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	345270	A. BUILDING _____ B. WING _____	C 03/05/2020

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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 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		4/2/20

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

Electronically Signed | 03/27/2020

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

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

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

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:

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

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,

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E 039	Continued From page 2	E 039		

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

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

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

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

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

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

(B) A mock disaster drill; or

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

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

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]

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E 039	Continued From page 3 (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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

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

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

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

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

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

(B) A mock disaster drill; or

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

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

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

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E 039	Continued From page 5 to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise	E 039		

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E 039	Continued From page 6 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to test their Emergency Preparedness (EP) plan in 2019 by either participating in a full-scale, community-based exercise or by conducting an individual facility-based functional exercise. The facility's failure to test their EP plan had the potential to affect all residents and staff. Findings included: The facility's EP manual was reviewed on 03/05/20. The review revealed there was no information available to show the facility tested their EP plan by participating in either a full-scale community-based exercise or by conducting an individual facility-based functional exercise during 2019. An interview on 3/5/20 at 11:03 AM with the Administrator revealed the facility did not participate in a community-based full-scale exercise last year (2019) to test their EP plan and	E 039	The facility experienced an actual, non-manmade emergency that required activation of our emergency plan and has conducted individual –based functional exercises following the onset of the emergency event in 2019. Prior to survey, facility posted an all staff in-service regarding disaster preparedness for 3-10-20 and had previously scheduled and posted notice of a community based table top exercise being conducted at facility on 3-11-20. On 3-10-20 Facility Administrator provided education to all staff regarding disaster preparedness. Facility prescheduled community base exercise was conducted on 3-11-20 as scheduled. On 3-12-20 facility activated our emergency plan due to the actual, non-manmade emergency pandemic COVID-19. Facility administrator is scheduled to	

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E 039	Continued From page 7 had last participated in one of these exercises in September 2018. The Administrator stated she tried repeatedly in 2019 to schedule the facility's participation in a full-scale community-based exercise but was told by their local EP resource person that the full-scale exercise was only required to be done every other year. The Administrator stated the facility did test their EP plan on 10/23/19 when they conducted a tabletop exercise which included group discussion and analysis.	E 039	attend Mitchell County Emergency Services Meeting May 12, 2020. Administrator has requested to participate in future community based exercises conducted by Mitchell County Emergency Services and through The Mountain Area Healthcare Preparedness Coalition. Facility will monitor its performance to ensure emergency preparedness plan is tested monthly for 4 months then quarterly for 3 quarters with the first monthly audit being conducted on or before March 31, 2020. The Administrator will review the results of the audits and those findings will be reported at the monthly QAPI meeting for 3 months. Then quarterly for 3 quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Operations or designee to maintain continued compliance. The Administrator will be responsible for the implementation of the acceptable plan of correction. Date when corrective action will be completed: 4/2/20	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 3/2/20 through 3/5/20. There were 8 allegations investigated and they were all unsubstantiated. Event ID# OKC111.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		4/2/20

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F 561	Continued From page 8 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide scheduled showers for 2 of 4 residents (Resident #3 and Resident #44) reviewed for activities of daily living. The findings included: 1. Resident #3 was admitted to the facility on 5/24/18 with diagnoses that included hereditary	F 561	On 3/5/20 the Director of Nursing validated that resident #3 and resident #44 did not receive their showers on 2/15/20, 2/22/20 and 2/29/20. Resident #3 and resident #44 were both offered a shower later that same week to make up for the missed showers, but declined. It was also verified that both residents received a shower on 3/4/20. A 100% audit was completed on showers by the	

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F 561	Continued From page 9 motor and sensory neuropathy, muscle weakness and contractures to both hands. The quarterly Minimum Data Set (MDS) assessment dated 2/5/20 indicated Resident #3 had intact cognition, was totally dependent on one-person physical assist for bathing and had impairment to both upper extremities. Resident #3's Treatment Administration Record (TAR) for February 2020 was not initialed for Resident #3 to indicate he received a shower on 2/15/20, 2/22/20 and 2/29/20. On 3/4/20 at 2:40 PM, an interview with Resident #3 revealed he had not received his scheduled showers for the past 3 Saturdays. Resident #3 stated he was scheduled to receive a shower on Wednesdays and Saturdays but had only received one shower a week on Wednesday for the past 3 weeks. Resident #3 further stated the facility had one nurse aide (NA) assigned to his hall on the weekends for the past 3 weeks. He said the NA who worked this past weekend stayed past the time her shift ended on 3/1/20 in order to give him a shower since he had not received a shower for 3 consecutive Saturdays. He shared that they did offer to make up his other missed Saturday showers on Tuesdays, but he did not want to take 2 showers on back-to-back days. On 3/4/20 at 4:03 PM, a phone interview with NA #5 revealed she worked with Resident #3 on 2/15/20 and 2/29/20 during the day shift and did not have time to give him his scheduled shower. NA #5 stated she could not leave the hall for 45 minutes to give any resident a shower. NA #5 had been assigned to work on 300 hall by herself	F 561	DON and no other issues were found. On 3/25/20 all nurses and CNAs were educated on completing showers on their assigned halls. Education included instructing CNAs to notify the nurse on their hall that they were unable to complete their showers. The nurse on the hall will report this to the RN Supervisor on Duty, the Assistant Director of Nursing or the Director of Nursing. The CNA on the hall will be able to stay over after his or her shift to complete the resident's shower or other accommodations will be made that are agreeable with the resident. The DON/designee will review random shower audits to ensure no showers are missed. The audit will consist of five random residents five times a week for four weeks, three random residents five times a week for four weeks and two random residents five times a week for four weeks starting on 3/23/20. The DON will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for three months. Then quarterly for three quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. The DON will be responsible for the implementation of the acceptable plan of correction.	

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F 561	Continued From page 10	F 561	Date when corrective action will be completed: 4/2/20	

on 2/15/20 and 2/29/20, and had 26 residents to take care of. NA #5 shared she stayed over on 3/1/20 past the time her shift ended to give Resident #3 his scheduled shower since he had not received one for the past 3 Saturdays. NA #5 further stated the facility had been understaffed for at least a month.

On 3/4/20 at 4:16 PM, an interview with Nurse #3 revealed she worked as the weekend supervisor and worked on 2/15/20, 2/22/20 and 2/29/20. Nurse #3 stated she was unaware that Resident #3 had missed his scheduled showers on those dates (2/15/20, 2/22/20 and 2/29/20). Nurse #3 stated Nurse #1 should have notified her so they could have made up Resident #3's scheduled shower on the next day. Nurse #3 further stated they usually had 1 NA per hall and a floater NA on the weekends but did not know that showers were missed due to not having enough staff.

On 3/4/20 at 4:42 PM, a phone interview conducted with Nurse #1 revealed she worked with NA #5 on 2/29/20 and verified that NA #5 worked as the only NA on the 300 hall on 2/29/20. Nurse #1 also worked on 2/22/20 and confirmed that Resident #3 did not get his scheduled shower on 2/22/20 and 2/29/20. Nurse #1 stated there was another NA who floated among the halls and helped with meals and incontinence care, but this NA did not have time to do resident showers. Nurse #1 could not remember if she had notified the weekend supervisor that Resident #3 had missed his scheduled showers on the past 3 Saturdays but shared that Resident #3 would let staff members know if he did miss his showers.

On 3/4/20 at 5:34 PM, an interview conducted

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F 561	Continued From page 11	F 561		

with NA #7 revealed she worked with Resident #3 on 2/15/20 and 2/29/20 during the evening shift and was unaware that Resident #3 had not received his scheduled shower for those days. NA #7 stated she did not give Resident #3 his shower because she did not know he did not receive them during the day shift. NA #7 shared Resident #3 never refused his scheduled showers.

On 3/5/20 at 9:23 AM, a phone interview with NA #4 revealed she worked on 2/15/20 and 2/29/20 and was assigned to be a "floater" NA. NA #4 stated she had to help on 200 hall, 300 hall and 400 hall as the floater NA. She further stated she had helped NA #5 on 300 hall with incontinence care, passing meal trays, feeding assistance and charting. NA #4 stated she did not provide any resident showers with NA #5 because they did not have enough time. NA #4 shared she only worked on Saturdays and they were supposed to have 2 NAs per hall but during the last 3 to 4 weeks, they have had to work with only 1 NA per hall and a floater NA.

On 3/5/20 at 9:30 AM, an interview conducted with NA #6 revealed she worked with Resident #3 on 2/22/20 on day shift and did not provide his scheduled shower on that day. NA #6 stated she worked on 300 hall by herself and did not have time to do all the showers that were scheduled for the day. NA #6 shared she had meant to offer Resident #3 a make-up shower on 2/23/20 but he had been in activities that day and she did not have the opportunity to ask him.

On 3/5/20 at 3:46 PM, an interview with the Director of Nursing (DON) revealed Resident #3 should have received his showers as scheduled.

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The DON was unsure if Resident #3 had been offered a make-up shower for the showers he missed. The DON stated the facility had challenges with the staffing due to callouts and unexpected situations but have been trying to obtain staff to provide care for the residents.

On 3/5/20 at 4:40 PM, an interview with the Administrator revealed all residents should receive at least 2 showers a week. She stated she was unaware that Resident #3 had missed his scheduled showers during the past 3 Saturdays, but the next shift should have made it up or a shower should have been offered the next day if they did not have time to get his shower done on the day it was scheduled.

2. Resident #44 was admitted to the facility on 10/5/18 with diagnoses that included intervertebral disc degeneration and muscle weakness.

The quarterly Minimum Data Set (MDS) assessment dated 1/3/20 indicated Resident #44 had intact cognition and required physical help from one person in part of bathing activity.

Resident #44's Treatment Administration Record (TAR) for February 2020 was not initialed for Resident #44 to indicate that he received a shower on 2/15/20, 2/22/20 and 2/29/20.

On 3/2/20 at 3:20 PM, an interview with Resident #44 revealed he was scheduled to receive a shower on Wednesdays and Saturdays but had not received his Saturday showers during the past 3 weeks. Resident #44 stated they did not have enough staff on Saturdays and had only 1 nurse aide (NA) working on his hall. Resident

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#44 shared the NA did not have enough time to give him his scheduled shower on Saturdays.

On 3/4/20 at 4:03 PM, a phone interview with NA #5 revealed she worked with Resident #44 on 2/15/20 and 2/29/20 during the day shift and did not have time to give him his scheduled shower. NA #5 stated she could not leave the hall for 45 minutes to give any resident a shower. NA #5 had been assigned to work on 300 hall by herself on 2/15/20 and 2/29/20, and had 26 residents to take care of. NA #5 shared she stayed over on 3/1/20 past the time her shift ended to give Resident #44 his shower. NA #5 further stated the facility had been understaffed for at least a month.

On 3/4/20 at 4:16 PM, an interview with Nurse #3 revealed she worked as the weekend supervisor and worked on 2/15/20, 2/22/20 and 2/29/20. Nurse #3 was unaware that Resident #44 had missed his scheduled showers on those dates (2/15/20, 2/22/20 and 2/29/20). Nurse #3 stated Nurse #1 should have notified her so they could have made up his shower on the next day. Nurse #3 further stated they usually had 1 NA per hall and a floater NA on the weekends but did not know that showers were missed due to not having enough staff.

On 3/4/20 at 4:42 PM, a phone interview conducted with Nurse #1 revealed she worked with NA #5 on 2/29/20 and verified that NA #5 worked as the only NA on the 300 hall on 2/29/20. Nurse #1 also worked on 2/22/20 and confirmed that Resident #44 did not get his scheduled shower on 2/22/20 and 2/29/20. Nurse #1 stated there was another NA who floated among the halls and helped with meals and incontinence

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care, but they did not have time to do showers. Nurse #1 could not remember if she had notified the weekend supervisor that Resident #44 had missed his showers on the past 3 Saturdays.

On 3/4/20 at 5:34 PM, an interview conducted with NA #7 revealed she worked with Resident #44 on 2/15/20 and 2/29/20 on evening shift and was unaware that Resident #44 had not received his scheduled shower for those days. NA #7 stated she did not give Resident #44 his shower because she did not know he did not get them during the day shift.

On 3/5/20 at 9:23 AM, a phone interview with NA #4 revealed she worked on 2/15/20 and 2/29/20 and was assigned to be a "floater" NA. NA #4 stated she had to help on 200 hall, 300 hall and 400 hall as a floater. She further stated she had helped NA #5 on 300 hall with incontinence care, passing meal trays, feeding assistance and charting. NA #4 stated she did not provide any resident showers with NA #5 because they did not have enough time. NA #4 shared she only worked on Saturdays and they were supposed to have 2 NAs per hall but during the last 3 to 4 weeks, they have had to work with only 1 NA per hall and a floater NA.

On 3/5/20 at 9:30 AM, an interview conducted with NA #6 revealed she worked with Resident #44 on 2/22/20 during the day shift and did not provide his scheduled shower on that day. NA #6 stated she worked on 300 hall by herself and did not have time to do all the showers that were scheduled for the day. NA #6 shared she provided Resident #44 a make-up shower on 2/23/20.

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F 561	Continued From page 15 On 3/5/20 at 3:46 PM, an interview with the Director of Nursing (DON) revealed Resident #44 should have received his showers as scheduled. The DON was unsure if Resident #44 had been offered a make-up shower for the showers he missed. The DON stated the facility had challenges with the staffing due to callouts and unexpected situations but have been trying to obtain staff to provide care for the residents. On 3/5/20 at 4:40 PM, an interview with the Administrator revealed all residents should receive at least 2 showers a week. She stated she was unaware that Resident #44 had missed his scheduled showers during the past 3 Saturdays, but the next shift should have made it up or a shower should have been offered the next day if they did not have time to get his shower done on the day it was scheduled.	F 561		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of behaviors (Residents #16 and #17), oxygen use (Resident #16), influenza immunization (Residents #50, #56, #22, #42 and #33) and prognosis (Resident #88) for 8 of 24 sampled residents reviewed for MDS accuracy. The findings included:	F 641	Resident #16's quarterly MDS dated 2/21/20 will be re- opened to correct accurate coding of oxygen therapy in use. This correction will occur on or before 4-1-20. Resident #17's quarterly MDS dated 2/23/20 was currently open and was completed and transmitted with accurate coding of rejection of care. This correction will occur on or before 4-1-20.	4/2/20

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F 641	Continued From page 16 1. a. Resident #16 was admitted to the facility on 2/5/18 and readmitted on 5/14/19 with diagnosis which included respiratory failure. Resident #16's Treatment Administration Record (TAR) dated February 2020 revealed she refused her continuous positive airway pressure (CPAP) treatments on the following dates: 2/4/20, 2/5/20, 2/6/20, 2/7/20, 2/11/20, 2/17/20, 2/19/20, 2/21/20, 2//25/20, 2/26/20 and 2/27/20. Resident #16's quarterly Minimum Data Set (MDS) assessment dated 2/21/20 coded the resident as being cognitively intact. Resident #16 was coded under behaviors for no rejection of care. An interview was conducted on 3/2/20 at 8:24 AM with Resident #16. She stated she wore a continuous positive CPAP at night, but had been refusing it for the past month because of the mask bothering her. The interview revealed staff had attempted to changer her mask to better fit her face however she felt like it was suffocating her and had continued to refuse the machine. An interview was conducted on 3/3/20 at 4:42 PM with Nurse #4. Nurse #4 stated Resident #16 had refused to wear her CPAP on a nightly basis. She stated a staff member from the CPAP company had came in the week prior to assist in finding a solution to the mask fitting however the resident had continued to refuse the machine. An interview was conducted on 3/03/20 at 4:35 pm with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #16's 2/21/20 quarterly MDS	F 641	Resident #50's quarterly MDS dated 1/8/20, Resident #56's quarterly MDS dated 1/15/20, Resident # 22's quarterly MDS dated 12/6/19, Resident #42's annual MDS date 1/2/20, and Resident #33's quarterly MDS dated 12/24/19 will be modified no later than 4/1/20 to correct accurate coding of date resident received influenza vaccination. Resident # 88's Significant Change MDS dated 12/7/19 was modified to correct accurate coding of prognosis or chronic disease that may result in a life expectancy of less than 6 months. This correction will occur on or before 4/1/20. The facility Resident Care Management Director, (RCMD) or designee will audit all current residents having an MDS completed in the last 14 days to verify accurate coding of oxygen use, rejection of care, Influenza Vaccine and resident prognosis is accurately coded. Corrections will be made by RCMD as identified per the RAI manual guidelines. Initial audit will be completed no later than 3-31-20. On 3-27-20 Resident Care Management Director, educated the MDS coordinators on accurate coding of the MDS sections O0100C, O0250A, O0250B, O0250C and J1400 and educated the MDS coordinators and Social Service Director on coding of the MDS section E0800 according to Resident Assessment Instrument (RAI) Manual guidelines.	

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F 641	Continued From page 17 assessment along with her February 2020 TAR. He confirmed rejection of care was marked "no" on the MDS assessment. MDS Coordinator #1 stated the MDS was coded inaccurately based on the TAR provided. He stated he answered thousands of MDS assessment questions for residents in the facility and mistakes happen. An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 3:46 pm who indicated the MDS assessment should be accurate and correspond with the residents needs or what she was doing. The DON stated she also understood it was missed out of human error not by intention. b. A physician's order dated 6/5/18 revealed Resident #16 had a order for oxygen therapy a 2 liters via nasal cannula as needed to keep oxygen saturation greater than 90%. Resident #16's quarterly Minimum Data Set (MDS) assessment dated 2/21/20 coded the resident as being cognitively intact. Resident #16 was coded for no oxygen therapy use. A MDS note dated 2/21/20 stated Resident #16 wore oxygen at 2 liters especially at night with a continuous positive airway pressure (CPAP). An interview was conducted on 3/2/20 at 8:24 AM with Resident #16. She stated she wore a continuous positive airway pressure (CPAP) at night but had been refusing it for the past month because of the mask bothering her. She stated instead of wearing the CPAP she wore oxygen via a nasal cannula at 2 liters every night. An interview was conducted on 3/05/20 at 11:32	F 641	Beginning no later than 4-1-20, Resident Care Management Director, or designee will audit a minimum of 3 MDS's weekly to ensure accurate coding of O100C2 Oxygen use while a resident, E0800 Rejection of care, O0250 Influenza Vaccine, and J1400 Prognosis to reflect the resident's status weekly X 6 weeks, then 3 residents per month X 4 months to ensure compliance is achieved and maintained. The Resident Care Management Director will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for two months. Then quarterly for two quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Care Management or designee to maintain continued compliance. Date when corrective action will be completed: 4/2/20	

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AM with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #16's 2/21/20 quarterly MDS assessment. He confirmed oxygen therapy was marked no. The MDS Coordinator #1 stated the MDS was coded inaccurately because he knew the resident wore oxygen.

An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 3:46 pm who indicated the MDS assessment should be accurate and correspond with the residents needs or what she was doing. The DON stated she also understood it was missed out of human error not by intention.

2. Resident #17 was readmitted to the facility on 12/5/17 with diagnosis which included hemiplegia, depression, cerebrovascular accident and hyperlipidemia.

Resident #17's care plan, most recently reviewed on 1/10/20, revealed a focus area which stated he was resistive to care such as therapy and often refused to let staff clean out old food from his nightstand drawers. The goal was for Resident #17 to cooperate with care and room cleaning through the next review date. Interventions listed included occupational therapy, education to the resident and allowing the resident to make his own decisions. The care plan did not include information regarding the resident's refusal of showers.

Resident #17's shower log dated February 2020 revealed he had refused a shower on the following dates: 2/1/20, 2/5/20, 2/15/20, 2/19/20, 2/22/20 and 2/29/20. Resident #17 refused 6 of his 9 scheduled shower days for the month of

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February 2020.

Resident #17's quarterly Minimum Data Set (MDS) assessment dated 2/23/20 coded the resident as being cognitively intact. Resident #17 was coded under behaviors for no rejection of care.

An observation was conducted on 3/2/20 at 10:12 AM of Resident #17. At the time of the observation Resident #17 was laying in bed. Urinals were observed on the side of his bed with black debris around the inside of the urinal. Resident #17 had tan debris on his shirt and covers and an odor was present.

An interview was conducted on 3/2/20 at 10:12 AM with Resident #17. He stated he often refused his showers due to not wanting to get out of the bed. The interview revealed it was the resident's choice to often refuse a shower despite encouragement from staff.

An interview was conducted on 3/3/20 at 4:52 PM with Nurse #4. Nurse #4 stated Resident #17 had refused all care including showers. She stated no matter how many times nursing staff asked the resident he still would refuse to take a shower.

An interview was conducted on 3/03/20 at 4:20 pm with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #17's 2/23/20 quarterly MDS assessment along with his February 2020 shower log. He confirmed rejection of care was marked "no" on the quarterly MDS. MDS Coordinator #1 stated the MDS was coded inaccurately based on the shower log provided, however said the care plan reflected rejection of care.

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An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 3:46 pm who indicated the MDS assessment should be accurate and correspond with the residents needs or what he was doing. The DON stated she also understood it was missed out of human error not by intention.

3. Resident #50 was admitted to the facility on 3/20/15 with diagnosis which included heart failure and non-Alzheimer's dementia.

The resident vaccination log for 2019 revealed Resident #50 received her influenza vaccination in the facility on the date of 11/5/19.

Resident #50's quarterly Minimum Data Set (MDS) assessment dated 1/8/20 coded the resident as being severely cognitively impaired. Resident #50 was coded as receiving her influenza vaccination on 10/23/2018.

An interview was conducted on 3/04/20 at 1:10 PM with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #50's 1/8/20 quarterly MDS assessment and the vaccination record. He confirmed the date coded on the MDS was inaccurate. MDS Coordinator #1 stated he had not been provided with the resident vaccination log and was having to look in the resident charts to verify the date of when the residents received the vaccination. He stated from now on he would ask to see the vaccination log.

An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 8:57 AM who indicated the MDS assessment should be

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accurate and correspond with the residents needs and immunization record. The DON stated they had discussed the MDS vaccination issue and incorrect dates. She stated the MDS Coordinator had thought the point click care system was automatically pulling the dates over however that was not the case.

4. Resident #56 was admitted to the facility on 12/24/18 with diagnosis which included diabetes mellitus and depression.

The resident vaccination log for 2019 revealed Resident #56 received her influenza vaccination in the facility on the date of 11/6/19.

Resident #56's quarterly Minimum Data Set (MDS) assessment dated 1/15/20 coded the resident as being cognitively intact. Resident #56 was coded as not eligible to receive the influenza vaccination.

An interview was conducted on 3/04/20 at 1:10 PM with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #56's 1/15/20 quarterly MDS assessment and the vaccination record. He confirmed the information coded on the MDS was inaccurate. MDS Coordinator #1 stated he had not been provided with the resident vaccination log and was having to look in the resident charts to verify the date of when the residents received the vaccination. He stated from now on he would ask to see the vaccination log.

An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 8:57 AM who indicated the MDS assessment should be accurate and correspond with the residents

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needs and immunization record. The DON stated they had discussed the MDS vaccination issue and incorrect dates. She stated the MDS Coordinator had thought the point click care system was automatically pulling the dates over however that was not the case.

5. Resident #22 was readmitted to the facility on 11/30/19 with diagnosis which included anemia, anxiety and depression.

The resident vaccination log for 2019 revealed Resident #22 received his influenza vaccination in the facility on the date of 11/5/19.

Resident #22's quarterly Minimum Data Set (MDS) assessment dated 12/6/19 coded the resident as being cognitively intact. Resident #22 was coded as receiving his influenza vaccination outside of the facility.

An interview was conducted on 3/04/20 at 1:10 PM with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #22's 12/6/19 quarterly MDS assessment and the vaccination record. He confirmed the date coded on the MDS was inaccurate. MDS Coordinator #1 stated he had not been provided with the resident vaccination log and was having to look in the resident charts to verify the date of when the residents received the vaccination. He stated from now on he would ask to see the vaccination log.

An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 8:57 AM who indicated the MDS assessment should be accurate and correspond with the residents needs and immunization record. The DON stated

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they had discussed the MDS vaccination issue and incorrect dates. She stated the MDS Coordinator had thought the point click care system was automatically pulling the dates over however that was not the case.

6. Resident #42 was admitted to the facility on 3/1/18 with diagnosis which included non-Alzheimer's dementia, Parkinson's disease and diabetes mellitus.

The resident vaccination log for 2019 revealed Resident #42 received her influenza vaccination in the facility on the date of 11/6/19.

Resident #42's annual Minimum Data Set (MDS) assessment dated 1/2/20 coded the resident as being severely cognitively impaired. Resident #42 was coded as receiving her influenza vaccination on 10/23/2018.

An interview was conducted on 3/04/20 at 1:10 PM with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #42's 1/2/20 annual MDS assessment and the vaccination record. He confirmed the date coded on the MDS was inaccurate. MDS Coordinator #1 stated he had not been provided with the resident vaccination log and was having to look in the resident charts to verify the date of when the residents received the vaccination. He stated from now on he would ask to see the vaccination log.

An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 8:57 AM who indicated the MDS assessment should be accurate and correspond with the residents needs and immunization record. The DON stated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24	F 641		

they had discussed the MDS vaccination issue and incorrect dates. She stated the MDS Coordinator had thought the point click care system was automatically pulling the dates over however that was not the case.

7. Resident #33 was readmitted to the facility on 9/10/19 with diagnosis which included non-Alzheimer's dementia, anemia, seizure and psychotic disorder.

The resident vaccination log for 2019 revealed Resident #33 received her influenza vaccination in the facility on the date of 11/5/19.

Resident #33's quarterly Minimum Data Set (MDS) assessment dated 12/24/19 coded the resident as being severely cognitively impaired. Resident #33 was coded as receiving her influenza vaccination on 11/1/2018.

An interview was conducted on 3/04/20 at 1:10 PM with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #33's 12/24/20 quarterly MDS assessment and the vaccination record. He confirmed the date coded on the MDS was inaccurate. MDS Coordinator #1 stated he had not been provided with the resident vaccination log and was having to look in the resident charts to verify the date of when the residents received the vaccination. He stated from now on he would ask to see the vaccination log.

An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 8:57 AM who indicated the MDS assessment should be accurate and correspond with the residents needs and immunization record. The DON stated

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F 641	Continued From page 25	F 641		

they had discussed the MDS vaccination issue and incorrect dates. She stated the MDS Coordinator had thought the point click care system was automatically pulling the dates over however that was not the case.

8. Resident #88 was admitted to the facility on 11/03/19 with diagnoses which included cerebral vascular accident (CVA), diabetes, Alzheimer's disease and dementia with a noted rapid decline in her health over the past six months.

Resident #88 was admitted to Hospice on 11/27/19 and had a Hospice Certificate dated 11/27/19, with a documented life expectancy of six months or less signed by the Hospice Medical Director.

The resident's Significant Change Minimum Data Set (MDS) dated 12/07/19 revealed the resident was coded for the area of Prognosis as not having a condition or chronic disease that may result in a life expectancy of less than 6 months. The resident was coded as having received Hospice Care while a resident.

An interview was conducted on 3/03/20 at 4:35 pm with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #88's 12/07/19 Significant Change MDS assessment and her Hospice Certificate dated 11/27/19. He confirmed Prognosis was coded inaccurately on the 12/07/19 MDS assessment based on the Hospice Certificate provided. He stated he answered thousands of MDS assessment questions for residents in the facility and mistakes happen.

An interview was conducted with the Director of

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F 641	Continued From page 26 Nursing (DON) on 3/05/20 at 3:46 pm who indicated the MDS assessment should be accurate and correspond with the residents' prognosis and programs. The DON stated she also understood it was missed out of human error not by intention.	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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		4/2/20

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F 656	Continued From page 27 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 record review, and resident and staff interviews, the facility failed to develop a care plan with goals and interventions for a resident who rejected treatments for 1 of 2 residents reviewed for behaviors (Resident #16). The finding included: Resident #16 was readmitted to the facility on 5/14/19 with diagnosis which included respiratory failure. Review of a physician order dated 5/14/19 revealed Resident #16 was to wear her CPAP at nighttime per home settings at bedtime related to obstructive sleep apnea. Review of Resident #16's care plan dated 1/3/19 revealed no focus area related to rejection of care. Resident #16's Treatment Administration Record (TAR) dated February 2020 revealed she had refused her continuous positive airway pressure (CPAP) treatments on the following dates: 2/4/20, 2/5/20, 2/6/20, 2/7/20, 2/11/20, 2/17/20, 2/19/20,	F 656	On 3/3/20 The Resident Care Management Director, (RCMD) updated resident #16 careplan to reflect refusal of CPAP. An audit of all current residents with an MDS completed in the past 14 days will be completed by 3-31-20 by the RCMD or designee to ensure any resident with E0800 rejection of care coded on the MDS will have a current care plan initiated or updated to reflect the rejection of care. Resident Care Management Director educated all members of the IDT team on 3/27/20 on implementing and updating the residents care plan according to the Resident Assessment Instrument, (RAI) Manual guidelines. Beginning no later than 4/1/20 Resident Care Management Director, (RCMD) or designee will audit a minimum of 3 random residents care plan weekly for accurate care planning of rejection of care X 6 weeks, then 3 residents per month x 4	

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F 656	Continued From page 28 2/21/20, 2/25/20, 2/26/20 and 2/27/20. Resident #16's quarterly Minimum Data Set (MDS) assessment dated 2/21/20 coded the resident as being cognitively intact. Resident #16 was coded under behaviors for no rejection of care. An interview was conducted on 3/2/20 at 8:24 AM with Resident #16. She stated she wore a continuous positive airway pressure (CPAP) at night but had been refusing it for the past month because of the mask bothering her. The interview revealed staff had attempted to changer her mask to better fit her face however she felt like it was suffocating her and had continued to refuse the machine. An interview was conducted on 3/3/20 at 4:42 PM with Nurse #4. Nurse #4 stated Resident #16 had refused to wear her CPAP on a nightly basis. She stated a staff member from the CPAP company had came in the week prior to assist in finding a solution to the mask fitting however the resident had continued to refuse the machine. An interview was conducted on 3/03/20 at 4:35 pm with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #16's 2/21/20 quarterly MDS assessment along with her February 2020 TAR and care plan. He confirmed rejection of care was marked "no" on the resident's 2/21/20 quarterly MDS assessment and the resident did not have a focus area on her care plan for rejection of care prior to 3/3/20 when the surveyor asked for a copy of the resident's care plan. MDS Coordinator #1 stated resident should have had a care plan reflecting her refusals of her CPAP	F 656	months to ensure compliance is achieved and maintained. The Resident Care Management Director will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for two months. Then quarterly for two quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Care Management or designee to maintain continued compliance. Date when corrective action will be completed: 4/2/20	

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F 656	Continued From page 29 treatments. An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 3:46 pm who indicated the care plan should be accurate and correspond with the residents needs or what she was doing. The DON stated she also understood it was missed out of human error not by intention.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		4/2/20

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F 657	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed to revise a care plan with interventions and goals for a resident who rejected showers for 1 of 2 residents reviewed for rejection of care. (Resident #17) The finding included: Resident #17 was readmitted to the facility on 12/5/17 with diagnosis which included hemiplegia (weakness on one side), depression, and cerebrovascular accident (stroke). Resident #17's care plan, most recently reviewed on 1/10/20, revealed a focus area indicating he was resistive to care such as therapy and often refused to let staff clean out old food from his nightstand drawers. The goal was to cooperate with care and room cleaning through the next review date. Interventions listed included occupational therapy, education to the resident and allowing the resident to make his own decisions. The care plan did not include information regarding the refusal of showers. Resident #17's shower log dated February 2020 revealed he had refused 6 of his 9 scheduled shower days for the month of February. Resident #17's quarterly Minimum Data Set (MDS) assessment dated 2/23/20 indicated he was cognitively intact. No rejection of care was noted. An observation was conducted on 3/2/20 at 10:12 AM of Resident #17. At the time of the	F 657	On 3/4/20 Resident Care Management Director updated resident #17's care plan to reflect rejection of care to include refusal of shower. An audit will be completed by 3-31-2020 by the RCMD or designee for all current resident's with an MDS completed in the last 14 days to ensure any residents with E0800 coded related to refusing showers care plan will be reviewed to validate accurate timely and revision of the care plan to include refusal of showers. Resident Care Management Director educated all members of the IDT team on 3-27-20 on timely revision and updating of the resident's care plan according to Resident Assessment Instrument, (RAI) Manual guidelines. Resident Care Management Director, (RCMD) or designee will audit a minimum of 3 random residents care plan weekly for accurate care planning of refusal of showers X 6 weeks, then 3 residents per month x 4 months to ensure compliance is achieved and maintained beginning no later than 4-1-20. The Resident Care Management Director will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for two months. Then quarterly for two quarters until substantial compliance has been achieved and the committee recommends	

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F 657	Continued From page 31 observation Resident #17 smelled of a foul odor, was lying in bed and had tan debris on his shirt and covers. An interview was conducted on 3/2/20 at 10:12 AM with Resident #17. He stated he often refused his showers due to not wanting to get out of the bed. The interview revealed it was the resident's choice to often refuse a shower despite encouragement from staff. An interview was conducted on 3/3/20 at 4:52 PM with Nurse #4. Nurse #4 stated Resident #17 had refused all care including showers. She stated no matter how many times nursing staff asked the resident he still would refuse to take a shower. An interview was conducted on 3/03/20 at 4:20 pm with MDS Coordinator #1. During the interview, the MDS Coordinator reviewed Resident #17's shower log. He stated the resident's care plan did not include his refusals to take showers. He further explained that based on the shower log provided, the care plan should have reflected Resident #17's preference to not take showers. An interview was conducted with the Director of Nursing (DON) on 3/05/20 at 3:46 pm who indicated the MDS assessment and care plan should be accurate and correspond with the residents needs. The DON stated she also understood it was missed.	F 657	quarterly oversight by the District Director of Care Management or designee to maintain continued compliance. Date when corrective action will be completed: 4/2/20	
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	F 690		4/2/20

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F 690	Continued From page 32 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to prevent a urinary catheter bag from touching the shower room floor for 1 of 2 residents (Resident #3) reviewed for urinary catheters.	F 690	On 3/5/20 the DON validated that resident #3s catheter bag was laying on the floor of the shower room during the resident's shower and that even though resident insisted that the CNA	

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F 690	Continued From page 33 The findings included: Resident #3 was admitted to the facility on 5/24/18 with diagnoses that included obstructive uropathy and neurogenic bladder. Resident #3's care plan initiated on 5/24/18 and last revised on 3/26/19 indicated Resident #3 had a urinary catheter related to obstructive and reflux uropathy. The goals listed were for Resident #3 to be/remain free from catheter-related trauma and for Resident #3 to show no signs and symptoms of urinary infection. The following interventions were listed: position catheter bag and tubing below the level of the bladder, handwashing before and after delivery of care, anchor catheter to prevent excess tension, observe/record/report to the doctor signs and symptoms of UTI (urinary tract infection) and perineal care as indicated. The quarterly Minimum Data Set (MDS) assessment dated 2/5/20 indicated Resident #3 was cognitively intact and had an indwelling urinary catheter. A review of a Physician Order dated 2/24/20 indicated Meropenem 500 mg (milligrams) IV (intravenously) every 8 hours x 7 days for UTI. On 3/2/20 at 3:32 PM, an observation of Resident #3 revealed him sitting inside his room with an IV fluid running through his right arm. During this observation, an interview with Resident #3 revealed he was currently receiving IV antibiotics for UTI. Resident #3 stated it was common for him to get UTI because he had a urinary catheter.	F 690	not hang the catheter bag on the shower chair the CNA should have placed it in a wash basin or put it down in a plastic bag. On 3/6/20 all residents with catheters were identified so residents could be monitored to ensure that catheter bags are not touching the floor. On 3/5/20 100% education was completed with all nursing staff on proper placement of catheter bags during showers as well as when the resident is in a wheelchair or the bed. Nursing staff was instructed to hang catheter bags on the shower chair or place the catheter bag in a basin or plastic bag during the shower. Nursing staff was also educated on making sure that catheter bags are not touching the floor when residents are in their wheelchairs or beds. The DON/designee will document random audits of residents with catheters to ensure that catheter bags are not touching the floor beginning 3/23/20. The audit will consist of five random residents five times a week for four weeks, three random residents five times a week for four weeks, and two random residents five times a week for four weeks. The DON will review the results of the random audits and those findings will be reported at monthly QAPI meeting for three months. Then quarterly for three quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or	

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F 690	Continued From page 34 On 3/4/20 at 10:35 AM, an observation of Resident #3 in the shower room revealed him sitting in the shower chair with the curtain pulled in the first shower stall. Resident #3's urinary catheter bag was observed laying flat on the floor, under the curtain, outside the shower stall and under the sink. There were two trash barrels and two dirty linen barrels right next to where the urinary catheter bag was observed laying flat on the shower room floor. Nurse aide (NA) #2 was assisting Resident #3 with his shower and both NA #1 and Nurse #2 were also present in the shower room. On 3/4/20 at 10:51 AM, an interview with NA #2 revealed this was her first time to give Resident #3 a shower and he had requested her to place his urinary catheter bag on the floor around the corner under the sink so it won't get wet during his shower. NA #2 stated she did not want to upset Resident #3 if she did not do as he asked. NA #2 further stated if Resident #3 had not made a request to place his urinary catheter bag on the floor, she would have hung it on the shower chair behind Resident #3 so that it did not touch the floor. On 3/4/20 at 10:59 AM, an interview with Nurse #2 revealed she did not notice Resident #3's urinary catheter bag being on the shower room floor. Nurse #2 stated she was focused on his urinary catheter insertion site and had not paid attention to where his catheter bag was placed. Nurse #2 stated that it was unacceptable for Resident #3's urinary catheter bag to be laying on the shower room floor and would change it right after the interview. On 3/4/20 at 11:07 AM, an interview with NA #1	F 690	designee to maintain continued compliance. The DON will be responsible for the implementation of the acceptable plan of correction. Date when corrective action will be completed: 4/2/20	

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F 690	Continued From page 35 revealed she had given Resident #3 a shower before and she usually hung his urinary catheter bag on the shower chair so that it did not touch the floor. NA #1 stated Resident #3 did not want his urinary catheter bag to get wet during showers and she tried her best for it not to, but she never placed it flat on the shower room floor. On 3/4/20 at 1:09 PM, a follow-up interview with Resident #3 revealed the nurse aides usually hung his urinary catheter bag on the side while he gets a shower. Resident #3 stated he had asked NA #2 to place the catheter bag on the floor this morning and admitted he had requested them to do so before sometimes to keep water from getting on the bag. On 3/5/20 at 3:46 PM, an interview conducted with the Director of Nursing (DON) revealed NA #2 had placed Resident #3's urinary catheter bag on the floor because he was upset and would not let her hang it on the shower chair but it was unacceptable to place it on the floor. The DON stated she could have placed it on a wash basin or put a bag around it to prevent it from touching the floor. On 3/5/20 at 4:40 PM, an interview with the Administrator revealed NA #2 should have followed the standards of clinical practice regarding urinary catheter care. The Administrator stated she understood NA #2 did what Resident #3 wanted but she could have found another solution to accommodate Resident #3's choice and maintain the standards of clinical practice.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		4/2/20

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F 693	Continued From page 36 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow Physician's orders for administering the correct ordered amounts of tube feeding for 1 of 1 sampled resident reviewed for tube feeding (Resident #69). Findings included: Resident #69 was admitted to the facility 09/11/18 with diagnosis including anoxic brain injury. Review of Resident #69's Physician orders dated 10/10/19 revealed she was to receive a tube	F 693	On 3/5/20 the DON validated that resident #69s tube feeding was set at 60cc/hour and should have been set at 50cc per hour. A medication error was completed and the Dietician, MD and family were notified. The DON also verified that the Dietician and MD stated that the extra 240 cc per day was not harmful to the resident. The pump was also replaced in case of a malfunction due to the pump itself. On 3/5/20 all residents with feeding tubes were evaluated to ensure that the settings on the pump matched the MD orders.	

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F 693	Continued From page 37 feeding of Osmolite 1.2 at 50 milliliters an hour (ml/hr) via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 total calories in a 24-hour period. Review of the quarterly Minimum Data Set (MDS) dated 01/22/20 revealed Resident #69 was severely cognitively impaired for decision making. The MDS also stated Resident #69 had a feeding tube and received 51% or more of her total calories from tube feeding. Review of Resident #69's care plan for tube feeding last updated 01/14/20 revealed she was to receive her tube feeding as ordered. The goal was for Resident #69 to remain free of aspiration through the next review date. Interventions included observation of any signs of aspiration, fever, shortness of breath, tube dysfunction or malfunction. Review of the Medication Administration Record for March 2020 revealed an order dated 10/10/19 for Resident #69 to receive Osmolite 1.2 at 50 ml/hr via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 calories in a 24-hour period. The MAR revealed the feeding was documented as running at the correct rate. Record review from 09/06/19 through 03/05/20 revealed Resident #69's weights were stable with no weight loss noted. An observation of Resident #69 on 03/04/20 at 3:50 PM revealed her tube feeding was infusing at 60 milliliters an hour with flushes of 350 ml every 4 hours. An observation of Resident #69 on 03/05/20 at	F 693	On 3/25/20 100% education was completed with all nurses that included instructing the nurses to check patients with feeding tubes at the beginning of the shift to make sure that the tube feeding settings match the MD orders. The Director of Nursing or designee will document random audits of residents with feeding tubes to ensure that the settings on the pump match the MD orders beginning on 3/23/20. The audits will consist of all residents with feeding tubes five times a week for four weeks, three times a week for four weeks and two times a week for four weeks. The DON will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for three months then quarterly for three quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. The DON will be responsible for the implementation of the acceptable plan of correction. Date when corrective action will be completed: 4/2/20	

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F 693	Continued From page 38	F 693		

2:00 PM revealed her tube feeding was infusing at 60 milliliters an hour with flushes of 175 ml every 4 hours.

An interview with Nurse #6 on 03/05/20 at 2:10 PM revealed Resident #69's tube feeding was infusing at 60 milliliters an hour with flushes of 175 ml every 4 hours. When asked what the Physician's order stated for Resident #69 regarding her tube feeding Nurse #6 stated the order read for the resident to receive tube feeding infusing at 50 milliliters an hour with flushes of 175 ml every 4 hours. An observation was conducted of Nurse #6 entering Resident #68's room to change the settings on the Kangaroo pump from 60 ml/hr to infuse at 50 ml/hr per Physician orders. Nurse #6 stated the label on the Osmolite bottle read that Nurse #7 had written and administered on 03/05/20 at 12:00 AM for Resident #69 to receive tube feeding at 60 ml/hr. Nurse #6 stated she had not checked Resident #69's tube feeding settings or compared them with the Physician's orders during her shift.

An interview with Nurse #4 on 03/05/20 at 2:16 PM revealed she had cared for Resident #69 from 2:30 PM to 11:00 PM on 03/04/20. Nurse #4 stated Resident #69's tube feeding was infusing at 60 ml/hr with flushes of 175 ml/hr every 4 hours on the date of 03/04/20. She stated she did not recall the flush running at 350 ml. A follow up interview with Nurse #4 revealed she had reviewed the Physician orders for Resident #69 and stated she had not verified the settings were correct on 03/04/20 and had made a mistake. Nurse #4 stated Resident #69's tube feeding should have been infusing at a rate of 50 ml/hr not 60 ml/hr. She stated she felt the feeding pump in which the tube feeding was delivered

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was malfunctioning and the flushes were recalculating and were not correct. The interview revealed she determined this after reviewing the Physician's order and going into Resident #69's room to check the pump. She stated she hadn't reported any issues with the feeding pump prior to 03/05/20 at 2:16 PM.

An interview with Nurse #7 on 03/05/20 at 5:39 PM revealed she had cared for Resident #69 during third shift on the dates of 03/04/20 and 03/05/20. She stated she administered a new bottle of Osmolite 1.2 tube feeding for Resident #69 every night at midnight. Nurse #7 stated she had accidentally put the wrong setting on the label and infused Resident #69's tube feeding at the rate of 60 ml/hr instead of 50 ml/hr. She stated she could not recall what she had set Resident #69's flushes at or if it was set to 350 ml/hr. Nurse #7 stated this happened because another resident who received tube feedings had been on the same hall and she had gotten the two residents confused. She stated she had been in a rush due to a nurse calling out on the date of 03/05/20 and wasn't paying attention. The interview revealed Nurse #7 did not know of any malfunctions with the feeding pump.

An interview with the Director of Nursing (DON) on 03/05/20 at 3:04 PM revealed she expected Physician orders to be followed for Resident #69's tube feeding and she wasn't sure why the feeding was not on the correct setting so the resident received the correct amount of feeding as ordered by the Physician. The interview revealed she had completed an assessment of the incident, notified the Physician, Dietitian and family of Resident #69. The DON stated the facility was handling the situation as a medication

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F 693	Continued From page 40 error by Nurse #4 and had replaced the feeding pump in case of a malfunction with the pump itself.	F 693		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide sufficient nursing staff to provide scheduled showers for 2 of 4 sampled	F 725	On 3/5/20 the DON validated that resident #3 and #44 were not documented as having received their showers on	4/2/20

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F 725	Continued From page 41 residents (Resident #3 and Resident #44). The findings included: This tag was cross-referenced to F-561: F-561 - Based on record review, resident and staff interviews, the facility failed to provide scheduled showers for 2 of 4 residents (Resident #3 and Resident #44) reviewed for activities of daily living. A review of the Daily Staffing Assignment Sheets revealed: 1. 2/15/20 - 1 nurse aide (NA) per hall plus 1 floater on day shift 2. 2/22/20 - 1 NA per hall plus 1 floater on day shift 3. 2/29/20 - 1 NA per hall plus 1 floater on day shift 4. 3/1/20 - 1 NA per hall plus 1 floater on day shift On 3/2/20 at 3:08 PM, an interview conducted with NA #3 revealed she had worked on 3/1/20 from 7 AM to 12 PM by herself on 400 hall. NA #3 stated she couldn't get any of the showers done that were scheduled for 3/1/20. NA #3 stated she tried to get them on the next day but if she did not have time, the residents would just have to wait until the next scheduled day. On 3/4/20 at 5:28 PM, an interview conducted with NA #8 revealed she had worked at the facility for 3 months on the evening shift. NA #8 stated she had worked by herself on 200 hall on a weekend but she could not remember when. NA #8 stated she couldn't get the scheduled showers done but she had offered bed baths to the residents who were supposed to get a full	F 725	2/15/20, 2/22/20 and 2/29/20. A 100% audit of showers was completed by the DON and no other issues were found. On 3/25/20 education was completed with 100% of floor nurses, Unit Coordinator and the Unit Supervisor to contact the DON or ADON when there are less than eight CNAs on day shift, 7 on on evening shift, and less than four CNAs on night shift so proper distribution of residents and duties can be discussed and a resolution reached. The facility will provide sufficient nursing staff to appropriately care for residents by continuing to contract with agency to supplement staff. The facility will review the master schedule and request agency employees to fill the open shifts. Nursing administration will cover open shifts as needed. Supplemental bonuses will be offered to current staff to cover open shifts as needed. Facility will continue to advertise for staff in local newspapers, Indeed, Facebook and work with local community college to recruit staff. The Administrator, DON and scheduler will meet five times a week for four weeks, three times a week for four weeks and two times a week for four weeks to review staffing pattern and make adjustments as needed beginning on 3/23/20. The Administrator and DON will review staffing and will report on staffing issues and new hires in the monthly QAPI Meeting for three months and quarterly for	

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F 725	Continued From page 42 shower. NA #8 shared she has never been asked to make up a shower that did not get completed on day shift. On 3/4/20 at 5:47 PM, an interview with Nurse #5 revealed she had worked with just 1 NA on an evening shift on 2/1/20 but she couldn't remember who the NA she worked with. The NA couldn't get a shower done because the resident required 2-person assistance. Nurse #5 shared it was impossible for the evening shift to pick up extra showers that did not get done on day shift because they had at least five showers to do each evening. On 3/4/20 at 8:33 AM, an interview with the Scheduler revealed the facility currently had 14 open NA positions which consisted of 2 12-hour full-time and 1 part-time position for day shift, 5 full-time positions for evening shift, 2 full-time positions for night shift and 4 prn (as needed) positions. The Scheduler stated the facility was supposed to have at least 2 NA per hall on both day and evening shifts and 1 NA per hall on night shift. The facility has had some challenges with not having enough staff to work due to callouts and unexpected situations affecting the scheduled staff members. The Scheduler stated they tried to call other staff members to come in and called the staffing agency for help. She continued to utilize agency staffing who worked 250-300 hours per week. They had posted their open positions online and on social media, had offered a sign-on bonus for new hires and had advertised in every newspaper. On 3/5/20 at 3:46 PM, an interview with the Director of Nursing (DON) revealed the staffing number depended on the census but the facility	F 725	three quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. The Administrator and DON are responsible for the implementation of the acceptable plan of correction. Date when corrective action will be completed: 4/2/20	

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F 725	Continued From page 43 needed at least 2 NAs per hall. The DON recognized that the staffing was an issue and that it was frustrating because it was hard for them to keep good help. The supervisors tried to call other staff members to come in when there were callouts and they offered a shift bonus for staff members who worked an extra shift. The DON shared the facility relied heavily on agency staffing which currently filled 10 to 11 open NA positions. On 3/5/20 at 4:40 PM, an interview with the Administrator revealed they could not control the callouts, but they covered them as quickly as they could and tried to get other staff members to come in. The Administrator stated they conducted job fares every quarter, shared on social media, advertised on papers, put up signs and offered sign-on bonuses for new hires. They also improved their orientation process to increase new employee retention. The Administrator shared she also went to the local colleges and talked to potential applicants.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		4/2/20

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F 761	Continued From page 44 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of an expired medication stored in 1 of 3 medication carts (300 Hall medication cart). The findings included: During an observation of the 300 Hall medication cart on 03/03/20 at 4:39 PM, the following medication was found in the cart and available for use: Sodium Chloride tablets, 1 gram tablets 100 count with 57 tablets remaining in the bottle with an expired date of 01/2020. An interview with the Nurse #2 on the 300 Hall on 03/03/20 at 4:45 PM revealed the medication was expired and should have been removed from the 300 Hall medication cart. An interview with the Director of Nursing (DON) on 03/05/20 at 4:34 PM revealed the medication should have been removed from the 300 Hall cart	F 761	On 3/5/20 the DON verified that an expired bottle of Sodium Chloride tablets had been left on the 300 hall cart. The DON also verified that the medication should have been pulled from the cart and discarded. The medication was taken off the cart and discarded by the nurse. On 3/6/20 an audit of all medication carts was completed and no other expired medications were found. On 3/25/20 100% education was completed with all nurses that included instruction that all medication carts are to be checked every shift for expired medications. Nurses were also instructed that any expired medications are to be pulled from the cart and sent back to the pharmacy or properly wasted in the facility. The DON/designee will document random medication cart audits to ensure that no expired medications are left on the	

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F 761	Continued From page 45 and sent back to pharmacy. She went on to say, the medication carts were supposed to be checked for expired medications by all the nurses. According to the DON, the pharmacy representative had recently gone through the medication carts twice and had missed the expired medication as well. An interview with the Administrator on 03/05/20 at 5:24 PM revealed she expected expired medications to be removed from the medication carts and returned to the pharmacy.	F 761	medication cart. The audit will consist of four medication carts five times a week for four weeks, three times a week for four weeks and two times a week for four weeks. The DON will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for three months then quarterly for three quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. The DON will be responsible for the implementation of the acceptable plan of correction.	