STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	02/28/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey was conducted from 02/24/20 through 02/28/20. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID # V96311.	E 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578		3/26/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/23/2020

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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F 578	Continued From page 1 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff and nurse practitioner interviews, the facility failed to maintain accurate advance directives throughout medical records for 3 of 3 residents reviewed for advanced directives (Resident #26, #66, and #16). The findings included: 1. Resident #26 was admitted to the facility on 12/05/19 from the hospital with diagnoses that included a urinary tract infection resulting in multi-factorial sepsis and acute delirium with psychotic features, Clostridium Difficile (C. Difficile) and chronic obstructive pulmonary disease (COPD) with respiratory failure. The hospital discharge summary dated 12/05/19 did not include a code status. A Physician progress note dated 12/06/19 revealed a discussion with Resident #26 about advanced care planning. Resident #26 chose her code status as attempt cardiopulmonary resuscitation (CPR) with an order reflecting perform CPR on the chart. This order was not made available during the survey.	F 578	Gateway Rehabilitation and Healthcare acknowledges receipt of the statement of Deficiencies and proposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Gateway Rehabilitation and Healthcare responses to this of Deficiencies does not denote agreement with the statement of deficiencies not does it constitute an admission that any deficiencies is accurate. further Gateway Rehabilitation and Healthcare reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and /or any other administrative or legal proceeding. F578 1)Residents #26, #66, and #16 identified during the survey advance directives were immediately corrected to reflect the correct code status. Nurses and unit	

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F 578	Continued From page 2 An admission Minimum Data Set (MDS) dated 12/12/19 revealed Resident #26 to be cognitively intact and able to make her needs known and be understood by others. There was no care plan for advanced directive included with the admission MDS. A portable Do Not Resuscitate (DNR) form also identified as a golden rod DNR form dated 01/01/20 was located on the chart and signed by a provider outside of the facility. There was no expiration included on this form. A Medical Order for Scope of Treatment (MOST) form with a prepared date of 01/10/20 with an effective date of 01/15/20 signed by the facility provider and Resident #26's court appointed guardian for DNR, comfort measures, no antibiotics, no intravenous (IV) fluids, and no feeding tubes was located on the chart. A progress note written by the Nurse Practitioner (NP) dated 01/10/20 revealed a discussion between the NP and Resident #26 about advanced care planning. Resident #26 chose her code status as DNR, no intravenous (IV) medications, no feeding tubes, no mechanical ventilation, no hospitalizations, and comfort care only after an in-depth detail of Resident #26's medical problems and overall clinical condition. It was noted Resident #26 was appointed a temporary guardian from Adult Protective Services (APS) by the court during her hospitalization and the guardian changed Resident #26's previously elected code status from DNR during her hospice care to a Full Code on admission. The progress note further revealed Resident #26 told the NP her choice was to be a	F 578	manager Identified during the survey were reeducated by the Director of Nursing on Maintaining accurate advance directives on 3/26/20. 2)Current Residents have the potential to be Affected. An audit of current residents Advance Directives to be completed by the Directed of Nursing, Nurse Management, and Interdisciplinary Team by 03/26/20. Discrepancies identified were addressed. 3)The Director of Nursing/Nurse Management will reeducate licensed nurses, Social worker, Interdisciplinary team and MD/NP regarding process for maintaining accurate Advance Directives by 03/26/20.The education will be ongoing and included in Orientation for new hires. The education will include the following: A. Advance Directives will be completed per physician orders to include telephone orders stating code status, accuracy on Advance Directives form, MOST form/STOP sign completed and transcription to the medication administration record. B. Additionally, the physician's order will be verified by two licensed nurses along with the Medical Director/Nurse Practitioner's signature. Advance Directives will be reviewed on admission, readmission, when there's a change of condition, and during care plan meeting to ensure accuracy. C. Additionally licensed nurses will review advance directives (code status) during end of month change and make changes to the physician order summary	

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F 578	Continued From page 3 DNR prior to hospitalizations and continued to be her choice. The NP made staff aware and the facility would locate Resident #26's previously signed formal paperwork with the golden rod DNR and the MOST form. The copy of the January monthly physician orders signed by the Nurse Practitioner (NP) on 01/02/20 revealed a blank code status. An additional copy of the January monthly physician orders signed by the NP on 01/10/20 revealed a handwritten code status of "FULL." Progress notes dated 02/07/20, 02/17/20, 02/19/20 and 02/24/20 all noted Resident #26's code status remained attempt CPR. A review of the February 2020 Medication Administration Record (MAR) revealed a handwritten code status of: "FULL." A review of the February monthly physician orders revealed a handwritten code status listed as "FULL" that was signed by the NP on 02/02/20. An amended physician progress note dated 02/26/20 revealed Resident #26's code status to be DNR/no CPR. An interview with Nurse #2 on 02/25/20 at 3:28 PM revealed she was the nurse assigned for Resident #26 and the nurse that admitted the resident would obtain orders for code status on admission. She stated she did not know how Resident #26's code status was not transcribed correctly.	F 578	as necessary. D. Physician order changes made for Advance Directives will be reported by the Director of Nursing/Designee during daily clinical meeting. 4.)Nurse Management and/or interdisciplinary Team member will audit 10 residents' medical records 3x weekly for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months to ensure advance directive accuracy. the Administrator will report the results of the quality monitoring (audits)to the Quality Assurance Improvement Committee. the findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. Completions date is 03/26/2020	

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An interview with Nurse #4 on 02/25/20 at 3:35 PM revealed she was a shift supervisor and stated the procedure for verifying code status would be to check the chart for the monthly physician orders. She stated the order for code status was near the top of the first page. She noted the nurse assigned to admit Resident #26 would have called the provider and verified the orders then transcribed the orders from the discharge summary or admitting paperwork and sent them to the pharmacy. She stated the orders were then placed in the providers book to be signed. She further stated the pharmacy would send a printed copy of the orders and MAR to the facility. Nurse #4 further revealed a nurse was to compare orders and the MAR at the end of the month to make sure they were correct. She indicated she was unsure how the order was missed.

An interview with the Interim Director of Nursing (DON) on 02/25/20 at 4:23 PM revealed the nurses would locate the code status in the front of the chart along with a golden rod DNR form and MOST forms if elected by the resident. The nurse would assume the resident was a FULL CODE in the event the chart was unable to be located. She further stated the nurses were provided training to include CPR and advance directive policies on an annual basis and impromptu in-service training was provided when needed. She further revealed the code status was obtained from the hospital discharge summary or FL-2 form on admission. She explained the provider would then be called to verify all orders obtained for admission including code status and the code status would be provided as a telephone order on the date of admission and must be witnessed by two facility nurses to be valid. The Interim DON further

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indicated the admission orders would be faxed to pharmacy to be transcribed to the monthly physician orders for the resident. The interim DON noted at the end of each month, a nurse was assigned to verify the current months MAR to the next month's physician orders sent from the pharmacy before the month ended. She explained if any discrepancies were located, the nurse was to transcribe the corrections in both locations and notify the pharmacy. The Interim DON looked in Resident #26's chart and confirmed there was not a physician order for code status in the Advance Directive Section of the chart, but she was able to locate a golden rod DNR and MOST form under the advance directive section in the chart. She further indicated there was a process failure and that an order for code status should be in every chart under advance directives. She stated the monthly physician orders and the MAR should reflect the same code status as the single physician order located under the advance directive section in the chart. The Interim DON indicated she was unsure why the physician order was not located in the chart under advance directives. She stated she was unsure how the monthly orders and MAR did not reflect the most updated code status for Resident #26. She further stated it must have been missed during end of month chart checks and the pharmacy must not have been notified when the order was obtained.

An interview with the Interim DON and Corporate Nurse Consultant on 02/26/20 at 9:37 AM revealed a telephone order dated 01/10/20 for Resident #26's code status of DNR had been located overnight in the physician's notification book. The DON stated the order must have been overlooked by the providers when checking

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orders and notifications provided by the nursing staff since it was left the day it was written. The interview further revealed the facility had completed a 100% audit of all resident's orders for code status, monthly physician orders, and the MAR's and they had made all corrections to make all three documents match.

With the Interim DON present, an additional review of Resident #26's MAR was made on 02/26/20 at 9:42 AM that revealed no changes were made to the previously handwritten code status of "FULL". The DON changed Resident #26's code status to reflect DNR directly following the review.

An interview with the Nurse Practitioner on 02/26/20 at 9:45 AM revealed she expected the nurses to verify the chart for a current code status.

2. Resident #66 was initially admitted to the facility on 01/23/20 with a re-admission from the hospital on 02/24/20 with diagnoses that included severe sepsis with shock, suspected aspiration pneumonia, traumatic brain injury, gastrostomy tube, and expressive dysphasia.

An Admission Minimum Data Set (MDS) dated 01/30/20 revealed Resident #66 to have short-term and long-term memory impairment, aphasia, and required extensive to total assistance for all care.

An admission physician order for Code Status or Medical Order for Scope of Treatment (MOST) form from January 2020 was unable to be located during the survey.

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A portable Do Not Resuscitate (DNR) form also referred to as a golden rod DNR form dated 01/23/20 was in the front of the chart. This form did not include an expiration date.

A MOST form dated 02/17/20 located in the advance directive section in the chart indicated DNR, limited additional interventions, antibiotics, and tube feedings as indicated

Re-admission physician orders dated 02/24/20 revealed a code status to be blank and orders were in the provider notification notebook in the charting room and unsigned on 02/25/20.

The code status portion of the admission orders dated 01/23/20 were blank. Further review revealed they were checked by the unit nursing manager and verified by Nurse #5 on 01/23/20. These orders were signed by the Nurse Practitioner (NP) on 02/03/20.

A history and physical progress note written by the physician dated 01/28/20 indicated Resident #66 to be a Full Code.

Monthly physician orders dated February 2020 revealed the code status was blank. These orders were signed by the NP on 02/02/20.

A progress note written by the NP dated 02/03/20 indicated Resident #66's code status to be a DNR. It further revealed a MOST form was signed on that date electing comfort measures, no antibiotics, no IV's and no tube feedings. The NP discontinued orders for antibiotics but continued medications and feedings via feeding tube. The MOST form dated 02/03/20 was unavailable during the survey.

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A history and physical completed by the physician on 02/11/20 revealed Resident #66's code status to be a FULL code.

A progress noted written by the NP dated 02/14/20 revealed an updated MOST form was completed to reveal Resident #66's family wanted treatment for infections to include antibiotics and intravenous (IV) fluids. The date the MOST form was completed was not included in the note.

An interview with the Unit Manager on 02/25/20 at 3:25 PM revealed that in the event a resident was found to not be breathing, she would verify the code status by the order in the front of the chart. She stated she had been taught to never look at the Medication Administration Record (MAR) for code status. She further stated the code status must only be verified by the physician order.

An interview with Nurse #4 on 02/25/20 at 3:35 PM revealed she was assigned to Resident #66 on that day and was a shift supervisor. She stated the procedure for verifying code status would be to check the chart for the monthly physician orders. She further stated the order for code status was near the top of the first page. She explained the nurse assigned to admit Resident #66 would have called the provider and verified the orders then transcribed the orders from the discharge summary or admitting paperwork and sent them to the pharmacy. She further explained the orders were then placed in the providers book to be signed and the pharmacy would send a printed copy of the orders and MAR to the facility. Nurse #4 further revealed a nurse was to compare orders and the MAR at the end of the month to make sure they were correct. She

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indicated she was unsure how the order was missed.

An interview with the Interim DON on 02/25/20 at 4:23 PM revealed the nurses would locate the code status in the front of the chart along with a DNR golden rod and MOST forms if elected by the resident. She stated the nurse would assume the resident was a FULL CODE in the event the chart was unable to be located. She further stated the nurses were provided training to include cardiopulmonary and advance directive policies annually and impromptu in-service training was provided when needed. She further revealed the code status was obtained from the hospital discharge summary or FL-2 form on admission. She explained the provider would then be called to verify all orders obtained for admission including code status and the code status would be provided as a telephone order on the date of admission and must be witnessed by two facility nurses to be valid. The Director of Nurses further indicated the admission orders would be faxed to pharmacy to be transcribed to the monthly physician orders for the resident. She further revealed at the end of each month, a nurse was assigned to verify the current months MAR to the next month's physician orders sent from the pharmacy before the month ended. She stated if any discrepancies were located, the nurse was to transcribe the corrections in both locations and notify the pharmacy. The Interim DON looked in Resident #66's chart and confirmed there was not a physician order for code status in the Advance Directive Section of the chart for Resident #66 since re-admission. She stated she was able to locate a golden rod DNR and MOST form. She further indicated there was a process failure and that an order for code status should be in every

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chart under advance directives. She further stated the monthly physician orders and the MAR should reflect the same code status as the single physician order located under the advance directive section in the chart. The DON indicated she was unsure why the physician order was not located in the chart under advance directives. She stated she was unsure how the monthly orders and MAR did not reflect the most updated code status for Resident #66. The DON further stated it must have been missed during end of month chart checks and the pharmacy must not have been notified when the order was obtained.

An interview with the Nurse Practitioner on 02/26/20 at 9:45 AM revealed she expected the nurses to verify the chart for a current code status. She further indicated she had signed the code status order for Resident #66 on the morning of 02/26/20.

3. Resident #16 was admitted to the facility on 07/16/15 with diagnoses which included Alzheimer's disease, diabetes, paraplegia with a left above the knee amputation, chronic pain, renal mass and pancreatic mass.

Review of the Care Plan dated 10/11/19 revealed Resident #16 was a full code and advanced directives were to be reviewed quarterly.

Resident #16 had a written order on 11/08/19 for Do Not Resuscitate (DNR) that was placed under a clear page protector on the front of the chart.

The progress notes dated 11/13/19 for Resident #16 revealed the resident had a code status of DNR and was electronically signed by the Nurse Practitioner (NP).

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The Medication Administration Record (MAR) dated 12/01/19 through 12/31/19 revealed the resident was a full code.

The progress notes dated 12/02/19 for Resident #16 revealed the resident had a code status of DNR and was electronically signed by the NP.

Resident #16's quarterly Minimum Data Set assessment dated 12/17/19 revealed the resident was moderately impaired for daily decision making and dependent on staff for all activities of daily living.

Resident #16's MAR dated 01/01/20 through 01/31/20 revealed the resident was a full code with a single black line marked through it and DNR was written above it.

Resident #16's MAR dated 02/01/20 through 02/29/20 further revealed the resident was a full code.

The progress notes dated 02/11/20 for Resident #16 revealed the resident had a code status of DNR and was electronically signed by the NP.

Observation of the front of Resident #16's chart on 02/24/20 at 3:45 PM revealed the resident had a yellow sticker which stated Full Code.

An interview with Nurse #7 on 02/25/20 at 3:25 PM revealed if a resident was in distress the nurse would look at the order on the chart. She further revealed nurses were trained to look at the order and not on the front of the chart or the MAR. Nurse #7 stated if there was a discrepancy a clarification order was written. She further

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F 578	Continued From page 12	F 578		

stated she'd never known any nurse to check the MAR.

An interview with Nurse #6 on 02/25/20 at 3:55 PM revealed the order was always in the front of the chart. She further revealed you couldn't go by what was on the front of the chart because the stickers fell off and residents changed their minds on code status.

An interview with Nurse #3 on 02/25/20 at 4:15 PM revealed she always checked the chart for a code order if a resident was in distress. She further stated she always checked the chart because the order could have changed or the sticker on the chart could have fallen off.

An interview with the Interim Director of Nursing on 02/25/20 at 4:45 PM revealed the nurses would immediately go to the chart to find the code status of a resident. She further revealed stickers were on the front of the chart for Full Code. She stated there was a possibility a nurse could look at the front of the chart, but all nurses were trained to look at the orders first. She further stated she thought the facility had a broken process with code status and stated she would immediately implement more education. She stated the Social Worker (SW) was heavily involved in the code status process but currently the facility did not have a SW and the Administrator had assumed the role until a SW was hired. The DON further revealed she would remove the sticker on the front of Resident #16's chart immediately and would correct the monthly orders and MAR.

An interview with Nurse #8 on 02/25/20 at 7:25 PM revealed she'd go to the chart for the code

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F 578	Continued From page 13 status on Resident #16. She further revealed she had orientation on hire regarding Advanced Directives and another in-service today. She stated she would not have done anything different before today's in-service because they always went to the chart for the code status. An interview with Nurse #9 on 02/26/20 at 7:05 AM revealed she always checked the chart for the code status. She further revealed she had an in-service last night and the only change was if the chart was not available, to check the MAR which was on the medication cart. An interview with Nurse #10 on 02/26/20 at 2:50 PM revealed she would go to the resident's chart if the resident was in distress to check their code status. She further revealed the new change for code status since the in-service was to check the MAR if the chart was not available. She stated Resident #16's MAR was changed to DNR.	F 578		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		3/26/20

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F 686	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to prevent contamination of materials during a treatment after scissors were dropped on the floor, failed to wash hands with soap and water or use hand sanitizer during wound treatments and failed to prevent contamination of wounds when saline saturated gauze dressings were used to clean around the outside of a resident's wounds multiple times for a resident who had a wound on her sacrum and a wound with infection of the bone in her left hip for 1 of 1 resident sampled for treatment of pressure ulcers (Resident #82). Findings included: Resident #82 was admitted to the facility on 01/31/20 with diagnoses which included a subacute osteomyelitis (bone infection) of the left femur (upper leg bone), chronic embolism and thrombosis (blood clots) of deep veins of both lower extremities, severe protein and calorie malnutrition, anemia, paraplegia (paralysis of lower body), type 2 diabetes, and multiple wounds which included in part a stage 4 pressure ulcer of left buttock and a pressure ulcer of sacral region (base of spine) with unspecified stage. A care plan dated 02/04/20 indicated Resident #82 had actual impairment to skin integrity related to fragile skin and infection. The interventions were listed in part to follow facility protocols for treatment, provide pressure reducing mattress to bed, monitor and document location, size and treatment of skin injury and report abnormalities and failure to heal to Physician.	F 686	F686 1) Resident #82's treatment was immediately corrected. Treatment nurse identified during the survey was reeducated by the Director of Nursing of correct sanitizer of contaminated scissors, proper hand washing and/or hand sanitizer before, during and after wound treatment, and proper use of cleaning outside of wounds with gauze dressing using a different gauze for each wipe around the wound on 03/26/20. 2) Residents that receive wound care have the potential to be affected. An Audit/Observation will be completed by the Director of Nursing to determine whether treatment procedures are being followed to ensure prevention of contamination during wound care treatments by (03/26/20). Issues identified were addressed. 3) The Director of Nursing/Designee will reeducate licensed nurses to include treatment procedures to ensure proper hand washing and/or use of hand sanitizer before, during and after treatment, correct sanitizing of contaminated scissors, and proper use of cleaning outside of wounds with saline gauze dressings using a different gauze for each wipe around the wound for prevention of contamination during wound care treatment by (03/26/20). The education will be ongoing and included in Orientation for new hires.	

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F 686	Continued From page 15 A care plan dated 02/04/20 indicated Resident #82 had infection related to multiple wounds. The interventions were listed in part to maintain universal precautions when providing resident care and administer antibiotics according to Physician's orders. An admission Minimum Data Set (MDS) 02/7/20 indicated Resident #82 was cognitively intact for daily decision making. The MDS further indicated Resident #82 required extensive assistance for toileting and hygiene and had a urinary catheter. The MDS also indicated Resident #82 had 1 stage 2 pressure ulcer, 3 stage 3 pressure ulcers, 3 stage 4 pressure ulcers and 1 unstageable deep tissue injury. A wound Physician's order dated 02/06/20 at 3:00 PM indicated to have Pharmacy mix 600 milligrams (mg) Clindamycin (antibiotic) and 80 mg Gentamycin (antibiotic) in 250 cubic centimeters of normal saline then moisten 4x4's with this solution and place into sacral and left hip wounds every day and cover with gauze and dressing. Wound management notes dated 02/20/20 indicated in part the wound on Resident #82's sacrum measured 10.9 centimeters (cm) in length x 8 cm width x 7.5 cm depth and the wound on her left hip measured 2.9 cm x 5 cm x 8.8 cm. Observations of wound treatments on 02/26/20 at 9:44 AM with the Treatment Nurse revealed in part the Nurse washed her hands with soap and water and then placed treatment supplies on top of a wax paper barrier on top of an overbed table. She then placed 4x4 gauze pads in multiple	F 686	4) Director of Nursing/Nurse Management will observe the Treatment Nurse provide wound care for 3 residents requiring treatment to ensure prevention of contamination before, during and after wound care treatment 3x a week for 4 weeks, then 1x a weekly x 2 months, then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. 03/26/20 is the completion date	

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medicine cups and poured normal saline over the gauze pads. The treatment Nurse put on gloves and assisted Resident #82 to turn to her right side. The observations revealed there were large dressings on Resident #82's left hip, right upper back, right lower back and sacrum. The observations revealed the Treatment Nurse removed dressings and pulled packing out of a large wound on Resident #82's left hip which drained a bloody drainage onto the skin around the bottom of the wound. She removed her gloves but did not wash her hands with soap and water or use hand sanitizer. She then put on clean gloves and took a gauze pad saturated with saline and a with a cotton tipped applicator cleaned inside the wound on Resident #82's left hip. She next took a gauze pad saturated with saline and wiped around the perimeter of the wound multiple times without changing the gauze pad. She changed her gloves and took a 4x4 saturated with saline and with a cotton tipped applicator cleaned inside of the wound on Resident #82's sacrum. She then took a gauze pad saturated with saline and wiped multiple times around the perimeter of the wound without changing the gauze pad. She changed her gloves did not wash her hands or use hand sanitizer and placed saturated gauze with the antibiotic solution of Clindamycin and Gentamycin and packed it into the wound on Resident #82's sacrum. She then began to pack the antibiotic saturated gauze into the wound on Resident #82's left hip and picked up scissors but dropped the scissors onto the floor. The Treatment Nurse picked up the scissors off the floor and took a gauze pad saturated with saline and wiped the blades of the scissors and then cut off the excess packing that had been placed inside the wound on Resident #82's left hip. She then placed

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dressings on top of the wounds on Resident #82's sacrum and left hip and discarded supplies into a clear plastic trash bag.

An interview on 02/27/20 at 10:25 AM with the Treatment Nurse revealed she washed her hands after she had completed all the wound treatments for Resident #82. She verified after she dropped the scissors onto the floor, she cleaned them with a gauze pad with saline on it. She further verified she had wipes which contained a bleach solution that she usually used to clean her scissors, but they were in the treatment cart outside of Resident #82's room.

A follow up interview on 02/28/20 at 1:07 PM with the Treatment Nurse with the Interim Director of Nursing present revealed it was her usual routine to wash her hands with soap and water before she started treatments. She explained she should have used hand sanitizer between her glove changes during the treatments of Resident #82's wounds, but the hand sanitizer was in her treatment cart outside of Resident #82's room in the hallway. She stated after she wiped around the outside of Resident #82's wounds once with the saline gauze, she should have thrown the gauze away and should have gotten a clean one to wipe around the wound again. She explained when she dropped the scissors on the floor, she should have cleaned them with bleach wipes instead of the saline saturated gauze.

An interview on 02/28/20 at 1:21 PM with the Interim Director of Nursing revealed she expected for the Treatment Nurse to wash her hands with soap and water in preparation for wound care. She stated after the Treatment Nurse removed her gloves from handling dirty dressings, she

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F 686	Continued From page 18 should have washed her hands with soap and water or should have used hand sanitizer before she put on clean gloves. She stated she would have expected after the Treatment Nurse dropped her scissors on the floor, she should have sanitized the scissors with the bleach solution prior to proceeding on with wound treatments. She explained she expected for the Treatment Nurse to wipe around the perimeter of the wound with the saline saturated gauze once, discard it and use a clean gauze pad saturated with saline for each time she needed to clean around the wound.	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 and staff interviews, the facility failed to keep a resident from smoking on a smoke free campus and failed to ensure the resident did not have smoking materials in their possession for 1 of 1 resident sampled for smoking (Resident #27). The findings included: Resident #27 was admitted to the facility on 01/09/20 with diagnoses that included nicotine dependence and tobacco use.	F 689	F689 1) Resident #27 identified during the survey had smoking assessment completed immediately, smoking materials confiscated and put in a locked box. Resident #27 no longer resides in facility. Nurse Aide #2 and nurse #1 identified during the survey received a one-on-one education on (03/19/20) By Director of Nursing/Designee on completing a smoking assessment and	3/26/20

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F 689	Continued From page 19 Resident #27's admission Minimum Data Set Assessment dated 01/16/20 revealed Resident #27 to be cognitively intact and required extensive assistance with transferring, and dressing. Resident #27 was independent with locomotion on and off the unit. Resident #27 was coded without current tobacco use during the assessment period. A review of Resident #27's most recent care plan, last updated on 01/13/20 revealed no care plan for Resident #27's desire to smoke or a care plan that assisted him with quitting. An observation on 02/05/20 at 12:54 PM revealed Resident #27 was sitting in his wheelchair on the walkway in front of the facility. Continued observation of Resident #27 revealed he was finishing a cigarette, as the surveyor approached him, he dropped his cigarette and exhaled a large plume of smoke. The lit cigarette was observed as it smoldered on the pavement. An interview with Resident #27 was attempted on 02/26/20 at 8:45 AM. He refused the interview as he had returned the previous evening from a leave of absence and had his smoking materials confiscated. During an interview with Nurse Aide #2 on 02/25/20 at 4:33 PM, she reported she was very familiar with Resident #27. She conveyed she was aware that Resident #27 smoked and reported that he often smoked "illegally". When asked for clarification, she reported he did not smoke in designated areas and often kept smoking materials on his person. When asked how she was aware he kept smoking materials	F 689	confiscating smoking material from a smoking resident. 2) Residents who smoke have the potential to be affected. Director of Nursing/Designee will complete an audit for current residents who smoke to ensure smoking assessment completed and smoking materials are stored appropriately and not in the residents' possession by (03/26/20). Issues identified were addressed. 3) The Director of Nursing/Interdisciplinary Team member will educate current staff on smoking policy to include: designated smoking areas, facility will retain/store smoking materials (residents are not allowed to keep), smoking assessments, confiscating smoking material from residents, and educate new admissions that may potentially smoke on admission that facility is smoke-free and offer a smoking cessation alternative (nicotine patch) by (03/26/20). Additionally if a resident is admitted and refuses smoking cessation and decides to smoke, staff to notify Administrator immediately, and then follow steps required for a resident who wishes to smoke, to include smoking assessment. Administrator will work with Social Worker on discharge planning for residents who wish to continue to smoke. The education will be ongoing and included in Orientation for new hires. 4) Director of Nursing/Interdisciplinary Team member will audit center to ensure safety per smoking policy 3x weekly for 4	

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F 689	Continued From page 20 with him, she reported she had seen him with cigarettes in his pockets while in the facility. She reported she did not report it because she did not think it was important. An interview with Nurse #1 on 02/25/20 at 7:17 PM revealed she was aware that Resident #27 was a smoker. She stated that smoking assessments should be completed on admission. She further specified she believed that the Activities Director was responsible for completing the smoking assessments. She reported that smoking materials should not be kept by residents but should be locked in the nurse's station and continued, stating that there were scheduled smoking times and the only place in the building that residents could smoke was in the courtyard. Nurse #1 reported the facility had recently instituted a no smoking policy throughout the facility and no new admissions after February 2019 would be allowed to smoke. An observation of the smoker's lock box with the Interim Director of Nursing, located in the nurse's station on 02/25/20 revealed there were no smoking materials for Resident #27. The observations further revealed inside the lock box was a list of residents who smoked and Resident #27's name was not on the list. During an interview with the Interim Director of Nursing on 02/25/20 at 7:29 PM, she reported the facility had ceased allowing new residents to smoke at the facility in February 2019. The DON continued, stating she was first made aware of Resident #27's desire to smoke "a week or two" after his admission and she had a conversation with him and explained to him that he would not be grandfathered into the smoking program and	F 689	weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. The administrator will report the result of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. completion date is 03/26/20	

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F 689	Continued From page 21	F 689		

that he would not be able to smoke while at the facility. She reported she felt that he was understanding and accepted he would not be allowed to smoke, and a smoking assessment was not completed. The Interim DON reported she and the Administrator had offered Resident #27 a smoking cessation patch as an option, but he refused. Resident #27 would often sign out on his own and leave the facility to visit with his friends and family and she was not aware he had smoking materials with him while he was in the facility. She reported if Resident #27 was observed smoking in the walkway out front of the building then he must have gotten the cigarettes and lighter when he left the facility on leave of absence and had them on him as there were no smoking materials kept by the facility for him. She also stated that if a staff member had noticed he was carrying cigarettes or other smoking materials with him, then they needed to immediately remove them from the resident and report it to herself or the Administrator.

During an interview with the Administrator on 02/25/20 at 7:44 PM, she reported she was familiar with Resident #27 and knew he was a smoker on admission to the facility and had explained the facility's no smoking policy. She reported she had multiple conversations with Resident #27 regarding his request to smoke in the facility and thought he had understood he would not be allowed to smoke while a resident and that she offered multiple times to provide smoking cessation patches to Resident #27, but he refused. She explained that a smoking assessment had not been completed because she felt it would be a signal to Resident #27 that he could smoke, and the facility would be taking responsibility for Resident #27's smoking. She

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F 689	Continued From page 22 stated no residents could smoke in the walkway in front of the facility and that no residents should have smoking materials on their person without supervision by a staff member. She reported she did not have an expectation of what her staff should do if they saw a resident with smoking materials on their person. She stated that Resident #27 was currently signed out of the facility but when he returned, she would have his room and person searched, confiscate any smoking materials found, and store them in the facility's smoke lock box. During a follow up interview with the Administrator on 02/26/20 at 8:39 AM revealed Resident #27 and his room were searched for smoking materials upon his return to the facility 02/25/20 around 11:00PM. She stated they found cigarettes and a lighter on his person and removed them from his possession and placed them in the facility's smoking materials lockbox. She reported she had another conversation with Resident #27 about not keeping smoking materials on his person and not smoking while on facility property. She also stated they had completed a smoking assessment on Resident #27 to determine if he was safe to smoke independently to ensure he was safe to smoke on his own while he was on leave of absences from the facility.	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	F 690		3/26/20

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F 690	Continued From page 23 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to apply a urinary catheter strap to secure catheter tubing to prevent pulling and failed to keep a catheter drainage bag off the floor during wound treatments for 1 of 1 sampled resident reviewed for urinary catheter care (Resident #82).	F 690	F690 1. Treatment Nurse applied a urinary catheter strap to secure tubing and repositioned the catheter drainage bag from off the floor to side of bed for Resident # 82. 2. Resident with Indwelling Urinary catheters have the potential to be	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

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F 690	Continued From page 24 Findings included: Resident #82 was admitted 01/31/20 to the facility with diagnoses which included subacute osteomyelitis (bone infection) left femur, chronic embolism and thrombosis (blood clots) of deep veins of both lower extremities, severe protein and calorie malnutrition, anemia, paraplegia (paralysis of lower body), type 2 diabetes, a stage 4 pressure ulcer of left buttock, an unstageable pressure ulcer of left heel, pressure ulcer of right upper back with unspecified stage an unstageable pressure ulcer of unspecified part of back and a pressure ulcer of sacral region with unspecified stage. A care plan dated 02/04/20 indicated Resident #82 had a urinary catheter due to pressure ulcers to sacrum, buttocks and ischium (part of hip bone) and the interventions were listed in part to provide catheter care each shift and as needed and to monitor and document for pain or discomfort due to catheter. An admission Minimum Data Set (MDS) dated 02/07/20 indicated Resident #82 was cognitively intact for daily decision making. The MDS further indicated Resident #82 required extensive assistance for toileting and hygiene and had a urinary catheter. Observations during wound treatments on 02/26/20 at 9:44 AM with the Treatment Nurse revealed Resident #82 was in bed. The observations further revealed when the covers were pulled back Resident #82 had urinary catheter tubing draped across her left thigh and there was no catheter strap visible. The observations also revealed Resident #82 was	F 690	affected. on (03/26/20) a Quality Review was conducted by Nurse Management of current residents with indwelling urinary catheter to ensure proper placement of urinary catheters drainage bag (Off Floor)and urinary catheter strap in place to percent pulling. Issues identifies were addressed. 3.Director of Nursing and Nurse Management will educate licensed nurses and certified nursing assistant on indwelling Urinary Catheter Policy by 03/26/20. The education will be ongoing and included on orientation for new hires. the education includes the following: A) Proper Placement of Urinary Catheter. Catheter drainage bags should be positioned below the bladder but not on the floor. B)Ensure urinary catheter strap in place to secure catheter tubing to prevent pulling. Licensed Nurses and Certified Nursing Assistants will complete rounds throughout their schedule shift to observe for proper placement for indwelling catheters and to ensure catheter strap in place. 4) Nurse Management and/or Interdisciplinary team member will conduct random audits to observe residents with indwelling urinary catheters for proper placement of drainage bag and ensure urinary catheter strap in place 3x weekly for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months to ensure accuracy. The director of Nursing will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The	

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F 690	Continued From page 25 turned to her right side and the bed was lowered by the Treatment Nurse to do wound treatments and Resident #82's catheter drainage bag was lying on the floor and was folded in half with yellow urine inside the bag and tubing. An interview on 02/26/20 at 10:40 AM with Resident #82 revealed she had a strap to secure her urinary catheter when she was in the hospital and when she was at home. She stated she would rather have a strap to keep the catheter tubing from pulling because the catheter had been pulled out before with the bulb inflated. She further stated she had felt the catheter pulling during care. An interview on 02/28/20 at 10:42 AM with Nurse #1 who was assigned to provide care to Resident #82 revealed the facility provided catheter straps to secure catheter tubing. She stated she had seen a catheter strap on Resident #82's catheter tubing in the past but had also seen her without a strap and thought Resident #82 did not like a catheter strap. She explained she thought catheter drainage bags should be kept off the floor. An interview on 02/28/20 at 12:59 PM with Nurse Aide #1 who was assigned to care for Resident #82 revealed she had given Resident #82 a bed bath and had provided catheter care. She explained catheter drainage bags were supposed to be kept below the resident's bladder and they should be off the floor. She stated the nurse put the catheter straps on residents who had urinary catheters, but she could not recall if Resident #82 had a strap on her catheter. An interview on 02/28/20 at 1:07 PM with the	F 690	findings will be reviewed monthly by the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. completion date is 03/26/20	

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F 690	Continued From page 26 Treatment Nurse with the Interim Director of Nursing present revealed she was focused on wound treatments and she did not see a catheter strap on Resident #82. She further stated she did not focus on Resident #82's catheter during wound treatments and did not see the catheter drainage bag on the floor. An interview on 02/28/20 at 1:21 PM with the Interim Director of Nursing revealed every resident with a catheter should have a catheter strap applied. She stated the catheter bag should be placed below the bladder but should not be touching the floor. She further stated staff should be mindful to keep the catheter drainage bag off the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to obtain a physician's order to provide a resident with oxygen therapy for 1 of 1 resident reviewed for respiratory care (Resident #2). Findings included:	F 695	F695 1) On 2/27/20 a new physician order was received for oxygen via nasal cannula at 3 liters per minute for Resident #2. 2) Resident who require oxygen therapy have the potential to be affected. On	3/26/20

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F 695	Continued From page 27 Resident #2 was admitted to the facility on 11/11/19 with diagnoses that included chronic obstructive pulmonary disease (COPD), congestive heart failure, and sepsis. Resident #2's physician orders revealed no corresponding order to provide the resident with oxygen. Additional review of the physician orders revealed no standing physician orders for oxygen as needed. Resident #2's care plan dated 11/13/19 revealed a care area for oxygen therapy related to congestive heart failure. Interventions included to monitor her for signs and symptoms of respiratory distress and to provide oxygen via a nasal cannula at 2 liters per minute. Resident #2's Admission Minimum Data Set Assessment dated 11/18/19 revealed she was moderately impaired for daily decision making. She required extensive assistance with bed mobility, dressing, eating and personal hygiene and was totally dependent on others for bathing and toilet use. Resident #2 was coded as not having any shortness of breath while walking, bathing, transferring, sitting, or lying flat and was coded as receiving oxygen therapy before and after admission to the facility. An observation of Resident #2 at 02/25/20 at 8:50 AM revealed she was in her room. Resident #2 was observed receiving oxygen via a nasal cannula at 3 liters per minute. An observation on 02/27/20 at 10:19 AM revealed Resident #2 was resting in her bed with her nasal cannula in place with her oxygen concentrator providing oxygen at 3 liters per minute. An	F 695	(02/28/20) a Quality Review was conducted by Nurse Management of current residents who require oxygen therapy to ensure physician orders in place. Issues identified were addressed. 3) Director of Nursing and Nurse Management will educate licensed nurses on obtaining orders for residents who require oxygen therapy by 03/26/20 The education will be ongoing and included in Orientation for new hires. The education includes the following: a) Upon admission, admitting nurse will review/verify discharge summary for resident with the physician and/or nurse practitioner. If a resident is admitted on oxygen and there's no orders for oxygen. Nurse must clarify with physician or nurse practitioner and receive orders for oxygen therapy. b) Additionally new admissions will be reviewed during Clinical Morning meeting. Nursing will review discharge summary to ensure residents' orders are correct. 4) Nurse Management and/or Interdisciplinary team member will conduct random audits of residents who receive oxygen therapy to ensure physician order is in place 3x weekly for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months to ensure accuracy. The Director of Nursing will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee and	

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F 695	Continued From page 28 interview with the resident at this time revealed she received oxygen therapy via nasal cannula since her admission to the facility and had used oxygen while at home before her admission. During an interview with Nurse #5 on 02/27/20 at 10:24 AM, she stated she was new to the facility but was familiar with Resident #2. She verified that Resident #2 did receive oxygen therapy via nasal cannula and that she did not believe it was a continuous order because Resident #2 would occasionally remove it. She was asked to locate the order for oxygen therapy in the resident's medical record and reported she was unable to find it. She further stated that if she was unable to find it in the resident's medical record, she would request an order be written by the physician. She reported that residents in the facility should not receive therapies or medications without a physician's order unless there were standing orders for the medications or treatments. She then verified that the facility did not utilize any standing orders. She also reported not knowing how Resident #2 started receiving oxygen therapy without a physician's order. An interview with the Interim Director of Nursing on 02/28/20 at 10:18 AM, revealed the lack of a physician's order for Resident #2's oxygen therapy was an oversight by the admitting nurse. She stated when Resident #2 was admitted from the hospital she was receiving oxygen therapy. She reported she would have liked for the admitting nurse to contact the hospital and verify that Resident #2 continued to need oxygen therapy and, if so, request a physician's order for oxygen therapy at that time. She verified that the facility did not utilize standing physician orders and that a resident in the facility should not	F 695	audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. completions date is 03/26/20.	

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F 695	Continued From page 29 receive therapies or medications without a written physician's order. During an interview with the Administrator on 02/27/20 at 2:50 PM, she reported she believed that Resident #2 was admitted to the facility from the hospital on oxygen therapy. The Administrator stated it was the responsibility of the admitting nurse to verify and transcribe orders from the hospital into Resident #2's medical record. She verified medications and therapies should not be received if there was not a physician's order. The Administrator then provided a newly written physician's order for oxygen via nasal cannula at 3 liters per minute for Resident #2 that was written on 02/27/20.	F 695		
F 812 SS=F	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.	F 812		3/26/20

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F 812	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to label, date and seal stored food and failed to discard stored food with expired best by dates. The facility also failed to keep the ceiling return vent in the kitchen's dessert preparation room free of dust. The findings included: 1. An initial tour of the kitchen on 02/24/20 at 9:35 AM with the Cook revealed in the kitchen's dry storage area a twenty-five-pound box of Par Boiled Long Grain Rice opened, not dated and the blue bag inside the box that contained the rice was not sealed. The tour also revealed a twenty-four-pound box of Confectioners Cane Sugar with 7 bags remaining in the box had an expired best buy date of 02/23/19 and a bag of Tortilla Chips, 9 ounces, with an expired best if used by date of 11/26/19. During an interview with the Cook on 02/24/20 at 9:35 AM the Cook stated the Par Boiled Rice should have been dated when opened and the blue bag should have been sealed after being used. She also stated the expired Confectioners Cane Sugar and Tortilla Chips should have been discarded after the expiration date. An interview with the Dietary Manager on 02/26/20 at 11:45 AM revealed she expected the rice to be dated and sealed when opened and food to be discarded after their expiration date had expired. During an interview on 02/26/20 at 3:30 PM the Administrator stated food should be discarded by	F 812	F812 1) All outdated items was discarded immediately 02/24/20 by Dietary Manager. The Maintenance Director immediately cleaned vent in kitchen on 2/24/20. 2) All Dietary Staff were Educated on 03/26/20 on cleaning and Sanitation, and proper labeling and dating by the Dietary Manager All education to include new staff will be completed on by 03/26/2020 and during orientation. 3) Dietary Manager will reeducate Dietary Staff on Monitoring storage, labeling, dating and sanitation. this education will be completed by 03/26/20. 4)The Dietary manager will complete monitoring tools 3 x a week for 4 weeks then 1 x a week for 2 months and monthly for 3 months The Dietary Manager will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. completion date is 03/26/20	

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F 812	Continued From page 31 the expiration date and sealed when opened. 2. An observation of the ceiling return vent in the dessert preparation room on 02/24/20 at 9:55 AM revealed the ceiling return vent to be covered with dust. During an interview on 02/24/20 at 9:55 AM the Cook stated the ceiling vent was dusty and needed to be cleaned. An interview with the Dietary Manager and District Manager on 02/26/20 at 11:45 AM revealed they expected the ceiling return vent in the dessert preparation room to be free of dust. During an interview on 02/26/20 at 3:30 PM the Administrator stated the ceiling return vent in the dessert preparation room should be free of dust.	F 812		
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 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;	F 842		3/26/20

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F 842	Continued From page 32 (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- (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;	F 842		

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F 842	Continued From page 33 (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 interviews, the facility failed to document doses of insulin given on a resident's medication administration record (MAR) for 1 of 4 residents reviewed for unnecessary medications (Resident #27). The Findings Included: Resident #27 was admitted to the facility on 01/09/20 with diagnoses that included long term use of insulin and type 2 diabetes mellitus. Resident #27's admission Minimum Data Set Assessment dated 01/16/20 revealed Resident #27 was cognitively intact and was coded as receiving insulin injections 6 of 7 days during the look back period. Resident #27's physician orders revealed orders that included Humalog Kwikpen 100 units/mL(milliliter) insulin pen to be used on a sliding scale at meal times, Basaglar Kwikpen 100 units/per mL - inject 30 units subcutaneously at bedtime, and Basaglar Kwikpen 100 units/mL - give 45 units, subcutaneously in the morning. Resident #27's most recent care plan dated 01/13/20 revealed a care plan for diabetes	F 842	F842 1) Nurse #3 and #4 received education on Medication Administration Record Documentation. Transcription Error completed for Resident # 27 for the following dates 2/14/20, 2/16/20, and 2/24/20. 2) Insulin-dependent residents have the potential to be affected. On (03/02/20) a Quality Review was conducted by Nurse Management of current residents who receive insulin to ensure doses of insulin given were documented on the Medication Administration Record. Issues identified were addressed. 3) Director of Nursing and Nurse Management will educate licensed nurses on Medication Administration Record Documentation by (03/26/20). The education will be ongoing and included in Orientation for new hires. The education includes the following: a) When documenting on a hard copy Medication Administration Record (non-electronic), the nurse will document	

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F 842	Continued From page 34 mellitus. The interventions included to administer medications as ordered and encourage diet and medications compliance. A review of Resident #27's Medication Administration Record (MAR) for February 2020 revealed on 02/14/20 the order for a 6:00 AM dose of Humalog Kwikpen 100 units/mL on a sliding scale was not signed off on. Further review revealed the same dose on 02/16/20 at 5:00 PM was not signed off on. There were also doses of Basaglar Kwikpen 100 units/mL not signed off as given on 02/24/20 at 6:00 AM. Facility provided staffing schedules for the month of February 2020, revealed Nurse #3 was scheduled to work on 02/16/20 and Nurse #4 was scheduled to work on 02/14/20 and 02/24/20 at the times where there was no sign off on the insulin being given. During an interview with Nurse #3 on 02/28/20 at 10:07 AM, she reported she had worked at the facility for "about 10 years". She stated she was familiar with Resident #27 and verified he had orders for insulin injections multiple times throughout the day. She also verified she worked 2nd shift (3:00 PM - 11:00 PM) 02/16/20. When questioned, Nurse #3 informed she knew "for a fact" that she provided Resident #27 with his scheduled and sliding scale doses of insulin on 02/16/20 and verified that it would be difficult for someone to determine if the medication was given if it was not signed off on. She reported it was policy for nurses to sign off on medications after they were provided to residents. She stated she should have signed off on the MAR after she gave Resident #27 his doses of insulin and that she was either too busy or became distracted and	F 842	immediately prior to administration and or immediately post administration based on preferred individual professional practice of the nurse. Should the resident decline or be unable to accept the medication the nurse will document following the standard protocol. b) Nurses will review medication administration record prior to the start of shift and at end of shift to ensure documentation completed. 4) Nurse Management and/or Interdisciplinary team member will conduct random audits of 5 residents who receive insulin to ensure doses of insulin given are documented on the Medication Administration Record 3x weekly for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months to ensure. The Director of Nursing will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. completion date is 03/26/20	

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F 842	Continued From page 35 forgot to sign off on the MAR. Multiple telephone calls were made in an attempt to interview Nurse #4. Voice messages were left, and no return calls were received. During an interview with the Interim Director of Nursing on 02/28/20 at 11:19 AM, she reported that it was her expectation that once a medication was given to a resident, that the nurse signed off on the MAR. She said this was to prevent any potential confusion by other staff members on whether the resident received the medication or not. She stated that if the insulin was provided to Resident #27 on 02/14/20, 02/16/20, and 02/24/20 then the MAR should reflect the administration with a nurse's signature on Resident #27's MAR. An interview with the Administrator on 02/28/20 at 2:52 PM revealed that Nurse #4 had been suspended earlier in the week, prior to the start of the survey for undisclosed issues. She stated she was completely unsure how a nurse could forget to sign off on a MAR after she gave a medication and reported that it should be done to prevent any confusion about whether the resident received the medication.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §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	F 867		3/26/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 36 by: Based on record review, observations and resident and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April 2019. This was for two recited deficiencies which were originally cited in April 2019 on a Recertification and complaint survey and subsequently recited in February 2020 on the current Recertification survey. The repeat deficiencies were in the areas of advanced directives and urinary catheter care. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1 a. F 578: Based on record review, staff and nurse practitioner interviews, the facility failed to maintain accurate advance directives throughout medical records for 3 of 3 residents reviewed for advanced directives (Resident 16, 26, and 66). During the recertification and complaint survey of 04/11/19, this regulation was cited for failure to have accurate and complete advance directives in the medical record for 2 of 2 residents reviewed for advance directives (Resident # 192 and Resident # 58). b. F 690: Based on observations, record reviews and resident and staff interviews, the facility failed to apply a urinary catheter strap to secure catheter tubing to prevent pulling and failed to	F 867	F867 1) On 3/17/20,the center reviewed the process for Advanced Directives and Urinary Catheters with regard to the repeat citation. Residents with Advance Directives 26, 66, and 16 identified during survey were immediately corrected.Treatment Nurse applied a urinary catheter strap to secure tubing and repositioned the catheter drainage bag from off the floor to side of bed for Resident # 82. The QAPI committee reviewed the current process for completion of Advanced Directives and for Urinary Catheters along with a root cause analysis of the current process to determine areas of opportunity and implementation of appropriate corrective actions utilizing a Performance Improvement Plan. 2) On 03/17/20, Facility Quality Assurance Performance Improvement (QAPI) committee will review the findings identified during annual survey 02/24/2020 - 02/28/2020.Resident with Indwelling Urinary catheters and Advanced Directives have the potential to be affected. on (02/26/20) a Quality Review was conducted by Nurse Management of current residents with indwelling urinary catheter to ensure proper placement of urinary catheters drainage bag (Off Floor)and urinary catheter strap in place to percent pulling.Current Residents have the potential to be Affected. An audit of	

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F 867	Continued From page 37 keep a catheter drainage bag off the floor during wound treatments for 1 of 1 sampled resident reviewed for urinary catheter care (Resident #82). During the recertification and complaint survey of 04/11/19, this regulation was cited for failure to maintain a urinary catheter bag below the level of the bladder to facilitate the flow of urine (Resident #186) and failed to keep the urinary catheter bag off the floor to reduce the risk of infection (Resident # 36) for 2 of 2 residents reviewed for urinary catheters. An interview on 02/28/20 at 3:05 PM with the Administrator. She explained the Quality Assurance (QA) committee met monthly and included herself, the Director of Nursing (DON), Medical Director, Pharmacist and Department Managers. She further explained they had standing agenda items but when something came up or there was an issue where they needed to do a Quality Assurance and Performance Improvement plan, they added it to the agenda. She stated she had only been at the facility since July 2019, but they had reviewed last year's survey results at every QA meeting since she had been at the facility. She explained the Interim DON had conducted inservices with staff and one-on-one inservices had also been conducted with staff. She stated they did follow ups and audits to prevent repeat deficiencies.	F 867	current residents Advance Directives to be completed by the Directed of Nursing, Nurse Management, and Interdisciplinary Team by 02/27/20. Discrepancies identified were addressed. Issues identifies were addressed. The Executive Director will conduct the meeting that includes participation of the interdisciplinary team members as well as the Medical Director. Meeting agenda will consists the areas of concern identified during the annual survey to include Advance Directives (F578) and Urinary Catheters (F690). Findings identified will have a plan of correction in place to include immediate correction, quality review, education and ongoing quality improvement monitoring in place to be reviewed by QAPI committee. 3) On 03/17/20), the Executive Director and Director of Nursing was educated regarding conducting an effective QAPI committee that identifies areas of concern, using Root Cause Analysis, develop a Performance Improvement Plan (PIP) that includes goals, actions taken, person responsible, completion date, and results. By 3/26/20, the Executive Director/Director of Nursing/IDT to be educated by the Regional Director of Clinical Services on conduction an effective QAPI committee that identifies areas of concern, using Root Cause Analysis, develop a Performance Improvement Plan (PIP) that includes goals, actions taken, person responsible, completion date, and results.	

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F 867	Continued From page 38	F 867	4) On 03/24/20, the Executive Director will present the Plan of Correction to the Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of nursing and or Nursing Supervisor. QAPI committee to meet weekly for four weeks, then as indicated based on the QAPI findings, but at a minimum monthly thereafter to review performance improvement related to areas identified during the annual survey 02/24/2020 - 02/28/2020. The Vice President of Operations, Senior Director of Operations and or Regional Director of Clinical Services will monitor and review the findings monthly for four months and randomly thereafter. Quality Monitoring schedule may be modified based on quality monitoring findings. Completion Date is 03/26/20	