) #11 was asked if there was a wound nurse to do the dressing changes for the unit. She stated that she would be doing the dressing change.

On 08/29/2018 at approximately 3:30 p.m., LPN #11 stated that she was ready to do the dressing change. Resident #113 was sitting in her recliner in the common area of the unit. She was taken to her room via the recliner by LPN #11. She was accompanied by one of the CNAs (certified nursing assistant) working on the unit. Once in the her room, LPN #11 explained to Resident #113 that she was going to do the dressing changes to her legs. She placed the resident's chair in a reclining position, removed the resident's socks and her TED (thromboembolitic hose) from her left leg. The treatment cart was already in the resident's room. LPN #11 went into the bathroom and washed her hands. She returned to the treatment cart, donned nonsterile gloves and removed items needed for the dressing changes from the cart and placed them on top of the cart (Colloid powder, Hydrogel dressing, 4 X 4 gauze, wound cleanser and skin prep pads). She opened up the hydrogel dressings and the 4 X 4 gauze using the wrappers as barriers from the top of the cart. She also opened up the top of the colloid powder. She then removed the old dressings from Resident #131's right shin and the top of her right foot. She placed the soiled dressings in a garbage receptacle attached to the treatment cart. LPN #11 then picked up the skin preps from the top of the cart. She opened one and cleaned the side of Resident #113's left foot, the heel of her left foot and toes of her left foot, and threw the skin prep pad in the trash receptacle. She retrieved a second skin prep and cleaned a

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necrotic area on the second toe of Resident #113's right foot. She wiped all around the outside of the necrotic area working towards the middle of the area. She used the same pad to clean the middle toe of the right foot and in between the two toes. She stated that the areas were due to Resident #113's peripheral vascular disease. LPN #11 then picked up the wound cleanser and sprayed it on both the right shin wound and the top of the right foot. She then picked up a 4 X 4 gauze and began rubbing the open area of Resident #113's right shin. She scrubbed the area back and forth from the outside of the wound to the inside and back out again. Resident #113 pulled her leg away, made a facial grimace and stated that it hurt. LPN #11 stated that she needed to get the wound clean. She continued to rub it removing exudate from the wound bed. When she was finished with the shin wound, she folded the 4 X 4 gauze pad over and used the same technique to clean the wound on the top of Resident #113's right foot, working from side to side cleaning the wound and removing exudate. When LPN #11 was done she used a wooden tongue depressor to remove colloid powder from the package, and placed the powder over the shin wound. She then used the same tongue dispenser to obtain more collagen powder and placed if over the foot wound. Resident #113 continued to pull her leg away. LPN #11 at one point placed her gloved hand over the wound on the shin area in an attempt to hold Resident #113's leg in place to apply the powder to the foot wound. Once the collagen powder was in place, LPN #11 then placed hydrogel dressings over the two areas. LPN #11 then removed her gloves and went to the bathroom to wash her hands.

After the dressing change was completed, LPN

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 71	F 880		

#11 was interviewed regarding her technique. She was asked about hand washing during the wound care and why she had not changed gloves. LPN #11 then went to the treatment cart and using her bare hand began digging through the waste receptacle. She stated, "I thought I changed my gloves." She dug down to the bottom of the receptacle which was full and stated, "See here's another pair." She was told that she had not been observed changing gloves or washing her hands during the dressing change observation. She had been observed moving from dirty to clean and back while cleaning the wounds, using the same gauze, skin preps, and tongue depressor to move from one wound to the other. She was asked if she normally used a barrier on top of the treatment cart. She stated, "I cleaned it before you got in here."

The above information was discussed during an end of the day meeting with the DON (director of nursing) and the administrator on 08/29/2018 at approximately 2:30 p.m. The DON was asked how the wound care should have been done. The DON stated that LPN #11 should have washed her hands and changed gloves during the wound care. A copy of the facility policy regarding wound care was requested.

The facility policy "Dressings, Dry/Clean" was presented on 08/30/2018 at approximately 4:00 p.m. The following information was contained in the policy: "Clean bedside stand. Establish a clean field...Position resident...wash and dry your hands thoroughly. Put on clean gloves, loosen tape and remove soiled dressing. Pull glove over dressing and discard into plastic or biohazard bag. Wash and dry your hands thoroughly. Open dry, clean dressing(s)...wash and dry your hands

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING ______ B. WING ______	08/30/2018

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F 880	Continued From page 72 thoroughly. Put on clean gloves...clean the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward), Use Gauze to pat the wound dry. Apply the ordered dressing and secure with tape or bordered dressing per order...Discard disposable items into designated container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly" No further information was obtained prior to the exit conference on 08/30/2018.	F 880		