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E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		3/3/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/24/2020

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

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(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

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E 039	Continued From page 2 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]	E 039		

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(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to

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test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises

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to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise

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E 039	Continued From page 6 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to participate in a tabletop exercise and a full-scale community-based exercise as part of their Emergency Preparedness (EP) program. The findings included: A review of the facility's EP manual revealed the facility had no evidence of participating in a tabletop exercise or conducting a full-scale exercise that was community based in the past year. An interview occurred with the Administrator on 2/6/2020 at 9:00am, who stated the facility had completed some different types of disaster drills but could find no evidence of a tabletop exercise or full-scale community-based exercise in the past year. The administrator reported she was signed up to take part in a tabletop exercise in March 2020 and will work on coordinating with the local police and emergency officials to schedule a	E 039	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. E039 1. Corrective action for resident(s) affected by the alleged deficient practice: No residents were identified. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents have the potential to be affected by this alleged deficient	

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E 039	Continued From page 7 community-based exercise to test their EP plan. On 2/6/2020 at 9:15am an interview was conducted with the Maintenance Director. He explained they had completed some disaster drills in the facility, such as fire drills, bomb threats and elopement drills, but was unaware of a tabletop or full-scale community-based exercise in 2019.	E 039	practice. On 02/20/2020, the Administrator along with the Director of Nursing, Activities Director, Social Worker, Business Office, Health Information Manager, Therapy Director, Maintenance Director, and Minimum Data Set Nurse and completed a table top exercise for Elopement as a part of their required emergency preparedness plan. The Administrator is working with the local Sherriff to schedule and completed a full scale community based exercise for active shooter as a part of their emergency preparedness plan. This exercise will be completed by 03/03/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/24/2020 the Nurse Consultant educated the Administrator. Areas covered were: • Emergency preparedness testing requirements for Long Term Care This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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E 039	Continued From page 8	E 039	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Nurse Consultant or designee will monitor compliance utilizing the E309 Quality Assurance Tool weekly for monthly for 3 months. The tool will review emergency preparedness testing for required drills and exercises. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 000	INITIAL COMMENTS A recertification with complaint investigation survey was conducted from 02/02/20 through 02/06/20 and 2 of 2 allegations were substantiated resulting in deficiencies at F550 and F584.	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	F 550		3/3/20

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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.

§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 observation, record review, resident interview, and staff interview, the facility failed to treat Resident #28 with dignity and respect causing her to feel as if she was an "inconvenience". The facility also failed to cover Resident #66 ' s urinary catheter drainage bag to

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken

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promote dignity. This was for 2 of 2 residents reviewed for dignity.

The findings included:

1. Resident #28 was admitted to the facility on 3/29/19 with diagnoses that included Parkinson ' s disease.

An Initial Allegation Report indicated an allegation of resident abuse was made on 11/1/19 at 7:00 PM related to an incident involving Resident #28 and Nursing Assistant (NA) #13. A facility visitor reported to the Administrator that he overheard NA #13 tell Resident #28 that "she was an inconvenience". There was no injury or harm identified for the resident.

The facility ' s Investigation Guide indicated NA #13 was suspended immediately upon report of the allegation pending the results of the investigation. Resident #28 was assessed for any signs/symptoms of injury and no concerns were identified. The physician and Responsible Party (RP) of Resident #28 were notified. Written statements were obtained from NA #13, the witness, and an interview was conducted with Resident #28 by the Administrator. These statements/interviews contained the following information:

- A typed-up interview completed by the Administrator with Resident #28 on 11/1/19 indicated the resident stated that she felt as if staff treated her inappropriately "sometimes". She indicated that NA #13 made her "feel like an inconvenience". Resident #28 was asked if NA #13 told her she was an "inconvenience" and she stated "yes".

F 550

or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F550

1. Corrective action for resident(s) affected by the alleged deficient practice:
For resident #28: Resident was interviewed on 02/17/2020 by the Social Worker regarding any care concerns or concerns of feeling like an inconvenience. Resident denied any concerns.

For resident # 66: On 02/24/2020 the resident was audited by the Nurse Consultant and noted with a Foley catheter Fig Leaf privacy bag in place.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the deficient practice.
On 02/17/2020 the Social Worker interviewed all alert and oriented residents for concerns related to dignity and feeling as thought they were an inconvenience. This was completed on 02/17/2020. 4 out of 24 residents reported concerns. Two of the residents had their concerns addressed via the grievance process by the Administrator. One resident clarified her concerns with the Nurse Consultant and Administrator and a task was entered into Point Click Care for Head of Bed to be elevated 30 minutes after meals. This was completed by the Nurse Consultant

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F 550	Continued From page 11 - A witness statement completed by a facility visitor on 11/1/19 indicated NA #13 came into Resident #28 ' s room and the resident asked to get up. The witness reported that NA #13 told Resident #28 that she was an inconvenience and she was talking down to the resident. - An undated written statement completed by NA #13 indicated she went into Resident #28 ' s room and was going to get her up when the resident stated that she had not wanted to get up. NA #13 reported that she told Resident #28 it would be an inconvenience for her to get her during the passing of dinner trays. The facility ' s Investigation Guide additionally indicated that the Social Worker (SW) interviewed all residents who were cognitively intact that resided on the 100 hall and no concerns were voiced related to the allegation. Nurses completed nursing assessments of all 100 hall residents to ensure no tearfulness, fearfulness, or signs of unusual behavior were present and no concerns were identified. The Nurse Consultant reviewed all grievances and incident reports for the past 30 days for any similar allegations and no issues were identified. Education was initiated for all full time, part time, and as needed staff related to verbal abuse, customer service, dignity, and resident rights by the Director of Nursing and Nurse Consultant. Ongoing monitoring was to be conducted of the grievances and Resident Council concerns by the Administrator, DON, and SW and information gathered would be reported in the monthly Quality Assurance (QA) meeting. This Investigation Guide indicated the root cause of the incident was that NA #13 failed to follow the facility ' s abuse prohibition policy and to treat	F 550	on 02/18/2020. One resident voiced an allegation of abuse and an initial allegation report was sent into the Healthcare Personnel Registry (HCPR) on 02/17/2020 by the Administrator. The allegation was unsubstantiated and the final report was faxed to the HCPR on 02/ /2020. On 02/17/2020 the nurse manager audited all non-alert and oriented resident for signs of abuse or neglect or prolonged care. This was completed on 02/17/2020. 1 out of 41 residents was noted with a bruise of unknown origin and an initial allegation report was sent in to the HCPR on 02/17/2020 by the Administrator. The bruise was investigated and abuse was unsubstantiated. The final report was faxed to the HCPR on 02/21/2020. Beginning on 02/18/2020 the nurse manager audited all current residents for the presence of a Foley catheter and a privacy bag. This audited was completed by 02/21/2020. 2 out of 6 residents were noted without a privacy bag and this was corrected by the Support Nurse on 02/21/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 02/19/2020, the Nurse Managers educated all full time, part time, and as needed (PRN) nurses and Certified Nursing Assistants on resident dignity and privacy. Areas covered were: • Respecting resident rights	

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F 550 Continued From page 12
Resident #28 with dignity.

An Investigation Report completed on 11/6/19 indicated the allegation of resident abuse made on 11/1/19 related to NA #13 and Resident #28 was substantiated. NA #13 was terminated at the close of the investigation on 11/6/19.

The quarterly Minimum Data Set assessment dated 11/18/19 indicated Resident #28 ' s cognition was fully intact. She had no behaviors and no rejection of care.

An interview was conducted with Resident #28 on 2/2/20 at 3:40 PM. Resident #28 was alert and oriented to person, place, and time. She recalled the incident with NA #13 that occurred on 11/1/19 and confirmed the statements she made in her interview with the Administrator. She stated she had not seen NA #13 after the incident occurred.

A phone interview was attempted with NA #13 on 2/3/20 at 2:12 PM. She was unable to be reached for interview.

A review of the In-Service/Education sign in sheets from 11/1/19 through 2/5/20 compared to the active staff roster revealed 100% of staff were not provided with education following the 11/1/19 incident with Resident #28 and NA #13. NA #1, NA #14 and NA #15 had not received education on verbal abuse, customer service, dignity, and resident rights as indicated in the facility ' s Investigation Guide. A review of the staff time cards from the close of the investigation on 11/6/19 through 2/5/20 indicated NA #1 worked 12 times, NA #14 worked 15 times, and NA #15 worked 16 times.

F 550

- Providing timely care
- Ensuring Foley Catheter bags are covered with a privacy bag at all times

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nurses or designee will monitor compliance utilizing the F550 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The tool will interview residents for concerns related to dignity, staff practices, and Foley catheter bags are covered. Monitoring will be rotated to include all shifts and weekends. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality

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F 550	Continued From page 13 During an interview with the Administrator on 2/6/20 at 10:10 AM she stated she expected all residents to be treated with dignity and respect by facility staff. She acknowledged that the education on verbal abuse, customer service, dignity, and resident rights that was indicated in the facility ' s Investigation Guide was not completed for 100% of the staff as NA #1, NA #14, and NA #15 had not received the education. The Administrator stated that the facility was in the process of updating the active employee list so that when education was provided they were able to track completion status for 100% of staff. 2) Resident #66 was admitted to the facility on 1/14/2020 with diagnoses that included obstructive uropathy (a condition in which the flow of urine is blocked) and pressure ulcers to the sacral area. The review of Resident #66's care plan revealed a problem area initiated on 1/15/2020 for a urinary catheter due to urine retention. One of the interventions included to keep the catheter bag covered adequately to promote dignity. The admission Minimum Data Set (MDS) assessment dated 1/21/2020 indicated Resident #66 had severe cognitive impairment, required extensive assistance from staff for all Activities of Daily Living and used an indwelling urinary catheter. On 2/2/2020 at 1:25pm, an observation was made of Resident #66 lying in his bed. He was noted to have an indwelling urinary catheter with the drainage bag attached to the left side of the bed. The urinary catheter drainage bag did not have a privacy cover and could be seen from the	F 550	Assurance Meeting until deemed as no longer necessary for compliance with dignity related to foley bags being covered. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 550	Continued From page 14 hallway. Resident #66 was observed lying in his bed on 2/3/2020 at 9:50am, the urinary drainage bag was attached to the side of the bed, with no privacy cover and was visible from the hallway. On 2/3/2020 at 11:00am Resident #66 was observed in his room. The urinary drainage bag was hanging on the left side of the bed without a privacy cover and was visible from the hallway. Nurse Aide #3 was interviewed on 2/3/2020 at 11:00am and stated normally residents with urinary catheters had a blue cover on the drainage bag for privacy but could not state why Resident #66 did not have one. An interview occurred with Nurse #1 on 2/3/2020 at 11:05am and stated residents with urinary catheters normally had a privacy cover on the drainage bag especially if they were up walking or working with therapy. She further added the drainage bag should have been changed to one with a privacy cover when Resident #66 was admitted to the facility but could not explain why this did not occur. An interview occurred with the Administrator on 2/6/2020 at 10:10am, she stated it was her expectation for nursing staff to use a privacy cover for urinary drainage bags.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		3/3/20

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F 584	Continued From page 15 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family, staff	F 584	The statements made on this plan of	

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F 584	Continued From page 16 interviews and record review, the facility failed to ensure laundered items were returned to Resident #54. This was for 1 of 1 resident reviewed for personal items. The findings included: Resident #54 was admitted on 9/1/17 with cumulative diagnoses of Congestive Heart Failure, Chronic Kidney Failure and Glaucoma. Resident #54's quarterly modified Minimum Data Set (MDS) dated 12/9/19 indicated he was cognitively intact, exhibited no behaviors, able to make himself understood, understood others and his vision was severely impaired. He was coded for extensive assistance with toileting, hygiene, a urinary catheter and frequently incontinent of bowel. Review of Resident #54's Activity Review dated 1/8/20 indicated choosing what clothes to wear was very important to him. In an interview on 2/2/20 at 1:46 PM, Resident #54 stated he was missing a lot of his clothes. He stated he was missing pajamas and underwear. He stated he reported the missing items to staff. In an interview on 2/3/20 at 2:50 PM, Nursing Assistants (NA) #5 and NA #6 stated they were aware that Resident #54 was missing his underwear but not aware of any missing pajamas. They stated a few months back, the laundry got backed up because two laundry staff quit and the new laundry staff were still learning. NA #5 stated the new laundry staff often put residents' clothes in the wrong rooms even when the items were marked with the resident's name.	F 584	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F584 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #54: the Administrator purchased new underwear for the resident on 02/05/2020. On 02/24/2020 the Administrator purchased new pajamas for the resident. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/17/2020 the Social Worker interviewed all current alert and oriented residents and residents who were their own responsible party for missing personal laundry. The audit was completed on 02/17/2020. 6 out of 24 residents were identified with missing clothing. A grievance report was initiated by the administrator and the missing items will be resolved through the grievance process by 02/24/2020. Beginning on 02/17/2020 the Social Worker interviewed the responsible parties of all current residents who were not alert and oriented for missing personal	

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Continued From page 17

In a telephone interview on 2/3/20 at 3:15 PM, Resident #54's family member confirmed he was missing laundered items.

In another interview and observation on 2/4/20 at 8:45 AM, Resident #54 was lying in bed. He stated he had just been given a bath. He stated the reason he had his sheet and blanket over him was because he was not wearing any underwear because the NA could not find any.

In an interview on 2/4/20 at 8:47 AM, Nurse #6 stated she was aware that Resident #54 was missing laundered items. She stated she notified the Housekeeping Supervisor again of Resident #54's missing underwear.

In an interview on 2/4/20 at 9:00 AM, the Social Worker (SW) stated she was not aware that Resident #54 was missing his laundered items. She stated it was the facility practice to complete a grievance form if missing items could not be located and she confirmed there were no grievances completed for Resident #54's missing laundered items.

In an interview on 2/4/20 at 9:13 AM, the Housekeeping Supervisor (HS) stated she started her position October 2019 but had worked in other areas of the facility for 4 years. She stated when she was named HS, all the laundry staff quit. She stated she had to hire all new staff and the only one experience staff member was out of maternity leave and returned to work yesterday. The HS stated she had been working to revamp the laundry room and identify who unlabeled items belonged too. She stated she had never seen but one pair of Resident #54's underwear in laundry and she was unsure if the aides were

F 584

laundry. This audit will be completed by 03/03/2020.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 02/19/2020, the Nurse Managers began educating all full time, part time, and PRN Nurses and CNA's on the following:

- Reporting missing laundry items

On 02/20/2020, the Administrator began educating all full time, part time, and PRN Housekeepers, Laundry department employees, and Laundry Supervisor on the following:

- Personal Laundry Policy

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.
Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

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F 584	Continued From page 18 throwing his underwear away. The HS stated she asked the aides to come to the laundry room to help identify missing items that were unlabeled or labeled items with fading. She stated the new laundry staff were still having some confusion about A or B bed and items only labeled with initials. In another interview and observation on 2/4/20 at 9:40 AM, NA #5 stated she bathed and dressed Resident #54 this morning and did not have any underwear to but on him so she just went in and put a pair of pajama pants on him. In an observation with NA #5, there was no underwear in any of Resident #54's drawers. She stated she had not had a chance yet to go to the laundry room to see if she could find his underwear. She also confirmed his family had written his name in all his clothing items. In another interview and observation of the laundry room on 2/4/20 at 2:20 PM, there was a rack of unlabeled items and a box of unlabeled socks. She stated if residents told her they had missing laundered items, she or the aides would come to the laundry room to look for the missing items. Laundry Assistant #1 was folding resident items and confirmed she has been in her position for 90 days. In another interview on 2/5/20 at 9:30 AM, Resident #54 stated he was not wearing any underwear under his pajama pants. In another interview on 2/6/20 9:13 AM, Resident #54 stated the facility purchased him some underwear yesterday. Observation of his new underwear revealed his named written in permanent marker.	F 584	The Administrator or designee will monitor compliance utilizing the F584 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The tool will monitor reports of missing laundry items and follow through utilizing the grievance process. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 584	Continued From page 19 In an interview on 2/6/20 at 10:28 AM, the SW stated the facility went and bought Resident #54 underwear yesterday and will be replacing his other missing items as well. The SW stated Resident #54 was frequently incontinent of bowel but wearing underwear was very important to him and his dignity. In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that any missing laundered items be located or replaced.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a	F 585		3/3/20

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F 585	Continued From page 20 grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F 585		

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F 585	Continued From page 21 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident, family, staff interviews and record review, the facility failed to complete a grievance form for laundered items that were not returned to Resident #54. This was for 1 of 1 resident reviewed for grievances. The findings included: Resident #54 was admitted on 9/1/17 with	F 585	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	

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F 585 Continued From page 22

cumulative diagnoses of Congestive Heart Failure, Chronic Kidney Failure and Glaucoma.

Resident #54's quarterly modified Minimum Data Set (MDS) dated 12/9/19 indicated he was cognitively intact, exhibited no behaviors, able to make himself understood, understood others and his vision was severely impaired. He was coded for extensive assistance with toileting, hygiene, a urinary catheter and frequently incontinent of bowel.

In an interview on 2/2/20 at 1:46 PM, Resident #54 stated he was blind. He stated he was missing a lot of his clothes and had reported the missing items to staff.

In an interview on 2/3/20 at 2:50 PM, Nursing Assistants (NA) #5 and NA #6 stated they were aware that Resident #54 was missing laundered items.

In a telephone interview on 2/3/20 at 3:15 PM, Resident #54's family member confirmed he was missing laundered items.

Review of the Missing Clothing Policy dated last revised 9/2014 read if missing items not located in the resident's room or in the laundry room, a grievance form should be completed.

In an interview on 2/4/20 at 9:00 AM, the Social Worker (SW) stated she was not aware that Resident #54 was missing his laundered items. She stated it was the facility practice to complete a grievance form if missing items could not be located and she confirmed there were no grievances completed for Resident #54's missing laundered items.

F 585

constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F585

1. Corrective action for resident(s) affected by the alleged deficient practice:
For resident #54: the Administrator purchased new underwear for the resident on 02/05/2020. On 02/24/2020 the Administrator purchased new pajamas for the resident.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
Beginning on 02/17/2020 the Social Worker interviewed all current alert and oriented residents and residents who were their own responsible party for missing personal laundry. The audit was completed on 02/17/2020. 6 out of 24 residents were identified with missing clothing. A grievance report was initiated by the administrator and the missing items will be resolved through the grievance process by 02/24/2020.

Beginning on 02/17/2020 the Social Worker interviewed the responsible parties of all current residents who were not alert and oriented for missing personal laundry. This audit will be completed by 03/03/2020.

For residents identified with missing personal laundry a grievance form was completed and follow up by 03/03/2020.

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F 585 Continued From page 23

In an interview on 2/4/20 at 9:13 AM, the Housekeeping Supervisor (HS) stated she asked the aides to come to the laundry room to and help identify missing items that were unlabeled or label items with faded labeling. She stated she did not complete a grievance form when she was notified of resident missing laundered items.

In another interview on 2/4/20 at 11:30 AM, NA #5 and NA #6 stated they she did not complete a grievance form for Resident #54's missing laundered items but rather they go to the laundry room when they had extra time to look for the items or just let the HS know.

In an interview on 2/4/20 at 11:40 AM, NA #7 stated she did not complete a grievance form for reports of missing items but rather let the HS know or went to the laundry room herself when she could get off the floor to look.

In an interview on 2/6/20 at 10:28 AM, the SW stated the facility went and bought Resident #54 underwear yesterday and will be replacing his other missing items as well. The SW stated Resident #54 was frequently incontinent of bowl but wearing underwear was very important to him and his dignity.

In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that a grievance form be completed for missing laundered items but the policy of completing a grievance form for missing items was not working and the process needed to be addressed.

F 585

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 02/19/2020, the Nurse Managers began educating all full time, part time, and PRN Nurses and CNA's on the following:

- Reporting missing laundry items
- Completing a grievance form when laundry items are missing
- Location of grievance forms and grievance process

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Administrator or designee will monitor compliance utilizing the F585 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The tool will monitor reports of missing laundry

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F 585	Continued From page 24	F 585	items and follow through utilizing the grievance process. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with the grievance process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident enrolled in the hospice program for 1 of 2 sampled residents	F 637	For resident #67, a corrective action was obtained on 11/08/19. On 11/08/19, a Significant Change in Status Minimum Data Set Assessment with an Assessment Reference Date of	2/21/20

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F 637

Continued From page 25

reviewed for hospice (#67).

The findings included:

Resident #67 was originally admitted to the facility on 9/9/19 with multiple diagnoses including portal vein thrombosis (a blood clot obstructing the portal vein which brings blood to the liver from the intestines) and cirrhosis of the liver.

The admission MDS assessment dated 9/16/19 indicated Resident #67 was cognitively intact and received limited assistance for meals and extensive assistance for all other Activities of Daily Living.

Resident #67's medical record revealed a physician's progress note dated 10/15/19 that she was awaiting a palliative care consultation.

A hospice note dated 10/27/19 indicated Resident #67 started to receive hospice services.

Review of Resident #67's care plan revealed a problem area initiated on 10/28/19 for hospice care due to failure to thrive.

A death in the facility MDS assessment dated 11/19/19 was completed.

On 2/4/2020 at 4:20pm the MDS Nurse was interviewed and stated she couldn't speak as to why a significant change MDS was not completed as there was a different person completing MDS assessments at that time. She could only say, a significant change in status MDS assessment should have been completed 14 days after Resident #67 enrolled in hospice services.

F 637

11/08/19 was opened for Resident #67. It was closed prior to being completed due to resident expiring on 11/19/19, which was before completion due date. The due date for this assessment to be completed on is 11/22/19.
Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents have the potential to be affected by the alleged deficient practice.
On 02/21/20, the Minimum Data Set Consultant completed a 100% audit of all residents who have been admitted to or discharged from hospice care during the past 90 days to ensure that Significant Change Minimum Data Set assessments have been completed.

The audit results are:

4 of 5 residents who were transferred either to or from hospice during the past 90 days had timely completion of Significant Change MDS.

1 of 5 residents who were transferred either to or from hospice was noted to not have had a Significant Change MDS completed during required timeframe after this transition in care. This was identified prior to this audit and a Significant Change MDS was completed with Assessment Reference Date of 1/31/20.

Systemic Changes

On 02/18/20, the Minimum Data Set Nurse Consultant in serviced the

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F 637	Continued From page 26 An interview occurred with the Administrator on 2/6/2020 at 10:10am and explained it was her expectation the MDS assessments be completed as required.	F 637	Minimum Data Set Coordinator on the requirement for and importance of completing a Significant Change Minimum Data Set assessment for all residents who are either admitted to or discharged from hospice services. Completion of a Significant Change MDS is also required if a resident changes hospice providers. The Assessment Reference Date for the MDS may be set up to 14 days after the significant change in status has been identified. The significant change MDS must then be completed no later than 14 days after the Assessment Reference Date. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will review 5 residents who have been either admitted to or discharged from hospice services OR who have changed hospice providers during the past 90 days to ensure that a Significant Change in Status Minimum Data Set assessment has been completed as required. This will be done using the quality assurance tool entitled “Significant Change in Status MDS Completion Audit Tool.” This audit will be done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of	

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F 637	Continued From page 27	F 637	Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		2/23/20

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F 640	Continued From page 28 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and transmit the quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 22 sampled residents reviewed (Resident #11). The findings included: Resident #11 was initially admitted to the facility on 10/11/19 with multiple diagnoses that included cerebrovascular accident (CVA), diabetes and congestive heart failure.	F 640	Resident #11: Specific deficiency for this resident was corrected on 02/06/20. The facility failed to complete the scheduled Omnibus Budget Reconciliation Act Minimum Data Set assessment for Resident #11 within regulated timeframe. The scheduled quarterly Minimum Data Set for this resident had an Assessment Reference Date of 01/18/20 with a completion due date of 02/01/20. After identification that the scheduled quarterly Minimum Data Set with	

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F 640	Continued From page 29 The most recent completed admission MDS assessment dated 10/18/19 revealed Resident #11 to have severe cognitive impairment and required extensive to total assistance with all Activities of Daily Living to include eating. Record review for Resident #11 indicated the most recent quarterly MDS was set with an Assessment Reference Date (ARD) of 1/18/2020. Upon further review, sections G, J, M, N, O and Z were incomplete, and the assessment had not been transmitted. During an interview with the MDS Nurse on 2/4/2020 at 9:40am she acknowledged the MDS was incomplete and needed to be transmitted. She was unable to state why the assessment had not been completed and transmitted only to say she had recently become the MDS nurse within the last 3 weeks. The Administrator was interviewed on 2/6/2020 at 10:10am and stated it was her expectation for the MDS assessments to be completed and transmitted within the required time frame.	F 640	Assessment Reference Date of 01/18/20 was late, it was finished and completed by the facility Minimum Data Set Nurse on 02/06/20. The Minimum Data Set was transmitted and accepted into the state database in Batch #1385 on 02/07/20. The Submission ID # was 182156122. Corrective action for residents with the potential to be affected by the alleged deficient practice. A 100% audit of all residents who have had an Minimum Data Set with an Assessment Reference Date during the past 30 days 01/22/20 – 02/22/20 was completed in order to identify if there were other late assessments. This audit was completed by the Regional Minimum Data Set Consultant on 02/23/20. The results of this audit were: 51 of 73 total assessments completed were identified as having been completed within required timeframe. 22 of 73 total assessments completed were identified as not having been completed within required timeframe. As of 02/23/20 all Minimum Data Set assessments that are currently opened to be worked on are within required timeframe for completion, with no late assessments identified. Systemic Changes On 02/18/20, the Regional Minimum Data	

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F 640	Continued From page 30	F 640	Set Nurse Consultant provided education to the Minimum Data Set Coordinator on the importance of scheduling and completing all Minimum Data Set assessments according to regulated timeframes per chapter 2 of the Resident Assessment Instrument manual. The education also included requirements for encoding Minimum Data Set data: Within 7 days after completing a resident's Minimum Data Set assessment or tracking record, the provider must encode the Minimum Data Set data (i.e., enter the information into the facility Minimum Data Set software). The encoding requirements are as follows: - For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days). - For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or Prospective Payment System assessment, encoding must occur within 7 days after the Minimum Data Set Completion Date (Z0500B + 7 days). - For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records). The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 640	Continued From page 31	F 640	requirements; The Director of Nursing, Administrator or designated Nurse Manager will review 5 random residents who have had any of the following Minimum Data Set types (Admission, Quarterly, Annual) completed during the past 30 days in order to validate whether or not the assessment was completed within the required timeframes according to Chapter 2 of the Resident Assessment Instrument manual using the Quality Assurance Tool titled “MDS Timely Completion.” This will be done on a weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		2/26/20

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F 641	Continued From page 32 Based on observation, record review, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Residents #17, #23, #35, and #51), medications (Residents #28, #46, and #60), active diagnoses (Residents #1, #6, and #43), pressure ulcers (Residents #6 and #28), and alarms (Resident #60) for 10 of 25 residents reviewed. The findings included: 1. Resident #23 was admitted to the facility on 3/9/18 with diagnoses that included Parkinson' s disease. A device and bed rail review assessment date 7/19/19 indicated Resident #23 had bilateral grab bars on the top section of her bed. Resident #23 was noted to use the grab bars for transfers and bed mobility. She had no other devices in use. The quarterly Minimum Data Set (MDS) assessment dated 11/11/19 indicated Resident #23 ' s cognition was intact. The assessment indicated she had bed rails used daily that were physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The physical restraints section of this MDS was signed by the MDS Nurse. An interview was conducted with the MDS Nurse on 2/3/20 at 3:35 PM. She stated that she was new to MDS coding and was helping out with	F 641	F641 Accuracy of Assessments For resident #17, a corrective action was obtained on 02/03/20. " The specific deficiency was corrected on 02/03/20 by modifying the MDS assessment with an Assessment Reference Date of 10/31/19 in order to correct miscoding of Section P0100A Restraints (Bedrails). This correction was completed by the facility MDS Coordinator. The corrected MDS was re-submitted and accepted by the state database on 02/05/20 in Submission ID #18198218. For resident #23, a corrective action was obtained on 02/03/20. " The specific deficiency was corrected on 02/03/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 11/11/19 was modified in order to correct the coding for Section P0100A Restraints (Bedrails). The corrected MDS was re-submitted and accepted by the state database on 02/05/20 in Submission ID #18198218. For resident #35, a corrective action was obtained on 02/03/20. " The specific deficiency was corrected on 02/03/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 12/07/19 was modified in order to correct the coding for Section P0100A Restraints (Bedrails). The corrected MDS was re-submitted and accepted by the state database on 02/04/20 in Submission ID	

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assessments until about 3 weeks ago when she began as the MDS Nurse full time. The 11/11/19 MDS for Resident #23 that indicated she had bed rails used daily that were physical restraints was reviewed with the MDS Nurse. She revealed that she had not understood what this question was asking when she completed this MDS. She explained that she thought it was just asking if the resident had bed rails and that she had not realized that she was only supposed to code this if the bed rail met the definition of a physical restraint. The MDS Nurse stated that Resident #23 ' s grab bars were not physical restraints and that this MDS was coded incorrectly.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately. She reported the former MDS Nurse left that position in October and the current MDS Nurse was new to MDS coding and was still learning.

2. Resident #46 was admitted to the facility on 12/27/19 with diagnoses that included end stage renal disease and orthopedic aftercare.

A physician ' s order for Resident #46 dated 12/27/19 indicated Percocet (opioid medication) 5-325 milligrams (mg) every 4 hours as needed (PRN) for pain.

2a. A review of the Medication Administration Records (MARS) from 12/28/19 through 1/3/20 indicated Resident #46 received PRN Percocet on 6 of 7 days (12/28/19 through 1/2/20). Resident #46 received no opioid medication on 1/3/20.

F 641

#18190095.

For resident #51, a corrective action was obtained on 02/03/20.
" The specific deficiency was corrected on 02/03/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 12/10/19 was modified in order to correct the coding for Section P0100A Restraints (Bedrails). The corrected MDS was re-submitted and accepted by the state database on 02/04/20 in Submission ID #18190095.

For resident #43, a corrective action was obtained on 02/06/20.
" The specific deficiency was corrected on 02/06/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 12/26/19 was modified in order to correct the coding for Section I-15800 to include Depression. The corrected MDS was re-submitted and accepted by the state database on 02/07/20 in Submission ID #18215622.

For resident #60, a corrective action was obtained on 02/04/20.
" The specific deficiency was corrected on 02/04/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 01/01/20 was modified in order to correct the coding for Section N0410A to accurately reflect the correct number of days they received Antipsychotic medication during 7 day ARD lookback window. Section

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The admission Minimum Data Set (MDS) assessment dated 1/3/20 indicated Resident #46 ' s cognition was intact. She was coded with opioid medications on 7 of 7 days. The medications section of this MDS was signed by the MDS Nurse.

An interview was conducted with the MDS Nurse on 2/5/20 at 1:10 PM. She stated that she was new to MDS coding and was helping out with assessments until about 3 weeks ago when she began as the MDS Nurse full time. The 1/3/20 MDS for Resident #46 that indicated she received opioid medication on 7 of 7 days during the MDS look back period was reviewed with the MDS Nurse. The MARs that indicated Resident #46 received opioid medication on 6 of 7 days during the MDS look back period (12/28/19 through 1/3/20) was reviewed with the MDS Nurse. The MDS Nurse revealed this coding for opioid medication was an error and should have been coded to indicated opioid medication was administered on 6 of 7 days.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately. She reported the former MDS Nurse left that position in October and the current MDS Nurse was new to MDS coding and was still learning.

2b. A review of the MARs from 12/30/19 through 1/3/20 indicated Resident #46 received PRN Percocet for pain on 4 of 5 days (12/30/19 through 1/2/20).

The admission MDS assessment dated 1/3/20 indicated Resident #46 ' s cognition was intact. There was no answer to the question that asked if

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P0200E was also modified in order to reflect correct coding of Wanderguard Alarm that was used daily during lookback timeframe. The corrected MDS was re-submitted and accepted by the state database on 02/05/20 in Submission ID #18198218.

For resident #28 (1), a corrective action was obtained on 02/05/20 for inaccurate coding of Anticoagulant.
" The specific deficiency was corrected on 02/05/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 11/18/19 was modified in order to correct the coding for Section N0410E to accurately reflect the correct number of days they received Anticoagulant medication during 7 day ARD lookback window. The corrected MDS was re-submitted and accepted by the state database on 02/05/20 in Submission ID #18198218.

For resident #28 (2), a corrective action was obtained on 02/24/20 for inaccurate coding of Unstageable Pressure Ulcer due to Unremoveable Dressing.
" The specific deficiency was corrected on 02/24/20 by the MDS Consultant. The MDS assessment with Assessment Reference Date of 11/18/19 was modified in order to correct the coding for Section M0300E1 to accurately reflect that the resident did not have an Unstageable Pressure Ulcer due to Non-Removable Dressing/Device. The corrected MDS

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PRN pain medications were received during the last 5 days. The pain section of this MDS was signed by the MDS Nurse.

An interview was conducted with the MDS Nurse on 2/5/20 at 1:10 PM. She stated that she was new to MDS coding and was helping out with assessments until about 3 weeks ago when she began as the MDS Nurse full time. The 1/3/20 MDS that indicated no answer to the question that asked if PRN pain medications were received during the last 5 days was reviewed with the MDS Nurse. The MARs that indicated Resident #46 received PRN Percocet for pain on 4 of 5 days from 12/30/20 through 1/3/20 was reviewed with the MDS Nurse. The MDS Nurse revealed this the coding was inaccurate and should have been coded to indicate that PRN pain medications were administered during the last 5 days.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately. She reported the former MDS Nurse left that position in October and the current MDS Nurse was new to MDS coding and was still learning.

3a. Resident #28 was admitted to the facility on 3/29/19 with diagnoses that included Parkinson ' s disease.

A review of the wound and skin assessments from 11/1/19 through 11/18/19 indicated Resident #28 had one pressure ulcer that was unstageable.

The quarterly Minimum Data Set (MDS)

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was re-submitted and accepted by the state database on 02/24/20 in Batch #1400.

For resident #46, a corrective action was obtained on 02/05/20.
" The specific deficiency was corrected on 02/05/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 1/3/20 was modified in order to correct the coding for Section N0410H to accurately reflect the correct number of days they received Opioid medication during 7 day ARD lookback window. J0100B was also modified in order to reflect correct coding for resident having received as needed (prn) pain medication during the ARD lookback timeframe. The corrected MDS was re-submitted and accepted by the state database on 02/06/20 in Submission ID #18206333.

For resident #1, a corrective action was obtained on 02/24/20.
" The specific deficiency was corrected on 02/24/20 by the MDS Consultant. The MDS assessment with Assessment Reference Date of 01/03/20 was modified in order to correct the coding for Section I15800 to accurately reflect the active diagnosis of Depression. The corrected MDS was re-submitted to the state database on 02/24/20 in Batch #1400.

For resident #6, a corrective action was obtained on 02/24/20.
" The specific deficiency was corrected on 02/24/20 by the MDS Consultant. The

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assessment dated 11/18/19 indicated Resident #28 ' s cognition was intact. She was coded with 1 unstageable pressure ulcer due to non-removable dressing/device and 1 unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar. The pressure ulcer section of this MDS was coded by the Support Nurse.

An interview was conducted with the Support Nurse on 2/4/20 at 4:11 PM. The wound and skin assessments from 11/1/19 through 11/18/19 that indicated Resident #28 had one unstageable pressure ulcer was reviewed with the Support Nurse. The 11/18/19 MDS that indicated Resident #28 had 1 unstageable pressure ulcer due to non-removable dressing/device and 1 unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar was reviewed with the Support Nurse. The Support Nurse revealed this MDS was coded inaccurately. She stated that Resident #28 had no pressure ulcers due to non-removable dressing/device.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately.

3b. Resident #28 was admitted to the facility on 3/29/19 with diagnoses that included Parkinson ' s disease.

The Medication Administration Records (MARs) for November 2019 indicated Resident #28 received no anticoagulant medication.

The quarterly MDS assessment dated 11/18/19 indicated Resident #28 ' s cognition was intact.

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MDS assessment with Assessment Reference Date of 01/17/20 was modified in order to correct the coding for Section I5700 to accurately reflect the absence of diagnoses of Anxiety. The corrected MDS was re-submitted to the state database on 02/24/20 in Batch #1400.

Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents have the potential to be affected by the alleged deficient practice.
A 100% audit of all current residents most recent OBRA MDS assessment will be conducted by the MDS Consultant.
This audit will include reviews for accurate coding of the following Sections of the MDS:
" Section P Physical Restraints
" Section P Alarms
" Section M Pressure Ulcers
" Section I Psychiatric Diagnoses
" Section J PRN Pain Medications
" Section N Antipsychotic, Anticoagulant and Opioid Use
This audit will be completed no later than 02/25/20. Any coding errors that are identified during the audit will be immediately modified and corrected and re-submitted to the state database.

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She was coded with anticoagulant medication on 7 of 7 days. The medications section of this MDS was coded by the Support Nurse.

An interview was conducted with the Support Nurse on 2/4/20 at 4:11 PM. The MARs that indicated Resident #28 received no anticoagulant medication and the 11/18/19 MDS that indicated Resident #28 received anticoagulant medication on 7 of 7 days were reviewed with the Support Nurse. The Support Nurse revealed this MDS was coding inaccurately and that it should have indicated no anticoagulant medications were received.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately.

4a. Resident #60 was admitted to the facility on 8/30/19 with diagnosis that included dementia.

A physician ' s order dated 12/25/19 indicated Seroquel (antipsychotic medication) 25 milligrams (mg) once daily at bedtime for Resident #60.

A review of the Medication Administration Records (MARs) from 12/26/19 through 1/1/20 indicated Resident #60 received Seroquel on 6 of 7 days (12/27/19 through 1/1/20).

The quarterly Minimum Data Set (MDS) assessment dated 1/1/20 indicated Resident #60 ' s cognition was moderately impaired. She was coded with no antipsychotic medication. The medications section of this MDS was signed by the MDS Nurse.

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Systemic Changes

On 02/18/20, the Regional Minimum Data Set Consultant completed an in service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record prior to completion of all Sections of the Minimum Data Set assessment. Special emphasis was on correctly counting and coding medications such as Antipsychotic, Opioids, Anticoagulants and prn pain medications. Other areas that were emphasized were how to accurately code Section P for Physical Restraints and Section P for Alarms. Correct coding of Active Diagnoses in Section I, including Depression and Anxiety were reviewed during the education. The importance of thorough review of all skin problems, focusing on Pressure Ulcers was discussed in order to be able to accurately code all portions of Section M.

This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators and new Dietary Managers.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
The Director of Nursing or designee will begin auditing the coding of Section J PRN pain medications; Section M Pressure Ulcers; Section I Psychiatric Diagnoses; Section N Antipsychotic,

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F 641	Continued From page 38 An interview was conducted with the MDS Nurse on 2/4/20 at 4:12 PM. She stated that she was new to MDS coding and was helping out with assessments until about 3 weeks ago when she began as the MDS Nurse full time. The 1/1/20 MDS for Resident #60 that indicated she received no antipsychotic medication and the MARs that indicated she received Seroquel on 6 of 7 days during the MDS look back period were reviewed with the MDS Nurse. The MDS Nurse revealed this was an error and the MDS should have been coded to indicate antipsychotics were received on 6 of 7 days. During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately. She reported the former MDS Nurse left that position in October and the current MDS Nurse was new to MDS coding and was still learning. 4b. Resident #60 was admitted to the facility on 8/30/19 with diagnosis that included dementia. A physician ' s order dated 11/26/19 indicated a wander/elopement alarm for Resident #60. A review of the Treatment Administration Records (TARs) from 12/1/19 through 1/1/20 indicated Resident #60 had a wander/elopement alarm utilized daily. The quarterly Minimum Data Set (MDS) assessment dated 1/1/20 indicated Resident #60 ' s cognition was moderately impaired. She was coded with no wander/elopement alarm in use. An interview was conducted with the MDS Nurse	F 641	Anticoagulant and Opioid use; Section P Physical Restraints and Section P Alarms of the Minimum Data Set Assessment using the quality assurance survey tool entitled Accurate MDS Coding Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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on 2/4/20 at 4:12 PM. She stated that she was new to MDS coding and was helping out with assessments until about 3 weeks ago when she began as the MDS Nurse full time. The 1/1/20 MDS for Resident #60 that indicated no wander/elopement alarm was in use and the TARs that indicated a wander/elopement alarm was in use daily were reviewed with the MDS Nurse. The MDS Nurse revealed this was an error and the MDS should have been coded to indicate a wander/elopement alarm was in use.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately. She reported the former MDS Nurse left that position in October and the current MDS Nurse was new to MDS coding and was still learning.
5) Resident #51 was originally admitted to the facility on 6/24/15 with diagnoses that included chronic pain syndrome, spinal stenosis and dementia.

A Device and Bed Rail Review assessment dated 7/19/19 indicated Resident #51 had bilateral grab bars on the top section of her bed. She was noted to use the grab bars for transfers and bed mobility, and they did not restrict her freedom of movement or normal access to the body. There were no other devices in use.

The quarterly Minimum Data Set (MDS) dated 12/10/19 revealed Resident #51 to have moderately impaired cognition. She required extensive assistance of 2 staff members for bed mobility and transfers. The assessment indicated she had bed rails used daily that were physical restraints (any manual method, physical or mechanical device, material or equipment

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attached or adjacent to the body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The physical restraint section of the MDS was signed by the MDS Nurse.

On 2/3/2020 at 3:35pm the MDS Nurse was interviewed and stated she was new to MDS coding and was helping out with assessments until about 3 weeks ago when she became the new MDS Nurse full time. She reviewed the 12/10/19 MDS for Resident #51 which indicated bed rails were used daily and were physical restraints. The MDS Nurse explained she had not understood what the question was asking when she completed the MDS and thought it was just asking if the resident had bed rails. She further stated she had not realized she was only supposed to code this if the bed rail met the definition of a physical restraint. The MDS nurse stated Resident #51's grab bars were not physical restraints and the MDS was coded incorrectly.

The Administrator was interviewed on 2/6/2020 at 10:10am and stated it was her expectation for the MDS to be coded accurately. She explained the former MDS Nurse left the position in October and the current MDS Nurse was new to MDS coding and was still learning.

6) Resident #17 was originally admitted to the facility on 2/22/12 with diagnoses that included dementia.

A Device and Bed Rail Review assessment dated 7/19/19 indicated Resident #17 had bilateral grab bars at the top section of her bed. She was noted to use the grab bars for bed mobility, and they did

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F 641	Continued From page 41 not restrict her freedom of movement or normal access to the body. There were no other devices in use. The quarterly Minimum Data Set (MDS) dated 10/31/19 revealed Resident #17 to have severe cognitive impairment. She required extensive assistance of 2 staff members for bed mobility and transfers. The assessment indicated she had bed rails used daily that were physical restraints (any manual method, physical or mechanical device, material or equipment attached or adjacent to the body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The physical restraint section of the MDS was signed by the MDS Nurse. On 2/3/2020 at 3:35pm the MDS Nurse was interviewed and stated she was new to MDS coding and was helping out with assessments until about 3 weeks ago when she became the new MDS Nurse full time. She reviewed the 10/31/19 MDS for Resident #17 which indicated bed rails were used daily and were physical restraints. The MDS Nurse explained she had not understood what the question was asking when she completed the MDS and thought it was just asking if the resident had bed rails. She further stated she had not realized she was only supposed to code this if the bed rail met the definition of a physical restraint. The MDS nurse stated Resident #17's grab bars were not physical restraints and the MDS was coded incorrectly. The Administrator was interviewed on 2/6/2020 at 10:10am and stated it was her expectation for the MDS to be coded accurately. She explained the former MDS Nurse left the position in October	F 641		

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F 641	Continued From page 42 and the current MDS Nurse was new to MDS coding and was still learning. 7. Resident #35 was admitted 4/9/18 with cumulative diagnoses of Cerebral Vascular Accident, dysphagia, and epilepsy. Review of Resident #35's February 2020 Physician orders read he may have ¼ bilateral side rails for positioning and bed mobility dated 10/23/19. Review of Resident #35's care plan revised 10/23/19 read he required the use of ¼ side rails to maintain independence with bed mobility as possible with an increased risk of entrapment and injuries. Review of Resident #35's Side Rail Assessment dated 10/24/19 read Resident #35 required ¼ upper side rails for positioning and bed mobility. Review of Resident #35's quarterly Minimum Data Set (MDS) dated 12/7/19 indicated severe cognitive impairment and he exhibited physical and verbal behaviors. Resident #35 was coded for extensive assistance with bed mobility and coded for the use of side rails as physical restraints. In an observation on 2/2/20 at 5:00 PM, Resident #35 was in bed leaning to the right with pillow in between his head and ¼ side rails. The bed was in the low position with bilateral fall mats on the floor. In another observation on 2/3/20 at 10:00 AM, Resident #35 was lying in the same position as previously stated but he was observed flaying his	F 641		

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right-side extremities and yelling.

In an interview on 2/3/20 at 10:20 AM, Nursing Assistant (NA) #5 stated the bilateral ¼ side rails did not restrict Resident #35 from movement or getting out of the bed.

In an interview on 2/3/20 at 11:34 AM, Nurse #5 stated Resident #35 was able to get out of bed and the ¼ bilateral side rails did not restrain him while in the bed. She stated the side rails were use for positioning since he tended to lean to the right.

In an interview on 2/3/20 at 2:20 PM, the MDS Nurse stated the bilateral ¼ side rails did not prevent Resident #35 from getting out of the bed but rather used because of his tendency to lean to the right. She stated Resident #35 has experienced falls onto the fall mat without injuries.

In another interview on 2/3/20 at 3:35 PM, the MDS Nurse stated it was her 3rd full week as an MDS Nurse so it was new to her. She confirmed helping out with some of the assessments for a couple of months, but she was brand new to MDS and acknowledged she was still learning. The MDS Nurse stated she did not understand the MDS question regarding side rails as physical restraints and was coding all side rails as restraints. She stated that a consultant group told her that she was coding the side rails incorrectly but she did not go back and modify the MDS.

In an interview on 2/6/20 at 10:11 AM, the Administrator stated the MDS Nurse still was learning and she should have gone and modified

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Resident #35's quarterly MDS to reflect he did not require the use of side rails as physical restraint. She further stated it was her expectation that Resident #35's MDS was coded correctly.

8. Resident #1 was admitted to the facility on 8/30/18 with the diagnoses of heart disease, insomnia, chronic pain, Lupus (inflammatory autoimmune disease), and rheumatoid arthritis.

The resident ' s quarterly MDS dated 1/3/2020 documented she had clear speech and understood/understands and had an intact cognition. The resident ' s active diagnoses were heart disease, anxiety, chronic obstructive pulmonary disease, chronic pain, insomnia, and Lupus. The resident received 7 days of antidepressant and antianxiety medication.

The care plan was updated on 12/26/19 and covered all the resident ' s current diagnoses and medication administration. The resident had goals and interventions for side effects to antidepressant medication.

There was a physician order for Bupropion XL 75 milligrams (antidepressant) two tablets twice a day which was documented on the medication administration record as administered as ordered during the MDS lookback period of 1/3/2020.

On 2/6/2020 at 9:40 am an interview was conducted with the MDS Coordinator who stated the depression diagnoses should have been coded on the 1/3/2020 quarterly MDS and would be corrected.

On 2/6/2020 at 10:15 am an interview was conducted with the Administrator who stated she

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expected the MDS to be coded accurately.

9. Resident #6 was admitted to the facility on 6/12/17 with the diagnoses of hemiplegia and hemiparesis, dysphagia, and diabetes.

The resident ' s quarterly MDS dated 1/17/2020 documented the resident had adequate hearing and was understood/understands and her cognition was intact. The active diagnoses were non-Alzheimer's dementia, hemiplegia, anxiety, depression, and psychotic disorder. The resident received 7 days of antidepressant and antipsychotic.

The resident's updated care plan of 1/9/2020 included psychotropic medication administration to include antianxiety, antidepressant and antipsychotic administration and assessment for side effects. Pharmacy to review and recommend for possible changes or reduction.

A review of the resident ' s January 2020 medication administration record revealed she did not receive an antianxiety medication or treatment for anxiety during the MDS lookback period of 1/17/2020.

On 2/6/2020 at 9:40 am an interview was conducted with the MDS Coordinator who stated the anxiety diagnoses should not have been coded on the 1/17/2020 quarterly MDS and would be corrected.

On 2/6/2020 at 10:15 am an interview was conducted with the Administrator who stated she expected the MDS to be coded accurately.

10. Resident #43 was admitted to the facility on

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9/4/17 with the diagnoses of post-concussional syndrome, unspecified injury at cervical 5 spine, and functional quadriplegia.

Resident #43 ' s quarterly MDS dated 12/26/19 documented that the resident had adequate hearing, clear speech, understood and understands. The resident was scored having an intact cognition for memory but does not have appropriate decision making. The active diagnoses were seizure, anxiety, functional quadriplegia, post-concussional syndrome, unspecified injury at cervical 5 spine, and chronic pain syndrome. His pain was assessed, and treatment was provided. The resident received 7 days of antianxiety and antidepressant medication.

The updated care plan dated 12/26/19 covered each of the resident ' s diagnoses including potentials and behaviors. The resident had goals and interventions for evaluation of side effects of antidepressant and anxiety medication.

A review of the resident ' s December 2019 medication administration record revealed documentation the resident received Escitalopram Oxalate Tablet 20 mg (antidepressant) each day for the MDS look-back period of 12/26/19. The resident was also documented as being assessed in the same timeframe for signs and symptoms of antidepressant side effects.

On 2/6/2020 at 9:40 am an interview was conducted with the MDS Coordinator who stated the depression diagnoses should have been coded on the 12/26/19 quarterly MDS and would be corrected.

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F 641	Continued From page 47 On 2/6/2020 at 10:15 am an interview was conducted with the Administrator who stated she expected the MDS to be coded accurately.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to	F 657	F657 Care Plan Timing and Revision Resident #4, a corrective action was	2/28/20

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review and revise care plans in the areas of activities (Residents #4 and #9) and medications (Resident #60) for 3 of 22 residents reviewed for care plan revisions. The facility also failed to ensure a Nursing Assistant (NA) was involved in the care planning process for 4 of 4 residents (Residents # 11, #28, #36, and #60) reviewed for participation in the care planning process.

The findings included:

1. Resident #4 was admitted to the facility on 3/16/18 with diagnoses that included heart failure.

The quarterly Minimum Data Set (MDS) assessment dated 1/7/20 indicated Resident #4 ' s cognition was intact.

A review of Resident #4 ' s physician ' s orders from 10/1/19 through 2/5/20 indicated she had not been on an antibiotic since October of 2019.

Resident #4 ' s active care plan was reviewed on 2/5/20. This care plan included the focus areas of attending and participating in most activities at the facility. The goal was for Resident #4 to attend and participate in activities. The goal additionally noted that Resident #4 was on an antibiotic. This goal was last revised on 4/12/19.

An interview was conducted with the MDS Nurse on 2/5/20 at 8:15 AM. She confirmed that Resident #4 was not on an antibiotic and that this care plan for activities was not accurate. She reported that the Activities Director was responsible for revising care plans related to activities.

An interview was conducted with the Activities

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obtained on 02/05/20.
On 02/05/20 the Activities care plan for resident #4 was revised in order to accurately reflect that resident is not currently receiving antibiotic medication. This was completed by the Activities Director.

Resident #9, a corrective action was obtained on 02/23/20.

On 02/23/20 the Activities care plan for resident #9 was revised in order to accurately reflect that he is no longer too weak to participate in his usual activities. This was completed by the MDS Consultant.

Resident #60, a corrective action was obtained on 02/04/20.

On 02/04/20 the Activities care plan for resident #60 was revised in order to accurately reflect that she is not currently receiving antibiotic medication. This was completed by the Activities Director.

Resident(s) #11, #28, #36 and #60, a corrective action was obtained on 02/24/20.

On 02/24/20 the care plans for the above residents (#11, #28, #36, and #60) were reviewed with their routine nursing assistants in order to potentially identify any areas that may need to be revised or update, as well as to potentially identify new concerns that need to be added to the care plan. This was completed by the

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F 657	Continued From page 49 Director on 2/5/20 at 8:30 AM. The Activities Director stated that she was responsible for developing and revising care plans related to activities. The care plan related to activities for Resident #4 that indicated she was on an antibiotic was reviewed with the Activities Director. The Activities Director revealed that Resident #4 was no longer on an antibiotic and that this care plan should have been revised. She further revealed she had not known how to revise a care plan once it was created. She was unable to explain why she had not asked another staff member how to revise the care plans. During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected care plans to be reviewed and revised to reflect the current status of the resident. She additionally stated that she expected staff responsible for care plan revisions to know how to revise the care plans. 2. Resident #9 was most recently admitted to the facility on 1/7/19 with diagnoses that included heart failure. The quarterly Minimum Data Set (MDS) assessment dated 7/19/19 indicated Resident #9 ' s cognition was intact. The 1/17/20 Activities Assessment indicated Resident #9 attended bingo and select food events. He was noted to self-propel his wheelchair through the facility. On 2/4/20 at 10:50 AM Resident #9 was observed in attendance at a resident council meeting.	F 657	MDS Coordinator. Corrective action for residents with the potential to be affected by the alleged deficient practice. A 100% audit was completed for all current residents who have had antibiotic medication completed/discontinued during the past 30 days in order to validate that the care plan for affected residents have been updated in order to show that antibiotic is no longer being administered. Audit results: 1 of 9 residents identified as having a care plan in place for antibiotic use even though resident is no longer receiving antibiotic. This resident□s care plan was updated on 02/23/20 in order to resolve the antibiotic use, so that it may reflect resident□s current status. This was completed by the MDS Consultant. 8 of 9 residents reviewed care plans accurately reflected that they currently do not receive antibiotic medication. A 100% audit was completed for all current residents□ activities care plans in order to validate whether or not this care plan reflects resident□s current ability to participate in activities. Audit results: 9 of 65 residents reviewed were identified as having an activities care plan that did not reflect their current activity status. These 9 residents□ care plans were revised on 02/23/20 by the MDS Consultant in order to accurately reflect their current activity status. 56 of 65 residents reviewed were noted to have care plans that accurately reflect their current activity ability and	

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During an interview with Resident #9 on 2/4/20 at 11:15 AM he indicated he enjoyed attending bingo.

Resident #9 ' s active care plan was reviewed on 2/5/20. This care plan included a focus area of being unable to participate in his usual daily activity routine. The goal indicated that Resident #9 had a new health issue that made him too weak to attend activities. This goal was last revised on 5/14/19.

An interview was conducted with the Activities Director on 2/5/20 at 8:30 AM. The Activities Director stated that she was responsible for developing and revising care plans related to activities. The care plan related to activities for Resident #9 that indicated he was too weak to attend activities was reviewed with the Activities Director. The Activities Director revealed that Resident #9 was no longer too weak to attend activities and that this care plan should have been revised. She further revealed she had not known how to revise a care plan once it was created. She was unable to explain why she had not asked another staff member how to revise the care plans.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected care plans to be reviewed and revised to reflect the current status of the resident. She additionally stated that she expected staff responsible for care plan revisions to know how to revise the care plans.

3a. Resident #60 was admitted to the facility on

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participation status.
A 100% audit of all current residents most recent care plan conferences was completed in order to validate whether or not resident s nursing assistant(s) were involved in the care planning process.
Audit results: 27 of 65 residents reviewed identified to have had nursing assistant participation in care plan meeting and process.
38 of 65 residents reviewed identified to not have had nursing assistant participation in their care planning meeting and process.
These 38 residents will have their care plans reviewed with their routine nursing assistant in order to possibly identify changes and revisions that need to be made to care plan. This will be completed by members of the Interdisciplinary Team including the MDS Coordinator and facility Social Services Director and MDS Consultant. These reviews will be completed no later than 02/28/20.
Systemic Changes

On 02/21/20, the MDS Nurse Consultant in-serviced the MDS Nurse and Interdisciplinary Team on the importance of maintaining up to date care plans that are reflective of the resident s current functioning level and special needs, and that the care plan should be updated/revised as the resident s needs change.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected

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8/30/19 with diagnosis that included dementia.

The quarterly Minimum Data Set (MDS) assessment dated 1/1/20 indicated Resident #60 ' s cognition was moderately impaired, and she received no antibiotic medications.

A review of the physician ' s orders and Medication Administration Records (MARs) from 1/1/20 through 2/4/20 indicated Resident #60 received no antibiotic medication.

Resident #60 ' s active care plan was reviewed on 2/4/20. This care plan included the focus area of antibiotic therapy related to a Urinary Tract Infection (UTI). This focus area was initiated on 9/2/18 and last revised on 10/28/19.

An interview was conducted with the MDS Nurse on 2/4/20 at 4:12 PM. The care plan related to antibiotic therapy for Resident #60 was reviewed with the MDS Nurse. The MDS Nurse stated that Resident #60 was not an antibiotic and that this care plan should have been revised to resolve this focus area. She reported the antibiotic was completed in December 2019.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected care plans to be reviewed and revised to reflect the current status of the resident.

3b. Resident #60 was admitted to the facility on 8/30/19 with diagnosis that included dementia.

The quarterly Minimum Data Set (MDS) assessment dated 10/1/19 indicated Resident #60 ' s cognition was moderately impaired.

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and/or in compliance with the regulatory requirements;
The Director of Nursing, Administrator or designated Nurse Manager will review 5 random (current) residents in order to validate whether or not the care plan accurately reflects the resident□s current activity status and antibiotic use status. The residents will also be reviewed to identify whether or not their nursing assistant was involved in the care planning meeting and/or process. This will be done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator
The title of the person responsible for implementing the acceptable plan of correction;
Administrator and /or Director of Nursing.

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A review of the care plan conference summaries dated 10/11/19 and 2/4/20 indicated a Nursing Assistant (NA) assigned to care for Resident #60 was not present in the meetings.

An interview was conducted with the Social Worker (SW) on 2/4/20 at 2:15 PM. The SW stated that care plan meetings were utilized to develop and review the care plans for all residents. She reported that the normal staff attendees were herself, the MDS Nurse and/or floor nurse, Activities Director, Dietary Manager, and rehabilitation staff if the resident was involved in therapy. The SW revealed that it was not normal facility practice for an NA assigned to the resident to attend the care plan meetings. She additionally revealed it was not normal facility practice for an NA assigned to the resident to be included in the care plan review/revision process. She stated that with the MDS Nurse and/or the floor nurse in attendance at the meeting that this was sufficient for the floor staffs ' involvement. The SW revealed she was unaware that the regulations required a direct care NA to be included in the care planning process.

An interview was conducted with NA #4 on 2/6/20 at 7:50 AM. She was asked if she ever reviewed the care plans for the residents she was assigned to. NA #4 revealed that the NAs reviewed the care guide/kardex, but not the care plans.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the regulations related to the care planning process to be followed.

4. Resident #28 was admitted to the facility on 3/29/19 with diagnoses that included Parkinson '

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s disease.

The admission Minimum Data Set (MDS) assessment dated 4/5/19 indicated Resident #28 ' s cognition was moderately impaired.

A review of the care plan conference summaries dated 7/11/19, 7/16/19, 10/2/19, and 2/4/20 indicated a Nursing Assistant (NA) assigned to care for Resident #28 was not present in the meetings.

An interview was conducted with the Social Worker (SW) on 2/4/20 at 2:15 PM. The SW stated that care plan meetings were utilized to develop and review the care plans for all residents. She reported that the normal staff attendees were herself, the MDS Nurse and/or floor nurse, Activities Director, Dietary Manager, and rehabilitation staff if the resident was involved in therapy. The SW revealed that it was not normal facility practice for an NA assigned to the resident to attend the care plan meetings. She additionally revealed it was not normal facility practice for an NA assigned to the resident to be included in the care plan review/revision process. She stated that with the MDS Nurse and/or the floor nurse in attendance at the meeting that this was sufficient for the floor staffs ' involvement. The SW revealed she was unaware that the regulations required a direct care NA to be included in the care planning process.

An interview was conducted with NA #4 on 2/6/20 at 7:50 AM. She was asked if she ever reviewed the care plans for the residents she was assigned to. NA #4 revealed that the NAs reviewed the care guide/kardex, but not the care plans.

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During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the regulations related to the care planning process to be followed.

5) Resident #11 was originally admitted to the facility on 10/11/19 with a readmission date of 11/5/19. Her diagnoses included cerebrovascular accident (CVA).

The admission Minimum Data Set (MDS) assessment dated 10/18/19 indicated Resident #11's cognition was severely impaired.

A review of the Care Plan Conference Summary dated 12/13/19 indicated a Nursing Assistant (NA) assigned to care for Resident #11 was not present in the meeting.

An interview occurred with the Social Worker (SW) on 2/4/2020 at 2:15pm, who stated the care plan meetings were utilized to develop and review the care plans for all residents. She reported the normal staff attendees were herself, if able, the MDS Nurse and/or floor nurse, the Activities Director, Dietary Manager and rehabilitation staff if the resident was involved in therapy. The SW revealed it was not normal facility practice for the NA assigned to the resident to attend the care plan meetings. She additionally stated it was not normal facility practice for the NA assigned to the resident to be included in the care plan review/revision process. She stated with the MDS Nurse and/or floor nurse in attendance at the meeting that was considered sufficient for the floor staff's involvement. The SW revealed she was unaware the regulations required a direct

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F 657	Continued From page 55 care NA to be included in the care planning process. An interview was conducted with Nurse Aide (NA) #4 on 2/6/2020 at 7:50am. NA #4 indicated the nurse aides reviewed the care guide/Kardex, but not the care plans for residents they were assigned to. On 2/6/2020 at 10:10am an interview occurred with the Administrator. She stated it was her expectation for the regulations related to the care planning process be followed. 6) Resident #36 was originally admitted to the facility on 11/25/13 with diagnoses that included end stage renal disease on dialysis. The annual Minimum Data Set (MDS) assessment dated 9/12/19 indicated Resident #36's cognition was intact. A review of the Care Plan Conference Summary dated 10/3/19 indicated a Nursing Assistant (NA) assigned to care for Resident #36 was not present in the meeting. An interview occurred with the Social Worker (SW) on 2/4/2020 at 2:15pm, who stated the care plan meetings were utilized to develop and review the care plans for all residents. She reported the normal staff attendees were herself, if able, the MDS Nurse and/or floor nurse, the Activities Director, Dietary Manager and rehabilitation staff if the resident was involved in therapy. The SW revealed it was not normal facility practice for the NA assigned to the resident to attend the care	F 657		

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F 657	Continued From page 56 plan meetings. She additionally stated it was not normal facility practice for the NA assigned to the resident to be included in the care plan review/revision process. She stated with the MDS Nurse and/or floor nurse in attendance at the meeting that was considered sufficient for the floor staff's involvement. The SW revealed she was unaware the regulations required a direct care NA to be included in the care planning process An interview was conducted with Nurse Aide (NA) #4 on 2/6/2020 at 7:50am. NA #4 indicated the nurse aides reviewed the care guide/Kardex, but not the care plans for residents they were assigned to. On 2/6/2020 at 10:10am an interview occurred with the Administrator. She stated it was her expectation for the regulations related to the care planning process be followed.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe the correct medication administration route for 1 of 1 resident reviewed for gastric feeding tube (Resident #11). The findings included:	F 658	F658 Comprehensive Care Plans Resident #11, a corrective action was obtained on 02/23/20. On 02/23/20 the care plan for Resident #11 was revised in order to accurately reflect their current status for medication administration route. This was completed	2/24/20

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F 658 Continued From page 57

Resident #11 was originally admitted to the facility on 10/11/19 with diagnoses including aphasia (impairment of language), gastrostomy and cerebral vascular accident (CVA).

Resident #11's admission Minimum Data Set (MDS) dated 10/18/19 indicated she had severe cognitive impairment. She required total assistance with all Activities of Daily Living and received all nutrition and fluids via a feeding tube.

Review of the active care plan revealed Resident #11 required tube feeding for all nutrition and fluids.

The active physician orders revealed an order dated 11/5/19 for Glucophage 1000 milligrams (mg) 1 tablet by mouth two time a day for diabetes and an order dated 1/30/2020 for Claritin 10mg 1 tablet by mouth one time a day for 10 days. All other medications were provided through the gastric feeding tube.

On 2/4/2020 at 9:50am an interview occurred with Nurse #1 who was working the medication cart for Resident #11's hall and had administered her medications earlier. She confirmed Resident #11 did not receive any medications by mouth and had not provided the morning doses of Glucophage or Claritin by mouth. Nurse #1 acknowledged the MAR read for the medications to be provided by mouth and was inaccurate.

An interview was conducted on 2/4/2020 at 3:50pm with Nurse #2 who was working on the medication cart for Resident #11's hall. She stated she was familiar with the resident and had administered her medications many times. Nurse #2 acknowledged Resident #11 did not receive

F 658

by the MDS Consultant.

Corrective action for residents with the potential to be affected by the alleged deficient practice.
A 100% audit was completed for all current residents who have feeding tubes in order to validate that their care plan accurately reflects the route in which they should receive medications.
Audit results:
7 of 7 residents reviewed were identified as not having route of medication administration reflected on care plan.
7 of 7 residents had care plan revisions completed on 2/23/20 in order to accurately reflect their current medication administration route. This was completed by the MDS Consultant.
Systemic Changes

On 02/21/20, the MDS Nurse Consultant in-serviced the MDS Nurse and Interdisciplinary Team on the importance of maintaining up to date care plans that are reflective of the resident□s current functioning level and special needs, and that the care plan should be updated/revised as the resident□s needs change including oral status/NPO status.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
The Director of Nursing, Administrator or designated Nurse Manager will review 5 random (current) residents in order to

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F 658	Continued From page 58 any medications by mouth and had transcribed the order for Claritin 10mg on 1/30/2020. The nurse stated the medication route by mouth was an error and should have reflected to administer the medication via the gastric feeding tube. On 2/5/2020 at 1:36pm a phone interview occurred with Nurse #4 who had revised the Glucophage 1000mg order on 1/5/2020. She explained she had only changed the time of administration to coincide with the other medications and did not catch the medication administration route as by mouth. She further stated Resident #11 received all her medications via the gastric feeding tube and nothing by mouth. At 2:30pm on 2/5/2020 a phone interview was conducted with Nurse #3 who had transcribed the order for Glucophage 1000mg on 11/5/19. She stated it was an error and should have stated to administer the medication through the gastric feeding tube. In an interview with the Administrator on 2/6/2020 at 10:10am, she expected all medication administration routes to be transcribed correctly when the order was received and/or reviewed.	F 658	validate whether or not the care plan accurately reflects the resident□s current medication administration route using the Quality Assurance tool titled Comprehensive Care Plan QA Tool. This will be done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
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 observations, staff and Responsible Party (RP) interviews and record review, the	F 677	The statements made on this plan of correction are not an admission to and do	3/3/20

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F 677	Continued From page 59 facility failed to provide nail care for activities of daily living dependent (ADL) Resident #35 and Resident #54 and failed to provide showers as scheduled for ADL dependent Resident #5 and Resident #19. This was 4 of 6 residents reviewed for ADLs. The findings included: 1. Resident #35 was admitted 4/9/18 with cumulative diagnoses of Cerebral Vascular Accident and contracture of the left elbow. Review of a grievance form dated 11/19/19 completed by Resident #35's RP read as follows: RP voiced that Resident #5's left hand was no being taken care of. She voiced his nails were not cut and very dirty. The concern was confirmed by the facility and would work on a process for routine nail care. Review of Resident #35's quarterly Minimum Data Set (MDS) dated 12/7/19 indicated severe cognitive impairment and he exhibited physical and verbal behaviors. Resident #35 was coded for extensive staff assistance with personal hygiene. Review of Resident #35's care plan revised 3/29/19 read Resident #35 required staff assistance with grooming and personal hygiene. There was no care plan for any refusals of nail care. Review of the undated electronic care guide for the aides to follow read as follows: required staff assistance with grooming and personal hygiene. Review of Resident #35's aide documentation for February 2020 read grooming(including nail care) was signed off by the aides for every shift.	F 677	not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 02/24/2020 nail care was provided and documented by the hall nurse. For resident #54, on 02/24/2020 nail care was provided and documented by the hall nurse. For resident # 5, on 02/24/2020 the nurse consultant updated the residents shower task to Tuesday and Friday 3-11. For resident #19, on 02/24/2020 the nurse consultant updated the residents shower task to Tuesday and Friday 7-3. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/18/2020, the nurse manager began auditing all current residents for the need of nail care. This audit will be completed by 03/03/2020. Nail care was provided to those residents identified in need of nail care. Beginning on 02/18/2020 the Nurse Secretary and Nurse Manager interviewed all current alert and oriented residents for	

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In an observation on 2/2/20 at 5:00 PM, Resident #35 was in bed. He had a left-hand contracture. His finger nails were long, jagged and dirty.

In an interview on 2/2/20 at 5:45 PM, Nursing Assistant (NA) #9 stated nail care was done as needed.

In another observation on 2/3/20 at 10:00 AM, Resident #35 was lying in bed. He had a left-hand contracture. His finger nails were long, jagged and dirty.

In another observation on 2/3/20 at 12:08 PM, Resident #35 was lying in bed. He had a left-hand contracture. His finger nails were long, jagged and dirty.

In an interview on 2/3/20 at 2:37 PM, the MDS Nurse stated she attempted to complete nail care on Resident #35 earlier on 2/3/20 but was only able to trim the nails on his right hand and unable to trim his nails on his contracted left hand. She stated she would be updating his care plan for the nail care refusal. The MDS Nurse confirmed the risk of untrimmed finger nails to a contracted hand to include skin injury.

In an interview on 2/3/20 at 2:50 PM, NA #5 stated she and the MDS Nurse attempted to complete his nail care on 2/3/20 but were unable to trim the finger nails on his contracted hand.

In an interview on 2/4/20 at 8:50 AM, Resident #35's RP stated she had voiced concerns about Resident #35's hygiene to include nail care. He had a left-hand contracture and his finger nails were long, jagged and dirty on observation. His

F 677

their preference regarding shower days. This will be completed by 03/03/2020.

The MDS nurse will then task the requested shower schedule to PCC task to fire to the CNA's for documentation. This will be completed by 03/03/2020.

For current non-alert and oriented residents, the CNA's were educated by the nurse managers on the new facility shower schedule and it should be followed as posted. Showers will be documented in the personal care task of Point Click Care. This will be completed by 03/03/2020.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 02/19/2020 and 02/24/2020, the Nurse Managers began education to all full time, part time, and PRN Nurses and CNA's on the following:

- New revised Shower schedule
- Nail care should be performed daily with baths/showers
- Refusal documentation
- Diabetic nail care schedule

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who

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RP stated she had completed a grievance about his nail care months ago but has not seen any improvement.

In an observation on 2/5/20 at 9:20 AM, Resident #35's finger nails on his contracted left hand had been trimmed. Resident #35 stated his left hand felt better.

In an interview on 2/5/20 at 1:09 PM, the Medical Record Supervisor stated after reviewing Resident #35's medical record, she did not locate any documented evidence of his refusals nail care.

In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that Resident #35's finger nails be clean and trimmed and if he refused, staff should go back and attempt until completed.

2. Resident #54 was admitted on 9/1/17 with cumulative diagnoses of Congestive Heart Failure, Chronic Kidney Failure and Glaucoma.

Review of Resident #54's quarterly modified Minimum Data Set (MDS) dated 12/9/19 indicated he was cognitively intact, exhibited no behaviors and his vision was severely impaired. He was coded as requiring extensive staff assistance with personal hygiene.

Review of Resident #54's care plan last revised 9/19/19 read he was legally blind and required staff assistance with his activities of daily living (ADLs). He was care planned for the refusal of showers.

Review of the undated electronic care guide for

does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor shower and nail care compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.

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F 677	Continued From page 62 the aides to follow read as follows: keep finger nails short. Review of Resident #54's aide documentation for February 2020 read grooming(including nail care) was signed off by the aides for every shift. In an observation on 2/2/20 at 1:46 PM, Resident #54's finger nails were observed to be very long and dirty. He stated he was blind but apparently his finger nails need some attention. He stated it had been awhile since anyone trimmed his nails. In an interview on 2/2/20 at 5:45 PM, Nursing Assistant (NA) #9 stated nail care was completed as needed. In an interview on 2/4/20 at 8:30 AM, NA #6 stated she was not aware of any refusals of nail care by Resident #54. In another interview and observation on 2/4/20 at 8:45 AM, Resident #54's finger nails were observed to be very long and dirty. He stated the staff must have not gotten around to trimming his nails. In another interview and observation on 2/5/20 at 9:30 AM, Resident #54's finger nails were observed to be very long and dirty. He stated the staff still had not gotten around to trimming his nails. In another interview on 2/5/20 at 9:40 AM, NA #5 stated Resident #54 preferred bed baths and seldom took showers. She stated she trimmed finger nails after showers because the nails are softer and easier to trim. In another interview and observation on 2/5/20 at	F 677		

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F 677	Continued From page 63 1:25 PM, Resident 54's finger nails were observed to be very long and dirty. He stated in the past 3rd shift trimmed his finger nails. He stated the staff must have forgotten to do it. Resident #54 stated he disliked his finger nails appearing long and dirty. He stated since he was blind, he was worried about scratching himself by accident. In an interview on 2/5/20 at 1:09 PM, the Medical Record Supervisor stated after reviewing Resident #54's medical record, she did not locate any documented evidence of his refusals nail care. In an interview on 2/5/20 at 1:30 PM, the Support Nurse stated she assessed Resident #54's finger nails and observed them to be long and dirty. She stated she was not aware of any refusals of nail care and she would complete nail care for Resident #54 immediately. In another interview on 2/5/20 at 2:05 PM, the Support Nurse stated she went in to complete Resident #54's nail care but his family member was in the room trimming his finger nails and declined her assistance. In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation Resident #54's nails be trimmed and clean. 3. Resident #5 was admitted on 12/16/17 with cumulative diagnoses of Congestive Heart Failure and oxygen dependence. Review of Resident #5's quarterly Minimum Data Set dated 1/7/20 indicated severe cognitive impairment and she exhibited no behaviors. She	F 677		

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F 677	Continued From page 64 was coded for staff physical help with bathing. Review of Resident #5's care plan last revised 7/12/19 read she required staff assistance with his activities of daily living (ADLs). She was not care planned for refusals of her showers. Review of the undated electronic care guide for the aides to follow made no mention of showers or bathing. Review of an undated Shower Schedule read Resident #5 was to receive a shower on 2nd shift Wednesdays and Saturdays. Review of the Activity Assessment dated 1/7/20 completed with the input of Resident #5 indicated choice between showers or bed baths was not very important to her. There was no documented input from Resident #5's Responsible Party (RP). In an interview on 02/02/20 at 5:07 PM, Resident #5's RP stated she did not think she was receiving showers. She stated showers were very important to her. Resident #5 appeared disheveled but absent of odors. In an interview on 2/3/20 at 250 PM, Nursing Assistant (NA) #5 stated Resident #5 did not exhibit any refusal of her ADLs. Review of Resident #5's Personal Care records from 12/16/19 to 2/4/20 revealed no documented evidence of any showers. In an observation on 2/5/20 at 9:25 AM, Resident #5 was appeared disheveled and absent of odors. She was lethargic and complained of not feeling well.	F 677		

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In an interview on 2/5/20 at 9:40 AM, NA #6 stated showers were very important to Resident #5 but she had not been feeling well for the last few days.

In an interview on 2/5/20 at 1:09 PM, the Medical Record Supervisor stated after reviewing Resident #5's medical record, she did not locate any documented evidence of his refusals of showers.

In an interview on 2/5/20 at 3:40 PM, NA #8 stated Resident #5 refused her showers but she completed a bed bath when she refused. NA #8 stated she did not recall if she reported Resident #5's refusals.

In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that Resident #5 received her showers as scheduled and was in the process of starting a shower team to ensure resident received their showers.

4. Resident #19 was admitted on 10/30/19 with cumulative diagnoses of Hypertension and Depression.

Review of Resident #19's admission Minimum Data Set (MDS) dated 11/6/19 indicated severe cognitive impairment with physical behaviors. She was coded for staff physical help with bathing.

Review of Resident #19's care planned last revised 10/30/19 read she required staff assistance with his activities of daily living (ADLs). She was not care planned for refusals of her showers.

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Review of the undated electronic care guide for the aides to follow made no mention of showers or bathing.

Review of an undated Shower Schedule read Resident #19 was to receive a shower on 1st shift Mondays and Thursdays.

Review of the Activity Assessment dated 11/4/19 completed with the input of Resident #19's family indicated choice between showers or bed baths was very important to her.

Review of Resident #19's Personal Care records from 11/28/19 to 2/4/20 revealed no documented evidence of any showers.

In an observation on 2/2/20 at 3:50 PM, Resident #19 was observed sitting on her bed. She appeared clean and well groomed. Resident #19 was unable to recall the last time she had a shower but stated she loved taking showers.

In another observation on 2/3/20 at 9:50 AM, Resident #19 was still in bed and not dressed for the day. She stated she did not need assistance getting ready.

In an interview on 2/3/20 at 10:20 AM, NA #5 stated Resident #19 required staff assistance with her ADLs to include bathing and showers.

In another interview on 2/5/20 at 9:40 AM, NA #5 stated she on occasion put Resident #19 in the whirlpool but she had to chart it in the electronic record as a shower. When questioned why Resident #19 did not receive a shower on Monday 2/3/20, she stated sometimes she documented a bed bath accidently and thought

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F 677	Continued From page 67 she gave Resident #19 a shower on 2/3/20. In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that Resident #19 received her showers as scheduled and was in the process of starting a shower team to ensure resident received their showers.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to ensure group activities were planned on the evenings and weekends to meet the needs of residents who expressed that it was important to them to attend group activities (Residents #2, #4, #9, #22, and #52) for 5 of 5 residents reviewed. The findings included: A review of the Activities Calendar from July 2019 through January 2020 revealed the following; - July 2019: There were 2 evening group activities planned during the entire month and 1 weekend	F 679	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F679 1. Corrective action for resident(s) affected by the alleged deficient practice:	3/3/20

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group activity was planned on all weekend days with the exception of 1 that had 2 group activities planned. The weekend group activities were all religious/spiritual activities.

- August 2019: There were 2 evening group activities planned during the entire month and 1 weekend group activity was planned on all weekend days with the exception of 1 that had 2 group activities planned and 1 that had no group activities planned. The weekend group activities were all religious/spiritual activities.

- September 2019: There were 3 evening group activities planned during the entire month and 1 weekend group activity was planned on all weekend days with the exception of 1 that had 2 group activities planned. The weekend group activities were all religious/spiritual activities.

- October 2019: There were 2 evening group activities planned during the entire month and 1 weekend group activity was planned on all weekend days with the exception of 1 that had 2 group activities planned. The weekend group activities were all religious/spiritual activities.

- November 2019: There were 2 evening group activities planned during the entire month and 1 weekend group activity was planned on all weekend days with the exception of 1 that had 2 group activities planned. The weekend group activities were all religious/spiritual activities.

- December 2019: There were 3 evening group activities planned during the entire month and 1 weekend group activity was planned on all weekend days with the exception of 1 that had 2 group activities planned. The weekend group

F 679

For resident□s #2, #4, #9, #22, and #52, the resident was interviewed on 02/18/2020 by the Social Worker for their activities preference for evenings and weekends.
On 02/18 and 02/21/2020 the Administrator and Activities Coordinator met to discuss how to incorporate the resident□s preference for activities in the evenings and on weekends. A new activity calendar will be generated by 03/01/2020 incorporating the ideas of the resident interviews.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 02/18/2020 the Social Worker interviewed all alert and oriented residents for their preference of evening and weekend activities.

The Administrator and Activity Director will generate a new activity calendar by 03/01/2020 incorporating the ideas of the resident interviews.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 02/24/2020, the Administrator educated the Activity Coordinator on the following:

" Offering activities to include the weekends and evenings.

This information has been integrated into

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activities were all religious/spiritual activities.

- January 2020: There were 2 evening group activities planned during the entire month and 1 weekend group activity was planned on all weekend days with the exception of 1 that had 2 group activities planned. The weekend group activities were all religious/spiritual activities.

1. Resident #22 was most recently admitted to the facility on 8/29/18 with diagnoses that included heart failure.

The annual Minimum Data Set (MDS) assessment dated 11/7/19 indicated Resident #22 ' s cognition was fully intact. This assessment indicated that it was very important to Resident #22 to do things with groups of people.

The Activity Assessment dated 11/7/19 indicated it was very important to Resident #22 to do things with groups of people. She was noted to attend almost every activity offered.

Resident #22 ' s active care plan included the focus area of participating in most activities offered in the facility. The interventions included ensuring that she was up and ready to attend each activity as needed.

During a Resident Council meeting held on 2/4/20 at 10:50 AM Resident #22 indicated there were hardly any activities on the evenings or weekends. She added that she enjoyed group activities and attended most activities that were held at the facility.

An interview was conducted with the Activities

F 679

the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Administrator will monitor compliance utilizing the F679 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months. The tool will monitor to ensure activities are offered at the scheduled times and meet the interest of the residents. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate.
Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.

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Director on 2/4/20 at 2:30 PM. The Activities Director confirmed there were normally no group activities planned in the evenings and typically only 1 group activity was planned on each weekend day. She additionally confirmed the weekend activities were all conducted by community church groups. She stated that she worked normal business hours on Monday through Friday and she was unable to conduct activities herself on the evenings or weekends, so she had not scheduled activities during these times.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected a sufficient amount of activities to be planned and held on the evenings and weekends to meet the needs/interests of the residents. She reported she was already working on a plan to revise the activity calendar to include a greater variety and availability/frequency of activities geared toward the residents ' needs and interests.

2. Resident #9 was most recently admitted to the facility on 1/7/19 with diagnoses that included heart failure.

The quarterly Minimum Data Set (MDS) assessment dated 7/19/19 indicated Resident #9 ' s cognition was intact.

The Activities Assessment dated 1/17/20 indicated Resident #9 ' s current interests included bingo, pets, and puzzles. Doing things with groups of people was noted to be somewhat important to Resident #9.

Resident #9 ' s active care plan included a focus

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area of being unable to participate in his usual daily activity routine. The goal indicated that Resident #9 had a new health issue that made him too weak to attend activities. This goal was last revised on 5/14/19. The interventions included, in part, asking about his activity preferences and helping him plan activities.

During a Resident Council meeting held on 2/4/20 at 10:50 AM Resident #9 indicated there were hardly any activities on the evenings or weekends. He stated that weekends were "rough", explaining that he got bored due to the lack of activities. He reported his favorite activity was bingo.

An interview was conducted with the Activities Director on 2/4/20 at 2:30 PM. The Activities Director confirmed there were normally no group activities planned in the evenings and typically only 1 group activity was planned on each weekend day. She additionally confirmed the weekend activities were all conducted by community church groups. She stated that she worked normal business hours on Monday through Friday and she was unable to conduct activities herself on the evenings or weekends, so she had not scheduled activities during these times.

A follow up interview was conducted with the Activities Director on 2/5/20 at 8:30 AM she revealed that Resident #9 ' s care plan was not an accurate representation of his current status. She explained that he was no longer too weak to attend activities and that this care plan should have been revised. She stated that Resident #9 attended activities such as bingo and parties.

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During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected a sufficient amount of activities to be planned and held on the evenings and weekends to meet the needs/interests of the residents. She reported she was already working on a plan to revise the activity calendar to include a greater variety and availability/frequency of activities geared toward the residents ' needs and interests.

3. Resident #4 was admitted to the facility on 3/16/18 with diagnoses that included heart failure.

The quarterly Minimum Data Set (MDS) assessment dated 1/7/20 indicated Resident #4 ' s cognition was intact.

The Activities Assessment dated 1/7/20 indicated it was very important to Resident #4 to do things with groups of people. She was noted to attend bingo, church activities, bands, parties, and resident council.

Resident #4 ' s active care plan included the focus area of attending and participating in most activities at the facility. The interventions included ensuring that she was up and ready to attend each activity as needed.

During a Resident Council meeting held on 2/4/20 at 10:50 AM Resident #4 indicated there were hardly any activities on the evenings or weekends. She reported she enjoyed group activities and she attended most of the activities at the facility.

An interview was conducted with the Activities Director on 2/4/20 at 2:30 PM. The Activities

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Director confirmed there were normally no group activities planned in the evenings and typically only 1 group activity was planned on each weekend day. She additionally confirmed the weekend activities were all conducted by community church groups. She stated that she worked normal business hours on Monday through Friday and she was unable to conduct activities herself on the evenings or weekends, so she had not scheduled activities during these times.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected a sufficient amount of activities to be planned and held on the evenings and weekends to meet the needs/interests of the residents. She reported she was already working on a plan to revise the activity calendar to include a greater variety and availability/frequency of activities geared toward the residents ' needs and interests.

4. Resident #2 was admitted to the facility on 7/1/16 with diagnoses that included heart failure.

The quarterly Minimum Data Set (MDS) assessment dated 10/4/19 indicated Resident #2 ' s cognition was moderately impaired.

The Activities Assessment dated 1/3/20 indicated it was somewhat important to Resident #2 to do things with groups of people. He was noted to attend parties, church activities, singing activities, and resident council.

Resident #2 ' s active care plan included the focus area of participating in most activities at the facility. The interventions included ensuring that

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he was up and ready to attend each activity as needed.

During a Resident Council meeting held on 2/4/20 at 10:50 AM Resident #2 indicated there were hardly any activities on the evenings or weekends. He reported he enjoyed group activities.

An interview was conducted with the Activities Director on 2/4/20 at 2:30 PM. The Activities Director confirmed there were normally no group activities planned in the evenings and typically only 1 group activity was planned on each weekend day. She additionally confirmed the weekend activities were all conducted by community church groups. She stated that she worked normal business hours on Monday through Friday and she was unable to conduct activities herself on the evenings or weekends, so she had not scheduled activities during these times.

During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected a sufficient amount of activities to be planned and held on the evenings and weekends to meet the needs/interests of the residents. She reported she was already working on a plan to revise the activity calendar to include a greater variety and availability/frequency of activities geared toward the residents ' needs and interests.

5. Resident #52 was admitted to the facility on 8/30/18 with diagnoses that included dementia.

The annual Minimum Data Set (MDS) assessment dated 8/9/19 indicated Resident #52

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F 679	Continued From page 75 ' s cognition was fully intact. This assessment indicated that it was very important to Resident #52 to do things with groups of people. The Activities Assessment dated 11/25/19 indicated it was very important to Resident #52 to do things with groups of people. She was noted to attend bingo, parties, games, exercises, bands, church and resident council. Resident #52 ' s active care plan included the focus area of attending and participating in most activities at the facility. The interventions included assisting her to and from activities as needed. During a Resident Council meeting held on 2/4/20 at 10:50 AM Resident #52 indicated there were hardly any activities on the evenings or weekends. She reported she enjoyed group activities and attended most activities at the facility. An interview was conducted with the Activities Director on 2/4/20 at 2:30 PM. The Activities Director confirmed there were normally no group activities planned in the evenings and typically only 1 group activity was planned on each weekend day. She additionally confirmed the weekend activities were all conducted by community church groups. She stated that she worked normal business hours on Monday through Friday and she was unable to conduct activities herself on the evenings or weekends, so she had not scheduled activities during these times. During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected a sufficient amount of activities to be planned and	F 679		

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F 679	Continued From page 76 held on the evenings and weekends to meet the needs/interests of the residents. She reported she was already working on a plan to revise the activity calendar to include a greater variety and availability/frequency of activities geared toward the residents ' needs and interests.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to follow the physician order for pressure ulcer prevention dressing for 1 of 6 residents reviewed for pressure ulcers (Resident #6). Findings included: Resident #6 was admitted to the facility on 6/12/17 with the diagnoses of hemiplegia and hemiparesis and diabetes. The resident had a physician order dated 8/14/19 for Duoderm dressing to the sacrum twice a week on Wednesday and Sunday and as needed to	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686	3/3/20

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protect skin and for comfort. The plan was to reassess the sacrum for open skin area.

The resident ' s quarterly Minimum Data Set dated 1/17/2020 documented the resident had adequate hearing and was understood/understands and her cognition was intact. The resident required two-person extensive assist for all transfers and toileting and 1 person for all other activities of daily living except meals. The active diagnoses were diabetes, non-Alzheimer's dementia, hemiplegia, and right above the knee amputation. The resident had no pressure ulcer.

A review of the resident ' s updated care plan dated 1/9/2020 revealed the resident had the potential for pressure ulcer and history of pressure ulcer of the sacrum.

On 2/2/2020 at 4:00 pm the resident was interviewed, and she stated that her "bum is burning" and that "the dressing on my butt had fallen off and no one put it back on."

An observation was done of the resident ' s incontinence care on 02/02/2020 at 4:06 pm. Incontinence care was provided by Nursing Assistant (NA) # ' s 9 and 10. The resident was noted to have scar tissue to the buttocks and sacrum from prior pressure ulcers that had healed. The ordered Duoderm dressing was not in place on the sacrum. The resident was cleaned, barrier cream was placed, and the resident was dressed. The resident had a pressure reduction cushion on her wheel chair and an air mattress on her bed.

An interview was conducted with NA #9 on

F 686

1. Corrective action for resident(s) affected by the alleged deficient practice: For resident# 6, on 02/17/2020 the nurse consultant updated the resident's duoderm order to check placement of the duoderm each shift to ensure it was in place.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 02/19/2020 the treatment nurse audited all current residents with treatments ordered to ensure the treatments were performed and any dressings ordered were in place and intact. This was completed on 02/19/2020.

The nurse consultant audited all current residents with duoderm orders to update the order with check every shift for placement of the dressing and replace as needed. This was completed by 02/19/2020.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 02/19/2020, the nurse managers began educating all full time, part time, and PRN Nurses and CNA's on the following topics:
• Carrying out the prescribed treatment order for pressure ulcers.
• What to do when a dressing is found off a wound.
• How to enter orders for duoderm dressing.

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2/2/2020 at 4:25 pm. NA #9 stated that Resident #6 ' s skin was intact, she was provided barrier cream and there was no dressing. NA #9 commented that he followed the care guide/kardex for care provided and wound dressings are on the nurses' care plan.

An interview was conducted with NA #10 on 2/2/2020 at 4:30 pm. NA #10 stated that she was familiar with the resident. NA #10 stated she also followed the resident ' s care guide/kardex for care provided and believed this resident required barrier cream because her skin was intact.

The resident was interviewed on 2/3/2020 at 11:30 am while sitting up in her wheel chair. The resident commented that her dressing (to the sacrum) was still off.

The Treatment Nurse was observed on 2/4/2020 at 2:30 pm to provide pressure ulcer prevention care to the resident's sacrum. The resident did not have a Duoderm dressing in place. The Treatment Nurse commented during care that there was an order for Duoderm dressing to prevent pressure ulcer and provide comfort and to change twice a week and as needed. She indicated when the Duoderm falls off or becomes soiled, the staff was expected to inform her or to replace it after care.

On 2/4/2020 at 2:40 pm the Treatment Nurse was interviewed who stated that she was not informed yesterday or today that the Duoderm was not on the resident's sacrum. Today was the ordered day for change when she noticed the dressing was not in place.

On 2/6/2020 at 7:50 am an interview was

F 686

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nurses or designee will monitor compliance utilizing the F686 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor compliance with pressure ulcer treatments. Monitoring will be rotated in order to include all shifts and weekends. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with pressure ulcer treatments. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.

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F 686	Continued From page 79 conducted with NA #4 who stated the NAs review the care guide/kardex before providing care, but not the nursing care plans. She said they don't have access to the electronic health record to view the nursing care plan. On 2/6/2020 at 10:45 am an interview was conducted with the Administrator who stated she expected staff to follow the physician order for all pressure ulcer care and prevention.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Responsible Party (RP) interviews and record review, the facility failed to apply Resident #35's left elbow splint as ordered. This was for 1 of 1 resident reviewed for range of motion. The findings	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal	3/3/20

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F 688 Continued From page 80
included:

Resident #35 was admitted 4/9/18 with cumulative diagnoses of Cerebral Vascular Accident and contracture of the left elbow.

Review of Resident #35's February 2020 Physician orders read an order dated 5/24/18-Restorative Nursing Order per OT: Don on and off resident's left upper extremity splint-tolerates up to 2 hours.

Review of Resident #35's care plan revised 3/29/19 read he was on restorative nursing for left upper extremity splinting and alteration in muscle/skeleton status related to a left hand and left elbow contracture. The goal was for him to wear his left upper extremity for 2 hours a day with the intervention of application of the splint as ordered. There was no care plan for any refusals of his left elbow splint.

Review of the undated electronic care guide for the aides to follow read as follows: Restorative Nursing Order per OT-don on and off left upper extremity splint-tolerated up to 2 hours. Report to nurse if there were any skin problems under the splint.

Review of Resident #35's quarterly Minimum Data Set (MDS) dated 12/7/19 indicated severe cognitive impairment and he exhibited physical and verbal behaviors. Resident #35 was coded for functional limited range of motion of 1 side upper and lower extremities.

In an observation on 2/2/20 at 5:00 PM, Resident #35 was in bed. He had a left elbow contracture and a left-hand contracture.

F 688

and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F688
The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:
1. Corrective action for resident(s) affected by the alleged deficient practice:

For resident #35, on Occupational Therapy worked with the resident for splinting of the left elbow from 02/04 to 02/12/2020. On 02/24/2020 the resident's task and orders were updated with application of the splint and palm guard per therapy recommendations.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

Beginning on 02/18/2020 the nurse manager audited all current residents with orders for splint use to ensure the splint was in place. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint the nurse manager ensured the device was in place, had an MD order, CNA task, and care plan. This process will be completed by 03/03/2020.

3. Measures /Systemic changes to

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F 688 Continued From page 81

In an interview on 2/2/20 at 5:45 PM, Nursing Assistant (NA) #9 stated Resident #35 did not wear any left upper extremity splints but only a left lower leg extremity for transfers. NA #9 stated he performed PROM to his left upper extremity during his activities of daily living (ADLs).

In another observation on 2/3/20 at 10:00 AM, Resident #35 was lying in bed. There was no observed splint to his left elbow.

In an interview on 2/3/20 at 10:20 AM, NA #5 stated Resident #35 did not have a left elbow splint and staff only performed PROM to his left upper extremity. NA #5 stated the facility did not have restorative aides but rather the aides on the floor provided any restorative programs ordered.

In an interview on 2/3/20 at 11:34 AM, Nurse #5 stated she thought his left elbow splint was discontinued but the aides provided PROM to his left upper extremity.

In another observation on 2/3/20 at 12:08 PM, Resident #35 was lying in bed. There was no observed splint to his left elbow.

In another observation on 2/3/20 at 2:34 PM, Resident #35 was lying in bed. There was no observed splint to his left elbow.

In another interview with NA #5 on 2/3/20 at 2:50

F 688

prevent reoccurrence of alleged deficient practice:

On 02/19/2020, the Nurse Managers began an in-service education to all full time, part time, and as needed nurses and CNA's. Topics included:

- The importance for applying splints as ordered by the MD.
- Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown.
- What to do when the device cannot be located.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nurses will monitor compliance utilizing the F688 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved.

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F 688	Continued From page 82 PM, she stated it was her understanding that Resident #35's left elbow splint was discontinued. She stated he was verbally and physically combative at times during ADL care. In another observation on 2/3/20 at 4:18 PM, Resident #35 was lying in bed. There was no observed splint to his left elbow. Review of A Physical Therapy (PT) Screen dated 7/29/19 read the reason for the screen was at family request. The screen read the PT attempted multiple times over the past 3 weeks to perform upper extremity passive range of motion (PROM) to ensure the program was appropriate and to re-train the staff. The PT was unable to get Resident #35 awake to participate or perform due to his agitation. The PT was to continue to attempt to review the programs and provide staff education. The screen was electronically signed by the Rehabilitation Director (RD). The RD was unable to provide any documented PT or Occupational Therapy (OT) Screen but rather only Rehab Post Fall and Device Screens since July 2019 to present. In an interview on 2/3/20 at 4:33 PM, the RD stated he found Resident #35's left elbow splint in a drawer in his room and stated he found some nursing notes regarding the refusal of the splint. The RD stated that since the aides had not been putting the splint on, Resident #35 would need to be re-evaluated by the OT. The RD stated Resident #35's left elbow splint was never discontinued and it was his expectation that the aides apply the left elbow splint as ordered. He	F 688	Monitoring will be rotated in order to include all ordered shifts and weekends. The Director of Nursing will monitor splint application and compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with splint application. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 688	Continued From page 83	F 688		

stated he was not aware the aides were not applying Resident #35's left elbow splint.

In an interview on 2/4/20 at 8:50 AM, Resident #35's RP stated she had voiced concerns about the staff not applying his left elbow splint. She recalled asking therapy to re-evaluate Resident #35 months ago but did not know the outcome of the evaluation. Resident #35 was up in a reclining chair at the nursing station. He was not wearing his left elbow splint.

In another interview on 2/4/20 at 2:00 PM, the RD stated he received a list of residents who were in the process of their scheduled MDS assessment for him to complete a therapy screen. He verified there was no documented evidence of a PT or OT Screen and only Rehab Post Fall and Device Screens at the time of Resident #35's quarterly MDS assessment dated 12/7/19. The RD stated unless the staff let him know of changes in Resident #35's left upper extremity, he would not know. He stated he contacted the OT and was to evaluate Resident #35 on 2/4/20.

In another interview on 2/5/20 at 9:17 AM, the RD stated the OT picked up Resident #35 for services. He stated Resident #35's left elbow splint still fit properly and a palm protector was ordered for his left hand. He also stated OT would be working on ROM of his left upper extremity.

In an interview on 2/5/20 at 1:09 PM, the Medical Record Supervisor stated after reviewing

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F 688	Continued From page 84 Resident #35's medical record, she did not locate any documented evidence of his refusals of splinting or any Physician order to discontinue his left elbow splint. Review of a Physician order dated 2/4/20 read OT was to treat Resident #35 for therapeutic exercise, therapeutic activity and orthotic management for joint contracture of his left hand and left elbow. Review of the OT Plan of Care dated 2/4/20 read his left elbow extension splint was appropriate with proper fit but staff needed training on the splint program. The goal was for Resident #35 to wear a left-hand palm protector and his left elbow splint. In an interview on 2/5/20 at 3:40 PM, the OT stated Resident #35 had not experienced a decline in his ROM to his left upper extremity but she picked him up to educate the staff on his splinting and PROM program. In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that Resident #35 be regularly assessed for contracture management and for his splints be applied as ordered.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		3/3/20

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F 689	Continued From page 85 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to promptly implement an intervention of a Physical Therapy evaluation that was developed through a root cause analysis of falls for 1 of 2 residents reviewed for falls (Resident #60). The findings included: Resident #60 was admitted to the facility on 8/30/19 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 10/1/19 indicated Resident #60 ' s cognition was moderately impaired. She required extensive assistance of 2 or more for bed mobility and transfers and the extensive assistance of 1 for locomotion on/off unit, toileting, and personal hygiene. Resident #60 ' s balance was not steady, and she was only able to stabilize with staff assistance. She had no functional impairment with range of motion, she utilized a wheelchair, and she was frequently incontinent of bladder and bowel. Resident #60 was actively receiving Physical Therapy (PT) that began on 9/18/19. The PT documentation indicated Resident #60 received PT from 9/18/19 through 10/24/19. An incident report dated 11/2/19 indicated Resident #60 had an unobserved fall with minor injury at 1:15 PM. Resident #60 was reported to	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #60, the Physical Therapist worked with the resident from 12/11 to 12/27/2020. An additional post fall screen was completed on the resident 02/24/2020 by the Physical Therapist with no recommendations at this time. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/20/2020 the Director of Nursing audited all current residents with falls in the past 90 days to ensure interventions documented on the incident report was entered in to the care plan and carried out. This will be completed by 03/03/2020.	

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attempt to ambulate from her bed to her roommates ' bed and she fell to the floor. She was assessed with a red mark to her right upper side and mid back. The Interdisciplinary Team (IDT) review, dated 11/2/19 and written by the Director of Nursing (DON), indicated 15-minute checks for Resident #60.

An incident report dated 11/7/19 indicated Resident #60 had an unobserved fall with minor injury at 1:57 PM. Resident #60 was found on the floor in her room, she stated she was attempting to walk to the bathroom, lost her balance and fell on the bed to the floor. She reported she hit her back on the bed when she fell, and a red area was noted to left side of her upper back. The IDT review, dated 11/7/19 and written by the DON, indicated the fall was discussed and the intervention was a PT evaluation and/or treatment.

The resident ' s medical record revealed the intervention of a PT evaluation was not implemented for Resident #60 after the 11/7/19 fall.

An incident report dated 11/24/19 indicated Resident #60 had an unobserved fall with minor injury at 3:20 AM. Resident #60 was found laying in the doorway of her room on the right side with a laceration to her upper lip with swelling and swollen nose. The IDT review, dated 11/25/19 and written by the DON, indicated the root cause was confusion and the intervention was a medication review.

Resident #60 ' s care plan included the focus area actual falls with the risk for further falls related to poor communication/comprehension,

F 689

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 02/20/2020, the administrator educated the interdisciplinary team (Director of Nursing, MDS Nurse, Dietary Manager, Business office manager, Medical Records director, Therapy manager, Social Worker, and Activity Director) on the following topics:
" Root cause analysis and timely fall interventions.
" On 02/24/2020 a new therapy screen request form was initiated.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nursing or designee will monitor compliance utilizing the F689 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor to ensure fall interventions are carried out timely. Reports will be presented to the weekly Quality Assurance committee by the

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F 689	Continued From page 87 gait, and psychotropic medications. This focus area was last revised on 11/25/19. The interventions included, in part, medication evaluation (initiated 11/25/19) and a PT consultation for strength and mobility (initiated 11/25/19). An incident report dated 11/26/19 indicated Resident #60 had an unobserved fall with no injuries at 2:29 PM. Resident #60 was found on the floor of the hallway lying on her left side. The resident stated that she tried to sit in her wheelchair and she missed the seat. The IDT review, dated 11/26/19 and written by the DON, indicated the root cause was confusion and the intervention was for a PT evaluation and/or treatment to include caregiver training as well as a medication review. A physician note dated 11/26/19 indicated Resident #60 was being seen related to falls and lethargy. She was noted with frequent falls due to trying to get up and walk without her walker or assistance and she was very unsteady with poor balance. Resident #60 was noted with a fall on the morning of 11/24/19 and split her lip with bruising and soreness/pain around the nose and mouth. The physician completed a medication review and indicated that a PT evaluation was to be completed. An incident report dated 11/29/19 indicated Resident #60 had an unobserved fall with no injury at 11:45 PM. The resident was found seated on the floor by her bed and she reported she was trying to reach something, and she slid off the bed. The IDT review, dated 12/2/19 and written by the DON, indicated the intervention of a reacher and ensuring personal items were within	F 689	Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 689	Continued From page 88 her reach. A PT Screen dated 12/11/19 completed by the Rehab Director indicated Resident #60 was referred for the screen by nursing staff. The screen indicated Resident #60 had repetitive falls in spite of measures in place to assist with prevention. PT had addressed falls in the past unsuccessfully, however, given continued frequent falls, PT will evaluate and attempt to decrease fall risk through improvement of balance and safety as well as family and staff training. A physician ' s order dated 12/11/19 indicated a PT evaluation and treatment after continued frequent falls in facility. A physician ' s clarification order dated 12/11/19 indicated PT 5 times per week for 8 weeks due to continued falls. A physician ' s order dated 12/27/19 indicated a discontinuation of PT due to maximum functional potential. An observation was conducted of Resident #60 in her room on 2/2/20 at 1:35 PM. She was alert but was unable to answer any questions related to her previous falls due to cognitive impairment and confusion. During an interview with the Administrator on 2/5/20 at 8:30 AM she reported the IDT members who reviewed falls were the DON, MDS Nurse, Support Nurse, and Rehab Director. She stated the DON was unavailable for interview and that questions related to falls could be directed to the MDS Nurse or Support Nurse.	F 689		

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An interview was conducted with the MDS Nurse on 2/5/20 at 9:40 AM. She stated that falls were reviewed every Monday through Friday by herself, Support Nurse, DON, and Rehab Director. She was asked what the process was for completing a PT evaluation if that was the intervention developed through root cause analysis of the fall. She stated that the Rehab Director was in the meeting and he completed the PT evaluation himself. She stated that normally the evaluation occurred within a day or two.

An interview was conducted with the Rehab Director on 2/5/20 at 9:47 AM. He confirmed that he attended the IDT meetings when falls were reviewed. He indicated he was involved in developing and/or revising interventions based on the root cause analysis of the fall. When asked the process for the completion of PT evaluation if that intervention was selected by the IDT fall review, he stated that he was the only full time PT at the facility and that he would complete the evaluation himself within 1 to 2 days. The 11/7/19 IDT review and the 11/26/19 IDT review of Resident #60 ' s falls that indicated the intervention of a PT evaluation and/or treatment were reviewed with the Rehab Director. The PT screen and PT evaluation that occurred on 12/11/19 was reviewed with the Rehab Director. The Rehab Director was unable to explain why a PT evaluation was not completed until 12/11/19 and he stated that "there is no excuse". He went on to stated that he believed he had completed Rehab Post Fall screens during November and indicated he thought Resident #60 was not appropriate for a PT evaluation and/or treatment. He explained that the Rehab Post Fall Screen was different than the PT Screen and PT

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F 689	Continued From page 90 evaluation. The Rehab Director was asked if he shared his viewpoint that a PT evaluation was not appropriate for Resident #60 during the 11/7/19 and 11/26/19 IDT fall review in which the intervention of a PT evaluation and/or treatment was selected. The Rehab Director was unable to recall if he shared his viewpoint during the 11/7/19 or 11/26/19 IDT fall reviews. He was then asked why a PT screen, PT evaluation, and subsequent PT treatment were completed on 12/11/19. The Rehab Director indicated that it was completed because the other interventions had not stopped the falls, so it was worth a try. During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the interventions developed through root cause analysis of a fall to be implemented promptly. She additionally stated that she expected the IDT members to express their viewpoints to the team in order to develop the most appropriate interventions.	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	F 690		3/3/20

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F 690	Continued From page 91 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. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to secure the indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheter use. (Resident #66) The findings included: Resident #66 was admitted to the facility on 1/14/2020 with diagnoses that included obstructive uropathy (a condition in which the flow of urine is blocked) and pressure ulcers to the sacral area. The physician orders revealed an order dated 1/14/2020 to ensure the catheter was secured in place.	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	

F 690 Continued From page 92

The review of Resident #66's care plan revealed a problem area initiated on 1/15/2020 for a urinary catheter due to urine retention. One of the interventions included a leg band to secure catheter.

The admission Minimum Data Set (MDS) assessment dated 1/21/2020 indicated Resident #66 had severe cognitive impairment, required extensive assistance from staff for all Activities of Daily Living and used an indwelling urinary catheter.

On 2/2/2020 at 1:25pm Resident #66 was observed lying in bed with the bed covers removed from his legs. A catheter securement device was not present, and the catheter tubing was underneath his left thigh.

Resident #66 was observed lying in his bed on 2/3/2020 at 9:50am with the bed covers in disarray. It was observed the urinary catheter tubing had become disconnected from the drainage bag tubing and the bed pad was saturated with urine. A urinary catheter securement device was not present.

On 2/3/2020 at 11:00am urinary catheter care was observed with Nurse Aide #3 who confirmed the resident did not have securement device present. She further explained all resident with urinary catheters should have some type of securement device present and could not explain why Resident #66 did not.

Nurse #1 was interviewed on 2/3/2020 at 11:03am and stated the indwelling urinary catheter needed to be secured to the resident's

F 690

cited:
1. Corrective action for resident(s) affected by the alleged deficient practice:
For resident #66: a leg band was applied on 02/24/2020 by the nurse manager. The nurse consultant entered task and order for catheter leg band securement to ensure it is in place on 02/24/2020.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
Beginning on 02/18/2020, the nurse manager audited all current residents with a Foley catheter to ensure a Foley securement device was in place. This audit was completed by 02/21/2020. 2 or 4 residents were noted without a leg band. 1 resident refused the leg band stating he did not want it. Care plan has been updated on 02/24/2020 by the nurse consultant with the resident's refusal and request to not use the leg band. 1 resident received the leg band on 02/24/2020. Orders and task to ensure the leg band is in place will be updated by the nurse consultant by 02/25/2020.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
Beginning on 02/19/2020 the nurse managers began educating all full time, part time, and prn nurses and CNA's on the following topics:
• Foley catheter care, preventing trauma, and ensuring the Foley securement device is in place at all times.

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F 690	Continued From page 93 inner thigh to prevent friction/movement. She further stated the nurse aides should have reported if there was not a catheter securement device present and had been unaware Resident #66's catheter tubing was not secured to his leg. An interview occurred with the Administrator on 2/6/2020 at 10:10am, she stated it was her expectation for indwelling catheter tubing's to be secured or properly anchored to the resident's thigh to prevent accidental pulling.	F 690	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F690 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Monitoring will be rotated in order to include all shifts and weekends. The Director of Nursing will monitor to ensure the Foley catheter securement device is in place. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with foley catheter securement. The weekly QA Meeting is attended by the Administrator,	

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F 690	Continued From page 94	F 690	Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
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, staff, resident interviews and record reviews, the facility failed to administer continuous oxygen at the Physician ordered flow rate for Resident #5 and Resident #36. This was for 2 of 2 residents reviewed for respiratory care. The findings included 1. Resident #5 was admitted on 12/16/17 with cumulative diagnoses of Congestive Heart Failure and oxygen dependence. Review of Resident #5's care plan last revised 7/12/19 read she required continuous oxygen therapy. Interventions included the administration of her continuous oxygen as ordered. Review of Resident #5's quarterly Minimum Data Set (MDS) dated 1/7/20 indicated severe cognitive impairment and she exhibited no behaviors. She was coded for the use of oxygen.	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #5, the MD orders state oxygen at 2 liters per minute. On observation on 02/18/2020 and 02/24/2020 by the nurse manager, the o2 flow rate was on 2 lpm.	3/3/20

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Review of Resident #5's February 2020 Physician orders included an order dated 12/18/17 for continuous oxygen at 2.0 liters per minute (L/M).

In an observation on 2/2/20 at 3:39 PM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.

In an observation on 2/3/20 at 10:15, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.

In an interview on 2/3/20 at 2:30 PM, Nurse #5 stated she assessed Resident #5's oxygen saturation and the oxygen flow rate every shift.

In an observation on 2/3/20 at 4:20 PM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.

In an observation on 2/4/20 at 8:30 AM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.

In an interview on 2/4/20 at 8:45 AM, Nurse #6 stated she assessed Resident #5's oxygen saturation and the oxygen flow rate every shift.

In an observation on 2/4/20 at 11:40 AM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.

In an observation on 2/4/20 at 3:45 PM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.

In an observation on 2/5/20 at 9:25 AM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.

F 695

For resident #36, the MD orders state oxygen at 2 lpm. On observation on 02/18/2020 and 02/24/2020 by the nurse manager, the o2 flow rate was on 2 lpm.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 02/18 and 02/19/2020, the nurse manager began auditing all current residents receiving oxygen. This audit was completed by 02/19/2020. Oxygen flow rate was observed for compliance with the MD order. 100% compliance noted.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 02/20/2020, the Nurse Managers began education to all full time, part time, and PRN Nurses and CNA's on the following:
• Resident's liter flow of oxygen must be set at the amount ordered by the MD. If the resident is bumping up the oxygen liters, then their respiratory status should be assessed and notify the MD of your findings. Residents should be reminded not to tamper with the liter settings and this should be documented in the nurse's notes.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has

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F 695	Continued From page 96 In an interview on 2/5/20 at 9:40 AM, Nursing Assistant (NA) #6 stated nurses were the only staff that adjusted oxygen rates. NA #6 also stated Resident #5 was not capable of adjusting her own oxygen rate. In another interview on 2/5/20 at 1:15 PM, Nurse #6 confirmed working with Resident #5 on 2/4/20 and 2/5/20. Nurse #6 was asked to assess the oxygen flow rate on the concentrator at eye level. She confirmed the oxygen was running at 2.5 L/M. She stated she must have not assessed Resident #5's oxygen flow rate at eye level to verify the Physician ordered rate. Nurse #6 stated Resident #5 was unable to adjust her oxygen concentrator flow rate. In an interview on 2/5/20 at 3:40 PM, NA #8 stated nurses were the only staff that adjusted oxygen rates. NA #8 also stated Resident #5 was not capable of adjusting her own oxygen rate. In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that Resident #5's oxygen be administrated at the Physician ordered rate. 2) Resident #36 was originally admitted to the facility on 11/25/13 with diagnoses that included congestive heart failure (CHF), pulmonary hypertension and end stage renal disease on dialysis. A physician order dated 3/4/19 revealed to check oxygen saturation levels every shift for chronic renal failure, oxygen at 2 liters via nasal cannula as needed during the day to maintain pulse oximetry above 90% due to chronic renal failure	F 695	been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F695 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Monitoring will be rotated in order to include each shift and weekends. The Director of Nursing will monitor compliance with oxygen liter flow according to MD orders. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with oxygen liter flow according to MD orders. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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and oxygen at 2 liters via nasal cannula every night.

The active care plan dated 12/5/19 revealed a problem area for the use of oxygen. Interventions included oxygen settings at 2 liters as needed.

The quarterly Minimum Data Set (MDS) assessment dated 12/13/19 indicated Resident #36 was cognitively intact and had impaired vision where he could see large print but not regular print in newspapers/books. He received supervision to limited assistance with Activities of Daily Living and used oxygen.

A physician progress note dated 12/27/19 indicated Resident #36 used oxygen at night and tended to use oxygen fairly continuously during the day as he felt more comfortable with it on. Resident #36 was to continue oxygen as desired during the day and every night at 2 liters via nasal cannula.

On 2/2/2020 at 1:15pm an observation was made of Resident #36 sitting on the side of his bed. The oxygen regulator on the concentrator was set at 3 liters flow by nasal cannula with humidification when viewed horizontally at eye level. Resident #36 was able to state he used 2 liters of oxygen and preferred to wear it through out the day and night. He further stated the staff assisted with making sure the correct amount was on the concentrator as he had difficulty seeing the bubble in the oxygen regulator.

On 2/3/2020 an observation was made of Resident #36 at 9:50am and 11:00am which revealed the oxygen regulator on the concentrator was set at 3 liters flow by nasal cannula with

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F 695	Continued From page 98 humidification when viewed at horizontal eye level. On 2/4/2020 at 3:30pm Resident #36 was observed sitting on the side of his bed. The oxygen regulator on the concentrator was set at 3 liters flow by nasal cannula with humidification when viewed at horizontal eye level. An interview occurred with Nurse #2 on 2/4/2020 at 3:45pm, who stated the oxygen flow rate on the concentrator was set at 2 liters, as she was standing over the machine, looking down. Nurse #2 stated when she observed the flow rate horizontally at eye level, she could see the flow was set at 3 liters. Nurse #2 adjusted the flow rate to administer 2 liters as ordered. On 2/6/2020 at 10:10am an interview was conducted with the Administrator. She stated it was her expectation for Resident #36's oxygen be administered at the physician's ordered rate.	F 695		
F 727 SS=B	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an	F 727		3/3/20

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average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:

Based on staff interviews and record review, the facility failed to staff a Registered Nurse (RN) for 8 consecutive hours daily for 3 of the last 6 days reviewed for RN coverage (1/31/20, 2/4/20, and 2/5/20).

The findings included:

Review of the daily staff posting, staff assignments, and daily census, revealed no RN coverage on 1/31/20 (census of 68), 2/4/20 (census of 70), and 2/5/20 (census of 70).

An interview was conducted with the MDS Nurse on 2/5/20 at 1:20 PM. She stated that she was an RN and she used to work on the floor until she switched to MDS full time after 1/17/20. She reported that on 1/31/20, 2/4/20, and 2/5/20, she was working as the MDS Nurse and was not working on the floor. She reviewed the staff posting and staff assignments for 1/31/20, 2/4/20, and 2/5/20 and confirmed there was no RN coverage on any of these dates.

During an interview with the Administrator on 2/6/20 at 10:10 AM she acknowledged there was no RN coverage on 1/31/20, 2/4/20, and 2/5/20. She stated that the facility was in a transition period with the MDS Nurse recently switching to that position full time. She indicated they had 1 RN who worked on the floor full time 2 RNs who worked part time. She reported that they were in the process of looking for an additional RN to hire to ensure they had RN coverage for 8 consecutive hours daily as required.

F 727

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F727
1. Corrective action for resident(s) affected by the alleged deficient practice:

No residents were identified as affected.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

On 02/24/2020 staffing sheets were reviewed by the Administrator from 02/06/2020 through 02/24/2020 to monitor that at least eight consecutive hours of registered nurse staffing was in place daily. __19___ out of ____19_____ days had at least 8 consecutive hours of registered nurse hours in place.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
Beginning on 02/24/2020, the Nurse Consultant educated the Administrator

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F 727	Continued From page 100	F 727	and Director of Nurses on the requirement of the facility to staff Registered Nurse Coverage for at least consecutive hours daily. Coverage by a Registered nurse for a least eight consecutive hours will be maintained by 03/03/2020. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F272 and 732 Quality Assurance Tool weekly for staffing of registered nurse hours daily x 2 weeks then monthly x 3 months. The Director of Nursing will monitor staffing for compliance with the requirement for at least 8 hours of registered nurse staffing daily. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is	

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F 727	Continued From page 101	F 727	attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		3/3/20

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F 732	Continued From page 102 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have an accurate staff posting on 24 of 36 days reviewed. The findings included: The daily staff posting was compared to the census data for 01/01/20 through 02/05/20 and revealed the following conflicting information: - 01/06/20 Staff posting census indicated 63 and the actual census was 64 - 01/07/20 Staff posting census indicated 63 and the actual census was 64 - 01/08/20 Staff posting census indicated 64 and the actual census was 65 - 01/09/20 Staff posting census indicated 65 and the actual census was 63 - 01/10/20 Staff posting census indicated 65 and the actual census was 64 - 01/11/20 Staff posting census indicated 65 and the actual census was 64 - 01/12/20 Staff posting census indicated 65 and the actual census was 64 - 01/13/20 Staff posting census indicated 65 and the actual census was 64 - 01/15/20 Staff posting census indicated 66 and the actual census was 65 - 01/16/20 Staff posting census indicated 66 and the actual census was 67 - 01/17/20 Staff posting census indicated 66 and the actual census was 67	F 732	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F732 1. Corrective action for resident(s) affected by the alleged deficient practice: No residents were identified as affected. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 02/24/2020 the staffing sheets were reviewed by the Administrator from 01/06/2020 through 02/24/2020 to ensure that daily nurse staffing postings reflected the correct daily census on each posting. The daily census was reviewed in PCC and compared to the staffing sheet. Corrections were made at the time of the audit by the Administrator. Completion date 02/24/2020. 3. Measures /Systemic changes to	

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F 732 Continued From page 103

- 01/19/20 Staff posting census indicated 67 and the actual census was 68
- 01/24/20 Staff posting census indicated 69 and the actual census was 68
- 01/25/20 Staff posting census indicated 69 and the actual census was 67
- 01/26/20 Staff posting census indicated 69 and the actual census was 67
- 01/27/20 Staff posting census indicated 69 and the actual census was 68
- 01/28/20 Staff posting census indicated 69 and the actual census was 68
- 01/29/20 Staff posting census indicated 69 and the actual census was 67
- 01/31/20 Staff posting census indicated 69 and the actual census was 68
- 02/01/20 Staff posting census indicated 69 and the actual census was 68
- 02/02/20 Staff posting census indicated 69 and the actual census was 68
- 02/03/20 Staff posting census indicated 69 and the actual census was 70
- 02/04/20 Staff posting census indicated 69 and the actual census was 70
- 02/05/20 Staff posting census indicated 69 and the actual census was 70

An interview was conducted with Transportation staff on 02/05/20 at 2:35 PM. She stated that she completed the daily staff posting. She indicated her normal routine was to complete the next day's posting the previous afternoon before she left for the day. She further that indicated that she worked Monday through Friday, so she completed the staff posting for the entire weekend on Friday afternoon. She revealed she had not updated the posting if any changes were made to the census information or to staffing information.

F 732

prevent reoccurrence of alleged deficient practice:

On 02/24/2020, the nurse consultant began educating the administrator, Director of Nurses and Nursing Scheduler on the requirement of the facility to document on the Daily Nurse Staffing Posting the current resident census each day.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nursing or designee will monitor compliance utilizing the F732 Quality Assurance Tool weekly for daily nursing staff postings that include the current resident census each day x 2 weeks then monthly x 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing

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F 732	Continued From page 104 During an interview with the Administrator on 02/06/20 at 10:10 AM she stated that she expected the staff posting to be accurate and to be revised as required by the regulations. She indicated she was new to the facility and was a new Administrator, so she was still in the process of learning all of the regulations and improving on processes and systems within the facility.	F 732	program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		3/3/20

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F 756	Continued From page 105 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews, the consultant pharmacist failed to identify incorrect mediation administration route for 1 of 2 residents reviewed for gastric feeding tube (Resident #11). The findings included: Resident #11 was originally admitted to the facility on 10/11/19 with diagnoses including aphasia (impairment of language), gastrostomy and cerebral vascular accident (CVA). Resident #11's admission Minimum Data Set (MDS) assessment dated 10/18/19 indicated she had severe cognitive impairment. She required total assistance with all Activities of Daily Living and received all nutrition and fluids via a feeding tube. Review of the active care plan revealed Resident #11 required tube feeding for all nutrition and fluids. The active physician orders revealed an order dated 11/5/19 for Glucophage 1000 milligrams	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident# 11, on 02/04/2020 the Claritin was discontinued due to completion of MD order. On 02/04/2020 the Glucophage route was changed to via g-tube by the hall nurse. No other medications were affected for this resident. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 756	Continued From page 106 (mg) 1 tablet by mouth two times a day for diabetes and an order dated 1/30/2020 for Claritin 10mg 1 tablet by mouth one time a day for 10 days. Resident #11's medical record revealed monthly medication reviews had been completed by the consultant pharmacist on 11/19/19, 12/19/19 and 1/22/2020. All reviews revealed no irregularities found for Resident #11. On 2/4/2020 at 9:50am an interview occurred with Nurse #1 who was working the medication cart for Resident #11's hall and had administered her medications earlier. She confirmed Resident #11 did not receive any medications by mouth and had not provided the morning doses of Glucophage or Claritin by mouth. Nurse #1 acknowledged the February 2020 Medication Administration Record (MAR) read for the medications to be provided by mouth and was inaccurate. An interview was conducted on 2/4/2020 at 3:50pm with Nurse #2 who was working on the medication cart for Resident #11's hall. She stated she was familiar with the resident and had administered her medications many times. Nurse #2 acknowledged Resident #11 did not receive any medications by mouth. She reviewed the February 2020 MAR and confirmed the order on the MAR for the Glucophage and Claritin to be taken by mouth was inaccurate. On 2/5/2020 at 9:06am, a phone interview was conducted with the facility's consultant pharmacist, who was familiar with Resident #11 and confirmed all her medications were administered through the gastrostomy tube. The	F 756	Beginning on 02/25/2020 the pharmacy consultant began auditing all current residents orders to identify any incorrect medication routes. This will be completed by 03/03/2020. Any medications identified with incorrect routes will be corrected by the nurse manager by 03/03/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/25/2020 the nurse consultant educated the consultant pharmacist on the following topics: " Drug regimen review should include reviewing all current residents medications for correct drug administration routes. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses will monitor compliance utilizing the F658, 686, 756, 757, and 758 Quality Assurance Tool weekly x 2 weeks then monthly x 3	

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F 756	Continued From page 107 pharmacist stated the error in administration route should have been caught on the monthly medication reviews and was likely an oversight. In an interview with the Administrator on 2/6/2020 at 10:10am, stated she expected the facility's consultant pharmacist to alert staff to errors in administration routes during the monthly medication reviews.	F 756	months. The Director of Nursing will monitor for correct medication routes. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this	F 757		3/3/20

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F 757	Continued From page 108 section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview, the facility failed to discontinue a narcotic medication as ordered resulting in 3 additional administrations of the medication for 1 of 2 residents reviewed for pain (Resident #46). The findings included: Resident #46 was admitted to the facility on 12/27/19 with diagnoses that included end stage renal disease and orthopedic aftercare. The hospital discharge summary for Resident #46 dated 12/27/19 indicated an order for Percocet (narcotic/opioid medication) 5-325 milligrams (mg) as needed (PRN) for up to 5 days. A physician ' s order for Resident #46 dated 12/27/19 at 1:12 PM indicated Percocet 5-325 mg every 4 hours PRN for pain for 5 days. This order was entered into the electronic medical record by MDS Nurse #1. A review of the Medication Administration Records (MARS) indicated the 12/27/19 order for PRN Percocet was administered 3 times after the ordered timeframe (1/1/20 at 9:21 PM, 1/2/20 at 11:30 AM, and 1/2/20 at 4:00 PM). The admission Minimum Data Set (MDS) assessment dated 1/3/20 indicated Resident #46 ' s cognition was intact. She was administered opioid medication during the review period.	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F757 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #46, on the Oxycodone was discontinued on 01/02/2020 due to automatic stop date. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/24/2020 the Nurse Consultant ran a report from Point Click Care to identify all current orders entered from 01/01/2020 to 02/24/2020 to identify any orders with automatic stop dates. Orders with a stop date entered will be reviewed for any input errors. This will be completed by 02/28/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/18/2020, the nurse managers	

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F 757	Continued From page 109 An interview was conducted with the MDS Nurse on 2/5/20 at 1:10 PM. The 12/27/19 PRN Percocet order for Resident #46 was reviewed. The MDS Nurse reviewed the electronic order and revealed she had entered the incorrect duration which pulled over to the MAR incorrectly. She explained that she entered a stop date of 1/2/20 at 11:59 PM rather than the 5 day stop date of 1/1/20 at 1:12 PM. The MDS Nurse stated that this was an error and she acknowledged that three of the PRN Percocet administrations were outside of the ordered timeframe. During a phone interview with the physician on 2/6/20 at 11:43 AM he stated that he expected his orders to be followed. The 3 administrations of PRN Percocet for Resident #46 that were outside of the ordered timeframe were reviewed with the physician. He indicated he had no concerns with the additional administrations of Percocet for this resident as he made another order for the PRN Percocet after this timeframe. The Administrator was interviewed on 2/6/20 at 10:10 AM and she reported she expected physician ' s orders to be followed and for orders to be entered into the electronic medical record correctly.	F 757	began educating all full time, part time, and PRN Nurses on the following topics: " Medication safety " Preventing medication errors when entering stop dates This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F658 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor compliance with medication stop dates. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator,	

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F 757	Continued From page 110	F 757	Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		3/3/20

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F 758	Continued From page 111 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident, staff, and physician, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication for 1 of 4 residents (Resident #28) reviewed for psychotropic medication use. The findings included: Resident #28 was admitted to the facility on 3/29/19 with diagnoses that included Parkinson ' s disease, dementia, and major depressive disorder. A physician ' s order for Resident #28 dated 3/29/19 indicated Abilify (antipsychotic medication) 10 milligrams (mg) once daily for anxiety related to major depressive disorder. A physician ' s order for Resident #28 dated 3/29/19 indicated documentation of the number of behaviors related to verbalizing depression, crying, and/or isolation was to be completed on	F 758	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F758 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident # 28, the clinical indication for the Abilify is Depression with psychosis. An MD note dated for 01/14/2020 list the following diagnosis: Depression, major, recurrent, severe with psychosis. Identified target behaviors of visual or auditory hallucinations are ordered to be monitored for the use of Abilify as of	

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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 758

Continued From page 112

the Medication Administration Record (MAR) every shift.

A physician ' s order for Resident #28 dated 4/4/19 indicated documentation of the number of behaviors related to depression and/or hallucinations was to be completed on the MAR every shift.

An antipsychotic review assessment for Resident #28 dated 4/4/19 included, in part, the following questions and answers:
- Describe the behaviors or reason why the antipsychotic medication is being used. Are the behaviors causing negative outcomes or disturbing for the resident or other residents?
New admit
- Describe staff interventions that have been attempted or may be attempted to try and minimize the behaviors.
No answer to this question

A physician ' s order for Resident #28 dated 4/11/19 changed the diagnosis for Abilify 10 mg once daily to depression with psychosis related to restlessness and agitation.

Resident #28 ' s care plan included the focus area of antipsychotic medication with risk for adverse side effects. This area was last revised on 4/11/19. The interventions included, in part, administer medications as ordered, consulting pharmacist to review psychotropic medications quarterly and as needed, and mental health consult as needed.

A pharmacy recommendation dated 9/26/19 indicated a Gradual Dose Reduction (GDR) was recommended for Resident #28 ' s Abilify 10 mg

F 758

2/26/20.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 02/25/2020 the pharmacy consultant will review all current residents on anti-psychotic medications for appropriate clinical indication. Any concerns noted will be reviewed with the MD for changes. This process will be completed by 03/03/2020.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
Beginning on 02/24/2020 the nurse consultant will begin educating the Director of Nursing, MDS Nurse, and Administrator on the acceptable diagnosis for Anti-psychotic medication.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nurses or designee will

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F 758	Continued From page 113 once daily. The physician declined the recommendation and indicated the following, "[history of] severe major depression [with] psychosis requiring [inpatient care]. Has failed past dose reduction attempts". An antipsychotic review assessment for Resident #28 dated 10/2/19 included, in part, the following questions and answers: - Describe the behaviors or reason why the antipsychotic medication is being used. Are the behaviors causing negative outcomes or disturbing for the resident or other residents? Dementia with behavioral disturbance - Describe staff interventions that have been attempted or may be attempted to try and minimize the behaviors. No behaviors - Describe when the last GDR occurred, what were the results, and is it time to request another reduction trial? None A physician ' s progress note dated 10/29/19 indicated Resident #28 ' s mood was good with no hallucinations or other psychotic symptoms. She had no behavioral issues but was noted with a "distant reported history of psychotic symptoms (seeing people that were not there about 5 years ago) and was actually hospitalized for depression and psychosis in the past". The physician reported that some of her symptoms were noted to go as far back as her teens. He indicated a neurology and/or psychiatric consultation would be considered in the future if needed. The quarterly Minimum Data Set assessment dated 11/18/19 indicated Resident #28 ' s	F 758	monitor compliance utilizing the F658, 686, 756, 757, and 758 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor for acceptable clinical indication and diagnosis for anti-psychotics. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance unnecessary medications and psychotropic medications. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 758	Continued From page 114 cognition was fully intact. She had no behaviors, no rejection of care, and no psychosis. Her active diagnoses included dementia, Parkinson ' s disease, depression, and restlessness and agitation. Resident #28 received routine antipsychotic medication on 7 of 7 days and no Gradual Dose Reduction (GDR) had been attempted. Resident #28 ' s medical record indicated she was not followed by a psychiatry provider at the facility. A review of Resident #28 ' s active physician ' s orders on 2/3/20 indicated the Abilify 10 mg once daily, initially ordered on 3/29/19, continued to be active. A review of behavior documentation from admission (3/29/19) through 2/3/20 revealed no behaviors occurred. An interview and observation were conducted with Resident #28 on 2/2/20 at 3:40 PM. The resident was alert and oriented to person, place, time, and situation. She was noted with no behavioral issues and no signs or symptoms of psychosis. She reported no issues with her mood and no presence of psychosis. During an interview with Nursing Assistant (NA) # 7 on 2/3/20 at 12:05 PM she reported she was familiar with Resident #28 and that she had no signs or symptoms of psychosis and no behavioral issues. She stated that sometimes Resident #28 cried, but she was able to be comforted with companionship and words of support.	F 758		

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F 758	Continued From page 115 During an interview with NA #12 on 2/3/20 at 3:20 PM she reported that Resident #28 was alert and oriented to person, place, time, and situation. She stated that Resident #28 had no signs or symptoms of psychosis and no behavioral issues. An interview was conducted with Nurse #8 on 2/3/20 at 3:30 PM. She stated that she was familiar with Resident #28 and that she had no behavioral issues and no signs or symptoms of psychosis. When asked why Resident #28 was on Abilify she stated, "I don ' t know". An interview was conducted with Nurse #7 on 2/4/20 at 10:40 AM. She restated Nurse #8 ' s report that Resident #28 had no behavioral issues and no signs or symptoms of psychosis. When asked why Resident #28 was on Abilify she stated that the diagnosis on the order was depression with psychosis. Nurse #7 was asked if she had ever seen any signs/symptoms of psychosis for Resident #28 and she revealed she had not. During a phone interview with the physician on 2/6/20 at 11:43 AM Resident #28 ' s routine order for Abilify 10 mg once daily that had been in place since 3/29/19 was reviewed. He stated that Resident #28 had no issues with psychosis since her admission to the facility, but due to a reported past history of psychosis he had continued the Abilify 10 mg that she was on prior to her admission. He indicated that Resident #28 ' s family had not wanted the medication changed as the resident reportedly had symptoms of psychosis about 5 years ago when the medication was changed as well as a past history of an inpatient stay related to psychiatric issues. He confirmed there had been no GDRs attempted since Resident #28 was admitted to the facility on	F 758		

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F 758	Continued From page 116 3/29/19. During an interview with the Administrator on 2/6/20 at 10:10 AM she indicated she expected a clinical indication for use to be present to justify the use of an antipsychotic medication.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard expired and/or spoiled food items in 2 refrigerators and opened and undated food items in the freezer for 3 of 3 food storage, cooling devices observed. Findings included: On 2/2/2020 at 1:07 pm during the initial tour, an	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	3/3/20

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F 812 Continued From page 117

observation was conducted with Kitchen Staff #1 who accompanied the tour of the kitchen including storage. The walk-in refrigerator had plastic gallon storage containers of tomato soup, brown stew, and brown gravy with an expired label of 2 days and they were not in their original container. The reach-in refrigerator had one plastic 8-ounce serving bowel with tomato soup that was visually spoiled with mold and no labeled expiration date. The walk-in freezer had 4 gallon size, open bags of frozen vegetables undated, 2 quart size, opened bags of waffles undated, 2 quart size, open bags of French toast undated, and 1 gallon size, opened bag of breaded chicken patties undated. All opened bag freezer items were without the original manufacturer label and date.

Kitchen Staff #1 was interviewed during observation and stated that whomever is on duty in the kitchen for that day was responsible to check the stored food and drink items for expiration date and discard and date label opened items.

On 2/3/2020 at 9:30 am the Dietary Supervisor was interviewed and informed of the expired and undated food items and stated a check list was initiated for kitchen staff to check for food and drink expired items daily after surveyor identification of expired food items and undated food items. The Dietary Supervisor commented that the cook assigned for the day was required to check for expired and undated food and drink items daily. The check list will be assigned to a kitchen staff member and will be used to remind staff to check all storage.

On 2/6/2020 at 10:30 am the Administrator was

F 812

constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F812
1. For dietary services; a corrective action was obtained on 2/2/2020.

During initial walk through of the kitchen 2 food items in the refrigerator and 1 food item in the freezer were found to have expired dates or found to have been opened and without a date. These items identified by surveyor were thrown away by the Dietary Service Director.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents have the potential to be affected by the alleged deficient practice. On 2/3/2020, the Dietary Service Director completed a kitchen walk through to ensure all food items were within their dates and dated properly.

3. Systemic changes

In-service education was provided to all full time, part time, and as needed staff. Topics included:

- Storage and dating policies and regulations.
- Inspections on shifts to observe all food are within their dates and tossed if out of date.

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F 812	Continued From page 118 interviewed and commented that all kitchen staff was responsible to ensure food items were dated for expiration when opened and when placed in an alternate storage container and discarded when expired on a daily basis.	F 812	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director will monitor procedures by kitchen inspections 5 times weekly x 4 weeks, then weekly x 2 months, and then monthly x 3 months using the Dietary Quality Assurance Audit. Monitoring will include kitchen inspections by the dietary manager to ensure food are stored and dated properly. An inspection checklist has been added to the log notebook for every shift to complete (to be completed by designated cook on shift); the inspection checklist includes assessing foods items to ensure they are dated and stored properly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		3/3/20

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F 867	Continued From page 119 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assurance Committee (QA) failed to maintain procedures and monitor interventions that the committee put into to place following the annual recertification survey dated 2/28/19. This was for two recited deficiencies in the areas of Resident Rights at F550-dignity previously cited 2/28/19 and Quality of Care at F688-splinting previously cited 2/28/19. The findings included: This citation is cross referenced to: F550-Based on observation, record review, resident interview, and staff interview, the facility failed to treat Resident #28 with dignity and respect causing her to feel as if she was an "inconvenience". The facility also failed to cover Resident #66's urinary catheter drainage bag to promote dignity. This was for 2 of 2 residents reviewed for dignity. F688- Based on observations, staff and Responsible Party (RP) interviews and record review, the facility failed to apply Resident #35's left elbow splint as ordered. This was for 1 of 1 resident reviewed for range of motion. In an interview on 1 2/6/20 at 10:40 AM, the Administrator stated there had been some changes in management recently and the new	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #28: Resident was interviewed on 02/17/2020 by the Social Worker regarding any care concerns or concerns of feeling like an inconvenience. Resident denied any concerns. For resident # 66: On 02/24/2020 the resident was audited by the Nurse Consultant and noted with a Foley catheter Fig Leaf privacy bag in place. For resident #35, on OT worked with the resident for splinting of the left elbow from 02/04 to 02/12/2020. On 02/24/2020 the resident□s task and orders were updated with application of the splint and palm guard per therapy recommendations.	

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F 867	Continued From page 120 Director Of Nursing started in October 2019. The Administrator stated since she started in May 2019, she was been working on culture change in the facility and there had been some staff turnover but no resident should have a dignity concern. The Administrator stated she had no answer for why splinting for the same resident cited last year was cited again this year. She stated when the resident yells or becomes combative, she intended to identify his triggers and implement more interventions so staff have more tools to work with rather than assuming his behaviors were refusals.	F 867	2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the deficient practice. On 02/17/2020 the Social Worker interviewed all alert and oriented residents for concerns related to dignity and feeling as thought they were an inconvenience. This was completed on 02/17/2020. 4 out of 24 residents reported concerns. Two of the residents had their concerns addressed via the grievance process by the Administrator. One resident clarified her concerns with the Nurse Consultant and Administrator and a task was entered into Point Click Care for HOB to be elevated 30 minutes after meals. This was completed by the Nurse Consultant on 02/18/2020. One resident voiced an allegation of abuse and an initial allegation report was sent into the HCPR on 02/17/2020 by the Administrator. On 02/17/2020 the nurse manager audited all non-alert and oriented resident for signs of abuse or neglect or prolonged care. This was completed on 02/17/2020. 1 out of 41 residents was noted with a bruise of unknown origin and an initial allegation report was sent in to the HCPR on 02/17/2020 by the Administrator. Beginning on 02/18/2020 the nurse manager audited all current residents for the presence of a Foley catheter and a privacy bag. This audited was completed by 02/21/2020. 2 out of 6 residents were	

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F 867	Continued From page 121	F 867	noted without a privacy bag and this was corrected by the Support Nurse on 02/21/2020. Beginning on 02/18/2020 the nurse manager audited all current residents with orders for splint use to ensure the splint was in place. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint the nurse manager ensured the device was in place, had an MD order, CNA task, and care plan. This process will be completed by 03/03/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 02/24/2020, the Nurse Consultant provided an in-service education to the Administrator and Director of Nursing Service. Topics included: " Preventing repeat survey tags " Quality assurance monitoring for F tag F550 and 688 This information has been integrated into the standard orientation training and in the required in-service refresher courses for administrator and Director of Nursing as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.	

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F 867	Continued From page 122	F 867	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor completion of ongoing audits for F550 and 688 for 6 months. Any negative findings will immediately be addressed and reviewed with the facility Clinical Nurse Consultant for interventions or additional training. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as	F 947		3/3/20

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F 947	Continued From page 123 determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Nursing Assistants (NA's) received annual dementia management training. This was for 2 of 5 NA's reviewed for staffing. The findings included: NA #1's date of hire was 10/12/14 . Review of NA #1's Education/In-services records indicated no evidence of dementia training. NA #2's date of hire was 12/4/18. Review of NA #2's Education/In-services records indicated no evidence of dementia training. In an interview on 2/5/20 at 3:40 PM, the Administrator stated the facility did not have a Staff Development Coordinator. She confirmed NA #1 and NA #2 had not completed any dementia training and she was unable to provide any evidence of dementia training since they were hired. She stated the Director of Nursing (DON) was recently hired in October 2019 and since that time, there had be some redistribution of duties and task taken off the Support Nurse to ensure staff education was completed and up to date. The Administrator stated it was her expectation that all active aides be up to date with dementia training.	F 947	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility�s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F947 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to provide nursing assistant annual dementia training. 1. Corrective action for resident(s) affected by the alleged deficient practice: Nursing Assistants #1 and 2 will complete Dementia Training (Care of the Cognitively Impaired Resident) in Health Care Academy online training by 03/03/2020. 2. Corrective action for residents with the potential to be affected by the alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 947	Continued From page 124	F 947	deficient practice. Beginning on 02/24/2020 the Nurse consultant began auditing all nursing assistants to identify completion of annual Dementia training. This audit will be completed by 03/03/2020. Any CNA identified without completed Dementia training will complete the course Care of the Cognitively Impaired Resident in Health Care Academy online training by 03/03/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 02/24/2020, the Nurse Consultant fired Dementia Training (in Health Care Academy online training) via Health Care Academy on line training to all full time, part time and as needed nursing assistants that did not have the annual education documented. All identified nursing assistants will complete the Dementia training by 03/03/2020 at which time all identified nursing assistants must be in-serviced prior to working. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020.	

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F 947	Continued From page 125	F 947	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses will monitor compliance utilizing the Dementia Training Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor all nursing assistants for compliance with the completion of annual Dementia training. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	