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	345416	A. BUILDING _____ B. WING _____	02/26/2020

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BERMUDA VILLAGE RETIREMENT CENTER	142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006

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E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this	E 036		3/6/20

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

Electronically Signed | 03/19/2020

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E 036	Continued From page 1 section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an annual emergency preparedness (EP) training and testing program for staff. The facility's failure to maintain their EP training and testing program had the potential to affect all of the residents in the facility. The findings included: The facility's emergency preparedness (EP) manual was reviewed on 2/26/20. The manual was updated February 2020 (no date specified). The facility's EP manual did not include information on training or testing of the emergency preparedness plan for the facility staff during 2019. On 02/26/20 at 9:23 AM the Administrator and	E 036	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? Disaster Plan table top exercise was conducted on 3/6/2020 with the following team members present: Administrator, Director of Nursing, MDS Nurse, Social Worker, Activities Director and Maintenance Supervisor 2. How will you identify others impacted by the deficient practice? All patients have the potential to be impacted. 3. What measures will be put in place or	

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E 036	Continued From page 2 Maintenance Director were interviewed together about the facility's emergency preparedness program. During the interview, the Administrator stated the facility had not conducted an annual exercise of executing the facility's disaster plan because she was unaware it needed to be completed annually. She stated the last EP drill was completed in September 2017, when the plan was developed. In the same interview, the Maintenance Director explained that he conducted monthly fire drills but had not assisted in arranging a drill to test the facility's emergency preparedness program plan.	E 036	systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. Department Head team was re-in serviced regarding the requirement to hold discussion-based session where team members meet to discuss roles during an emergency situation. b. Roles were reviewed per position by the Administrator on 3/6/2020 c. Calendar of activities was reviewed by the Administrator to assure compliance with disaster planning initiatives. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Administrator will assure compliance by assurance of adherence to established schedule and reporting disaster related activities to the QA committee for review, additional discussion and recommendations.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to assess a resident's capability to self-administer	F 554	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice?	3/20/20

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F 554	Continued From page 3 medications kept in his room. This was for 1 of 1 resident reviewed for choices (Resident #17). The findings included: Resident #17 was admitted to the facility on 12/16/19 with diagnoses that included Parkinson's disease, left sided hemiplegia and others. The most recent Minimum Data Set (MDS) dated 12/23/19 specified the resident's cognition was moderately impaired. A care area assessment (CAA) dated 12/2719 specified Resident #17 was alert with confusion at times. Review of the physician orders for Resident #17 revealed there was no order for antacid medication or zinc oxide barrier cream. Further review of the medical record for Resident #17 revealed there was assessment for self-administering medications or care plan to self-administer medications. On 02/24/20 at 10:20 AM Resident #17 had antacids tablets and zinc oxide barrier cream on his nightstand. Resident #17 was in bed during the observation. On 02/25/20 at 8:28 AM Resident #17 had antacid tablets and zinc oxide barrier cream on his nightstand. Resident #17 was not in his room during the observation. On 02/25/20 at 3:52 PM Resident #17 had antacid tablets and zinc oxide barrier cream on his nightstand. Resident #17 was in his room in bed and interviewed about the medications. He	F 554	The identified medication (TUMS) was discussed with the patient/family who agreed to removal of the medication on 2/26/2020 by a Supervisor until the Self Administration of Medication Assessment could be completed. The assessment was completed on 2/28/2020 by Supervisor and Nurse. The patient was determined to be unsafe to self-administer medication and POA agreed to maintain all medications in medication cart. 2. How will you identify others impacted by the deficient practice? Review of all patient rooms to identify medications at bedside was conducted on 2/28/2020 by Supervisor and Nurse. Any medication was immediately removed from the room until we verified that MD had assessed and order was obtained for self-administer. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. Self-Administration of Medication Policy was reviewed by DON on 2/28/2020. b. Policy added to the Admission Packet. c. Nursing staff to include RNs, LPNs and CNAs were re-in serviced on requirements of the Self-Administration Policy and to notify Charge Nurse when medications are identified in patient	

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F 554	Continued From page 4 stated he kept the medications there and took the antacid medications occasionally for gas. He explained he used the zinc oxide cream to apply to his buttocks when they itched. On 02/25/20 at 4:00 PM Nurse #2 was interviewed and described Resident #17 as alert during the day but very confused in the evening. She added that he was not assessed to self-medicate and should not be allowed to give himself medications. She explained that she relied on nurse aides to report medications brought from home to her because they typically found them when placing personal items in drawers. Nurse #2 was unaware the resident had medications at bedside and had not seen them in the room. On 02/26/20 at 8:45 AM the Director of Nursing (DON) was interviewed and stated that residents could self-administer medications if determined by the physician to be safe to do so. She stated that if a resident expressed the desire to self-administer medications, the physician was notified and conducted an assessment. She was unaware if any residents were assessed to self-administer medications. The DON stated that Resident #17 would be questionable as to whether or not he could self-administer medications. The DON was unaware of the medications in Resident #17's room and added they should not be there, and that education was provided to families about brining medications from home.	F 554	room/area. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Director of Nursing, or individual assigned, will assure compliance by conducting surveillance rounds 2x per week x 60 days to assure adherence to the policy. Adverse findings will be addressed immediately, reported to the Administrator and documented. Adverse findings will be presented to the facility Quality Assurance Committee. Members of the committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		3/2/20

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F 641	Continued From page 5 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the life expectancy for 1 of 2 sampled residents for Hospice and failed to accurately code a resident's mechanically altered diet for 1 of 2 residents reviewed for nutrition (Resident #34 and #14). The findings included: 1. Resident #34 was admitted to the facility on 12/10/18 and readmitted on 11/12/19 with diagnoses that included terminal cancer. Review of the medical record revealed a physician ordered Hospice referral made on 11/12/19. A document titled "Certification Statement" dated 11/13/19 specified Resident #34 was certified for Hospice and was terminally ill with a life expectancy of six months or less. The significant change Minimum Data Set (MDS) dated 12/9/19 specified the resident's cognition was severely impaired, he was on Hospice but section J1400 was not coded as having a life expectancy of less than 6 months. On 02/25/20 at 9:19 AM the MDS Coordinator was interviewed and explained she started in November and was new to MDS. She reviewed the MDS dated 12/09/19 completed for Resident #34 and explained she had not completed that MDS. However, in the interview she stated the mistake was an oversight. She explained that	F 641	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? The identified patient had been discharged. No corrective action could be taken to amend the closed record. MDS coordinator made corrections in effected resident□s MDS assessment 2. How will you identify others impacted by the deficient practice? The MDS of all patients receiving hospice services was reviewed by the MDS nurse on 3/2/2020 to assure completion of appropriate assessment. The MDS of all patients on mechanically altered diet was reviewed by MDS nurse on 3/2/2020. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. The Director of Nursing reviewed the RAI indicators for Significant Change related to orders for Hospice care with the MDS Coordinator on 3/6/2020. b. Patient□s exhibiting a change in condition related to Hospice Services or	

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F 641	Continued From page 6 during the time the MDS was completed, she was being trained by a consultant who did not explain to her that any resident under Hospice care should have section J1400 on the MDS coded as yes. The MDS Coordinator reviewed the RAI (Resident Assessment Instrument) manual for guidance on coding section J1400 that directed to code the section "yes" when a resident was on Hospice. On 02/25/20 at 2:20 PM the Administrator was interviewed and explained that facility had struggled to have a nurse in the role of MDS Coordinator. She added that the facility had hired outside consultants to work to make sure MDS assessments were being completed timely and accurately. She stated that a consultant had also been used to train the MDS Coordinator and she expected the MDS assessments to be completed accurately. 2. Resident #14 was admitted to the facility on 09/01/19 with diagnoses that included dysphagia and others. A physician's order dated 09/05/19 specified Resident #14 was to have a pureed diet. The Minimum Data Set (MDS) dated 12/06/19 specified the resident's cognition was severely impaired and she did not receive a mechanically altered diet. On 02/25/20 at 2:07 PM the MDS Coordinator was interviewed and explained that she was new and had missed coding pureed diet for Resident #14. On 02/25/20 at 2:20 PM the Administrator was	F 641	altered diets will be reported to the Director of Nursing by the nurse assigned to the patient. c. Review of patients with new orders for Hospice Consult or altered diets will be reviewed by the interdisciplinary team during scheduled morning clinical meeting. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Director of Nursing, or individual assigned, will assure compliance by conducting audit of all orders for Hospice Care to assure significant change assessments and accuracy of coding quarterly x 6 months for any existing or new hospice patient, and any new mechanically altered diet orders. Adverse findings will be addressed immediately, reported to the Administrator and documented. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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F 641	Continued From page 7 interviewed and explained that facility had struggled to have a nurse in the role of MDS Coordinator. She added that the facility had hired outside consultants to work to make sure MDS assessments were being completed timely and accurately. She stated that a consultant had also been used to train the MDS Coordinator and she expected the MDS assessments to be completed accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		3/25/20

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F 656	Continued From page 8 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to implement care plan interventions for a resident to have a rolled washcloth in his hand for contracture management for 1 of 2 residents (Resident #9) investigated for activities of daily living. The findings included: Resident #9 was readmitted to the facility on 12/10/18 with diagnoses that included hemiplegia following cerebrovascular accident, heart failure, atrial fibrillation and others. Review of Resident #9's resident care guide dated 12/10/18 did not indicate the rolled washcloth to his left hand was to be used. Review of the comprehensive Minimum Data Set (MDS) dated 12/09/19 revealed that Resident #9 was cognitively intact for daily decision making and required extensive assistance with activities of daily living (ADL). No behavior or rejection of	F 656	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? Assistive Device for Patient was obtained on 2/26/2020 by nurse. 2. How will you identify others impacted by the deficient practice? a. Root cause analysis was conducted to determine cause for identified practice. It was determined that software was not translating to the care guide due to user error. b. 100% patient audit was conducted on 2/26/2020 by MDS Nurse to identify assistive devices ordered. c. 100% audit of care guides was conducted on 2/26/2020 by 2/26/2020 to assure accurate communication to the direct care team.	

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F 656	Continued From page 9 care was noted during the assessment reference period. Review of a care plan initiated on 12/12/19 read in part, Resident #9 required extensive assistance with all areas of ADLs related to decline in physical mobility as result of deconditioning. Mechanical lift for transfers and he preferred to stay in bed. The goal read, Resident #9 will receive assistance with all ADL as evidence by good grooming, neat and clean appearance, no breaks in skin and be free of body odors daily. The interventions included: rolled washcloth to left hand for contracture management. An observation of Resident #9 was made on 02/24/2020 at 12:39 PM. Resident #9 was resting in bed with eyes open and was alert and verbal. Resident #9's left hand appeared flaccid and was lying next to his body in the bed. The hand was in a ball and no washcloth was noted in the hand. An observation and interview were conducted with Resident #9 on 02/25/2020 at 9:00 AM. Resident #9 was resting in bed and was alert and verbal. He stated that he had a stroke several years ago and his left side was paralyzed. His left hand appeared flaccid and was in a ball and no washcloth was noted in the hand. An observation and interview were conducted with Resident #9 on 02/26/2020 at 8:48 AM. Resident #9 was resting in bed and was alert and verbal. His left hand appeared flaccid and was in a ball lying next to him in the bed. No washcloth was noted to the left hand. Resident #9 was able to use his right hand to open his left and confirmed there was no washcloth in his hand. He	F 656	3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. Nurses re-in serviced on order entry as it relates to assistive devices. b. Review of patients with new orders for assistive devices will be reviewed by the interdisciplinary team during scheduled morning clinical meeting to assure implementation. c. All current staff will be in-service by 3/25/2020 on expectations to review and follow the care guide on each resident specifically pertaining to ensuring any assistive device needed is provided to the resident. d. New staff will be to be trained on reviewing the care guide on all patients during their orientation. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The MDS Coordinator, or individual assigned by the Director of Nursing in her absence, will assure compliance by conducting audit of all orders for Assistive Devices to assure accuracy of coding/communication 1x week x 4 weeks then 1x monthly x 4 months for 4 patients to assure adherence to the policy. Adverse findings will be addressed	

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F 656	Continued From page 10 stated that he used an orange carrot looking device in the past, but the staff stopped using it. Resident #9 was unsure why the staff did not put the device in his hand but stated he certainly could not do it by myself. An interview was conducted with Nurse Aide (NA) #1 on 02/26/2020 at 9:19 PM. NA #1 stated that she had only worked at the facility about 3 weeks and this was her first day taking care of Resident #9. She stated that she reviewed his care guide to learn about his care needs and did not see any splints, devices, or roll washcloth noted. She stated that if they were on the care guide, she would have applied them as directed. An interview was conducted with Nurse #4 on 02/26/2020 at 9:21 AM. Nurse #4 confirmed she was caring for Resident #9. She stated that he currently had no splint or devices that he used for contracture management of his left hand. An interview was conducted with the Director of Nursing (DON) and the MDS Coordinator on 02/26/2020 at 12:16 PM. The MDS Coordinator stated that she was fairly new to the facility and was still very much learning all the responsibilities she had in the facility. She stated that she added the rolled washcloth to Resident #9's care plan on 12/12/19 and sent out an alert to the staff on the units. The DON asked the MDS Coordinator if she had checked the box to add the care plan intervention to the resident care guide. The MDS Coordinator indicated she was not aware that she had to click a box to add the intervention to the resident care guide and that would explain why the intervention was not on the care guide and why the direct care staff were unaware of the intervention.	F 656	immediately, reported to the Administrator and documented. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CENTER	142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006

(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 656	Continued From page 11 A follow up interview was conducted with the DON and the Administrator on 02/26/2020 at 2:19 PM. The DON stated she educated the MDS Coordinator about adding care plan interventions to the resident care guide and instructed her that every intervention on the care plan should be on the resident care guide. The DON stated she expected the staff to follow and implement the care plan as directed.	F 656		
F 677 SS=D	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, record review, resident, and staff interview the failed to provide nail care to a dependent resident (Resident #9) and failed to shave a resident with chin hairs (Resident #22) for 2 of 2 residents investigated for activities of daily living. The findings included: 1. Resident #9 was readmitted to the facility on 12/10/18 with diagnoses that included hemiplegia following cerebrovascular accident, heart failure, atrial fibrillation and others. Review of the comprehensive Minimum Data Set (MDS) dated 12/09/19 revealed that Resident #9 was cognitively intact for daily decision making and required extensive assistance with activities of daily living (ADLs). No behavior or rejection of	F 677	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? Patient #9 received immediate care and nails were cleaned and trimmed. Patient #22 received immediate attention and was shaved. 2. How will you identify others impacted by the deficient practice? On 2/26/2020 100% patient audit was conducted to review nail care and presence of facial hair. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e.	3/6/20

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F 677	Continued From page 12 care was noted during the assessment reference period. An observation of Resident #9 was made on 02/24/2020 at 12:39 PM. Resident #9 was resting in bed with his eyes open and was alert and verbal. Resident #9's left hand appeared flaccid and was lying next to his body in the bed. Resident #9's fingernail on his left hand were approximately a quarter inch to half inch long. Resident #9's fingernails on his right hand were approximately a quarter inch long and were dirty with a dried brown/black substance under them. His lunch tray was in front of Resident #9 and he was using his right hand to pick up a cheeseburger and French fries that he was eating for lunch. An observation and interview were conducted with Resident #9 on 02/25/2020 at 9:00 AM. Resident #9 was resting in bed and was alert and verbal. He stated that he had a stroke several years ago and his left side was paralyzed. His left hand appeared flaccid and his fingernails were approximately a quarter inch to a half inch long. The fingernails on his right hand were approximately a quarter inch long and were noted to have dried brown/black substances under them. His breakfast meal was in front of him and he was using his right hand to pick up bacon strips and eat them. An observation and interview were conducted with Resident #9 on 02/26/2020 at 8:48 AM. Resident #9 was resting in bed and was alert and verbal. His left hand appeared flaccid and was lying next to him in the bed. Resident #9 was able to use his right hand to open his left and the skin was intact but macerated and did have a	F 677	what quality assurance program will be put in place? In-service was held for All direct care staff, including c.n.a and nursing, on 2/28/2020 regarding the importance of assuring residents in their care are appropriately assisted with grooming when needed. C.N.A supervisor will be responsible for conducting and documenting routine checks on patients to ensure expectations are being met on going. New hires will be trained on complying with our expectations that ADL care be carried out in accordance to their care guide. This training will occur during their orientation/training. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? CNA supervisor, or individual assigned by the Director of Nursing, will conduct rounds 2x week x 60 days to assure patient grooming. Adverse findings will be addressed immediately, reported to the Director of Nursing and documented. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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F 677	Continued From page 13	F 677		

slight odor to it. His fingernails on his left hand were approximately a quarter inch to a half inch long. The fingernails on his right hand were approximately a quarter inch long and were noted to have dried brown/black substance under them. Resident #9's breakfast tray was in front of him and he was using his right hand to pick up an orange slice and eat it. Resident #9 was asked about his fingernails and he replied, "oh yes they sure need to be trimmed." He stated that someone was supposed to come around and clip them for him, but they never showed up and he was unable to recall when the last time he nails had been trimmed or cleaned. Resident #9 stated that stuff like that bothered him because he was not able to do those things for himself since having his stroke.

An interview was conducted with Nurse Aide (NA) #1 on 02/26/2020 at 9:19 PM. NA #1 stated that she had only worked at the facility about 3 weeks and this was her first day taking care of Resident #9. She stated that nail care was done during bathing or any time that we see it needed to be done. NA #1 stated she had not seen Resident #9's nails thus far on shift and added she knew she could file them but was unsure if she could trim them or not. She stated she would have to find out for sure.

An interview was conducted with Nurse #4 on 02/26/2020 at 9:21 AM. Nurse #4 confirmed she was caring for Resident #9. She stated that nail care was provided during bathing. She added Resident #9 refused to go to the shower and preferred a bed bath and his nails should be trimmed during the bed bath. Nurse #4 also stated that the staff should be cleaning Resident #9's hands and nails prior to each meal.

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F 677	Continued From page 14	F 677		

A follow up interview was conducted with NA #1 on 02/26/2020 at 12:19 PM. NA #1 stated that she had asked her supervisor if she could trim nails and she was told as long as the resident was not a diabetic. NA #1 stated she went to Resident #9's room and confirmed that his nails were long and dirty, and she cleaned them and trimmed. NA #1 stated that Resident #9 was very thankful for taking care of that for him.

An interview was conducted with the DON and the Administrator on 02/26/2020 at 2:19 PM. The DON stated she expected the staff to provide nail care during bathing or anytime there was a need. She stated that the staff should also be cleaning the resident's hands and nails prior to each meal. The Administrator stated that they had a NA supervisor who was responsible for checking things like that and they would get her to help identify any care issues so they could provide the care.

2. Resident #22 was admitted to the facility on 12/10/18 with diagnoses that included dementia, osteoarthritis, and others.

Review of a care plan initiated 12/18/19 read in part, Resident #22 required extensive assistance with all areas of activities of daily living related to decline in physical mobility, being chair bound, and requiring mechanical lift. The goal read, Resident #22 will receive assistance with activities of daily living as evidence by, grooming, neat and clean appearance, no breaks in skin and be free of body odors daily. The interventions included: assist with hygiene and activities of daily living as needed.

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F 677	Continued From page 15	F 677		

Review of the comprehensive Minimum Data Set (MDS) dated 01/06/2020 revealed that Resident #22 was severely impaired for daily decision making and had no speech. The MDS further revealed that Resident #22 required total assistance with person hygiene.

An observation of Resident #22 was made on 02/24/2020 at 11:02 AM. Resident #22 was resting in bed with eyes open but was nonverbal. She was dressed in pink sweater and was covered with a comforter. Resident #22 was observed to have grey hairs on her upper lip, down to her chin and onto her neck that were approximately a quarter inch long.

An observation was made of Resident #22 on 02/25/2020 at 8:50 AM. Resident #22 was resting in bed with eyes open but was nonverbal. She was dressed in pink sweater and was covered with a comforter. Resident #22 was observed to have grey hairs on her upper lip, down to her chin and onto her neck that were approximately a quarter inch long. She was being assisted with her breakfast meal by facility staff.

An observation of Resident #22 was made on 02/26/2020 at 8:45 AM. Resident #22 was resting in bed with eyes open but was nonverbal. She was dressed in pink and blue gown and was covered with a comforter. Resident #22 was observed to have grey hairs on her upper lip, down to her chin and onto her neck that were approximately a quarter inch long.

An interview was conducted with Nurse Aide (NA) #2 on 02/26/2020 at 9:08 AM. NA #2 confirmed she was familiar with Resident #22 and her care needs. She stated she had not provided any care

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F 677	Continued From page 16 to Resident #22 yet because she was serving breakfast. NA #2 stated that when female resident had facial hair, it was shaved off unless they refused. If the resident refused this would be reported to the nurse. She added that Resident #22 should have been shaved during her bath days which were Tuesday and Friday. NA #2 stated that it was not Resident #22's shower day but she could certainly shave the facial hair off. An interview was conducted with NA #3 on 02/26/2020 at 12:31 PM. NA #3 confirmed that she cared for Resident #22 on 02/25/2020 and gave her a bed bath. NA #3 stated that she noted Resident #22's facial hair but did not shave it off because in the past the resident had fought with her. NA #3 confirmed that Resident #22 was not fighting yesterday but she did not attempt to remove her facial hair because she did not want to upset her. NA #2 agreed that Resident #22 had almost a full beard and needed a full shave and she should have done it on 02/25/2020 during her bed bath. An interview was conducted with the Director of Nursing (DON) and the Administrator on 02/26/2020 at 2:19 PM. The DON stated she expected the staff to shave residents that needed to be shaved on a daily basis. She stated that the if the resident refused then it should be reported to the nurse. The Administrator stated that they had a NA supervisor who was responsible for checking things like that and they would get her to help identify any care issues so they could provide the care.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/25/20

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F 686	Continued From page 17 §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 observations, record review, and staff interviews the facility failed to apply the physician ordered treatment to a pressure ulcer for 1 of 1 resident (Resident #26) investigated for pressure ulcers. The findings included: Resident #26 was readmitted to the facility on 01/31/2020 with diagnoses that included iron deficiency anemia, gastrointestinal hemorrhage, multiple sclerosis and others. Review of the Minimum Data Set (MDS) dated 12/18/19 revealed that Resident #26 was severely cognitively impaired for daily decision making and required total assistance of 2 staff members with bed mobility. No pressure ulcers were identified on the assessment but indicated the application of ointments/medication other than to feet were used during the assessment reference period.	F 686	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? Patient # 26 was assessed by Nurse with consult to MD to ensure proper recommended treatment was being followed. This took place on 2/25/2020 with no adverse outcome identified. 2. How will you identify others impacted by the deficient practice? All patients with wounds were assessed by the Nurse Supervisor with physician orders audited to assure accurate transcription. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place?	

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F 686	Continued From page 18 Review of a physician order dated 02/12/2020 read, clean areas to right and left buttock with normal saline, pat dry apply Alginate AG (antimicrobial fiber structured dressing) and cover with dry dressing change every day. Review of the Medication Administration Record (MAR) dated 02/01/2020 through 02/25/2020 indicated the dressing had been applied as ordered. An observation of wound care was conducted with Nurse #2 on 02/25/2020 at 2:15 PM. Nurse #2 stated that Resident #26 recently readmitted to the facility from the local hospital and was noted to have the area of breakdown on her buttocks which was a Stage 2 area. She indicated she would be applying Critic-Aid paste to the area which was applied every shift and as needed. Nurse #2 entered Resident #26's room and turned her onto her right side. After pulling her brief to the side she used a wipe to remove old paste from Resident #26's buttocks. Once the paste was removed the area was visualized and was approximately 1.5 centimeters (cm) by 1.0 cm x 0.2 cm and was a shallow crater that was pink in color. There was a dark brown scab that was loose and when wiped would move but did not come off. No odor was noted. Nurse #2 changed her gloves and proceed to apply a healthy application of the Critic-Aid paste to Resident #26's buttocks and then fastened her brief and removed her gloves before exiting the room. An interview was conducted with the Director of Nursing (DON) on 02/25/2020 at 2:31 PM. The DON stated that Resident #26 had some excoriation to her buttocks and when she recently	F 686	a. Nurses re-in serviced on adherence to physician orders related to wound treatments. b. Wound treatment orders will be reviewed by the interdisciplinary team during scheduled morning clinical meeting to assure accurate transcription. c. During our new hire training/orientation staff will be to be trained on importance of adhering to physician's orders related to wound treatments. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Director of Nursing, or designee, will assure compliance by conducting observation of 2 wound treatments per week x 4 weeks then 1 x monthly x 4 months to assure accuracy of treatment per physician orders. Adverse findings will be addressed immediately, reported to the Administrator and documented. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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F 686	Continued From page 19	F 686		

returned from a hospital stay it had progressed to a Stage 2 with new measurements. She stated that Nurse #5 would measure the wounds weekly and ensure the correct treatment orders were in place and communicated with the families and physician as needed. The DON stated that currently they were using Alginate AG on Resident #26's stage 2 pressure ulcer to her buttocks and covering it with a dry dressing. She added that the hall nurses completed the wound treatments on a daily basis.

An interview was conducted with Nurse #5 on 02/25/2020 at 3:10 PM. Nurse #5 stated she came in weekly and performed wound rounds that included measuring each wound and making sure the correct treatment order was in place and complete any required documentation that was needed. Nurse #5 stated that Resident #26 started with some excoriation and after her recent hospital stay had progressed to a stage 2. She indicated that she examined Resident #26's wound on 02/19/2020 and it was draining a bit, so she continued the Alginate AG dressing as previously ordered. She added that she made sure the order was still active and, on the MAR. Nurse #5 stated that the hall nurses should perform the daily dressing with the ordered treatment until she re-examined the area and determined that something else was more appropriate. She indicated that the facility had protocols and she followed them to determine which treatment option to use. Nurse #5 stated that if she had any additional questions or concerns, she would communicate with the physician. She again confirmed that the treatment order for Resident #26's buttock wound was Alginate AG and cover with dry dressing.

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F 686	Continued From page 20 A follow up interview was conducted with the DON on 02/25/2020 at 3:27 PM. The DON stated that she trusted Nurse #5's judgement and the last time the wound was evaluated she ordered the Alginate AG and that is what should be used. The interview further revealed Nurse #2 should be aware of the treatment order by reviewing the MAR. A follow up interview was conducted with Nurse #2 on 02/25/2020 at 3:37 PM. Nurse #2 stated that she was unaware that the treatment to Resident #26's buttocks was Alginate AG, she stated she always used the Critic-aid paste and must have overlooked the order on the MAR. An interview was again conducted with the DON and the Administrator on 02/26/2020 at 2:12 PM. The DON stated she expected Nurse #2 to follow the prescribed treatment order for pressure ulcers by checking the MAR and doing what was ordered by the physician.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, resident, staff, and Medical Doctor interview the facility failed to provide adequate supervision to	F 689	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice?	3/25/20

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F 689	Continued From page 21 prevent a confused resident from wandering outside the building for 1 of 2 residents investigated for provide supervision to prevent accidents (Resident #84). The findings included: Resident #84 was admitted to the facility on 02/22/2020 with diagnoses that included: traumatic subarachnoid hemorrhage, dementia and others. Review of an elopement risk assessment dated 02/22/2020 indicated that Resident #84 scored a 10 which indicated he was at risk for elopement. The section of the assessment that indicated interventions that were initiated was left blank. The assessment was completed by Nurse #1. No Minimum Data Set (MDS) information was available for Resident #84. Review of a nurse's note dated 02/22/2020 at 11:12 PM read, Resident #84 observed totally confused and disoriented, walking in darkened room without using call bell for assistance. He was not using a wheelchair or walker he was returned to bed only to note that he got out of bed once more. Resident #84 was not comprehending safety issues and next shift was alerted to his increased fall risk. Signed by Nurse #6. Review of a nurses note dated 02/23/2020 at 12:35 PM read in part, while charting at the nurse's station at approximately 12:00 PM this nurse looked up and saw Resident #84 outside the front doors. He was dressed in slipper socks, had no walker, and no wheelchair. This nurse	F 689	Patient who ambulated to front porch was safely assisted into the facility without incident. 2. How will you identify others impacted by the deficient practice? Elopement risk assessments were reviewed for all patients. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. Department Head team reviewed policy and procedure for completion of elopement Assessment, care planning and staff awareness of patients at risk. b. Department Head team re-in serviced all c.n.a and nursing staff in the elopement procedure and how to identify and monitor patients at risk. c. Staff retrained on the interventions that must be followed in the event a resident trigger as an elopement risk. d. New staff will be to be trained on importance of adhering and following out our elopement policy 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Administrator will assure compliance	

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F 689	Continued From page 22 went to Resident #84 immediately and guided him back inside and to his room. When nurse asked Resident #84 why he was outside he said, "I am looking for my car." Resident #84 was placed in his wheelchair and left at the nurse's station and his family was called. Resident #84's family stated they would be there in 35 minutes to sit with him. The Medical Doctor (MD) evaluated Resident #84 as he was admitted yesterday, and he was now on every 30-minute checks. The note was signed by Nurse #1. Review of a nurse's note dated 02/23/2020 at 1:00 PM read in part, Nurse #1 reported to this nurse that Resident #84 was standing outside just past the double doors by himself with no walker or wheelchair. Nurse #1 went out and got Resident #84 and he stated he was "looking for his car." Family was notified and planned to sit with him. No injuries and no fall noted but did have on non-skin socks. Resident #84 had left his wheelchair and walker in his room. He was noted with confusion. He was started on every 30-minute checks and family to arrange for sitter care. Signed by Nurse #5. Review of a MD progress note dated 02/23/2020 read in part, Resident #84 was a poor historian and disoriented on exam. Per nursing staff he was out of bed attempting to leave the facility this morning. The review of system stated, unable to perform review of system due to mental acuity, the patient is delirious. The physical exam revealed that Resident #84 was in no acute distress but was agitated and presented with impaired cognition and memory, his judgement was impulsive. The assessment and plan read in part, delirium and probably dementia. Hyperactivity suspected secondary to new	F 689	by reviewing all adverse event reports related to patients at risk exiting the facility by implementing interventions as necessary. DON/designee will conduct audit of the elopement risk assessment for all new admits x60 days. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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environment change, discussed with nursing staff and plan for neuro checks every shift and will evaluate tomorrow. Unable to perform cognitive testing today due to delirium. The progress note was signed by the MD.

An observation and interview were conducted with Resident #84 and his family member on 02/24/2020 at 9:37 AM. Resident #84 was sitting up in bed and was dressed appropriately for the weather. He was observed to have a dark purple bruise surrounding his left eye and sutures were noted to a laceration above his left eye. Resident #84 stated that he went outside yesterday to water his neighbors plants and fell and busted his head open. Resident #84's family member corrected him and stated that his facial injuries occurred when he was home prior to his admission to the facility. Resident #84 smiled and shrugged his shoulders and when asked specifically about going outside yesterday at the facility he could not recall the event. The family member stated that the facility told them that the family had to stay with Resident #84 at all times and since he got outside the family has been at the facility around the clock.

An interview was conducted with Nurse #1 on 02/25/2020 at 11:40 AM. Nurse #1 confirmed that she admitted Resident #84 to the facility on 02/22/2020. She stated that on admission Resident #84 was alert and oriented x 4, he knew the month and year but did have periods of confusion. She stated that in report Sunday morning 02/23/2020 it was reported he had gotten up and was looking for his wife. Nurse #1 stated that on Sunday morning after she got report Resident #84 was observed to be wandering out in the hallway with no assistive

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device. She added she had returned him to his room 2-3 times that morning and encouraged Resident #84 to use his wheelchair or walker, but he would not use them. Nurse #1 stated that sometime between 11:00 AM and 12:00 PM she was at the nurse's station that faced the double exit door and she looked up and noted Resident #84 standing right outside the doors. She stated he was dressed in street clothes, slipper socks, but had no walker or wheelchair and was by himself. Nurse #1 reported she immediately went outside and got Resident #84 and brought him back inside the facility. She added that Resident #84 reported that he was looking for his car. Nurse #1 stated that approximately 30 minutes prior to finding Resident #84 outside he was wondering on the unit and she had returned him to his room and assisted him to his wheelchair. The family had called earlier and stated that they were coming to the facility so Resident #84 was placed in his wheelchair and left him at the nurse's station until his family arrived and they were made aware of the incident. Nurse #1 stated that she had been charting for about 20 minutes when she noted Resident #84 outside, she stated she did not see him walk by her through the doors and did not hear the doors open. Nurse #1 stated that generally when the doors opened, she would look up to see who was coming or going. She further indicated the front door was equipped with a doorbell that would go off when the door opened but stated it was not on and she did not know how to turn it on. Nurse #1 was unaware if the doorbell was supposed to be on or not. Resident #84 was started on 30-minute checks and once his family arrived, they stayed with him the remainder of her shift. In addition to the 30-minute checks the MD was at the facility approximately 30 minutes after and evaluated

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Resident #84. Nurse #1 reported that on 02/23/2020 it was sunny outside but could not recall what the temperature was but stated Resident #84 was not outside for long at all.

An interview was conducted with Nurse #5 on 02/25/2020 at 3:01 PM. Nurse #5 indicated she was the weekend supervisor and was notified by Nurse #1 on 02/23/2020 that Resident #84 was found right outside the door under the portico. Nurse #5 stated that Nurse #1 reported she was at the nurse's station and looked up and noted Resident #84 outside and immediately went and brought him back inside the facility. Resident #84 reported that he was looking for his car. Nurse #5 stated that it was reported to her that Resident #84 was only outside briefly and when he was brought back inside the facility was placed on 30-minute checks and his family arrived shortly thereafter and remained with him for the remainder of the shift. She added that Resident #84 was dressed in street clothes and had on slipper socks and no injuries were noted. Nurse #5 stated that Resident #84 was alert and oriented and knew the month, date, year and knew where he was at. Just prior to being found outside Resident #84 had been wandering outside of his room and Nurse #1 had returned him to his wheelchair in his room. Nurse #5 stated that Resident #84 was easily redirected and once returned was not left alone for the remainder of the shift and was evaluated by the MD as well.

An interview was conducted with the Director of Nursing (DON) on 02/25/2020 at 3:40 PM. The DON stated she did not think Resident #84 was actually trying to leave, he was aware of where he was at and was looking around for his car. She

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added she did not believe that the incident was an elopement because he was alert enough to know his surroundings. However since Resident #84 had gotten outside and had diagnosis of dementia they initiated 24-hour sitter car as precautionary measures. The DON stated that they completed an elopement risk on admission but was not sure what the facility did when a resident was at risk. The DON stated she would have wanted the staff to make more frequent checks on Resident #84 as she had done this in the past when a resident scored high on the elopement risk assessment. The DON was unaware if the doorbell was on or not but stated the alarm would not stop anyone from leaving but would alert the staff that someone was going outside. She added if a resident tried to exit the facility, they would initiate 30-minute visual checks and provide a sitter. She added that dementia does not getter better and for the safety of Resident #84 they planned to continue the safety checks as they don't want him wandering outside.

An interview was conducted with the MD on 02/26/2020 at 11:31 AM. The MD stated that she came to the facility on Sunday 02/23/2020 and was told that Resident #84 was trying to leave the facility but was not told that he had actually exited the facility unsupervised. The MD stated she believed that Resident #84 had some delirium with the environment changes he had. She stated when she visited with Resident #84 his family kept telling him where he was , but he kept asking the same question over and over again. The MD stated she would not want Resident #84 to go outside for safety reasons as he had some underlying dementia that got acutely worse when he came to the facility. She added that during her

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F 689	Continued From page 27 visit with Resident #84 there were 4 family members reorienting him and he was still very much acutely delirious and was not appropriate to be outside unattended. An interview was conducted with the DON and the Administrator on 02/26/2020 at 2:21PM. The DON again stated that the facility had not considered the incident a true elopement because he was on the porch. The Administrator stated that the facility had security cameras on the doors, but she had not reviewed them because she did not have access to them due to the facility recently being under new ownership. She further stated that they had considered a security system for the doors in the facility and this would certainly be talked about further given the incident with Resident #84.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to administer oxygen as prescribed for 1 of 2 sampled residents reviewed for oxygen use (Resident #85).	F 695	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? Patient # 85 was seen by Nurse; NP was made aware. No adverse findings were	3/25/20

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F 695	Continued From page 28 The findings included: Resident #85 was admitted to the facility on 02/14/2020 with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure, and dependence on supplemental oxygen. Review of Resident #85's oxygen saturation level from 02/14/2020 to 02/26/2020 revealed that her oxygen saturation level ranged from 90-98%. Review of a physician order dated 02/15/2020 read, oxygen at 1 liter per minute. Review of the comprehensive Minimum Data Set (MDS) dated 02/21/2020 revealed that Resident #85 was cognitively intact and required set up to limited assistance with activities of daily living. The MDS further indicated that Resident #85 had shortness of breath when at rest and with exertion and required the use of oxygen. An observation and interview were conducted with Resident #85 on 02/24/2020 at 9:40 AM. Resident #85 was resting in bed with eyes open. She was alert and verbal and indicated she wore oxygen all the time at home and usually required 2-3 liters of oxygen. Resident #85 stated that she was not sure how much oxygen she was on since coming to the facility but stated she hoped it was the same as when she was at home. She indicated she did not bother the concentrator in her room the staff "tended to that." Resident #85 had oxygen tubing in her nose that was connected to a concentrator on the other side of the room and the concentrator was set deliver 2 liters of oxygen.	F 695	identified. 2. How will you identify others impacted by the deficient practice? All patients receiving oxygen therapy are at risk and were assessed by the Nurse Supervisor with orders verified and concentrator settings verified. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. Licensed nurses in-serviced regarding monitoring oxygen delivery per concentrator in accordance with physician□s orders. b. 100% audit was conducted by Nurse Supervisor on 2/29/2020 to assure accuracy of oxygen settings. c. Review of patients with new orders for oxygen therapy via concentrator will be reviewed by the interdisciplinary team during scheduled morning clinical meeting. d. During our new hire training/orientation new employee will be trained on our expectation to following all physicians orders 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Nurse Supervisor, or designee assigned by the Director of Nursing in her	

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F 695	Continued From page 29 An observation of Resident #85 was made on 02/25/2020 at 11:20 AM. Resident #85 was up ambulating in her room. She had oxygen tubing in her nose that was connected to a concentrator on the other side of the room. The concentrator was set to deliver 2 liters of oxygen. An observation was made of Resident #85 on 02/26/2020 at 9:02 Am. Resident #85 was in bed eating breakfast. She was alert and verbal and had oxygen tubing in her nose that was connected to a concentrator on the other side of the room. The concentrator was set to deliver 2.5 liters of oxygen. An observation was made of Resident #85 on 02/26/2020 at 11:00 AM. Resident #85 was up and about in her room. She had oxygen tubing in her nose that was connected to concentrator that was set to deliver 2.5 liters of oxygen. An interview was conducted with Nurse #1 on 02/26/2020 at 11:03 AM. Nurse #1 stated that Resident #85 was on 2 liters of oxygen to keep her oxygen saturation above 90%. Nurse #1 was asked to review the physician order and stated "I did not now that order was there" for 1 liter of oxygen. Nurse #1 stated that she had been trying to wean Resident #85 off of her oxygen but had been unsuccessful. Nurse #1 observed Resident #85's oxygen concentrator and confirmed that it was set to deliver 2.5 liter of oxygen. Nurse #1 replied "I will take her down to 1 liter and see how she does." An interview was conducted with the Director of Nursing (DON) on 02/26/2020 at 2:29 PM. The DON stated that she expected the staff to check the oxygen flow rate each time they were in the	F 695	absence, will conduct random audit 2 x per week to validate concentrator settings in accordance with physician□s orders. Adverse findings will be addressed immediately, reported to the Administrator/DON. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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F 695	Continued From page 30 resident's room and should be following the physician order for oxygen use.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, Consultant Pharmacist, and Nurse Practitioner interview the facility failed to maintain their medication error rate at 5% or below by not following physician orders. There were 2 (Resident #9 and Resident #90) out of 31 errors resulting in a 6.45% medication error rate. The findings included 1. Resident #9 was readmitted to the facility on 12/10/18 with diagnoses that included gastroesophageal reflux disease (GERD). Review of a physician order dated 12/09/19 read, Protonix (used to treat GERD) 40 milligrams (mg) by mouth twice a day 1 hour before meals and separate from other medications. The order was signed by the Nurse Practitioner (NP). An observation of Nurse #2 preparing Resident #9's medication was made on 02/25/2020 at 9:20 AM. The medications included Protonix 40 mg along with 7 other medications. Nurse #2 was observed to administer Resident #9's medications to him. Resident #9's breakfast tray was sitting in	F 759	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? Resident□s #9 and #90 were assessed by DON and NP consulted. No adverse findings were identified. 2. How will you identify others impacted by the deficient practice? All patients have the potential of being impacted. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. Licensed nurses were re-educated on medication administration policy and procedure. b. Med Pass competencies to be completed with all Licensed Nurses by 3/25/2020.	3/25/20

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F 759	Continued From page 31 front of him and he was eating the French toast that was on his tray. Nurse #2 was observed to hand Resident #9 the cup of medication that included the Protonix 40 mg. Resident #9 took the medications and put them in his mouth and took a drink of water. Nurse #2 verified that Resident #9 had swallowed all the medications including the Protonix 40 mg. An interview was conducted with Nurse #2 on 02/25/2020 at 5:11 PM. Nurse #2 stated that she did not notice the directions on the medication card that stated to administer the Protonix 1 hour before meals and separate from other medications. She stated she had always administered the Protonix with the other medications but added she would change the time of administration to 6:00 AM so it could be given before his meals and separate from Resident #9's other medications. An interview was conducted with the Director of Nursing (DON) on 02/25/2020 at 5:36 PM. The DON stated that Resident #9 was on Protonix back in 2018 and recently was changed to twice a day on 12/09/19. She stated that when the physician order was entered into the system it should have been scheduled prior to his meals so that it could have been given before meals and separate from his other medication as written by the provider. The DON stated that she was unaware if the facility did end of month checks on physician orders or not. She stated that they did them prior to going to electronic medical record but since then was unaware if they were being done. The DON stated she expected the orders to be entered correctly and then followed by the nursing staff.	F 759	c. Pharmacy consultant providing random medication administration observation/competencies monthly for 6 months. d. A med pass competency will be completed on all new staff with in 60 days of employment. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Director of Nursing, or designee, will assure compliance by conducting med pass observation 1 x weekly x 4 weeks and 1 x monthly x 4 month to assure accuracy and adherence to physician orders. Adverse findings will be addressed immediately, reported to the Administrator and documented. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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An interview was conducted with the Consultant Pharmacist (CP) on 02/26/2020 at 10:30 AM. The CP stated she visited the facility once a month to perform drug regimen review which included reviewing the discharge summary and comparing it to the electronic medication administration record and verifying times of administration were appropriate. The CP stated she reviewed Resident #9's physician orders and recalled the physician specifically wrote the Protonix order for 1 hour prior to meals and separate from other medications. The CP stated that the manufacture recommended the Protonix to be administered 30-60 minutes prior to meals for absorption purposes. She added that if the physician or provider wrote the order that way then the medication should be administered following the physician order. The CP stated she had not noted the Protonix time and stated the nursing staff should have entered the time to be given before meals and separate from his other medications as the provider specifically wrote for.

An interview was conducted with the Nurse Practitioner (NP) on 02/26/2020 at 12:55 PM. The NP stated that she evaluated Resident #9 on 12/06/19 and was already on Protonix daily. She stated that Protonix was generally given before meals as sometime is can interfere with the absorption of other medications. The NP stated the Protonix was increased to twice a day and they were going to repeat his laboratory values and monitor his hemoglobin levels. She stated she did not recall writing specific instructions about the Protonix but stated for most indications it needed to given 30-60 minutes prior to meals as directed by the manufacture.

2. Resident #90 was admitted to the facility on

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02/21/2020 with diagnoses that included adult failure to thrive and orthostatic hypotension.

Review of a physician order dated 02/21/2020 read, Calcium Carbonate 600 milligrams (mg) (1500 mg) by mouth every day for calcium replacement.

An observation of Nurse #3 preparing Resident #90's medication was made on 02/25/2020 at 8:35 AM. Nurse #3 was observed to dispense Calcium Carbonate 600 mg 1 tablet into a medication cup along with Resident #90's other medication and enter her room for administration. Resident #90 took the medication cup and put the pills that included Calcium Carbonate 600 mg into her mouth and took a drink of water. Nurse #3 verified that Resident #90 had swallowed all of the medication including the Calcium Carbonate 600 mg.

An interview was conducted with Nurse #3 on 02/25/2020 at 5:14 PM. Nurse #3 confirmed that she had given Resident #90 Calcium Carbonate 600 mg 1 tablet and she needed to have given Resident #90 2.5 tablets to equal the 1500 mg that was ordered. She stated that she had an issue with calcium before and the pharmacy had called, and they adjusted the dose, but she did not recall that occurring with Resident #90's Calcium order. She stated that she should have given 2.5 tablets of the Calcium Carbonate to give the 1500 mg that were ordered.

An interview was conducted with the Director of Nursing (DON) on 02/25/2020 at 5:29 PM. The DON stated that the pharmacy should have indicated the correct number of tablets to give to equal the 1500 mg and the order should have

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F 759	Continued From page 34 been changed or clarified. The DON stated she expected all physician orders to be followed and the staff were expected to do a triple check of the medication record to the medication card and should have been aware of what they were giving and give the correct dose and number of tablets. An interview was conducted with the Consultant Pharmacist (CP) on 02/26/2020 at 10:30 AM. The CP stated she visited the facility each month and completed drug regimen reviews on each of the residents. The CP stated the drug regimen reviews included reviewing discharge summaries and compare them to the electronic medication administration record, make sure the orders were put in correctly, make sure everything appeared correctly on the medication administration record, ensure the times were appropriate, and also keep up with any gradual dose recommendation that would be required. The CP stated that she visited the facility earlier in the month and Resident #90 had not admitted yet so her chart would be reviewed when she came to the facility in March 2020. An interview was conducted with the Nurse Practitioner (NP) on 02/26/2020 at 12:55 PM. The NP stated medication should be administered as ordered and if the staff needed any clarification orders they could certainly reach out to the provider as needed. A follow up interview was conducted with the DON on 02/26/2020 at 2:02 PM. The DON stated that she expected the staff to follow the physician orders and administered medications as prescribed by the provider.	F 759		
F 805	Food in Form to Meet Individual Needs	F 805		3/13/20

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F 805 SS=D	Continued From page 35 CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review, the facility failed to puree foods to an edible consistency for 1 of 5 residents on a pureed diet (Resident #14). The findings included: Resident #14 was admitted to the facility on 09/01/19 with diagnoses that included Alzheimer's dementia, dysphagia and others. A physician's order dated 09/05/19 specified Resident #14 was to have a pureed diet. A physician's progress note dated 09/27/19 revealed Resident #14 was hospitalized for aspiration pneumonia and required a pureed diet. The most recent Minimum Data Set (MDS) dated 12/06/19 specified the resident's cognition was severely impaired, she required extensive 2-person assistance with activities of daily living and one-person assistance for feeding. A care plan updated on 12/13/19 specified Resident #14 was to have a diet as ordered by the physician. On 02/24/20 at 12:54 PM a family member of Resident #14 complained that the pureed food	F 805	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? After this was brought to facilities attention Dietary Manager immediately offered the family a replacement meal. Manger also re-educated staff and monitored residents outgoing food to ensure it was the correct consistency. 2. How will you identify others impacted by the deficient practice? Patients with orders for pureed diet have the potential to be impacted and were assessed by the Director of Nursing on 2/24/2020. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place? a. Procedure for preparation of pureed foods was reviewed by Interdisciplinary Team. b. Dietary staff was re-in serviced by the Dietary Manager in desired consistency of	

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F 805	Continued From page 36 items served to Resident #14 were too hard to eat. Observations of the pureed diet served to Resident #14 revealed the pureed meat had solidified into a bowl shape. On 02/24/20 at 12:58 PM the Food Service Director (FSD) was asked to observe the pureed meat served to Resident #14. The FSD observed the pureed meat and stated it was too thick, adding the cook had "missed the mark." The FSD apologized to the family and offered to get an alternate food item and the family declined. Resident #14 did not eat the pureed meat. In a follow-up interview with the FSD on 02/24/20 at 1:15 PM the FSD explained pureed food was to be served at baby food consistency. He added that pureed foods were to be pureed in a food processor and either an appropriate liquid or thickener was to be added to reach the correct consistency. The FSD also stated the morning cook had added too much thickener to the pureed meat, causing it to over thicken and harden. The FSD was also asked about the tray line monitoring system for auditing foods and stated the pureed meat likely hardened with time because Resident #14 was the last resident served the pureed meat. On 02/26/20 at 2:26 PM the Administrator was interviewed and stated she expected pureed food to be served at the correct consistency.	F 805	pureed foods. c. Vendor was obtained to provide pureed foods to offer enhanced dietary options. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Dietary Manager, dietary supervisor will assure compliance by random observation of puree meal prep/delivery 3x per week x 30 days, then 2x per week x 30 days to assure compliance. Adverse findings will be presented to the facility Quality Assurance Committee. QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	
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 -	F 812		3/13/20

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F 812	Continued From page 37 §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 observations and staff interviews the facility failed to ensure staff wore a hair restraint when they worked in a food service area when they plated resident foods and served resident meals. This was observed during a meal service and had the potential to affect all 35 residents who were served meals. The findings included: On 02/26/20 at 8:14 AM the breakfast meal service was observed. The facility utilized a remote kitchenette located in the dining area of the skilled nursing facility. Observations of the kitchenette revealed it was equipped with a steam table. During the meal observation, Nurse Aide (NA) #2 assisted with the meal preparation by placing uncovered fresh fruit cups on individual trays; and she loaded the trays into an insulated food cart. After the nurse aide loaded the food	F 812	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? Identified staff member was counseled by Food Service on 2/26/2020 regarding the use of hairnet during food preparation, plating and placement in thermal delivery system. 2. How will you identify others impacted by the deficient practice? All patients have the potential to be impacted. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be	

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F 812	Continued From page 38 cart with trays she proceeded to leave the kitchenette service area to deliver the meal trays to residents on the hall. NA #2 was not wearing a hair restraint while plating the fresh fruit on trays and she had long hair. On 02/26/20 at 11:22 AM the Food Service Director (FSD) was interviewed and explained that nurse department staff helped with the meal service but did not cook or serve food from the tray line. He added that dietary staff were expected to wear a hat or hairnet to keep hair covered during meal service. The FSD reported that nurse aides who assisted in the kitchenette should have their hair restrained but that he was not their supervisor and did not monitor compliance. On 02/26/20 at 2:45 PM the Director of Nursing (DON) was interviewed and explained the nursing department assisted with the meal service from the kitchenette area. She stated she was not aware her staff needed to wear hair restraints when assisting with the meal service.	F 812	put in place? a. CNA and Dietary staff were re-in serviced by Director of Nursing in the use of hair nets during food preparation, plating and placement of plate in thermal delivery system. b. New staff will be to be trained on facility expectation to wear the hairnets behind the counter. Signs have been posted in this areas as well. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Dietary Manager will assure compliance by conducting random audit 1x per week x 4 weeks then monthly x 4 month. Adverse findings will be addressed immediately, reported to the Administrator and documented. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		3/25/20

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F 842	Continued From page 39 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 40 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate medical record in the area of physician orders for 1 of 3 (Resident #91) residents medications reconciled during medication pass. The findings included: Resident #91 was admitted to the facility on 02/12/2020 with diagnoses that included tachycardia, hypertensive heart disease, congestive heart failure, and others. Review of the Minimum Data Set (MDS) dated 02/19/2020 revealed that Resident #91 was cognitively intact for daily decision making and required supervision with activities of daily living. Review of a discharge summary from the local	F 842	1. What corrective action(s) will be accomplished by the facility to correct the deficient practice? DON reviewed orders for Patient 91 on 2/26/2020. 2. How will you identify others impacted by the deficient practice? 100% audit of all patients who have been admitted in the last 30 days was conducted on 2/28/2020 by Nurse designated by DON. 3. What measures will be put in place or systemic changes will be made to ensure the deficient practice will not recur i.e. what quality assurance program will be	

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F 842	Continued From page 41 hospital dated 02/12/2020 indicated Resident #91 was to take Vitamin B12 (supplement) 1000 milligrams (mg) by mouth every day. Review of a physician order that was entered into the electronic medical record on 02/12/2020 indicated Resident #91 was to take Vitamin B12 100 mg by mouth every day. The ordered was entered by Nurse #1. Review of the Medication Administration Record (MAR) dated 02/12/2020 through 02/29/2020 indicated that Resident #91 was receiving Vitamin B12 100 mg po every day. An interview was conducted with the Director of Nursing (DON) on 02/25/2020. The DON stated that this was definitely a keying error, when entering the order from the discharge summary Nurse #1 left off a zero making the order a 100 mg instead of 1000 mg as ordered. The DON stated that there should have been a reconciliation check as well. She explained that one nurse would enter the medication from the discharge summary and then another nurse would go behind them and ensure that they were all entered correctly. An interview was conducted with Nurse #1 on 02/26/2020 at 9:05 AM. Nurse #1 stated that recalled entering Resident #91's medication from the discharge summary into the electronic medical record. She stated "Vitamin B12 is always a 1000 mg" and I just missed a zero. Nurse #1 was not sure if the facility had any reconciliation process and would have to speak to the DON about that because she was not involved in anything like that.	F 842	put in place? a. Licensed nurses re-educated by DON regarding transcription of medication. b. Reconciliation of medications ordered for newly admitted patients has been added to the regularly scheduled clinical meeting. c. During our training/orientation process new hires will be trained on our reconciliation requirements. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Director of Nursing, or designee, will assure compliance by oversight of reconciliation of 100% of new admissions X 60 days and monthly reconciliation x6 months. Adverse findings will be addressed immediately, reported to the DON and documented. Adverse findings will be presented to the facility Quality Assurance Committee. The QA committee will review trends and identify need for amendment to action plan or need for continued auditing.	

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F 842	Continued From page 42 A follow up interview was conducted with the DON and the Administrator on 02/26/2020 at 2:02 PM. The DON stated that the facility was not currently doing any month to month reconciliation check because they did not have the support staff to do it. She added that currently the process for entering new order was one nurse would enter the medications from the discharge summary and another nurse would go behind them and ensure they were entered correctly. The DON stated that the second check did not occur with Resident #91's medications that were entered by Nurse #1 on 02/12/2020. The DON stated that she expected the staff to follow the reconciliation process and ensure the medications were entered correctly into the electronic medical record.	F 842		