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	345233	A. BUILDING _____ B. WING _____	C 02/01/2019

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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
E 000	Initial Comments An unnanounced recertification and complaint investigation survey was conducted on 1/29/19 through 2/1/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Prepardness. Event ID# 2BWB11	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation (Event ID #2BWB11) was conducted on 01/29/2019 through 02/01/2019. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J. Tag F600 constituted substandard quality of care. Immediate jeopardy began on 12/26/18 and was removed on 02/01/19. An extended survey was completed.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		3/1/19

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

Electronically Signed | 02/22/2019

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on, record review, observations and staff and resident interviews the facility failed to provide privacy covers for urinary catheter bags for 2 of 3 residents sampled for dignity and respect (Residents #55 and #59). The findings included: 1. Resident #55 was admitted to the facility on 04/20/18 with diagnoses that included, urinary retention, urgency of urine, history of stroke, and malignant neoplasm of prostate.	F 550	1.)Resident #55 and Resident # 59 were found to have been denied the right to privacy and dignity as their urinary catheters were not in a dignity /privacy bag per facility protocol. Each resident immediately had their closed urinary drainage bag placed at a clinically appropriate level and into their respective dignity bags giving them privacy and dignity. 2.)All residents with catheters have the potential to be adversely effected by this	

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F 550	Continued From page 2 A review of Resident #55's most recent quarterly Minimum Data Set (MDS) assessment dated 11/27/18 revealed he was severely cognitively impaired for daily decision making. The MDS also revealed Resident #55 was coded as requiring extensive assistance with most activities of daily living (ADL) and had an indwelling catheter. A review of Resident #55's care plan revised on 11/27/18 revealed the potential for injury related to the presence of an indwelling catheter and a self-care deficit due to dementia. Interventions included to check the tubing for kinks, keep the collection bag below his bladder level and to involve Resident #55 in decisions regarding his care. On 01/30/19 at 9:12 AM an observation was completed of Resident #55 lying in bed, with his urinary catheter bag uncovered and lying on the floor. During an interview with Resident #55 on 01/30/19 at 9:12 AM he reported he would prefer to have his catheter collection bag covered. An additional observation was completed of Resident #55 on 02/01/19 at 12:49 PM. Resident #55 was observed in his room, sitting in his wheelchair with his urinary catheter bag uncovered under his wheelchair. An interview with Nurse #2 on 01/30/19 at 9:16 AM revealed it was the responsibility of Nurse Aides (NAs) to complete catheter care, ensure the collection bag was off the floor and ensure privacy bags were in place.	F 550	deficient practice. 100% of the licensed clinical staff have been educated to the use of dignity bags for catheters. All aspects of catheter care were reviewed at this time. New bags were ordered and all residents with indwelling catheters now have appropriate catheter bags. All new hires/agency staff since 2/1/2019 have been in serviced to this policy and POC, and this training will continue on with orientation of all new staff. 3.) Audits of all residents with an indwelling catheter will be completed and residents observed for proper use of the dignity bag by the DON/Designee daily x 2 weeks, weekly x 4 weeks and monthly x 3 months to insure substantial compliance. 4.) Results of these audits will be reported to QAPI monthly x 3 months to insure ongoing substantial compliance with resident rights for privacy and dignity.	

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During an interview with NA #4 on 01/30/19 at 9:17 AM revealed the facility had dignity bags available and verified Resident #55 should have a dignity bag for over his urinary catheter collection bag and did not explain why it was not covered.

An interview with the Director of Nursing on 01/31/19 at 11:06 AM revealed the facility had dignity bags for urinary catheter collection bags and she reported the dignity bags should always be in place. She stated it was her expectation that hall nurses paid attention and ensured dignity bags were always in place. She indicated it was the floor staffs' responsibility to ensure the dignity bags were in place.

2. Resident #59 was initially admitted to the facility 11/16/18 with diagnoses including heart failure, neurogenic bladder, hypertension (high blood pressure), and muscle weakness.

Review of the admission Minimum Data Set (MDS) dated 12/06/18 revealed Resident #59 was cognitively intact and had an indwelling urinary catheter.

Review of Resident #59's care plan for suprapubic catheter last updated 01/29/19 revealed the facility was to provide catheter care on care rounds and as needed.

An observation of Resident #59's catheter bag on 01/29/19 at 10:11 AM revealed there was no dignity bag covering the catheter bag.

An interview with the Director of Nursing (DON) on 01/29/19 at 10:37 AM revealed she expected Resident #59 to have a dignity bag covering the

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F 550	Continued From page 4 catheter bag. The DON stated Resident #59 had a suprapubic catheter placed on 11/28/19 and the hospital probably sent him back with a catheter bag with no dignity bag in place. An interview with the Administrator on 02/01/19 at 6:45 PM revealed she tried to make sure catheter bags had dignity bags in place daily but since Resident #59 had the suprapubic catheter placed 01/28/19 she just missed applying the dignity bag. The Administrator stated she expected catheter bags to be covered with dignity bags.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		3/1/19

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F 580	Continued From page 5 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident, physician, and staff interviews, the facility failed to notify the Physician of a resident's significant change in condition for 1 of 1 resident sampled for notification (Resident #90). The findings included: Resident # 90 was admitted to the facility on 12/27/18 with a diagnosis of hypertension, diabetes mellitus, cerebrovascular accident, non-Alzheimer's dementia, and muscle weakness.	F 580	1.)Resident #90 experienced a significant change in condition beginning on 1/28/2019, Temp of 101, shortness of breath, and on 1/31/2019 was transferred to the ER for evaluation. A facility must immediately inform physician and families of any significant changes in condition. 2.) All residents with a significant change in condition have the potential to be adversely effected by this deficient practice. 100% of the licensed staff have been in serviced by DON/Designee, completed 2/6/2019, regarding the need	

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F 580	Continued From page 6 The admission Minimum Data Set (MDS) dated 01/03/19, noted Resident #90 to be moderately cognitively impaired. The MDS further revealed Resident #90 required extensive, two-person assistance with all activities of daily living (ADL). Review of nursing note dated 01/28/19 at 3:30 PM revealed Physician #1 had examined Resident #90 and new orders had been obtained to initiate 2 liters of intravenous fluid and lab work for the morning of 1/29/19. Review of the nursing note dated 01/29/19 at 5:00 PM written by Nurse #1 revealed Resident #90 had a temperature of 101 degrees. The note further revealed Resident #90 had stated to the nurse,"he did not feel like he was breathing good enough" and had a poor appetite. Review of the Physician Standing Orders revealed orders to notify the physician for a fever of 100.0 or greater. The review revealed an order to start supplemental oxygen at 2 liters/min for shortness of breath for a duration of 72 hours and to notify the physician. Review of the Medication Administration Record (MAR) for Resident #90 revealed an order initiated on 01/15/19 for Tylenol 650mg scheduled to be administered three times daily at 10:00 AM, 4:00 PM and 12:00 AM. The review revealed on 01/29/19 Nurse #1 had not initialed giving Resident #90 his scheduled 4:00 PM dose. Review of Nursing Note dated 01/29/19 at 7:30 PM written by Nurse #3 revealed Resident #90's wife had requested he be sent to the Emergency Room (ER) for an evaluation. The note revealed	F 580	for immediate notification when a resident presents with a significant change in condition, any need to change treatments, any accident requiring physician intervention, a transfer or discharge or a change in room or roommate. All new hires and agency used since completion of training on 2/6/19 have been inserviced to this policy and POC and this training will continue with all new hires/agency use through orientation. 3.) Audits and observations of residents by the DON/Designee/clinical management staff have been ongoing for any changes. As changes are documented, the immediate notification is done per state guidelines. Audits continue daily x 2 weeks, weekly x 2 weeks, and monthly x 3 months to insure timely notification to physicians and families/POA. 4.) Results of the audits will be reported to QAPI by the DON/Designee x 3 months to insure ongoing substantial compliance.	

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Nurse #3 called the physician and obtained orders to send Resident #90 to the Emergency Room (ER).

On 1/31/19 at 2:18 PM an interview was conducted with Nurse Aide (NA) #1 and revealed she had been responsible for Resident #90 on 01/29/19. NA #1 stated Resident #90 had been restless with an elevated temperature of 101.0 on the morning of 1/29/19 which she stated she reported to Nurse #1.

On 1/31/19 at 4:08 PM an interview was conducted with Nurse #1. The interview revealed she had been Resident #90's nurse on 01/29/19. Nurse #1 stated Resident #90 had an elevated temperature on the morning of 01/29/19 for which she administered Tylenol 650 mg at 10:00 AM and rechecked the resident's temperature in which she could not recall the result. She stated Resident #90 had been anxious and told her he wasn't able to catch his breath with an oxygen saturation of 89%. Nurse #1 stated she did not give Resident #90 any supplemental oxygen per physician standing orders because his oxygen saturation had increased to 91%. She stated Resident #90's morning vital signs had not been documented, she had not notified the physician of his shortness of breath and elevated temperature and she did not assess Resident #90 after her second medication pass at 2:00 PM on 01/29/19. Nurse #1 further stated she left the facility at 3:00 PM that afternoon after giving report to Nurse #2.

On 1/31/19 at 04:46 PM an interview was conducted with Nurse #2. The interview revealed he had received report from Nurse #1 on 01/29/19 at 4:30PM. Nurse #2 stated he was not informed of Resident #90's complaints of

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shortness of breath, or elevated temperature. Nurse #2 did not assess Resident #90. The interview revealed Nurse #2 had not administered Resident #90's scheduled dose of Tylenol and normally did not work on the North side of the facility in which Resident #90 was located.

On 1/31/19 at 4:56 PM an interview was conducted with Nurse #3. Nurse #3 stated she had received report from Nurse #2 on 01/29/19 at 6:00PM and was notified of Resident #90's lab results. Nurse #3 stated she received the critically low carbon dioxide level, the amount of carbon dioxide in the blood stream of 16 milliequivalents per liter (mEq/L) for Resident #90 and informed the physician at 6:50 PM. Nurse #3 stated Resident #90's wife came to the nurse's desk at 7:30 PM requesting her husband to be sent to the ER because she thought he had pneumonia. Nurse #3 stated she did not go to Resident #90's room to assess him due to him being sent to the emergency room at the wife's request. The interview revealed Nurse #3 did not leave the nurse station, Resident #90's wife dressed him and brought him to the nurses station awaiting EMS arrival.

On 2/01/19 at 8:41AM an interview was conducted with the Director of Nursing (DON). The DON stated her expectations were for the nurse to have notified the physician of Resident #90's elevated temperature on 1/29/19 and to have initialed the scheduled 4:00PM dose of Tylenol as ordered. She stated her expectations were for the nurse to follow facility protocol, physician standing orders and to notify the physician accordingly.

On 2/01/19 at 10:10 AM an interview was

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F 580	Continued From page 9 conducted with Physician #1. Physician #1 stated he had not been notified on 1/29/19 of Resident #90's shortness of breath or elevated temperature but had seen Resident #90 on the dates of 1/25/19 and 1/28/19. The interview revealed Physician #1 had been notified of Resident #90's abnormal lab result on 1/29/19 at 6:50 PM in which he initiated orders to obtain a repeat basic metabolic panel (BMP) on the morning of 1/30/19. Physician #1 was notified at 7:30 PM of Resident #90's wife's request for the resident to be sent to the emergency room. The interview revealed his expectations were for the Nurse to administer medications as ordered and to notify him with any change in resident condition.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, family, staff and Physician interviews the facility failed to protect a	F 600	1.) Facility failed to provide Resident #38, # 90, # 309, # 207 freedom from physical	3/1/19

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resident's right to remain free from physical abuse or neglect for 3 of 3 sampled residents reviewed for abuse and neglect (Resident #38, #90, and #309) Nurse aide (NA) #1 grabbed Resident #38 by the arms, yelled at her and pushed her while seated in a wheel chair into a linen cart. Resident #38 was observed to have a new skin tear on her left forearm after NA #1 was observed to grab her arms. Staff neglected to assess and implement standing orders for Resident #90 who experienced shortness of breath and an elevated body temperature. Staff failed to prevent Residents #207 and #309 from engaging in physical and verbal altercations with each other.

Immediate Jeopardy began on 12/26/18 for Resident #38 when NA #1 grabbed her by the arms, yelled at her and pushed her into a linen cart. Immediate Jeopardy was removed on 02/01/19 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential of minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Examples #2 and #3 were cited at a scope and severity of a "D" where a plan of correction is required.

Findings included:

1. Resident #38 was admitted to the facility on 07/12/18 with diagnoses that included dementia without behaviors, cognitive communication deficit, altered mental status, major depressive disorder and anxiety disorder among others.

A review of Resident #38's most recent quarterly

abuse or neglect. Resident #38 suffered a skin tear which was immediately treated per physician order and resident was immediately assessed for any other signs and symptoms of abuse with no findings. Resident #90 was transferred to the hospital for respiratory distress and returned to facility after being treated for pneumonia, lactic acidosis and respiratory failure. Resident #309 was involved in a resident to resident altercation with Resident #207 over a telephone vs tv remote issue. #207 pushed #309 and he fell, reported he bumped his head. #309 complained of a headache later that evening and was sent to the hospital for evaluation. #309 was diagnosed with a slight contusion and no new orders were written upon readmission to facility.
2.)All residents have the potential to be adversely effected by this deficient practice. 100% of facility staff were in serviced, completed 2/6/2019, including all new hires and any agency staff used, by DON/Designee on what constitutes abuse, how to watch for signs and symptoms of staff burn out and the stressors that lead to it, who any allegations of abuse would be reported to and when, and what actions need to be instituted to protect residents from each other in a escalating situation. This training about abuse, recognizing the stressors and proper notification will be ongoing for all new hires and agency through the orientation process.
3.) Interviews by Social Services/Designee of cognitive residents and observations of care provided to the

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F 600	Continued From page 11 Minimum Data Set (MDS) Assessment dated 11/09/18 revealed Resident #38 was cognitively impaired for daily decision making and was observed to have verbal and other behaviors directed towards others 1-3 days during the look back period. Resident #38 was coded as being totally dependent with bathing with a 2 person assist. A review of Resident #38's care plan, last updated 12/05/18, revealed care plan areas for verbally abusive behaviors and socially inappropriate and disruptive behavior. Interventions included not to argue with Resident #38, monitor and document behaviors, approach Resident #38 warmly and positively, administer medications as ordered and to allow Resident #38 to make choices and participate in care. A review of a 24 hours report dated 12/26/18 at 8:30 AM revealed two nurse aides (NA #2 and NA #3) observed NA #1 push Resident #38 against a linen cart while he prepared to provide Resident #38 with a bath, grab her arms and yell that she was not going to hit him again. A review of NA #1's written statement dated 12/26/18 revealed he was assisting Resident #38 with a shower and while he was pushing her into the bathroom, Resident #38 kicked him in the face. He reported to step away from Resident #38 while she continued to swing at him (unspecified with what appendage) and he reportedly asked Resident #38 "would you please stop hitting me". He then reported noting a skin tear to Resident #38's left forearm. There was no mention in his statement that he placed his hands on Resident #38.	F 600	cognitively impaired residents by the DON/Designee continue daily as submitted with the original IJ ablation POC and will continue daily x three weeks, weekly x 4 weeks and monthly x 3 months. 4.)Results of interviews and audits will be presented by DON/Designee to QAPI x 3 months to insure ongoing substantial compliance.	

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Observations made of Resident #38 01/31/19 at 5:43 PM revealed verbal behaviors directed towards staff that included cursing and yelling at them. No physical behaviors by Resident #38 were noted towards staff or other residents. An interview with Resident #38 was unsuccessful as her cognitive state prevented Resident #38 from following the line of questioning.

An attempt to interview NA #1 on 01/31/19 at 1:42 PM proved unsuccessful.

An interview with NA #2 on 01/31/19 at 11:33 AM revealed she was in the shower room with NA #1, NA #3 and Resident #38. NA #2 reported that she observed NA #1 bend down to move a foot pedal on Resident #38's wheelchair when Resident #38 kicked NA #1. NA #2 then observed NA #1 push Resident #38 back in her wheelchair, then stand up grab Resident #38's arms and heard NA #1 tell Resident #38 that she would not hit him again. NA #2 stated she immediately intervened and told NA #1 to leave and once he left she went and told her supervisor, Nurse #1. She reported Nurse #1 immediately sent NA #1 home. She reported Resident #38 had a skin tear to her left forearm which was treated. She reported she had not seen NA #1 since the incident. During a follow up interview with NA #2 on 01/31/19 at 1:39 PM she reported that she observed Resident #38 kick NA #1 in the face, and after NA #1 was kicked in the face, NA #2 observed NA #1 to stand up and grab both of Resident #38's arms, crossed them and held them against her chest while yelling that she would not hit him again. She reported it was her belief the skin tear to Resident #38's forearm came when NA #1 grabbed Resident #38's arms and held them to her chest. She reported when

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NA #1 pushed Resident #38 pushed her in her wheelchair into a linen cart she came into contact with the linen cart on her right side and the skin tear was noted on her left forearm.

A review of NA #3's written and signed statement dated revealed she was in the shower room at the time of the incident in which NA #1 pushed, grabbed Resident #38's arms and yelled at Resident #38. NA #3's written statement specified she heard NA #1 state to Resident #38 "you're not gonna kick me" then she reported hearing an unknown collision. She reported never visually seeing the incident.

An interview with NA #3 was attempted on 01/31/19 at 10:59 AM and was unsuccessful. Contact with NA #3 proved unsuccessful after several attempts to reach her during the survey.

An interview with Nurse #1 was attempted on 01/31/18 at 11:44 AM which was unsuccessful.

During an interview with the Director of Nursing (DON) on 01/31/18 at 2:51 PM she reported she was made aware of the incident of NA #1 abusing Resident #38 on 12/26/18 when she arrived at the facility at 8:00 AM on 12/26/18. She reported the incident occurred before she arrived and to her knowledge it was reported that NA #1 became frustrated with Resident #38 and grabbed both of her arms and pushed Resident #38. She reported She reported that NA #2 immediately stepped in and told NA #1 to leave and reported it to her supervisor (Nurse #1) who immediately sent NA #1 home. She reported NA #1 was familiar with Resident #38 and her behaviors and he should have been aware of appropriate interventions to utilize to redirect or attempt to

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calm Resident #38. The DON verified Resident #38 had been noted with a skin tear to her left forearm after the incident that was treated.

An interview with the Administrator on 01/31/18 at 3:11 PM revealed she was made aware of the incident of NA #1 abusing Resident #38 during the morning of 12/26/18. She reported to her knowledge Resident #38 kicked NA #1 in the face while he was preparing to shower her and he retaliated, pushed her into a linen cart, grabbed her arms and yelled at her that she would not hit him again. She reported it was immediately reported and NA #1 was sent home by Nurse #1. She stated NA #1 was very familiar with Resident #38, her behaviors and should have known appropriate intervention to take when Resident #38 began with abusive behaviors. She reported she immediately began an investigation into the incident, and substantiated the allegation due to there being an eyewitness and terminated NA #1. She reported when she spoke with NA #1 about the incident he denied it happening as reported and stated that he politely asked Resident #38 to stop hitting him. She stated NA #1 did not return to the facility during the investigation and only returned long enough to be informed that the allegation was substantiated and he was terminated. She reported while he was in the building he was escorted and had no contact with any of the residents. She reported it was absolutely unacceptable to ever grab a residents arms, cross them and hold them to a resident's chest if the resident was lashing out at a staff member. She reported, once he got kicked he should have backed off, stepped away and asked for another staff member to step in and attempt to provide care.

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The Administrator was notified of Immediate Jeopardy on 01/31/19 at 6:41 PM.

The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 02/01/19 at 4:11 PM.

Credible Allegation of Immediate Jeopardy removal
F-600

FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

Resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 12/26/2018 at approximately 7:00 am, Resident #1 was taken into the shower room, Nurse Aide (NA) #2 stated that Nurse Aide (NA) #1 was trying to adjust the foot rest on the shower chair when Resident #1 kicked (NA) #1in the face. (NA) #1 grabbed the shower chair and pushed it into the linen barrels. Resident #1 then tried to hit (NA) #1 when he grabbed both of her arms, held them to her chest, and proceeded to yell and curse at her. At this time Nursing Aide (NA) #2 took over caring for Resident #1 and

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(NA) #1 left the shower room.

On 12/26/2018 at approximately 7:20 am (NA) #1 was sent home by the supervisor and placed on suspension (officially terminated on 12/28/2018) after exiting the shower room (NA) #1 was accompanied by the nursing supervisor and escorted out of the building.

On 12/27/2018 at approximately 3:00 pm (NA) #1 was interviewed. He stated on 12/26/18 he assisted resident #1 with a shower. While taking Resident #1 to the bathroom the resident kicked (NA) #1 in the face. As (NA) #1 was moving away, the resident was swinging multiple times at (NA) #1. (NA) #1 said to Resident #1 "would you please stop hitting me", at that time (NA) #1 noticed a skin tear to Residents #1 left forearm. (NA) #1 made no mention of being tired or frustrated at the time of the incident.

On 12/26/2018 at approximately 7:30 AM statements from (NA) #2 and NA #3 were was obtained by the DON. Nursing Aide (NA) #3 provided a statement that she was showering another resident in another stall and did not visually witness any actions but did hear (NA) #1 say "you are not going to kick me" and a noise of something ramming against something else. (NA) #2 stated that (NA) #1 was trying to adjust the foot rest on the shower chair when Resident #1 kicked (NA) #1in the face. (NA) #1 grabbed the shower chair and pushed it into the linen barrels. Resident #1 then tried to hit (NA) #1 when he grabbed both of her arms, held them to her chest, and proceeded to yell and curse at her.

On 12/26/2018 after leaving the shower room the treatment nurse assessed Resident #1 for injury

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and noted two skin tears, one on each forearm, that were cleansed and a dressing applied.

On 12/26/2018 at approximately 8:30am the Licensed Nursing Home Administrator (LNHA) was notified of the occurrence. At this time statements were reviewed and the collection of facts began.

On 12/26/2018 at approximately 9:25 am the LNHA interviewed Resident #1 and she reported that someone yelled at her and held her arms.

On 12/26/2018 at approximately 10:21 am the initial allegation was faxed to DHHS for review.

NA #1 returned to the facility on 12/27/2018. NA # 1 entered the building and immediately was taken into the LNHAs office where his statement was written. NA # 1 was notified at that time that his employment was terminated. The LNHA then escorted NA # 1 out of the building.

Law enforcement was not contacted at the time of the incident. On 2/1/2019 McDowell County Sheriff's Department was notified.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 12/27/2018 the DON, staff development coordinator and LNHA began to round the building using an Abuse/Neglect Questionnaires to interview all alert and orientated residents. The questionnaire revealed no further resident's allegations of abuse.

On 12/28/2018 the DON, staff development

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coordinator and LNHA interviewed all residents which also revealed no further allegations of abuse.

Skin assessments were completed by the licensed nurses, by 12/29/2018 on all cognitively impaired residents. Residents were assessed for injuries or possible physical abuse with no concerns noted.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

On 1/31/2019 the Clinical coordinator, DON, Charge nurse and LNHA initiated small group meetings with 100% of staff, to include Nursing, dietary, laundry, housekeeping and maintenance department discussed the facility's policy and procedures on abuse, abuse reporting, definition of abuse, mistreatment of residents, staff responsibility to report and zero tolerance resident abuse. Education was presented to all staff in the facility at that time. No staff will be allowed to work until participating in the small group discussions on abuse, types of abuse and reporting abuse. The small group meetings will be completed by 2/1/2019. The discussion and in-service will be added to new employee orientation. All staff to include Nursing, dietary, laundry, housekeeping and maintenance department receive "Hand in Hand", "Understanding the world of dementia" and "The person and the disease" annually.

Starting on 2/1/2019 the Social Worker (SW) will do weekly rounds asking interview able residents if staff are not abusing resident but treating residents with dignity and respect. The weekly

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SW rounds will be completed for 6 months and the results taken to the monthly QAPI meetings for review and further recommendations.

Starting on 2/1/2019, the administrative nursing staff will monitor direct resident care and observe residents for injuries of unknown origin. 10 % of residents will be observed daily from varied shifts x 4 weeks, then weekly x 4 weeks, then monthly for 6 months to ensure no abuse is occurring. Starting on 2/1/2019, the audit results will be taken to the QAPI meeting monthly for discussion and further recommendations.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

On 2/1/2019, the DON and LNHA notified the daily quality assurance and performance improvement (QAPI) team. The facilities Medical Director was made aware of the plan February 1, 2019 and approved. The daily QAPI team's role in this plan of correction includes implementation and monitoring, ensuring the interventions are effective.

Beginning 2/1/2019, The Social Worker will do weekly rounds asking interviewable residents if staff are being good to the residents for 6 months. In addition, beginning on 2/1/2019, The Administrative nursing staff will monitor direct care of 10% of resident's daily from varied shifts for 4 weeks, then weekly for 4 weeks, and then monthly for 6 months starting 2/1/2019 to ensure no abuse is occurring. The results of the audits

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will be presented to QAPI team each week for 6 months.

The daily QAPI team's role in this plan of correction includes implementation and monitoring, ensuring the interventions are effective. The QAPI team will also make recommendations for revisions as needed. The daily QAPI review findings will be brought to the next monthly QAPI meeting on February 13, 2019 for additional review and recommendations. The results of the audits will be presented to QAPI team each week for 6 months.

Beginning 2/1/2019, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained.

Deer Park Health and Rehabilitation alleges compliance of removal of IJ as of 2/1/2019.

Immediate Jeopardy was removed on 02/01/19 at 7:34 PM when interviews with direct care staff, administrative staff and non-nursing staff confirmed they had received in-service training on the facility's Abuse Policy and other interventions spelled out in the Assurance of Compliance were verified in place.

2. Resident # 90 was admitted to the facility on 12/27/18 with a diagnosis of hypertension, diabetes mellitus, cerebrovascular accident, non-Alzheimer's dementia, and muscle weakness.

The admission Minimum Data Set (MDS) dated 01/03/19, noted Resident #90 to be moderately cognitively impaired. The MDS further revealed

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Resident #90 required extensive, two-person assistance with all activities of daily living (ADL).

Review of the nursing note dated 01/28/19 at 12:00 PM written by Nurse #1 revealed Resident #90 was found lying on the floor. Resident #90 stated he told staff 9 times that he wanted to go to bed and that was why he had fallen into the floor. The note revealed Physician #1 was in the facility and notified of Resident #90's fall.

Review of nursing note dated 01/28/19 at 3:30 PM revealed Physician #1 had examined Resident #90 and new orders had been obtained to initiate 2 liters of intravenous fluid and lab work for the morning of 1/29/19.

Review of the nursing note dated 01/29/19 at 5:00 PM written by Nurse #1 revealed Resident #90 had a temperature of 101 degrees. The note further revealed Resident #90 had stated to the nurse,"he did not feel like he was breathing good enough" and had a poor appetite.

Review of the Physician Standing Orders revealed orders to notify the physician for a fever of 100.0 or greater. The review further revealed an order to start supplemental oxygen at 2 liters/min for shortness of breath for a duration of 72 hours and to notify the physician.

Review of the Medication Administration Record (MAR) for Resident #90 revealed an order initiated on 01/15/19 for Tylenol 650mg scheduled to be administered three times daily at 10:00 AM, 4:00 PM and 12:00 AM. The review revealed on 01/29/19 Nurse #1 had not initialed giving Resident #90 his scheduled 4:00 PM dose.

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Review of Nursing Note dated 01/29/19 at 7:30PM written by Nurse #3 revealed Resident #90's wife had requested he be sent to the Emergency Room (ER) for an evaluation. The note revealed Nurse #3 called the physician and obtained orders to send Resident #90 to the Emergency Room (ER).

On 1/31/19 at 2:18 PM an interview was conducted with Nurse Aide (NA) #1 and revealed she had been responsible for Resident #90 on 01/29/19 7:00 AM to 3:00 PM first shift. NA #1 stated Resident #90 had been restless with an elevated temperature of 101.0 on the morning of 1/29/19 which she stated she reported to Nurse #1.

On 1/31/19 at 4:08PM an interview was conducted with Nurse #1. The interview revealed she had been Resident #90's nurse on 01/29/19 for first shift 7:00 AM to 3:00 PM. Nurse #1 stated Resident #90 had an elevated temperature greater than 100.0 on the morning of 01/29/19 for which she administered his regular dose of ordered Tylenol 650 mg at 10:00 AM and rechecked the resident's temperature in which she could not recall the result. She stated Resident #90 had been anxious and told her he wasn't able to catch his breath with an oxygen saturation of 89%. Nurse #1 stated she did not give Resident #90 any supplemental oxygen per physician standing orders because his oxygen saturation had increased to 91% while she was in the room with Resident #90. The interview revealed Resident #90's morning vital signs had not been documented, the physician had not been notified, nor had Nurse #1 assessed Resident #90 after her second medication pass at 2:00PM on 01/29/19 because her shift was

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ending.

On 1/31/19 at 04:46 PM an interview was conducted with Nurse #2. The interview revealed he had received report from Nurse #1 on 01/29/19 at 4:30PM. Nurse #2 stated he was not informed of Resident #90's complaints of shortness of breath, or elevated temperature. Nurse #2 did not assess Resident #90. The interview revealed Nurse #2 normally did not work on the North side of the facility in which Resident #90 was located due to short staffing. Nurse #2 did not assess Resident #90 because no issues were reported from Nurse #1.

On 1/31/19 at 4:56 PM an interview was conducted with Nurse #3. Nurse #3 stated she had received report from Nurse #2 on 01/29/19 at 6:00PM and was notified of Resident #90's lab results. Nurse #3 stated she received the critically low carbon dioxide level, this is when the body fails to remove carbon dioxide through the lungs or the kidneys or perhaps because of an electrolyte imbalance, particularly a deficiency of potassium, of 16 mEq/L for Resident #90 and informed the physician at 6:50 PM. Nurse # 3 stated Resident #90's wife came to the nurse ' s desk at 7:30 PM requesting her husband to be sent to the ER because she thought he had pneumonia. Nurse #3 stated she did not go to Resident #90's room to assess him due to him being sent to the emergency room at the wife's request. The interview revealed Nurse #3 did not leave the nurse station, Resident #90's wife dressed him and brought him to the nurse' s station awaiting Emergency Medical Service (EMS) arrival.

Review of the EMS report dated 01/29/19 at 7:35

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PM revealed Resident #90 had a temperature of 100.0. The report revealed Resident #90 had been placed on 4 Liters of supplemental oxygen by EMS staff. The EMS assessment revealed Resident #90 had wheezing in all lobes, was tachypneic, breathing abnormally fast, and showing signs of sepsis with an oxygen saturation reading of 91%.

Review of the Hospital Discharge Summary dated 1/29/19 revealed diagnoses including hypoxemic respiratory failure, multifocal pneumonia and lactic acidosis.

On 2/01/19 at 8:41AM an interview was conducted with the Director of Nursing (DON). The DON stated her expectations were for the nurse to have notified the physician of Resident #90's elevated temperature on 1/29/19 and to have initialed the scheduled 4:00PM dose of Tylenol as ordered. She stated her expectations were for the nurse to follow facility protocol and physician standing orders.

On 2/01/19 at 10:10AM an interview was conducted with Physician #1. Physician #1 stated he had not been notified on 1/29/19 of Resident #90's shortness of breath or elevated temperature but had seen Resident #90 on the dates of 1/25/19 and 1/28/19. The interview revealed Physician #1 had been notified of Resident #90's abnormal lab result on 1/29/19 at 6:50 PM in which he initiated orders to obtain a repeat basic metabolic panel (BMP) on the morning of 1/30/19. Physician #1 was notified at 7:30 PM of Resident #90's wife's request for the resident to be sent to the emergency room. The interview revealed his expectations were for the Nurse to administer medications as ordered and

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to follow facility protocol.

3. Resident #309 was admitted to the facility on 11/02/18 with diagnoses which included urinary tract infection, altered mental status and dementia.

The admission comprehensive Minimum Data Set (MDS) assessment dated 11/09/18 revealed Resident #309 was Hispanic and spoke little English, had short and long term memory problems and had modified independence with daily decision making skills. The MDS also indicated Resident #309 was ambulatory on and off the unit without physical assistance from staff and displayed no verbal or physical behaviors.

Review of Resident #309's current undated Care Plan indicated in part that he had a history of violent behavior prior to admission. The established goal was for Resident #309 to have no injuries related to medication usage or side effects through the next review dated 02/13/19. The interventions included to give Resident #309 his medications as ordered by the physician, discuss the side effects of the medications with him and his family, and to monitor him for adverse side effects of his medications, report the adverse side effects to the physician and to monitor his behaviors.

Review of Resident #309's Nurse's Notes from 11/02/18 to 11/26/18 had no documentation of aggressive behavior.

Resident #207 was admitted to the facility on 11/08/18 with diagnoses which included coronary artery disease and renal insufficiency.

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The admission comprehensive MDS dated 11/15/18 revealed Resident #207 was cognitively intact, displayed no verbal or physical behaviors and ambulated on and off the unit without physical assistance from staff.

Review of Resident #207's current Care Plan revealed no care plans developed for aggressive behaviors.

Review of Resident #207's Nurse's Notes from 11/08/18 to 11/26/18 had no documentation of aggressive behavior documented.

Review of Resident #309's Nurse's Note dated 11/27/18 at 8:50 PM completed by Nurse #5 revealed, Nurse #5 heard Resident #207 yell "that's my phone". Upon entering the Resident's room she observed Resident #309 standing face to face to Resident #207 saying "television". Resident #207 handed the television remote to Resident #309 and Resident #309 threw the remote to the floor. Resident #207 told Nurse #5 that he could not understand what Resident #309 was saying to him and that he would not sleep in the room with Resident #309 another night. The Nurse's note indicated Nurse #5 moved Resident #309 to another room for the night and the situation could be dealt with on a more permanent basis the following morning. The note also indicated the Director of Nursing (DON) along with the Resident's responsible parties and their physicians were notified.

Review of the facility Incident Report (IR) dated 11/27/18 at 8:50 PM completed by Nurse #5 revealed, Nurse #5 heard Resident #207 yell "that's my phone". Upon entering the Resident's room she observed Resident #309 standing face

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to face to Resident #207 saying "television". Resident #207 handed the television remote to Resident #309 and Resident #309 threw the remote to the floor. Resident #207 told Nurse #5 that he could not understand what Resident #309 was saying to him and that he would not sleep in the room with Resident #309 another night. The IR indicated Nurse #5 moved Resident #309 to another room for the night and the situation could be dealt with on a more permanent basis the following morning. The IR also indicated the Director of Nursing (DON) along with the Resident's responsible parties and their physicians were notified.

Review of Resident #309's nurse's note dated 11/28/18 7:45 AM completed by Nurse #6 indicated she heard Resident #207 yell and upon entrance to the room she observed Resident #207 with his hands around Resident #309's neck and pushed him backwards to the floor with Resident #309 hitting his head on the bed frame. The nurse's note also indicated Nurse #6 checked Resident #309's head for injuries which there were none but because Resident #309 complained of a headache he was sent to the Emergency Department (ER) for assessment.

Review of Resident #309's Physician order dated 11/28/18 indicated an order to send Resident #309 to the ED.

Review of Resident #309's progress notes from the ED visit on 11/28/18 indicated an X-ray of Resident #309's head was obtained which showed a contusion. The progress notes indicated Resident #309 was transferred back to the facility without any treatment necessary.

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Review of an Internal Investigation Report (IIR) completed by the facility on 12/03/18 revealed, on 11/28/18 at 9:00 AM Resident #207 was observed with his hands around Resident #309's neck and aggressively pushed Resident #309 across the room which caused him to fall backwards hitting his head on the bed frame. The IIR indicated Resident #309 was sent to the ED for evaluation and treatment.

On 01/31/19 at 6:02 PM an interview was conducted with the Social Worker (SW) who explained on the morning of 11/28/18 the management team was made aware of the verbal incident between Residents #309 and Resident #207 the night before and that Resident #309 was initially moved to a different room until a more permanent solution could be implemented. The SW stated during the management meeting they were informed of a physical altercation between Resident #309 and Resident #207 and went to Resident #309 and Resident #207's room and found the altercation had already taken place. Resident #207 was sitting in his wheelchair in the hall while staff were in the room assisting Resident #309 out of the floor. The SW indicated during an interview with Resident #207 afterwards he stated he was in the bathroom when Resident #309 opened the bathroom door and said something he could not understand that made him feel threatened. Resident #207 stated he came out of the bathroom and shoved Resident #309 backwards and Resident #309 fell to the floor. The SW stated the decision was made to move Resident #207 to a room on a different hallway where their paths would not cross and on 12/08/18 Resident #207 had a planned discharge home. The SW added the residents had been roommates since Resident #207 was admitted on

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11/08/18 and there had been no adverse situations between them that she was aware of.

During an interview on 02/01/19 at 8:58 AM with Nurse #6 she stated she was on the hall the morning of 11/28/18 and heard Resident #207 yelling and she went to his room and observed Resident #207 with his hands around Resident #309's neck and pushed him backwards to the floor in which Resident #309 hit his head on the bed frame. Nurse #6 stated she immediately went to Resident #309 who was on the floor and by that time other staff members were there to intervene with Resident #207 and took him out of the room. Nurse #6 stated they assisted Resident #309 out of the floor and she assessed the back of his head but there were no apparent injuries. Nurse #6 stated Resident #309 complained of a headache and was sent to the ED for evaluation but returned shortly afterwards with a diagnosis of a contusion but had no new orders to follow. Nurse #6 added she worked with the two residents frequently and was not aware of any negative situations between the two before that day. Nurse #6 added Resident #207 was moved to a room in a different part of the facility away from Resident #309 that day and did not think the two residents ever saw each other again.

On 02/01/19 at 11:00 AM during an interview with the DON she stated she was made aware of the verbal incident between Residents #309 and #207 the night of 11/27/18 by Nurse #5 and agreed with the decision to move Resident #309 to a different room until a more permanent solution was reached. The DON stated she instructed the Nurse to pass along the incident to the Administration the next day because she was out of town.

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On 02/01/19 at 1:45 PM during an interview with Nurse Aide (NA) #5 she explained that on the morning of 11/28/18 she and a coworker heard someone yell "they are fighting" and ran to the room where they observed Resident #309 lying in the floor. NA #5 stated Nurse #6 was already in the room and was assessing Resident #309 while she and her coworker removed Resident #207 from the room. NA #5 stated that afterwards Resident #309 told them he was looking for his shoes and went to his room to get them. NA #5 stated Resident #309 was sent to the ED and came back to the facility later that day and was separated from Resident #207 until Resident #207 was moved to a different room. NA #5 also indicated she was not aware of any time the two roommates did not get along.

During an interview on 02/01/19 at 2:40 PM NA #6 stated she heard someone yell "they are fighting" and ran down to the room. She stated Nurse #6 was already in the room standing between Resident #309 who was on the floor and Resident #207 who was standing behind the Nurse. Resident #207 stated he was in the bathroom and Resident #309 came in on him and he thought Resident #309 was going to attack him. NA #6 stated they took Resident #207 out of the room until they got Resident #309 out of the floor and assessed him then took Resident #309 to the dayroom for his breakfast before they sent him to the ED. NA #6 stated Resident #207 was transferred to a different room away from Resident #309. The NA also stated she was not aware of any previous verbal or physical situation between the two roommates before 11/28/18.

An interview was conducted on 02/01/19 at 5:50

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F 600	Continued From page 31 PM with the Administrator who stated she was made aware of the verbal and physical incident between Resident #309 and Resident #207 in the early morning of 11/28/18. The Administrator explained that she agreed with the decision to initially move Resident #309 out of the room the night of the verbal altercation on 11/27/18 but before permanent plans could be made the incident of the physical altercation happened early the next morning. The Administrator stated the Police were notified because Resident # 207 was cognitively intact and by his admission had shoved Resident #309 to the floor. The Administrator stated the Police investigated the incident that day and determined Resident # 309's Responsible Party (RP) would have to file charges against Resident #309 but Resident #309's RP was in Raleigh and declined to file charges. The Administrator stated the facility also conducted an internal investigation and substantiated the incident. The Administrator stated Resident #207 was moved to another room on a different hallway away from Resident #309 and remained in that room until he was discharged home on 12/08/18. The Administrator indicated the incident between the two roommates was unforeseen because neither resident had given any indication of negative behaviors toward each other or any other resident since being at the facility.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		3/1/19

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F 607	Continued From page 32 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy when they failed to notify local law enforcement after an allegation of abuse when Nurse aide (NA) #1 grabbed Resident #38 by the arms, yelled at her and pushed her while seated in a wheel chair into a linen cart (Resdent #38). The facility also failed to notify the State Agency of an allegation of resident to resident abuse when Resident #309 was pushed to the floor by Resident #207, within the 2 hour time frame for 2 of 4 sampled residents reviewed for abuse (Resident #309). Findings included: 1. A review of the facility's policy entitled "Abuse Prevention" which was last revised on 04/10/17 read, in part, all alleged violations involving abuse, neglect or exploitation are reported immediately with notification to the legal guardian, spouse or responsible family member or significant other of the alleged or suspected abuse, neglect or mistreatment and notification of the physician within 24 hours. Further review of the policy indicated contact with local law enforcement was to be initiated as required by state law. Resident #38 was admitted to the facility on	F 607	1.)Facility failed to implement written policies regarding the prevention of abuse, neglect and exploitation of residents and failed to provide training as required by state regulation. Resident # 38 received a skin tear following an altercation with a staff member, resident #309 and resident #207 were involved in a resident to resident altercation over a telephone/tv remote issue. Per facility protocol, law enforcement is to be notified following any allegation of staff to resident abuse and the resident to resident altercation is reportable to the State Agency within two hours of the alleged incident. 2.)All residents have the potential to be adversely effected by this deficient practice. 100% of facility staff, including new hires and any agency staff used have been educated on the facility policy and procedure when dealing with allegations of abuse, neglect or exploitation of residents by 2/6/2019, which included who to report alleged incidents to, who the abuse coordinator is, who else is notified and under what times frames. This education will be ongoing through the orientation process. 3.) Interviews of cognitive residents and	

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F 607	Continued From page 33 07/12/18 with diagnoses that included dementia without behaviors, cognitive communication deficit, altered mental status, major depressive disorder and anxiety disorder among others. A review of Resident #38's most recent quarterly Minimum Data Set (MDS) Assessment dated 11/09/18 revealed Resident #38 was cognitively impaired for daily decision making and was observed to have verbal and other behaviors directed towards others 1-3 days during the look back period. Resident #38 was coded as being totally dependent with bathing with a 2 person assist. A review of a 24 hour initial report dated 12/26/18 at 8:30 AM with facsimile (fax) confirmation date of 12/26/18 at 11:23 AM revealed two nurse aides (NA #2 and NA #3) observed NA #1 push Resident #38 against a linen cart while he prepared to provide Resident #38 for a bath. The report indicated NA #1 grabbed Resident #38's arms and yelled that she was not going to hit him again. The report further indicated that law enforcement was not notified. A review of the facility's 5 working day report dated 12/28/18 revealed the allegation was investigated by the Administrator and was substantiated. A review of Resident #38's care plan, last updated 12/05/18, revealed care plan areas for verbally abusive behaviors and socially inappropriate and disruptive behavior. Interventions included not to argue with Resident #38, monitor and document behaviors, approach Resident #38 warmly and positively, administer medications as ordered and to allow Resident	F 607	observation of care to the cognitively impaired residents are underway by the DON/Designees daily x 3 weeks, weekly x 4 weeks and monthly x 3 months to prohibit and to insure prevention of any abuse, neglect or exploitation. 4.)Any and all findings are to be reported by the DON/Designees to QAPI monthly x 3 months to insure ongoing substantial compliance to implementation of facility policies regarding prevention and proper reporting of any allegations.	

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#38 to make choices and participate in care.

An interview with Resident #38 was unsuccessful due to her cognitive capacity.

An interview with the Director of Nursing on 01/31/19 at 2:51 PM revealed the Administrator was the facility's abuse coordinator and was responsible for investigating allegations of abuse.

An interview with the Administrator on 01/31/19 at 4:52 PM revealed she had not reported the incident when NA #1 pushed, grabbed and yelled at Resident #38 to local law enforcement and did not have an explanation on why she did not report it. She reported once she finished her investigation she should have reported it to the local law enforcement agency. She stated she did not know if the facility's Abuse Policy dictated when law enforcement should be called.

2. Resident #309 was admitted to the facility on 11/02/18 with diagnoses which included urinary tract infection, altered mental status and dementia.

The admission comprehensive Minimum Data Set (MDS) assessment dated 11/09/18 revealed Resident #309 was Hispanic and spoke little English, had short and long term memory problems and had modified independence with daily decision making skills.

The MDS also indicated Resident #309 was ambulatory on and off the unit without physical assistance from staff and displayed no verbal or physical behaviors.

Resident #207 was admitted to the facility on

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11/08/18 with diagnoses which included coronary artery disease and renal insufficiency.

The admission comprehensive MDS dated 11/15/18 revealed Resident #207 was cognitively intact, displayed no verbal or physical behaviors and ambulated on and off the unit without physical assistance from staff.

Review of Resident #309's nurse's note dated 11/28/18 7:45 AM completed by Nurse #6 indicated she heard Resident #207 yell and upon entrance to the room she observed Resident #207 with his hands around Resident #309's neck and pushed him backwards to the floor with Resident #309 hitting his head on the bed frame.

Review of an Internal Investigation Report (IIR) completed by the facility on 12/03/18 revealed, on 11/28/18 at 9:00 AM Resident #207 was observed with his hands around Resident #309's neck and aggressively pushed Resident #309 across the room which caused him to fall backwards hitting his head on the bed frame. The IIR indicated Resident #309 was sent to the ED for evaluation and treatment.

Review of the Initial Allegation Report (IAR) revealed the incident date was 11/28/18 and the time the facility became aware of the incident was 9:00 AM.

Review of the Facsimile Transmittal Form revealed the IAR was faxed to the State Agency on 11/28/18 at 4:09 PM.

An interview was conducted on 02/01/19 at 5:50 PM with the Administrator who explained she was made aware of the physical altercation between

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F 607	Continued From page 36 Resident #309 and Resident #207 in the early morning of 11/28/18. The Administrator added that she did not report the incident to the State Agency within the two-hour time frame because she did not think Resident to Resident Abuse was reportable.	F 607		
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 observation, record reviews, resident and staff interview the facility failed to provide showers as scheduled (Resident # 1, #60, #33, #36, #59 and #89), and failed to provide nail care (Resident #47) for 7 of 7 residents sampled for activities of daily living. The findings included: 1. Resident #1 was admitted to the facility on 05/21/18 with diagnoses that included Heart Failure, Hypertension, Diabetes mellitus, Hyperlipidemia, Hemiplegia and Depression. Review of the Quarterly Minimum Data Set (MDS) dated 01/11/19 revealed Resident #1 was cognitively intact. The MDS further revealed Resident #1 was dependent of staff, requiring two-person assistance for bed mobility, transfers, toilet use and dressing. Resident #1 required extensive assistance of one staff member for bathing.	F 677	1.) Facility failed to provide necessary ADL services to impaired Residents # 1, #60, #33, # 36, # 59.#89 and #47 by failing to give showers as scheduled and to provide nail care. Each resident was provided a shower and nail care prior to survey completion. 2.)100% of residents have the potential to be adversely effected by this deficient practice. All residents will be observed by DON/Designees if cognitively impaired or interviewed if cognitively intact to be sure they are receiving necessary services to maintain good nutrition, grooming, and personal/oral hygiene. 3.)Observations and interviews will be done by DON/Clinical Designees 3 x weekly for 4 weeks, weekly x 4 weeks and monthly x 3 months to insure appropriate and adequate support to maintain ADL care including showers when scheduled and nail care as needed. In services to 100% licensed clinical staff were	3/1/19

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F 677	Continued From page 37 On 1/29/19 at 9:35AM an interview was conducted with Resident #1. The interview revealed she had not received a shower in 2 weeks prior to the morning of 1/29/19. A follow up interview conducted on 2/01/19 at 11:01AM revealed Resident #1 felt ashamed of herself due to not being provided with a shower as scheduled. Review of Resident #1's January 2019 activities of daily living (ADL) flowsheet revealed the resident had received showers on the dates of 1/1/19, 1/3/19, 1/10/19, 1/12/19, 1/15/19 and 1/29/19. The review revealed Resident #1 had not received a shower during the two-week period of 1/15/19 to 1/29/19. On 1/30/19 at 10:47AM an interview was conducted with Nurse Aide (NA) #2. The interview revealed she had worked in the facility for 6 years. The interview revealed the facility no longer had a shower team and the NAs on the hall did not have enough time to give the residents showers due to short staffing. The interview revealed residents often go extended periods of time without showers due to staffing. On 1/31/19 at 8:30 AM an interview was conducted with NA # 3. The interview revealed she had worked in the facility for 11 years. The interview revealed due to short staffing, residents were not receiving their scheduled showers. The interview revealed Resident #1 had not been given a shower for an extended period. On 2/1/19 at 11:31AM an interview was conducted with the Director of Nursing. The interview revealed her expectations were for residents to receive a minimum of 2 showers per	F 677	completed 2/6/2019 regarding provision of adequate and timely ADL care. Newly hired clinical staff will be trained and a shower team reinstituted to provide showers and ADL care on a timely basis. 4.)All observations and interviews will be reported to QAPI by DON/Designees x 3 months to insure ongoing substantial compliance.	

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week.

On 2/1/19 at 3:58PM an interview was conducted with the Administrator. The interview revealed she had attempted to schedule a shower team however the NAs scheduled were pulled to work on the resident halls due to short staffing. She stated her expectations were for residents to get their showers as scheduled and a minimum of once per week. She stated it was not acceptable for the NAs to let a resident go without a shower.

2. Resident #60 was admitted to the facility on 12/27/18 with diagnoses that included Hypertension, Diabetes mellitus, Hyperlipidemia and Depression.

Review of the quarterly Minimum Data Set (MDS) dated 12/07/18 revealed Resident #60 was cognitively intact. The MDS further revealed Resident #60 required extensive, one- person assistance for bathing and was independent for bed mobility, dressing and eating.

Review of Resident #60's January 2019 activities of daily living (ADL) flowsheet revealed the resident had received showers on the dates of 1/1/19, 1/4/19, 1/9/19, 1/15/19, 1/18/19, 1/20/19, 1/25/19 and 1/29/19.

On 2/01/19 at 12:03PM an interview was conducted with Resident #60. The interview revealed the residents scheduled shower days were Tuesdays and Fridays however she had not received a shower as scheduled on 2/01/19. The interview revealed Resident #60 had asked staff for her scheduled shower and received a reply of, "nobody is giving showers today". The interview revealed she was upset and felt saddened

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because of not receiving her scheduled shower. The interview revealed Resident #60 hadn't received a shower on Fridays in 3 weeks.

On 2/01/19 at 12:06PM an interview was conducted with NA #2. The interview revealed the facility did not have enough staff to give Resident #60 a shower. The interview revealed she had to tell Resident #60 she could not have a shower due to short staffing.

On 2/01/19 at 12:09 PM an interview was conducted with the Director of Nursing. The interview revealed her expectations were for staff to give Resident #60 her scheduled shower however due to short staffing they couldn't help it.

3. Resident # 33 was admitted to the facility on 8/03/18 with diagnosis that included Hypertension, Hyperlipidemia, Non-Alzheimer's Dementia, Parkinson's Disease, Anxiety and Depression.

Review of the Quarterly Minimum Data Set (MDS) dated 11/08/18 revealed Resident #33 was moderately cognitively intact. The MDS further revealed Resident # 33 was dependent, requiring one-person assistance for bathing and limited assistance of one-person for bed mobility and transfers.

Review of Resident #33's January 2019 ADL flowsheet revealed the resident had received showers on the dates of 1/9/19, 1/16/19, 1/18/19, 1/23/19, and 1/30/19. The review revealed Resident # 33 had only received a total of 5 showers for the month of January when they were supposed to receive 10.

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On 1/30/19 at 10:47AM an interview was conducted with Nurse Aide (NA) #2. The interview revealed she had worked in the facility for 6 years. The interview revealed the facility no longer had a shower team and the NAs on the hall did not have enough time to give the residents showers due to short staffing. The interview revealed residents often go extended periods of time without showers due to staffing.

On 2/1/19 at 11:31AM an interview was conducted with the Director of Nursing. The interview revealed her expectations were for residents to receive a minimum of 2 showers per week.

On 2/1/19 at 3:58PM an interview was conducted with the Administrator. The interview revealed she had attempted to schedule a shower team however the NA's scheduled were pulled to work on the resident halls due to short staffing. She stated her expectations were for residents to get their showers as scheduled

4. Resident #89 was admitted to the facility 03/14/16 with diagnoses including diabetes and non-Alzheimer's dementia.

Review of the quarterly Minimum Data Set (MDS) dated 01/02/19 revealed Resident #89 was moderately impaired for decisions and was totally dependent for bathing.

Review of Resident #89's care plan most recently updated 01/08/19 for activities of daily living (ADL) revealed he was to receive assistance with his shower on shower days and as needed.

An observation of Resident #89 on 01/30/19 at

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2:13 PM revealed his hair appeared uncombed and his face was oily.

An observation on Resident #89 on 01/31/19 at 10:28 PM revealed his hair appeared uncombed and his face was oily.

Review of the bathing record for January 2019 for Resident #89 revealed he only received 2 showers in January. Resident #89 received a shower on 01/07/19 and 01/10/19 on the 7:00 AM to 3:00 PM shift. The rest of the shower record for January 2019 revealed showers were documented as having not occurred.

An interview with the Director of Nursing (DON) on 01/31/19 at 4:42 PM revealed if the shower record contained the number "8" that meant bathing did not occur. The DON stated if bathing was refused it was recorded as an "R" on the bathing log. The DON stated based on the January 2019 bathing record it appeared Resident #89 only had 2 baths that month. The DON stated she would do some checking to see if she could find supplemental documentation to show additional baths had occurred.

An interview with NA #1 on 02/01/19 at 12:20 PM revealed if the shower record contained the number "8" on the log it meant bathing did not occur. NA #1 stated if a resident refused a shower it was recorded as an "R" on the bathing log. NA #1 reviewed the bathing log for Resident #89 and confirmed the he received 2 showers for the month of January 2019. NA #1 stated staff did the best they could but they could not do showers as scheduled due to not enough staff.

A follow up interview with the DON on 02/01/19

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12:28 PM revealed she could not find any supplemental documentation that additional bathing had occurred for Resident #89. The DON stated she felt it was unacceptable for residents to receive 2 showers a month. The DON stated she expected residents to receive at least 2 showers a week and more as needed or as requested. The DON stated the facility did not have enough staff to provide showers as needed.

5. Resident #59 was initially admitted to the facility 11/16/18 with diagnoses including heart failure, neurogenic bladder, and muscle weakness.

Review of the admission Minimum Data Set (MDS) dated 12/06/18 revealed Resident #59 was cognitively intact and required extensive assistance with dressing and personal hygiene. The MDS also revealed Resident #59 had not had a bath during the assessment period.

Review of Resident #59's care plan for ADL dated 11/29/18 revealed the facility was to assist Resident #59 with bathing twice a week.

Review of the shower record for Resident #59 for January 2019 revealed he received a shower on the 3:00 PM to 11:00 PM shift on 01/02/19. Resident #59 received a shower on the 7:00 AM to 3:00 PM shift on 01/13/19, 01/16/19, and 01/23/19. The rest of the shower record for January 2019 revealed showers were documented as having not occurred.

An interview with Resident #59 on 01/29/19 at 10:00 AM revealed he wanted to get a shower twice a week but that did not always happen. Resident #59 stated there was not always enough

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staff to give him a shower twice a week.

An interview with NA #9 on 01/29/19 at 10:11 AM revealed the facility was short staffed and residents did not always get their showers like they were supposed to.

An interview with the Director of Nursing (DON) on 01/31/19 at 4:42 PM revealed if the shower record contained the number "8" that meant bathing did not occur. The DON stated if bathing was refused it was recorded as an "R" on the bathing log. The DON stated based on the January 2019 bathing record it appeared Resident #59 only had 4 baths that month. The DON stated she would do some checking to see if she could find supplemental documentation to show additional baths had occurred.

A follow up interview with the DON on 02/01/19 12:28 PM revealed she could not find any supplemental documentation that additional bathing had occurred for Resident #59. The DON stated she expected residents to receive at least 2 showers a week and more as needed or as requested. The DON stated the facility did not have enough staff to provide showers as needed.

6. Resident #36 was admitted to the facility 09/13/18 with diagnoses including non-Alzheimer's dementia and muscle weakness.

The significant change Minimum Data Set (MDS) dated 11/09/18 revealed Resident #36 was cognitively intact and required extensive assistance with dressing and personal hygiene. The MDS also stated Resident #36 was totally dependent for bathing.

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Review of Resident #36's care plan for ADL last updated 12/20/18 stated Resident #36 was to receive assistance with bathing.

Review of the January 2019 shower record for Resident # 36 revealed she received a shower on the 7:00 AM to 3:00 PM shift on 01//1/19. Resident #36 received a shower on the 3:00 PM to 11:00 PM shift on 01/13/19 and 01/22/19. Resident #36 refused a shower on 01/04/19. The rest of the shower record for January 2019 revealed showers were documented as having not occurred.

An interview with NA #9 on 01/29/19 at 10:11 AM revealed the facility was short staffed and residents did not always get their showers like they were supposed to.

An interview with Resident #36 on 01/29/19 at 3:05 PM revealed she would like to receive a shower at least once a week but she did not always get a shower once a week.

An interview with the Director of Nursing (DON) on 01/31/19 at 4:42 PM revealed if the shower record contained the number "8" that meant bathing did not occur. The DON stated if bathing was refused it was recorded as an "R" on the bathing log. The DON stated based on the January 2019 bathing record it appeared Resident #36 only had 3 baths that month. The DON stated she would do some checking to see if she could find additional documentation to show additional baths had occurred.

A follow up interview with the DON on 02/01/19 12:28 PM revealed she could not find any supplemental documentation that additional

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bathing had occurred for Resident #36. The DON stated she expected residents to receive at least 2 showers a week and more as needed or as requested. The DON stated the facility did not have enough staff to provide showers as needed.

7. Resident #47 was admitted to the facility on 04/05/18 with diagnoses which included depression.

Review of Resident #47's quarterly Minimum Data Set (MDS) dated 11/16/18 revealed her cognition was moderately impaired, required extensive assistance with her ADLs which included personal hygiene and needed set up assistance only from staff for eating. The MDS also indicated Resident #47 had upper and lower body impairment on one side (right) and had no behaviors of rejecting care.

Review of Resident #47's current Care Plan most recently reviewed by staff 02/04/18 revealed she required staff assistance with all Activities of Daily Living (ADLs). The established goal was that she would be well groomed and free of odors through the next review (02/20/19) by utilizing interventions such as fingernails cleaned and checked during showers, provide assistance as needed for ADLs and to provide assistance as needed to complete ADLs.

Review of Resident #47's ADL flow sheet for the month of 01/2019 indicated an area for "Personal Hygiene" which was marked as care given nearly every shift but no area specific to "Nail Care" was designated on the flow sheet.

Observation on 01/29/19 at 10:59 AM of Resident #47 with partially polished fingernails

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approximately 0.75 of an inch on her left hand and all of which had a brown substance embedded underneath each fingernail.

During an interview with Resident #47 on 01/29/19 at 10:59 AM she stated she liked her fingernails long but that she could not clean them herself and the staff had to clean them for her. The Resident added she did not like for her nails to be dirty.

Observation on 01/29/19 at 12:43 PM Resident #47 in bed feeding herself with her left hand using her fork and her fingers. The brown substance remained under her left hand fingernails.

Observation on 01/31/19 at 8:38 AM Resident #47 in bed feeding herself breakfast. The Resident was observed to put her left forefinger into her bread which had butter and jelly on top of the bread then ate the butter and jelly off of her finger. All of her fingernails on her left hand had a brown substance underneath the nails.

Observation on 01/31/19 at 9:09 AM Patient Care Aide (PCA) #1 went into Resident #47's room to pick up her breakfast tray. The brown substance remains underneath the fingernails of her left hand.

Observation on 01/31/19 at 9:30 AM Nurse #7 went into Resident #47's room to medicate her. The Resident's fingernails remained with a brown substance underneath them.

Observation on 01/31/19 at 11:21 AM Resident #47 up in wheel chair in the hall way holding a pack of crackers in her left hand. The brown substance remained under the fingernails on her

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left hand.

During an interview with Nurse #7 on 01/31/19 at 11:42 AM she confirmed she was responsible for Resident #47 that day and explained Resident #47 required total assistance with her ADLS, made her needs known to staff and was not resistive to care especially nail care. The Nurse stated Resident #47's nail care should be provided during her showers and whenever needed. The Nurse also stated she did not notice that Resident #47's nails were dirty when she medicated her that morning.

Observation on 01/31/19 at 12:05 PM Resident #47 sitting in her wheel chair in her room eating lunch which consists of pork chops, vegetable blend and macaroni and cheese. The Resident was observed to eat with her left hand and fingers. The brown substance remained underneath the finger nails of her left hand.

During an interview with Resident #47 on 01/31/19 at 12:05 PM she stated she did not like for her fingernails to be dirty and that it bothered her that she had to eat with them dirty.

Interview with NA #7 on 01/31/19 at 12:08 PM who confirmed she was taking care of Resident #47 that day and stated Resident #47 liked her fingernails long and polished and received nail care on her bath days which she would often refuse. Observation of Resident #47's fingernails along with NA #7 noted them with the brown substance underneath her fingernails while she ate her lunch. The NA acknowledged the Resident's fingernails were dirty and that she should have noticed how dirty they were when she got the Resident up earlier that morning but

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F 677	Continued From page 48 she was in a hurry because she had a hectic morning. The NA told Resident #47 that she would clean her nails. Interview with Nurse #8 on 01/31/19 at 12:25 PM confirmed she was responsible for Resident #47 and revealed the residents received nail care on their bath days and whenever they needed it. At this time, an observation of Resident #47's fingernails with the brown substance was made with Nurse #8 who stated Resident #47 should not have to eat with her fingernails in the condition they were in and that her expectation was that her face and hands be washed before every meal. The Nurse added that had the NAs washed her face and hands before lunch they would have noticed the brown substance underneath her fingernails and should have cleaned them as well. Interview with the Director of Nursing (DON) on 02/01/19 at 11:09 AM revealed Resident #47 liked her fingernails long and she was proud of them. The DON stated she expected Resident #47's fingernails to be cleaned on her bath days and more often if needed.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		3/1/19

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F 684	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews the facility failed to assess a resident who had shortness of breath and an elevated temperature for 1 of 1 resident reviewed for respiratory distress (Resident #90). Resident # 90 was admitted to the facility on 12/27/18 with a diagnosis of hypertension, diabetes mellitus, cerebrovascular accident, non-Alzheimer's dementia, and muscle weakness. The admission Minimum Data Set (MDS) dated 01/03/19, noted Resident #90 to be moderately cognitively impaired. The MDS further revealed Resident #90 required extensive, two-person assistance with all activities of daily living (ADL). Review of the nursing note dated 01/29/19 at 5:00 PM written by Nurse #1 revealed Resident #90 had a temperature of 101 degrees. The note further revealed Resident #90 had stated to the nurse, "he did not feel like he was breathing well enough" and had a poor appetite. Review of the Physician Standing Orders revealed orders to notify the physician for a fever of 100.0 or greater. The review further revealed an order to start supplemental oxygen at 2 liters/min for shortness of breath for a duration of 72 hours and to notify the physician. Review of the Medication Administration Record (MAR) for Resident #90 revealed an order initiated on 01/15/19 for Tylenol 650mg scheduled to be administered three times daily at 10:00 AM, 4:00 PM and 12:00 AM. The review revealed on	F 684	1.)Facility failed to provide Resident #90 with care in accordance with professional standards of practice as he presented with fever of 101 and orders to notify physician when fever was over 100. On 1/29/19 this resident was transferred to the hospital per his wife's request. PCP sent him per her request. He did not return to the facility. 2.)All residents have the potential to be adversely effected by this deficient practice. DON/Designees began immediate in servicing of 100% of licensed staff to insure compliance with policy and procedure to assess, treat and provide care in accordance with professional standards of practice. This training included proper notification of physician and POA for any significant change in condition and was completed 2/6/19. All new hires and any agency staff used have been in serviced on this policy and POC and this training will continue through the orientation process for ongoing hires and agency. 3.)DON/Designees will review/audit the 24 hour report daily x 4 weeks for any changes in resident condition to insure proper physician/POA notification and to insure care is provided according to professional standards. DON/Designee will also review 100% of telephone orders 3 x weekly x 4 weeks. weekly x 4 weeks and monthly x 3 months to insure deliverance of care according to professional standards of practice. 4.) DON/Designees will present audit	

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F 684	Continued From page 50 01/29/19 Nurse #1 had not initialed giving Resident #90 his scheduled 4:00 PM dose. Review of Nursing Note dated 01/29/19 at 7:30PM written by Nurse #3 revealed Resident #90's wife had requested he be sent to the Emergency Room (ER) for an evaluation. The note revealed Nurse #3 called the physician and obtained orders to send Resident #90 to the Emergency Room (ER). On 1/31/19 at 2:18 PM an interview was conducted with Nurse Aide (NA) #1 and revealed she had been responsible for Resident #90 on 01/29/19 7:00 AM to 3:00 PM first shift. NA #1 stated Resident #90 had been restless with an elevated temperature of 101.0 on the morning of 1/29/19 which she stated she reported to Nurse #1. On 1/31/19 at 4:08PM an interview was conducted with Nurse #1. The interview revealed she had been Resident #90's nurse on 01/29/19 for first shift 7:00 AM to 3:00 PM. Nurse #1 stated Resident #90 had an elevated temperature greater than 100.0 on the morning of 01/29/19 for which she administered his regular dose of ordered Tylenol 650 mg at 10:00 AM and rechecked the resident's temperature in which she could not recall the result. She stated Resident #90 had been anxious and told her he wasn't able to catch his breath with an oxygen saturation of 89%. Nurse #1 stated she did not give Resident #90 any supplemental oxygen per physician standing orders because his oxygen saturation had increased to 91% while she was in the room with Resident #90. The interview revealed Resident #90's morning vital signs had not been documented, the physician had not	F 684	findings to QAPI monthly x 3 months to insure ongoing substantial compliance, insuring care continues to be provided according to professional standards of practice.	

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been notified, nor had Nurse #1 assessed Resident #90 after her second medication pass at 2:00PM on 01/29/19 because her shift was ending.

On 1/31/19 at 04:46 PM an interview was conducted with Nurse #2. The interview revealed he had received report from Nurse #1 on 01/29/19 at 4:30PM. Nurse #2 stated he was not informed of Resident #90's complaints of shortness of breath, or elevated temperature. Nurse #2 did not assess Resident #90. The interview revealed Nurse #2 normally did not work on the North side of the facility in which Resident #90 was located due to short staffing. Nurse #2 did not assess Resident #90 because no issues were reported from Nurse #1.

On 1/31/19 at 4:56 PM an interview was conducted with Nurse #3. Nurse #3 stated she had received report from Nurse #2 on 01/29/19 at 6:00PM and was notified of Resident #90's lab results. Nurse #3 stated she received the critically low carbon dioxide level, this is when the body fails to remove carbon dioxide through the lungs or the kidneys or perhaps because of an electrolyte imbalance, particularly a deficiency of potassium, of 16 mEq/L for Resident #90 and informed the physician at 6:50 PM. Nurse # 3 stated Resident #90's wife came to the nurse ' s desk at 7:30 PM requesting her husband to be sent to the ER because she thought he had pneumonia. Nurse #3 stated she did not go to Resident #90's room to assess him due to him being sent to the emergency room at the wife's request. The interview revealed Nurse #3 did not leave the nurse station, Resident #90's wife dressed him and brought him to the nurse's station awaiting Emergency Medical Service

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(EMS) arrival.

Review of the EMS report dated 01/29/19 at 7:35 PM revealed Resident #90 had a temperature of 100.0. The report revealed Resident #90 had been placed on 4 Liters of supplemental oxygen by EMS staff. The EMS assessment revealed Resident #90 had wheezing in all lobes, was tachypneic, breathing abnormally fast, and showing signs of sepsis with an oxygen saturation reading of 91%.

Review of the Hospital Discharge Summary dated 1/29/19 revealed diagnoses including hypoxemic respiratory failure, multifocal pneumonia and lactic acidosis.

On 2/01/19 at 8:41AM an interview was conducted with the Director of Nursing (DON). The DON stated her expectations were for the nurse to have notified the physician of Resident #90's elevated temperature on 1/29/19 and to have initialed the scheduled 4:00PM dose of Tylenol as ordered. She stated her expectations were for the nurse to assess a resident that was having shortness of breath and follow facility protocol and physician standing orders.

On 2/01/19 at 10:10AM an interview was conducted with Physician #1. Physician #1 stated he was not notified on 1/29/19 of Resident #90's shortness of breath or elevated temperature but had seen Resident #90 on the dates of 1/25/19 and 1/28/19. Physician #1 was notified at 7:30 PM of Resident #90's wife's request for the resident to be sent to the emergency room. The interview revealed his expectations were for the Nurse to administer medications as ordered and to notify him of any significant changes in

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F 684	Continued From page 53 condition.	F 684		
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 observations, record review and staff interviews, the facility failed to implement interventions to prevent falls for 2 of 3 residents reviewed for accidents (Resident # 33 and #89). The findings included: 1. Resident #33 was admitted to the facility on 8/03/18 with a diagnosis of non-Alzheimer's dementia, Parkinson's disease, anxiety, depression, restlessness and agitation. Review of the quarterly minimum data set (MDS) dated 11/08/18 revealed Resident #33 was cognitively intact. The MDS further revealed Resident #33 required limited assistance of one staff member for bed mobility and transfers. Resident #33 was independent for walking and locomotion using a wheelchair as a mobility device. The MDS revealed Resident #33 was coded as not steady, but able to stabilize without human assistance moving from a seated position to standing and for walking. Resident #33 was coded as not steady and unable to stabilize	F 689	1.)Facility failed to implement interventions to prevent falls. Resident #33 and #89 had no major injury but repeat falls. Resident #33 had a new fall assessment completed 2/4/2019 and care plans updated to reflect new referral to PT/OT for strengthening exercises and safety training. Following therapy evaluation, it was decided a Geri chair for rest period positioning was a valid intervention to prevent further unsafe attempts by this resident to transfer and ambulate without assistance. Resident #89 is actively dying, on comfort measures only and at present not attempting to transfer or ambulate. 2.)All residents have the potential to be adversely effected by this deficient practice. 100% of all residents have had a new fall assessment completed as of 2/13/2019 and care plans updated to reflect any change in interventions as needed. 3.) DON/Designees began immediate in	3/1/19

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F 689	Continued From page 54 without assistance moving on and off of the toilet and for surface to surface transfers. Resident #33 had experienced two or more falls without injury and two or more falls with injury in which were not coded as being major injury. Review of a care plan dated 1/10/19 read in part, Resident #33 is at risk for falls related to unsteady gait. The goal for Resident #33 was to not sustain a major injury related to falling over next review. Interventions included placing the call bell within reach, cue for safety awareness, assistance from staff and completion of a fall risk assessment. Review of Resident #33's medical record revealed no documented fall risk assessment. Review of the facility incident reports from 10/25/18 to present revealed the following: · The incident report dated 10/25/18 at 7:45 PM revealed a witnessed fall. Resident #33 was standing at the doorway to his room and suddenly dropped onto his buttocks. Immediate action taken to minimize the reoccurrence of falls included: instruct resident to walk behind his wheelchair to maintain proper balance and control. Interventions in place at the time of the fall included non-skid socks. No injuries were noted. · The incident report dated 10/25/18 at 8:00 PM revealed a witnessed fall. Resident #33 was pushing his wheelchair down the hall, pushed the wheelchair handles down to the floor and fell on his knees. Immediate action taken included placing the resident back in his wheelchair. No other interventions were initiated.	F 689	servicing 2/13/2019 of 100 % of facility staff to insure fall policy was implemented appropriately, completed 2/15/2019, which includes all new hires to date and any agency staff used, as well. This education will continue for all new hires and agency use through the orientation process. DON/Designees will audit Incident Reports 5 x weekly for 4 weeks, weekly x 4 weeks and monthly x 3 months to insure fall assessments are completed according to policy and procedure and that the Interdisciplinary Team care plan updates and interventions are followed through with per facility protocol. 4.) All audit results will be reported to QAPI by the DON/Designees x 3 months to insure ongoing substantial compliance to this plan.	

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Interventions in place at the time of the fall included non-skid socks. No injuries were noted.

· The incident report dated 10/25/18 at 8:10 PM revealed a witnessed fall. Resident #33 was walking and pushing his wheelchair when he fell to his knees. Immediate action taken included reeducation to Resident #33 to sit in the wheelchair to propel. Interventions in place at the time of the fall included non-skid socks. No injuries were noted.

· The incident report dated 12/14/18 at 2:00 PM revealed a witnessed fall. Resident #33 stated he had lost his balance and "tipped" over. The report revealed no immediate action taken. A follow up investigation report dated 12/18/18 revealed a new intervention of verbal redirection for the incident. No injuries were noted.

· The incident report dated 12/14/18 at 11:00 PM revealed an unwitnessed fall. Resident #33 was found on the fall mat at his bedside with blood observed on the mat. Resident #33 sustained a bloody nose and "bump" on his head. Immediate action taken included every 15-minute frequent observation of resident for 3 days. Interventions in place at the time of fall included fall mat at bedside. Resident #33 was taken to the hospital for an evaluation.

· The incident report dated 12/16/18 at 9:45 AM revealed a witnessed fall. Resident #33 was observed falling to his knees in the bathroom. No new interventions were initiated on the incident report. A follow up investigation report dated 12/18/18 revealed a new intervention of

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verbal redirection for the incident. The report revealed past interventions included non-slip socks, use of the resident ' s wheelchair to walk and a fall mat. No injuries were noted.

· The incident report dated 1/09/18 at 7:25 AM revealed an unwitnessed fall. Resident #33 was found lying on his fall mat with an abrasion to his forehead. Immediate action taken included instruction to use his wheelchair for support while ambulating. Interventions in place at the time of fall included fall mat at bedside. Noted injuries included a superficial abrasion to residents' forehead.

· The incident report dated 1/09/18 at 12:50 PM revealed a witnessed fall. Resident #33 was found on the floor in the hallway. The report revealed Resident #33 had been ambulating pushing his wheelchair for support. No new interventions were initiated on the incident report. A follow up investigation report dated 1/18/19 revealed a new intervention of reviewing the resident's medications with the physician. The report revealed past interventions included placing the resident near the nurse desk.

· The incident report dated 1/29/19 at 1:45PM revealed an unwitnessed fall. Resident #33 was found lying on his right side in front of the wheelchair with his head toward the door. Immediate action taken to minimize the reoccurrence of falls included: trying a trial diet of mechanical soft. The report did not indicate interventions were in place at the time of the fall.

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No injuries were noted.

· On 1/31/19 at 8:29AM an interview was conducted with Nurse Aide (NA) #3. The interview revealed Resident #33 did not use his call bell or ask for assistance from staff.

On 1/30/19 at 9:15AM an interview was attempted with Resident # 33. The interview revealed Resident #33 refused to speak with the surveyor.

On 1/31/19 at 8:32 AM an interview was conducted with NA #5. NA#5 stated Resident #33 had frequent falls due to attempting to stand without staff assistance.

On 1/31/19 at 10:28 AM an interview was conducted with Nurse #5. Nurse #5 stated Resident #33 had experienced frequent falls due to not using the call bell and trying to get up unassisted. The interview revealed no intervention attempted had kept Resident #33 from falling.

On 1/31/19 at 10:09AM an interview was conducted with the Director of Nursing (DON). She stated Resident #33 had been care planned for falls and the interventions put into place for Resident # 33 included frequent visual monitoring, reeducation, maintaining the resident in a visible area and redirection. She stated the interventions had not worked due to the resident attempting to ambulate without assistance of staff and different interventions should have been attempted after Resident #33 experienced 37 falls in the last 6 months.

On 1/31/19 at 1:54PM an interview was

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conducted with the Administrator. The Administrator stated resident falls were reviewed in Quality Assurance (QA) meetings which were held monthly and include all interdisciplinary members. She stated during the monthly meetings quality measures were reviewed for falls analyzing the number of resident falls and what shifts they occur on looking for trends. The Administrator stated Resident # 33 had been identified as a fall risk and discussed in the QA meetings. The Administrator stated she was aware Resident #33 had experienced 37 falls in the last 6 months and the facility should have tried additional interventions to aide in fall prevention. The Administrator had no explanation of why an intervention for the resident to walk behind his wheelchair was implemented. The interview revealed Resident #33 had not been evaluated for any fall prevention devices. The administrator stated her expectation was for an appropriate intervention to be put into place for Resident #33.

2. Resident #89 was admitted to the facility 03/14/16 with diagnoses including hypertension (high blood pressure), diabetes, non-Alzheimer's dementia, and dysphagia (difficulty swallowing).

Review of the quarterly Minimum Data Set (MDS) dated 01/02/19 revealed Resident #89 was moderately impaired for decision making and required extensive assistance with bed mobility and transfers. The MDS also stated Resident #89 had 2 or more falls with no injury and 2 or more falls with injury since the last assessment.

Review of Resident #89's care plan most recently updated 01/08/19 for falls revealed he was at risk for falls due to having a history of falls and poor

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safety awareness. The care plan also stated Resident #89 would not ask for assistance and would transfer himself sometimes. The goal was for Resident #89 to not experience major injuries from falls through the next review. Interventions included monitoring for changes in his condition that may warrant increased supervision and notifying the Physician, reminding him to ask for assistance as needed, having his call light within easy reach, placing dycem (a non-slip material used to help with sliding) in his wheelchair, encouraging him to use the call light, offering frequent safety cues for safety precautions, keeping his bed in the lowest position, encouraging him to be out of his room as much as possible for increased supervision, removing his wheelchair from his room when he was in bed, wearing non-skid socks or shoes when out of bed, and having frequent visual checks.

Review of facility incident reports from 10/09/18 to present revealed the following:

On 10/09/18 Resident #89 had an unwitnessed fall. A nurse saw Resident #89 on the floor on his side at the door of his room. His wheelchair was at the door and he had one shoe off and one shoe on. Immediate action taken to minimize reoccurrence of falls was Resident #89 was brought to the nurse's station. Summary of the investigation revealed Resident #89 got up with no assistance and fell in the floor. Past interventions attempted were to encourage call light use for assistance. New interventions were to bring Resident #89 to the nurse's desk to cool off since the heat was on in his room and he was sweating. The notification summary stated no follow-up was needed.

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On 10/22/18 Resident #89 had a witnessed fall. Resident #89 was seen going to his knees in his room while holding onto his wheelchair. The wheelchair was not locked. When Resident #89 was asked if he was trying to transfer to bed he nodded "yes". Immediate action taken to minimize reoccurrence was Resident #89 was assisted to his wheelchair, his clothes were changed, and he was assisted to bed. Summary of the investigation revealed Resident #89 was in his room holding onto his wheelchair and went down on his knees. Past interventions attempted were to monitor for changes in condition that may warrant increased supervision, remind Resident #89 to ask for assistance as needed, have his call bell in reach, keep his bed in the lowest position, use non-skid shoes/socks, and offer frequent safety cues for safety precautions. New interventions were to offer frequent safety cues for safety precautions and encourage Resident #89 to call for assistance. The care plan was updated to reflect risk factors and interventions 10/24/18.

On 11/03/18 Resident #89 had an unwitnessed fall in the bathroom between rooms 201 and 203 when he was attempting to transfer to the toilet. Resident #89 was assessed and no injury was noted. Resident #89 was assisted to the toilet and undergarment was changed. Immediate action taken was to take Resident #89 in his wheelchair to the nurse's station for increased visibility. Past interventions attempted were to encourage calling for assistance, having the call light within reach, non-skid shoes/socks, and offering frequent cues for safety precautions. New intervention was to encourage to call for assistance. The care plan was updated to reflect risk factors and interventions 11/05/18.

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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 689	Continued From page 61 On 11/04/18 Resident #89 had a witnessed fall in the hall outside his room. Per a nurse aide (NA) he was on the tip of his wheelchair and he slid to the floor. No immediate action was taken to minimize reoccurrence. Summary of investigation revealed Resident #89 was witnessed sitting on the edge of his wheelchair and slid out of his wheelchair into the floor on his buttocks. Past interventions included encouraging to call for assistance, having his call light within reach, wearing non-skid socks/shoes, and offering frequent cues for safety precautions. New interventions were to encourage Resident #89 to call for assistance. The care plan was updated to reflect risk factors and interventions on 11/05/18. On 11/09/18 Resident #89 had an unwitnessed fall in his room and was found sitting on the floor. Resident #89 had no visual injuries. Vital signs were obtained and neuro checks were performed. No immediate action was taken to minimize reoccurrence. Summary of investigation revealed Resident #89 was sitting on the floor when staff found him and he stated he was okay. Past interventions included dycem, educate for safety awareness, and call light usage. New interventions were to re-educate for safety awareness and using call light for assistance and using assistive devices when ambulating. On 11/24/18 Resident #89 had an unwitnessed fall in his room. His wheelchair had been removed from his room. There were no injuries noted. No immediate action was taken to minimize reoccurrence. Follow up of the fall on 11/26/18 stated Resident #89 was found in the floor of his room and he had crawled toward the	F 689		

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F 689	Continued From page 62	F 689		

door to look for help. Resident #89 couldn't find his wheelchair. Past interventions were to have dycem on his wheelchair seat, education for safety awareness, and having the call light and walker for assistance. New interventions were to re-educate on safety awareness, use of call light, and check placement of dycem.

An interview with NA #9 on 01/29/19 at 10:11 AM revealed Resident #89 did not usually use his call light and had several falls in the past due to trying to get up by himself.

An interview with Nurse #4 on 02/01/19 at 8:20 AM revealed Resident #89 would try to get up by himself and had fallen in the past.

An interview with the Director of Nursing (DON) on 01/31/19 at 10:09 AM revealed she felt it was not acceptable to leave the Immediate Action section of the incident report blank. The care plan was reviewed with the DON and she stated different fall interventions should have been tried for Resident #89 since the interventions on his care plan were not effective. The DON had no explanation for why different fall interventions were not tried for Resident #89.

An interview with the Administrator on 01/31/19 at 10:20 AM revealed falls were discussed in morning meeting daily and in the Quality Assurance (QA) monthly meetings. After a fall care plan interventions were reviewed to see if they were helpful and falls were evaluated to see if there were trends. The Administrator stated Resident #89 was independent and did not like to ask for staff assistance. The Administrator stated different fall interventions should have been tried for Resident #89 and had no explanation as to

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F 689	Continued From page 63 why they were not.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		3/1/19

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F 690	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and physician interview the facility failed to ensure a resident's urinary catheter bag and tubing did not come into contact with the floor for 1 of 4 residents reviewed for catheter care (Resident #55). The findings included: Resident #55 was admitted to the facility on 04/20/18 with diagnoses that included, urinary retention, urgency of urine, history of stroke, and malignant neoplasm of prostate. A review of Resident #55's most recent quarterly Minimum Data Set (MDS) Assessment dated 11/27/18 revealed he was cognitively impaired, coded as requiring extensive assistance with most activities of daily living and had an indwelling catheter. A review of Resident #55's care plan last reviewed on 11/27/18 revealed a care plan area for the potential for injury related to the presence of an indwelling catheter. Interventions included to checking the tubing for kinks, and to keep the collection bag below his bladder level. Review of Resident #55's January physician orders sheet revealed orders dated 11/26/18 for an indwelling catheter due to gross hematuria and indwelling catheter care to be completed on each shift among others. On 01/30/19 at 9:12 AM an observation was completed of Resident #55. Resident #55 was observed in bed, with his urinary catheter bag	F 690	1.) Facility failed to insure Resident #55's right to privacy/dignity when the catheter bag and tubing was found out of his dignity bag and on the floor. The catheter closed drainage bag was immediately placed into a dignity bag and hung appropriately lower than his bladder on the side of his wheelchair. 2.) All residents with indwelling urinary catheters have the potential to be adversely effected by this deficient practice. 3.) 100% of residents with indwelling urinary catheters were immediately assessed for proper positioning and dignified covering of their closed urinary drainage systems. All care plans for residents with indwelling catheters were reviewed and updated to reflect the proper positioning and use of dignity bags to cover the urine collection bag, completed 2/15/2019. 100% of all licensed staff, new hires and any agency staff were in serviced on this dignity policy completed by DON/Designee on 2/12/2019. The general care of residents with catheters was reviewed and this entire training process will continue through the orientation process. 4.) DON/Designees will audit and observe residents with indwelling urinary catheters 3 x weekly x 4 weeks, weekly x 4 weeks and monthly x 3 months to insure proper use of dignity bags and appropriate positioning of closed drainage system. Results of the audits and observations will be reported to QAPI monthly x 3 months	

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F 690	Continued From page 65 lying flat on the floor. The catheter bag was observed to have a clip but it was not attached to anything. Observation on 01/30/19 at 9:38 AM revealed Resident #55 was observed in bed, with his urinary catheter bag lying flat on the floor. NA #4 was present during this observation and she proceeded to pick up Resident #55's catheter bag off the floor and attached it securely to the bed frame. During an interview with nurse aide (NA) #4 on 01/30/19 at 9:38 AM it was revealed that catheter bags and tubing should not come into contact with the floor. NA #4 reported the catheter bag should be attached securely to the bed frame while residents are in bed. An additional observation was completed of Resident #55 on 02/01/19 at 12:49 PM. Resident #55 was observed in his room, sitting in his wheelchair with his urinary catheter tubing on the floor under his left foot before rising back up to the catheter bag which was attached underneath his wheelchair. An interview completed on 01/30/19 at 4:12 PM with the facility's Medical Director revealed it was his expectation that catheter bags and tubing not come into contact with the floor due to infection control issues. He reported catheter bags should be kept off the floor but below the bladder. During an interview with the Director of Nursing on 01/31/19 at 11:06 AM she reported it was her expectation that catheter bags be secured to the bed frame while residents are in bed. She stated resident's catheter bags and tubing should never	F 690	to insure ongoing substantial compliance to this plan.	

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F 690	Continued From page 66 be in contact with the floor.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow Physician's orders for administering the correct ordered amounts of tube feeding for 1 of 1 sampled residents (Resident #23) reviewed for tube feeding. Findings included: Resident #23 was admitted to the facility 10/09/15	F 693	1.) Facility failed to follow Physician order for administering the correct amount of tube feeding to Resident #23. The order was written for 65 ml/hour and upon observation was found to be running at 60ml/hr. The tube feeding was adjusted to 65ml/hr on 2/1/2019 in accordance with physician order. 2.)All residents with enteral tube feedings have the potential to be adversely effected	3/1/19

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F 693	Continued From page 67 with diagnoses including Alzheimer's disease, dysphagia (difficulty swallowing), and aphasia (inability to understand or express speech). Review of the quarterly Minimum Data Set (MDS) dated 10/31/18 revealed Resident #23 was moderately impaired for decision making. The MDS also stated Resident #23 had a feeding tube and received 51% or more of his total calories from tube feeding. Review of Resident #23's care plan for dehydration last updated 11/07/18 revealed he was to receive his tube feeding as ordered. Record review from 08/18/18 through 01/19/19 revealed Resident #23's weights were stable with no weight loss noted. Review of Resident #23's Physician orders dated 12/18/18 revealed he was to receive a tube feeding of Jevity 1.5 at 65 milliliters an hour for 18 hours a day. An observation of Resident #23 on 01/31/19 at 7:51 AM revealed his tube feeding was infusing at 60 milliliters an hour. An observation of Resident #23 on 02/01/19 at 8:16 AM revealed his tube feeding was infusing at 60 milliliters an hour. An interview with Nurse #4 on 02/01/19 at 8:20 AM revealed she cared for Resident #23 from 7:00 AM to 3:00 PM 01/31/19 and 02/01/19. Nurse #4 stated thought Resident #23's tube feeding was supposed to be administered at a rate of 60 milliliters an hour. Nurse #4 looked at Resident #23's Medication Administration Record	F 693	by this deficient practice. 100% of residents with tube feedings were assessed and observed by DON/Designee to make sure their feedings were running at the ordered rate, with no further findings. Completed 2/1/2019. 3.) DON/Designee in serviced 100% of licensed staff to facility protocol regarding following Physician orders and policy and procedure for enteral tube feedings, completed 2/8/2019. This training included all new hires and any agency staff to date and will remain ongoing through orientation. 4.) All residents with enteral tube feedings will be assessed and observed by DON/Designee to insure appropriate order is followed and appropriate feeding is administered 3x weekly x 4 weeks, weekly x 4 weeks and monthly x 3.Esults of audits and observations will be reported to QAPI by the DON/Designee monthly x 3 to insure ongoing substantial compliance to this plan.	

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F 693	Continued From page 68 (MAR) and saw the tube feeding should have been administered at 65 milliliters an hour. Nurse #4 stated she should have administered Resident #23's tube feeding at a rate of 65 milliliters an hour not 60 milliliters an hour. An interview with the Director of Nursing (DON) on 02/01/19 at 8:40 AM revealed she expected Physician orders to be followed for Resident #23's tube feeding and she wasn't sure why the feeding was not on the correct setting so the resident received the correct amount of feeding as ordered by the Physician. An interview with the Physician on 02/01/19 at 10:01 AM revealed he expected the order for Resident #23's tube feeding to be followed.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to ensure portable oxygen was available at all times for 1 of 4 residents reviewed for respiratory care (Resident # 36). Findings included:	F 695	1.) Facility failed to ensure portable oxygen was available to Resident #36 when she was observed with an empty portable tank on her wheelchair. The tank was replaced with a full tank on 2/1/19. 2.) All residents requiring the use of portable oxygen and/or respiratory care	3/1/19

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F 695	Continued From page 69 Resident #36 was admitted to the facility 09/13/18 with diagnoses including thyroid disorder, non-Alzheimer's dementia, and muscle weakness. Review of Resident 36's Physician orders revealed an order dated 10/13/18 for oxygen at 2 liters per minute via nasal cannula as needed to keep oxygen saturations greater than 90%. Review of Resident #36's care plan for oxygen therapy last updated 10/13/18 stated Resident #36's oxygen supply was to be available at all times. The significant change Minimum Data Set (MDS) dated 11/09/18 revealed Resident #36 was cognitively intact and required extensive assistance with bed mobility and transfers. The MDS also stated Resident #36 received oxygen therapy. Observation of Resident #36 on 01/29/19 at 3:05 PM revealed she was in her wheelchair with an empty portable oxygen tank on the back of her wheelchair. An interview with Resident #36 on 01/29/19 at 3:05 PM revealed she had not used her portable oxygen tank that day and was not sure when it was last replaced. An interview with NA (nurse aide) #8 on 01/29/19 at 3:07 PM revealed portable oxygen tanks were checked when the first round of the shift was done. NA #8 stated the first round for second shift had not yet been done. NA #8 observed Resident #36's portable oxygen tank and	F 695	have the potential to be adversely effected by this deficient practice. 100% of licensed staff, including all new hires to date and any agency staff, were in serviced on providing oxygen and other appropriate respiratory care per physician order consistent with professional standards of practice, completed 2/8/2019. Training to this policy will be ongoing through the orientation process. 3.) DON/Designees performed audits/observation of 100% of residents requiring use of portable oxygen to insure their tanks were functioning properly, completed 2/1/2019. None found to be deficient. 4.) Residents requiring portable oxygen will be observed and audited by DON/Designees 3 x weekly x 4 weeks, weekly x 4 weeks and monthly x 3 months to insure the tanks are functioning. DON/Designee will report to QAPI x 3 months the results of further audits/observations to insure ongoing substantial compliance to this plan.	

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F 695	Continued From page 70	F 695		

confirmed it was empty.

An interview with NA #9 on 01/29/19 at 3:10 PM revealed she had taken care of Resident #36 on the 7:00 AM to 3:00 PM shift that day but did not assist her out of bed and was not sure who did assist her out of bed. NA #9 stated she checked residents' portable oxygen tanks when she assisted them out of bed but she was not sure what the facility's policy was for checking portable oxygen tanks.

An interview with Nurse #9 on 01/29/19 at 3:15 PM revealed she was not aware Resident #36's portable oxygen tank was empty and she did not know when the tank last contained oxygen. Nurse #9 stated she had not checked Resident #36's portable oxygen tank for the 7:00 AM to 3:00 PM shift on 01/29/19. Nurse #9 stated residents usually notified staff when their portable oxygen tanks were empty. When Nurse #9 was asked about the process for replacing portable oxygen tanks for residents who were nonverbal or otherwise unable to alert staff their portable oxygen tank was empty she stated she was not sure but she thought the nurse aides replaced the portable oxygen tanks. Nurse #9 stated she had only worked at the facility for 6 shifts and did not know the process for nurse aides checking to see if portable oxygen tanks contained oxygen. Nurse #9 replaced Resident 36's empty portable oxygen tank with a full oxygen tank.

An observation of Resident #36 on 01/30/19 at 4:32 PM revealed she was up in her wheelchair and her portable oxygen tank was empty on the back of her wheelchair.

An observation of Resident #36 on 01/31/19 at

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F 695	Continued From page 71 7:53 AM revealed she was up in her wheelchair and her portable oxygen tank was empty on the back of her wheelchair. An observation of Resident #36 on 02/01/19 at 11:30 AM revealed she was up in her wheelchair and her portable oxygen tank was empty on the back of her wheelchair. An interview with the Director of Nursing (DON) on 02/01/19 at 11:52 AM revealed she expected residents to have oxygen in their portable oxygen tanks. The DON examined Resident #36's portable oxygen tank and confirmed it was empty. The DON stated she expected nurses or NAs to check residents' portable oxygen tanks each shift to ensure residents had access to oxygen at all times.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §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	F 725		3/1/19

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F 725	Continued From page 72 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, record reviews, family interviews and staff interviews, the facility failed to provide showers due to insufficient staffing for 6 of 7 sampled residents reviewed for activities of daily living (Residents #1, #60, #33, #59, #89 and #67). The findings included: This tag is crossed referred to: 1. F677: Activities of Daily Living Skills: Based on observation, record reviews, resident and staff interview the facility failed to provide showers as scheduled (Resident # 1, #60, #33, #59 and #89), and failed to provide nail care (Resident# 67) for 6 of 7 residents sampled for activities of daily living. Observation on 1/29/19 at 10:35AM revealed Housekeeper #1 assisting a resident with a water basin, soap and towels. Further observation revealed her asking a resident if they needed to use the restroom. An interview on 2/01/19 at 8:10AM with Housekeeper #1 revealed she often assisted residents with care stating the residents relied on her. Housekeeper #1 stated the facility	F 725	1.) Facility failed to provide showers and nail care services by sufficient numbers of personnel, providing for adequate ADL services for Residents #1, #60, #33, #59, #89,(showers) and #67 (nail care). The showers and appropriate ADL care was provided to Residents #1, #60, #33, #59, #89 and #67, completed 2/1/2019. 2.) All residents have the potential to be adversely affected by this deficient practice. A review of present staffing patterns by the Temporary Administrator placed on 2/6/2019 and the DON/Designees allowed for the replacement of the CNA shower team. Immediate focus on the present hiring and rehire practices of the facility saw the add on of 16 licensed staff members to date, 2/15/2019. Facility has implemented a mentoring program for all newly hired staff, to be buddied up with present staff to facilitate easier assimilation into facility processes and familiarization to policy and procedures. 3.) 100% of licensed staff were in serviced by the DON/Designees on the residents right to adequate and timely ADL care	

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	345233	A. BUILDING _____ B. WING _____	C 02/01/2019

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DEER PARK HEALTH & REHABILITATION	306 DEER PARK ROAD NEBO, NC 28761

(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 725	Continued From page 73 did not have enough staff to meet the resident's needs. On 1/30/19 at 10:47AM an interview was conducted with Nurse Aide (NA) #2. The interview revealed she had worked in the facility for 6 years. NA #2 stated the facility no longer had a shower team and the NA's on the hall did not have enough time to give the residents showers due to short staffing. NA #2 stated residents often go went extended periods without showers due to staffing. On 1/31/19 at 8:30 AM an interview was conducted with NA # 3. NA #3 stated she had worked in the facility for 11 years. NA # 3 stated due to short staffing residents were not receiving their scheduled showers. The interview revealed Resident #1 had not been given a shower for two weeks. On 1/31/19 at 2:28 PM an interview was conducted with NA#1. NA # 1 stated residents were not receiving scheduled showers due to short staffing. On 2/01/19 at 9:12AM an interview was conducted with NA#4. During the interview she stated she felt burnt out due to the staffing in the facility. She stated she had to choose resident care over resident showers due to staffing. On 2/01/19 at 12:06PM an interview was conducted with NA #2. NA #2 stated the facility did not have enough staff to give Resident #60 a shower. The interview revealed NA #2 had to tell Resident #60 she could not have a shower due to short staffing.	F 725	from sufficient staff with appropriate competencies to attain and/or maintain the highest practicable physical, mental and psychosocial well-being of each resident, completed 2/15/2019, this includes all new hires and any agency used and will continue through the orientation process for ongoing new hires/agency. 4.) DON/Designees will audit shower schedules and nail care 3x a week x 4 weeks, weekly x 4 weeks, and monthly x 3 months to insure all residents are provided adequate ADL care and to insure adequate staffing patterns are maintained for showers scheduled to be provided timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 725	Continued From page 74 On 2/01/19 at 12:09 PM an interview was conducted with the Director of Nursing (DON). The interview revealed her expectations were for staff to give Resident #60 a scheduled shower however due to short staffing the DON stated they couldn't always get to the showers. The DON stated business office staff who were NA's were being pulled to work on the resident halls to provide care. The interview revealed she did not feel the facility had an appropriate amount of staff to provide resident care. On 2/01/19 at 3:58PM an interview was conducted with the Administrator. The Administrator stated she was responsible for facility staffing. The interview revealed the facility census did not have an impact on facility staffing. The Administrator stated she had requested to the corporate office to receive agency staffing with no success and had been advertising online for additional help. She stated the facility did not have enough staff to adequately provide resident care due to a high turnover rate and call outs by staff members. The interview revealed she had attempted to schedule a shower team however the NA's scheduled were pulled to work on the resident halls due to short staffing. She stated her expectations were for residents to get their showers as scheduled and a minimum of once per week. She stated it was not acceptable for the NA's to let a resident go without a shower.	F 725		