STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	**417 CLOVERDALE ROAD SYLVA, NC 28779**

(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 000	INITIAL COMMENTS No deficiencies were cite as a result of the complaint investigation Event ID #YIJO11.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the	F 565		8/6/18

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

Electronically Signed | 08/06/2018

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F 565	Continued From page 1 families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes, review of pre-planned menus, interview with the resident council and interview with staff, the facility failed to respond to resident requests reported in two of three resident council meetings. The findings included: Review of resident council meeting minutes noted in the 4/26/18 and 5/22/18 meetings a request by resident council to have sweet potatoes more often. On 07/11/18 at 2:30 PM fifteen residents were present at the resident council meeting (facilitated by survey staff) and reported a request had been made in prior meetings to have sweet potatoes instead of so many white potatoes and that the concern was ongoing. Review of the pre-planned four week menus on 07/13/18 noted white potatoes were served 26 of 56 meals (lunch and supper) and sweet potatoes were served 1 of 56 meals. On 07/13/18 at 10:30 AM the Food Service Director reported he was not aware of the resident council requests to have sweet potatoes more often. The Food Service Director stated he tried to attend resident council meetings when possible to address any food issues but, other than that, did not receive feedback from resident council meetings.	F 565	1. On 07/13/2018 the annual survey was conducted by DHHS. During the survey process resident council meeting minutes the facility failed to respond to resident requests reported in two of three resident council meetings. Residents had requested sweet potatoes instead of so many white potatoes in two of the three resident meetings and the requests were not communicated to the Dietary Manager. The process for notifying a department of any issues/concerns/requests discussed at resident council failed. The Activity Director who is responsible for notifications to departments did not notify the dietary department about the request for more fruits and vegetables and sweet potatoes. A communication tool to notify departments did not exist, relying instead on the daily stand-up meeting to address any issue. This method of communication failed because all managers are not always present for stand-up. 2. A resident council meeting was conducted on 07/19/18. The Activity Director, Dietary Manager and Administrator were present at the meeting. Changes to the menu were discussed with the council. The Administrator explained how we will be more responsive to resident requests. A resident food committee was established with five residents being on the committee. The committee will meet with	

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F 565	Continued From page 2 On 07/13/18 at 2:30 PM the Activity Director stated she became involved with resident council meetings in April of 2018. The Activity Director stated she shared resident council concerns at the morning staff meetings and didn't have a system in place to formally report resident council concerns and receive response from department managers about areas of concern. The Activity Director stated she thought she told the Food Service Director about the residents request for more sweet potatoes after the April and May resident council meetings.	F 565	the Dietary Manager monthly and discuss the four week menu cycle. All requests will be submitted to the registered dietician for review. The registered dietician will approve changes that meet the dietary needs of the residents. The dietary manager will notify the food committee of the results of the requests submitted to the registered dietician for approval. The Activity Director will utilize the resident council issue form to record all issues/concerns/requests identified by the resident council. The form will be given to the appropriate department manager within 1 business day following the resident council meeting. The department manager will have no more than three days to respond with a plan addressing the issue. The Activity Director will discuss the issue/concern/request and the plan for resolving the issue with the administrator within 5 business days of submission of plan. Any issue/concern/request will be documented in the minutes of the resident council. The documentation will reflect the actions taken to resolve any issues/concerns/requests discussed at the previous month's resident council meeting. 3. Minutes of the food committee will be maintained by the dietary manager and report the actions taken to address the food concerns/issues/requests monthly to the QAPI committee. The administrator will attend the food committee at least quarterly to validate that the requests for menu changes are being addressed. The Activity Director will audit at a minimum of 5 residents each week, the	

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F 565	Continued From page 3	F 565	audits will focus on issues/concerns/requests expressed by residents and will present the results of the audits monthly to the QAPI committee. The results of the audits and any recommendations will be presented to the QAPI committee for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The administrator will be responsible for monitoring the minutes of the resident council minutes to make sure the solutions to any concern/issue/request identified at resident council are being addressed and sustained. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		8/6/18

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F 580	Continued From page 4 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to report a significant weight loss to a resident's physician for 1 of 6 residents reviewed for nutrition. (Resident #56) The findings included:	F 580	1. On 07/13/2018 the annual survey was conducted by DHHS. Based on medical record review and staff interviews the facility failed to report significant weight loss to the resident's physician. Resident #56 was admitted on 6/18/18.	

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F 580	Continued From page 5 Resident #56 was admitted to the facility 06/18/18 with diagnoses which included encephalopathy, acute mastoiditis, myocardial infarction, acute respiratory failure with hypoxia, essential hypertension, dysphagia, jaundice, altered mental state, nutritional anemia and hypothyroidism. The admission Minimum Data Set for Resident #56 dated 06/25/18 assessed him with severe cognitive impairment, on a mechanically altered diet (puree texture), height 68" and with no admission weight. The Care Area Assessment associated with the admission MDS for Resident #56 included a review of the following problem areas: Nutrition-Resident is ordered puree diet with nectar thickened liquids due to dysphagia and recent aspiration pneumonia. He requires assistance with meals. He is currently on Speech Therapy caseload. Other diagnoses include chronic encephalopathy, vitamin deficiency, hypothyroidism, respiratory failure, hypertension, anemia and congestive heart failure. Will monitor intake, weight and pertinent labs. Review of the admission care plan dated 06/28/18 for Resident #56 noted the following problem areas and approaches: -Resident at risk for decline in nutrition/hydration related to recent pneumonia, acute renal failure, encephalopathy, impaired cognition, general weakness, dysphagia and no natural teeth. Approaches to this problem included to notify physician of significant weight changes. -Resident at risk for complications of hypertension, congestive heart failure and pneumonia. Approaches to this problem area	F 580	The admission Minimum Data Set assessed resident with severe cognitive impairment, on a mechanically altered diet with admission weight. A review of the admission care plan dated 6/28/18 noted resident was at risk for decline in nutrition/hydration related to resident's illnesses. Approaches to the problem included notifying the physician of significant weight change. Review of the weights recorded in the electronic medical record showed resident #56 weighed 186 pounds. The weight recorded was an error. The weight recorded did not deduct the weight of the wheelchair. 7/05/18 indicated a 35 pound weight loss from the weight recorded on 6/29/18. The weight of the wheelchair is approximately 35 pounds. The dietary manager stated he did not review weights and relied on the Registered Dietician to address any weight concerns. The communication tool used to notify the physician of any concerns regarding residents did not notify the physician of any weight concerns related to Resident #56. The communication tool that is in place to notify a physician of a significant weight change was not followed by the nurse. In addition, the process for significant weight change review was not completed by the C.N.A. and nurse. The weekly IDT/Risk meeting was not held per facility policy and the failure to conduct the meeting resulted in incorrect weights being recorded. 2. Staff education was provided by the	

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F 580	Continued From page 6 included to monitor weight and notify physician of significant weight change. Review of weights recorded in the electronic system for Resident #56 noted the following: 06/29/18-186 pounds 07/05/18-151 pounds 07/12/18-156 pounds Review of physician progress notes revealed the following: 06/21/18-Initial visit by the physician of Resident #56 noted he was admitted after a hospital stay for encephalopathy and debility. The weight for Resident #56 in the physician's progress note was 186 pounds. Subsequent progress notes on 07/09/18 by the physician and 07/10/18 by the nurse practitioner did not address the weight change since admission. On 07/12/18 at 4:00 PM the Food Service Director stated he did not review weights and relied on the consultant Registered Dietitian to address any weight concerns involving residents. On 07/12/18 at 4:05 PM review of the doctors communication book (a book staff used to report any concerns to the physician/nurse practitioner) noted the weight change of Resident #56 was not noted. On 07/12/18 at 4:30 PM (in a phone interview) the Registered Dietitian (RD) reported she usually was at the facility once a week to address weight discrepancies and any clinical nutrition concerns of residents. The RD stated she did all clinical work including review of weights at each visit and, in between visits, staff would call or email if there were any concerns. The RD stated she was	F 580	Director of Nursing and Unit Manager. The initial in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included, resident change, physician notification processes, admission and ongoing weight completion and documentation, and processes for significant weight changes review and notification. A review of all residents was conducted on 8/2/2018 for significant weight loss/gain and addressed during the weekly risk meeting. Any weight that shows a drastic weight loss from the last weight will immediately be reweighed and validated by the nurse and reported to the DON. The Director of Nursing along with the IDT will conduct weekly audits for significant weight loss/gain at the Risk meeting. The process of weekly audits will be ongoing. 3. The Director of Nursing will notify the administrator weekly on the progress of the audits. The DON will report the compliance of weights being completed within the prescribed time frame as established by policy to the QAPI committee monthly for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The administrator will be responsible for monitoring the results of the IDT/Risk meeting to ensure the significant weight changes are being addressed per facility policy. 4. The Administrator will be responsible for insuring the processes, audits and	

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F 580	Continued From page 7	F 580		

currently on vacation and the last time she was at the facility was 06/26/18. When the weight discrepancy of Resident #56 was discussed with the RD she reported she was not aware of it and noted it could be a scale issue and that staff were supposed to reweigh a resident within 24 hours if there was a big discrepancy between weights. The RD stated the nurses typically reported weight variances to the physician and indicated she most likely would have identified the weight variance of Resident #56 on her next visit to the facility.

On 07/13/18 at 11:00 AM the Director of Nursing (DON) stated the interdisciplinary team met weekly on Thursdays to discuss resident concerns including weight variances. The DON stated the team did not meet on 07/05/18 because of staff vacation and did not meet on 07/12/18 because of the survey team in the building. The DON identified Restorative Aide #1 as the staff member in charge of resident weights.

On 07/13/18 at 1:13 PM Restorative Aide #1 stated she obtained monthly weights on residents and entered them in the electronic medical record. Restorative Aide #1 stated when a resident's weight was put in the electronic record she was not able to see the prior weights to know of any discrepancies. Restorative Aide #1 stated the DON reviewed weights and let her know of any residents that needed to be reweighed. Restorative Aide #1 stated she was not aware of any residents that were in need of a reweight.

On 07/13/18 at 2:40 PM Nurse #4 stated she weighed Resident #56 on 07/12/18 because a weekly weight was due. Nurse #4 explained that

action plans are implemented.

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F 580	Continued From page 8 a weekly weight was done for all residents during their first month of admission and it populated in the electronic system when the weight was due. Nurse #4 stated she could not see other weights for Resident #56 unless she reviewed the weight history in the electronic system. Nurse #4 stated she routinely worked with Resident #56 and did not realize there was a significant weight change since admission. On 07/13/18 at 3:00 PM (in a phone interview) the physician of Resident #56 stated he came to the facility every week and depended on staff to report any concerns that needed to be identified with residents. The physician stated he was not aware of the significant weight loss of Resident #56 and expected to be notified if a resident had a significant weight change so he could determine if it was an actual weight loss, if medications needed to be adjusted or a dietary consult was indicated.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		8/6/18

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F 584	Continued From page 9 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to remove soiled linen and clean/santize the mattress of a bed noted to have a strong, foul odor resembling urine for 1 of 1 resident reviewed for a safe/clean/comfortable/homelike environment (Resident #44). Findings Included: Resident #44 was admitted to the facility 04/13/16 with diagnoses which included dementia without	F 584	1. On 07/13/2018 the annual survey was conducted by DHHS. Based on observations, record review and staff interviews the facility failed to remove soiled linen and clean and sanitize the mattress of a bed noted to have a strong urine odor. Resident #44 had an annual care plan dated 3/19/18 described the resident as occasionally incontinent of bowel and bladder and required assistance of staff for toileting tasks. Resident #44 was described as confused	

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F 584	Continued From page 10 behavioral disturbance, Alzheimer's disease, and urinary tract infection. Review of the quarterly Minimum Data Set (MDS) dated 6/14/18 assessed the cognition of Resident #44 to be severely impaired with no behaviors or rejection of care. The MDS also assessed the functional status for activities of daily living and identified limited assistance by 1 person was needed for transfers, dressing, and toilet use. Extensive assistance by 1 person was needed for personal hygiene. The MDS identified Resident #44 was occasionally incontinent of bladder and frequently incontinent of bowel. Review of the Care Area Assessment (CAA) of the annual MDS dated 3/19/18 described Resident #44 being occasionally incontinent of bowel and bladder and required assistance of staff for toileting tasks such as transfers, hygiene, management of clothing, and any incontinence care needed. Resident #44 was described as confused and cannot find her room, bathroom, or complete toileting tasks. Resident #44 had limited mobility and poor cognition related to Alzheimer's inhibiting ability for making daily decisions. Review of Resident #44's care plan last revised 06/20/18 described the resident was usually continent of bowel and bladder with occasional bladder incontinence that required assistance with toileting tasks. The goal was to maintain some continence daily through the next review. The approach was to assist to the toilet routinely and per request. Assist with hygiene and management of clothing as needed, observe for incontinence routinely and as needed, and provide incontinence care routinely and as needed.	F 584	and cannot find her room, bathroom or complete toileting tasks. Resident #44 has limited mobility and poor cognition related to making daily decisions. During the observations resident #44's room had a strong, foul odor resembling urine. The fitted bed sheet had a dinner plate size circle with a strong odor resembling urine. The foul odor was noticeable outside the entrance door into the hallway of resident #44's room. A second observation of resident #44's room the same fitted sheet with the strong odor was still on the bed. C.N.A. assisted resident #44 to the bathroom and provided incontinence care and assisted with changing of wet clothing. The C.N.A. stated she did not observe the bed linen was wet. During an interview on 07/11/18 the DON confirmed resident #44's bed linen was wet and had a strong odor resembling urine. The DON revealed his expectation was for soiled linen to be removed, the mattress be wiped with sanitizer wipes and clean linen placed on the bed. An analysis of the situation revealed that the C.N.A. failed to follow established guidelines. The C.N.A. failed to recognize that the bed was soiled and that the linens needed to be replaced and that the bed needed to be sanitized. 2. Staff education was provided by the Director of Nursing and Unit Manager. C.N.A. received an individual in-service. Initial in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be	

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F 584	Continued From page 11 During an observation on 07/11/18 at 4:46 PM, Resident #44's room has a strong, foul odor resembling urine. The fitted sheet/bed linen had a circle area in the middle of the sheet approximately the size of a large dinner plate with a strong, foul odor resembling urine. The foul odor was noticeable outside the entrance door and into the hallway of Resident #44's room. During a second observation 07/11/18 at 5:51 PM, Resident #44 self-transferred from the wheelchair into the bed. The bed continued to have the same fitted sheet and strong, foul odor as described. During an interview on 07/11/18 at 6:33 PM, NA #4 explained she had assisted Resident #44 to the bathroom and realized the brief and pants were wet. She assisted Resident #44 with incontinence care, dressing, and donned a dry, clean pair pants. NA #4 revealed she helped transfer Resident #44 from the bed to the wheelchair and noted the resident's clothes were wet. She stated she did not observe the bed linen was wet. During an interview on 07/12/18 at 8:34 AM, the Director of Nursing (DON) confirmed Resident #44's bed linen was wet and had a strong, foul odor resembling urine. The DON revealed his expectations was for the soiled bed linen to be removed, the mattress be wiped with sanitizer wipes, and clean linen placed before Resident #44 returned to the bed.	F 584	on-going. In-services included providing care in a safe, clean, comfortable, and homelike environment, specifically ensuring that resident linens are changed when soiled The management team will conduct room round audits daily, Monday thru Friday, and will report finding at the morning meeting. Random weekend room audits will be performed by the Manager on Duty to ensure that residents are being provided a safe, clean, comfortable, and homelike environment. This audit process will be ongoing. 3. The Director of Nursing will notify the administrator weekly on the progress of the audits. The Director of Nursing will report to the QAPI committee monthly the results of the audits for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained.. The DON will report the compliance of incontinence care as established by policies and procedures to the QAPI committee monthly For a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		8/6/18

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F 677	Continued From page 12 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide perineal care for 1 of 2 residents reviewed for incontinence care (Resident #44) and failed to assist 2 of 4 dependent residents (Resident #2, Resident #27) with tray set up and feeding assistance. Findings Included: 1. Resident #44 was admitted to the facility 04/13/16 with diagnoses which included dementia without behavioral disturbance, Alzheimer's disease, and urinary tract infection. Review of the quarterly Minimum Data Set (MDS) dated 6/14/18 assessed the cognition of Resident #44 to be severely impaired with no behaviors or rejection of care. The MDS also assessed the functional status for activities of daily living and identified limited assistance by 1 person was needed for transfers, dressing, and toilet use. Extensive assistance by 1 person was needed for personal hygiene. The MDS identified Resident #44 was occasionally incontinent of bladder and frequently incontinent of bowel. Review of the Care Area Assessment (CAA) of the annual MDS dated 3/19/18 described Resident #44 being occasionally incontinent of bowel and bladder and required assistance of staff for toileting tasks such as transfers, hygiene, management of clothing, and any incontinence	F 677	1. On 07/13/2018 the annual survey was conducted by DHHS. Based on observations record review and staff interviews the facility failed to provide perineal care for 1 of 2 residents. Resident #44 was admitted to the facility on 4/13/16 with a diagnosis which included dementia without behavioral disturbance, Alzheimer's disease and urinary infection. The quarterly minimum Date Set dated 6/14/18 assessed the cognition of resident to be severely impaired with o behaviors or rejection of care. The MDS also assessed the functional status for activities of daily living and identified limited assistance by 1 person was needed for transfers, dressing and toilet use. Extensive assistance by person was needed for personal hygiene. Resident was occasionally incontinent of bladder and frequently incontinent of bowel. Review of the facilities infection control policy for disposable briefs read in part "the equipment/supplies necessary included a skin cleansing preparation." The procedure was to remove the soiled brief, clean the skin of the resident and replace with a fresh brief. During an observation n 7/11/18 C.N.A. #4 assisted resident to the toilet. C.N.A. #4 removed the pants and soiled brief, wiped the perineal area from front to back using dry toilet paper. C.N.A. #4 assisted	

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care needed. Resident #44 was described as confused and cannot find her room, bathroom, or complete toileting tasks. Resident #44 had limited mobility and poor cognition related to Alzheimer's inhibiting ability for making daily decisions.

Review of Resident #44's care plan last revised 06/20/18 described the resident was usually continent of bowel and bladder with occasional bladder incontinence that required assistance with toileting tasks. The goal was to maintain some continence daily through the next review. The approach was to assist to the toilet routinely and per request. Assist with hygiene and management of clothing as needed, observe for incontinence routinely and as needed, and provide incontinence care routinely and as needed.

Review of the facility's infection control policy for disposable briefs read in part the equipment/supplies necessary included a skin cleansing preparation. The procedure was to remove the soiled brief, clean the skin of the resident, and replace with a fresh brief.

During an observation on 07/11/18 at 4:46 PM, Resident #44's room had a strong, foul odor resembling urine. On 07/11/18 at 5:04 PM, NA #4 assisted Resident #44 to the toilet. Resident #44's pants were a darker color at the perineal and buttocks area and appeared to be wet. NA #4 removed the pants and soiled brief, wiped the perineal area from front to back using dry toilet paper. NA #4 assisted Resident #44 with dressing by applying a clean brief and a clean pair of pants.

During an interview on 07/11/18 at 6:33 PM, NA resident with dressing by applying a clean brief and a clean pair of pants. C.N.A. #4 explained she used dry toilet paper to provide perineal care, but usually would use a wet wipe to cleanse the skin following urinary incontinence. C.N.A. #4 revealed she was trying to get through her rounds and didn't retrieve the skin cleansing preparation incontinence product used for perineal care.
An analysis of the event revealed that the C.N.A. did not ask for help when it was noted that she did not have the necessary supplies available to perform perineal care. It also revealed that the C.N.A. did not prepare properly before starting the perineal care, as evidenced by the lack of skin clean cleansing product. In addition, the C.N.A. failed to seek assistance by utilizing the call light system available to her.
2. Staff education was provided by the Director of Nursing and Unit Manager. C.N.A. #4 received an individual in-service. Initial in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included accurately providing ADLs, specifically incontinence care.
A monitoring tool has been put in-place by the Director of Nursing to document observations of incontinence care being provided to the residents. A minimum of 10 observations will be conducted each week for four weeks. CNAs will be monitored by the nurse in charge. The nurses who provided incontinence care

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F 677	Continued From page 14 #4 explained she assisted Resident #44 to the toilet and noticed the resident was wearing a wet brief. NA #4 explained she used dry toilet paper to provide perineal care, but usually would use a wet wipe to cleanse the skin following urinary incontinence. She explained there were no wipes readily available, so she used the dry toilet paper. NA #4 revealed she was trying to get through with her rounds and didn't retrieve the skin cleansing preparation incontinence products used to provide perineal care. During an interview on 07/12/18 at 8:34 AM, the Director of Nursing revealed his expectations for urinary incontinence care was for the staff to cleanse the skin with wet wipes, or soap and water. 2. Resident #27 was admitted to the facility 07/24/15 with diagnoses which included diabetes, congestive heart failure, hypomagnesemia, pneumonia, dysphagia, anemia, ataxia, hypokalemia, altered mental status, jaundice, dementia without behavioral disturbance, dysuria, hypertension, vitamin deficiency, constipation, osteoporosis and sick sinus syndrome. A quarterly Minimum Data Set assessment dated 05/23/18 for Resident #27 noted severe cognitive impairment, supervision of one staff person with meals, a height of 60" and weight 93 pounds. The Care Area Assessment for activities of daily living (ADL) associated with the 03/09/18 significant change assessment read, Resident #27 requires extensive-total assistance with most ADLS due to her dementia and impaired mobility related to femoral fracture. She is more involved at some things than others. She is assisted with transfers, bathing, eating, dressing, bed mobility,	F 677	will be observed by the unit manager or the Director of Nursing. Monitoring will continue to be conducted for at least three months and until the QAPI committee determines that the concern is in compliance. After the first month 5 observations will be conducted randomly each week until the QAPI committee determines that the concern is in compliance. 3. The Director of Nursing will notify the administrator weekly on the progress of the audits. The Director of Nursing will present the results of the audits monthly at the QAPI meeting for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The Director of Nursing will be responsible for monitoring the audits being completed. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	

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hygiene and toileting. Staff provide set up assistance and encourage her to participate with upper extremity dressing and requires more staff assistance at meals. Staff provide level of assist needed to ensure completion of tasks. Expect this resident to continue to vacillate and overall decline in time with advanced age and progression of dementia and chronic conditions, we do not expect her to return to previous baseline.
The Care Area Assessment for nutrition associated with the 03/09/18 significant change assessment read, Resident #27 has a diagnoses of vascular dementia. She requires staff to feed her at meals due to impaired cognition. She consumes 50% or less of most meals despite staff assistance and her weight fluctuates. She was able to feed herself with staff encouragement and occasional hands on assist at baseline. Resident occasionally picks up cups and grabs finger foods but requires staff encouragement and hands on assist. With her diagnosis of dementia it is expected that her weight and ability to complete ADLs and cognition will continue to fluctuate and eventually decline.
The Care Area Assessment for dehydration associated with the 03/09/18 significant change assessment read, Resident #27 has a diagnoses of vascular dementia and recent diagnosis of pneumonia post fall and femoral fracture. She requires staff to feed her at meals due to impaired cognition. She consumes 50% or less of most meals despite staff assistance and weight fluctuates. She was able to feed herself with staff encouragement and occasional hands on assist at baseline. Resident occasionally picks up cups and grabs finger foods but requires staff encouragement and hands on assist. With her diagnosis of dementia it is expected that her

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weight and ability to complete ADLs and cognition will continue to fluctuate and eventually decline.

Review of the care plan and approaches for Resident #27 noted the following:
-A problem area dated 05/24/18 noted Resident #27 is at risk for adverse consequences related to receiving antidepressant medication for treatment of weight loss and poor appetite.
-A problem area dated 05/24/18 noted Resident #27 needs assistance with activities of daily living due to a diagnosis of dementia.
Approaches to this problem area included staff must initiate and complete activity of daily living tasks such as bed mobility, transfers, hygiene , bathing, dressing and locomotion as well as encourage to participate with activities of daily living, offering cues, task segmentation and provide extensive to dependent assistance to complete tasks.
-A problem area dated 05/24/18 noted Resident #27's weight fluctuates with a history of significant weight loss and significant weight gain and is at risk for further weight loss.
Approaches to this problem area included staff to encourage consumption of meals, snacks and fluids and assist as needed with meals if resident does not feed herself.

On 07/09/18 from 11:57 AM-1:35 PM observations were made of Resident #27 in the main dining room. Resident #27 was observed seated in the main dining room, at a table, with three other resident.s The tray card of Resident #27 indicated she ate in "restorative dining." Included with the meal served to Resident #27 was a 1/2 pint upright plastic cylinder shaped container of milk. This container had a plastic lid with a pull tab around the base of the lid to open.

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The milk was taken off the serving tray by staff and placed, unopened, in front of Resident #27. From 11:57 AM until approximately 1:15 PM Resident #27 sat staring at her meal and only ate a few bites of a roll. Staff did not speak to Resident #27 and did not assist her with the meal. At approximately 1:15 PM Resident #27 propelled herself to another table and picked up a cup (which contained a milkshake and belonged to another resident) and began to drink. The resident at the table began to yell and staff intervened and removed the cup from Resident #27. Resident #27 stayed in the dining room for another 10 minutes and staff assisted her past her untouched food and drink and out of the dininng room at approximately 1:25 PM. Nursing Assistants #2 and #7 were present in the dining room and stated there were typically more staff present to assist with meals but, since they were the only two for the lunch meal they were not able to assist all residents.

On 07/13/18 at 1:48 PM the Occupational Therapist that worked with Resident #27 stated Resident #27 required assistance with meals which included set up help with items opened up and liquids put in a cup because of lack of processing abilities.

3. Resident #2 was admitted to the facility 08/01/15 with diagnoses which included dementia without behavioral disturbance, rheumatoid arthritis, osteoarthritis, weakness, dysphagia, macular degeneration, chronic obstructive pulmonary disease, moderate protein-calorie malnutrition, abnormal weight loss and iron deficiency anemia.

The annual Minimum Data Set for Resident #2

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dated 06/28/18 assessed her with severe cognitive impairment and requiring supervision of one staff with eating.

The Care Area Assessments associated with the annual Minimum Data Set included the following areas of review for Resident #2:
Cognition-Resident #2 has a diagnoses of dementia. She is alert and verbal and can make simple decisions, but not with complex issues. Her cognition varies and she is better at some times, more confused at other times. Staff anticipate needs not expressed.
Visual-Resident #2 has a diagnosis of macular degeneration and a history of bilateral iridectomy with artificial lens implants. She has dry eyes and complains of blurriness at times. She has difficulty with small print but can see large print and appears to track with eyes.
Nutrition-Resident #2 has an established diagnosis of Alzheimer's disease. Functioning has been slowly declining. She does not have behavior issues. She has dementia, rheumatoid arthritis and osteoarthritis. She is deemed underweight for age and has a history of weight loss and variable appetite. Her weight is stable at this time. She receives a regular diet as well as milkshakes. She feeds herself after set up and her appetite is variable. She usually prefers to consume liquids and supplements on her meal trays. Expect poor intake and weight loss in time with progression of the disease process/dementia and advanced age.

The care plan for Resident #2 last updated 04/05/18 included the following problem areas and approaches:
-Resident #2 is at risk for poor nutrition and significant weight loss due to variable po intake

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and low ideal body weight.
Approaches to this problem area included staff to encourage consumption of meals and fluids and assist as needed with meal intake.
-Needs assist with activities of daily living due to diagnosis of dementia.
Approaches to this problem area included to encourage resident to do as possible for herself, such as self feeding. Assist with what resident cannot and provide level of care needed to complete simple tasks.

On 07/12/18 at 5:25 PM Resident #2 was observed in the main dining room, seated at a table for the supper meal. Included with the meal served to Resident #2 was a 1/2 pint upright 5 1/2" plastic cylinder shaped container of milk with a 1" opening. The milk was taken off the serving tray by staff and placed in front of Resident #2. In addition, a 4 ounce open carton of milkshake was on the table, in front of Resident #2. There were no straws or cups available for use for Resident #2. Resident #2 was observed attempting to hold the upright plastic cylinder container of milk between the palms of both hands and position it upright to drink the milk. Resident #2 used both palms to also pick up the carton of milkshake and position it upright to drink the milkshake. The Administrator was present in the room at the time of the observation and was asked about the milk and milkshake being served without a cup or straw to make consumption of the product easier for Resident #2. The Administrator noted the difficulty Resident #2 had with drinking the milk and milkshake and requested staff bring two cups. Nursing Assistant #8 poured the milk and milkshake into cups for Resident #2 and Resident #2 was able to drink the liquids without difficulty.

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F 677	Continued From page 20 Nursing Assistant #8 stated she had worked at the facility for eight months and had never been told to provide a straw or cup at meals for residents served the carton milkshake or cylinder shaped container of milk. On 07/13/18 at 10:30 AM the Food Service Director stated the plastic upright milk containers had been used since he came into the position January 2018. The Food Service Director stated he never thought about how difficult it might be for some residents to open or pick up the milk containers or that a cup or straw might make drinking the milk easier for some residents. On 7/13/18 at 1:40 PM the Occupational Therapist that treated Resident #2 stated Resident #2 had severe shoulder contractures, cognitive issues and pain in both hands due to arthritis which limited her ability to use her hands. Because of the limitations, the Occupation Therapist stated Resident #2 would benefit from liquids being poured into a cup for ease of drinking.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		8/6/18

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F 684	Continued From page 21 Based on medical record review and staff interviews the facility failed to ensure 2 of 3 weekly skin assessments for a newly admitted resident were done for 1 of 3 residents reviewed for non pressure skin issues. (Resident #56) The findings included: Resident #56 was admitted to the facility 06/18/18 with diagnoses which included encephalopathy, acute mastoiditis, myocardial infarction, acute respiratory failure with hypoxia, essential hypertension, dysphagia, jaundice, altered mental state, nutritional anemia and hypothyroidism. The admission Minimum Data Set for Resident #56 dated 06/25/18 assessed him with severe cognitive impairment. The admission care plan for Resident #56 dated 06/28/18 included the following problem area and approaches: -Resident is at risk for pressure ulcer due to incontinence of bowel and bladder, needs for significant assistance with activities of daily living, poor nutrition, impaired communication. Approaches to this problem area included to conduct a systematic skin inspection weekly and to pay particular attention to the bony prominences. Nurses notes in the medical record of Resident #56 included the following: 06/23/2018 6:33 PM -Bilateral lower extremities noted to have open areas of what appears to be blisters that have opened and drained. Adaptic applied to open areas and covered with 4x4 border gauze. 06/24/2018 5:40 PM-Has removed dressings	F 684	1. On 07/13/2018 the annual survey was conducted by DHHS. Based on medical record review and staff interviews the facility failed to ensure 2 of 3 weekly skin assessments for a newly admitted resident were done for 1 of 3 residents reviewed for non-pressure skin issues. Resident #56 was admitted to the facility on 06/18/18 with diagnosis which included encephalopathy, acute mastoiditis, myocardial infarction, acute respiratory failure with hypoxia, essential hypertension, dysphagia, jaundice, altered mental state, nutritional anemia and hypothyroidism. The MDS for resident assessment them with severe cognitive impairment. The admission care plan dated 06/28/18 noted the following problem area and approaches: Resident is at risk for pressure ulcer due to incontinence of bowel and bladder, needs for significant assistance with activities of daily living, poor nutrition, and impaired communication. Approaches to this problem area included to conduct a systematic skin inspection weekly and to pay particular attention to the bony prominences. Review of the TAR and physician orders on 07/12/18 noted the only treatment since admission included barrier cream to peri-area with each incontinent episode and as needed. 06/16/18 – 07/03/18 skin prep to bilateral heels for 14 days. On 07/13/18 Nurse #6 reported she must have signed the TAR on 07/02/18 and forgot to do the body audit. Nurse #6 reported she assessed the resident and the skin was intact because scabs on	

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F 684	Continued From page 22 from bilateral lower extremities on 3 different occasions. Wounds remain unchanged with multiple mishaped lesions that weep at times. 06/28/2018 5:05 PM -Noted area of reddened skin on the inner aspect of right thigh that appears to be moisture related accompained by an area approximately the size of a quater that has penterated the epidermis and is noted to be oozing blood at times. 07/01/2018 4:57 PM-States his legs itch. Bilateral lower extremity excoriation from scratching. No signs/symptoms of infection. Cleansed with normal saline. Review of the Treatment Administration Record (TAR) and physician orders on 07/12/18 noted the only treatments for Resident #56 since admission included: 06/28/18-ongoing Barrier cream to peri-area with each incontinent episode and as needed 06/19/18-07/03/18 Skin Prep tp bilateral heels for 14 days. Review of the June 2018 and July 2018 Treatment Administration Record noted weekly skin audits were scheduled due for Resident #56 on 06/25/18, 07/02/18 and 07/09/18. The 06/25/18 skin audit was signed as done by Nurse #5 though a corresponding assessment was not located in the medical record of Resident #56. The 07/02/18 and 07/09/18 skin audits were signed as done by Nurse #6. A skin assessment for 07/02/18 was not located in the medical record of Resident #56. The 07/09/18 skin audit indicated Resident #56 had normal skin turgor and no alterations in skin. On 07/11/18 at 8:15 AM the Minimum Data Set nurse stated that weekly skin audits were located	F 684	resident's legs were intact. On 07/13/18 physician stated (in a phone interview) he expected weekly skin audits to be done and relied on them to know about any issues involving residents. The analysis completed for this issue revealed that the nurses responsible for the treatments failed to read the plan of care dated 06/28/2018 and to follow the prescribed plan of action related to wound care. In addition nurse #6 failed to record the body audit as required by facility policy and improperly assessed the skin as being intact, when it was not. 2. Staff education was provided by the Director of Nursing and Unit Manager. Nurse #6 received an individual in-service. In-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included accurately and completely documenting skin assessments upon admission and weekly A monitoring tool has been put in-place by the Director of Nursing/Unit Manager to document compliance of conducting and accurately documenting skin assessments. A minimum of 10 observations will be conducted each week for a minimum of four weeks and until the QAPI committee determines the concern is in compliance. Staff will be monitored by the Director of Nursing/Unit Manager. After the first month 5 observations will be conducted randomly each week for a minimum of two months and until the QAPI committee determines the concern is in compliance.	

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F 684	Continued From page 23 in the electronic record under "observation" and the due date for the weekly skin assessment was located in the resident's Treatment Administration Record. On 07/12/18 at 8:00 AM Resident #56 was observed in the hallway, with gauze dressing covering his left lower leg. On 07/12/18 at 12:00 PM Nurse #4 stated she regularly worked with Resident #56 and, on admission, Resident #56 was covered with a rash which they thought was due to an allergic reaction to medication. Nurse #4 stated the rash cleared everywhere but the resident's lower extremities. Nurse #4 stated when she came on duty the morning of 07/12/18, Resident #56 had picked the scabs on his legs and she covered them with a gauze dressing. On 07/12/18 at 3:00 PM Resident #56 was observed during a treatment to his left leg. The gauze wrap covering his left lower extremity was removed by Nurse #4 and an approximate 6" area on the medial aspect of the left inner shin was noted to have multiple open, bloody wounds. Nurse #4 stated Resident #56 had ongoing issues with a rash on his lower extremities since admission. Nurse #4 stated the rash would scab and they tried to keep Resident #56 from scratching and re-opening the scabs. On 07/13/18 at 2:22 PM Nurse #6 reported she must have signed the TAR for Resident #56 on 07/02/18 and forgot to do the body audit. Nurse #6 stated she assessed the skin of Resident #56 on 07/09/18 and assessed his skin as intact because the scabs on his legs were intact.	F 684	3. The Director of Nursing will notify the administrator weekly on the progress of the audits. The Director of Nursing will present the results of the audits monthly at the QAPI meeting for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The Director of Nursing will be responsible for monitoring the audits being completed. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	

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F 684	Continued From page 24 On 07/13/18 at 3:00 PM (in a phone interview) the physician of Resident #56 stated he expected weekly skin audits to be done and relied on them to know about any issues involving residents. On 07/13/18 at 4:30 PM the Director of Nursing stated he expected skin audits to be done as ordered and included in the resident's electronic medical record. On 07/13/18 at 4:45 PM Nurse #5 stated (via phone interview) that she couldn't recall the circumstances of the body audit for Resident #56 on 06/25/18 or recall if she documented her findings. Nurse #3 looked through the medical record of Resident #56 and was unable to locate the 06/25/18 body audit (completed by Nurse #5) for Resident #56.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to secure smoking materials for 1 of 2 independent smoking residents (Resident #33) and monitor 1 of 4 supervised smoking residents (Resident #34) to ensure that she did not have smoking materials secured from another resident.	F 689	1. Based on observations, record review and staff and resident interviews , the facility failed to secure smoking materials for 1 of 2 independent smoking residents and monitor 1of 4 supervised residents to ensure that resident did not have smoking materials secured from another resident.	8/6/18

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F 689	Continued From page 25 The findings included: A review of the smoking policy and procedure revealed that smokers were assessed and designated as either independent or supervised smokers. All independent smokers were defined as using all smoking materials safely and responsibly, stating smoking rules and appropriate smoking places, observed all smoking rules and adhered to policy, may not carry smoking materials or lighters, smoking materials were labeled with the resident's name and locked in the medication room or nurses station and had not required supervision for smoking. Restrictions of privileges occurred with failure of the resident to comply with smoking rules, one of which was to not share smoking materials with other residents, resulting in removal of smoking privileges. Supervised smokers were defined as demonstrating unsafe behaviors in using smoking or lighting materials, unable to state smoking rules, may not carry smoking materials or lighters and smoking materials were labeled with the resident's name and locked in the medication room at the nurses' station, needing assistance with smoking and could only smoke during designated times during the day. Residents agreed to abide by the smoking rules upon admission and signed a smoking contract whether they were independent or supervised. 1. Resident #33 was admitted on 02/21/18 with diagnoses which included history of malignant neoplasm of the rectum, dysphagia, weakness and major depressive disorder. A review of the Smoking Policy, evaluation, and	F 689	Resident #33 was admitted on 02/21/16 with diagnoses which included history of malignant neoplasm of the rectum, dysphagia, weakness and major depressive disorder. An observation on 07/09/18 revealed resident #33 coming out of his room in his wheelchair with cigarettes and a lighter sitting in his lap. An interview with resident revealed he kept his cigarettes and lighter in his room. An observation on 07/11/18 revealed resident #33 rolling out of his room in his wheelchair going out to smoke with cigarettes and lighter in his hand. On observation on 07/13/18 revealed resident #33 rolled in from the outside, then rolled past the AD office and down the hallway past the nurses' station and into his room, partially closed the door and was observed transferring himself into the bed. An interview on 07/13/18 revealed resident #33 was aware of the smoking policy and had signed a contract indicating he understood the policy and would comply with the policy. Resident #33 stated he would try to be more careful and not give out cigarettes and try to remember to turn in his smoking materials to the nurse. Resident #34 admitted to the facility on 09/08/16 with diagnoses which included cerebral infarction, Parkinson's disease, muscle weakness, hemiplegia, impulsiveness and chronic pain. An observation on 07/11/18 revealed resident #34 was observed reaching into her purse and taking out a cigarette and lighter. She gave the smoking materials to resident #33 who rolled away with the	

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contract dated 11/02/16 revealed the facility had assessed Resident #33 as a safe smoker and he was allowed to smoke independently.

A review of the most recent quarterly Minimum Data Set (MDS) dated 05/28/18 revealed Resident #33 was cognitively intact and required supervision and set up with most activities of daily living (ADL). The MDS also revealed the resident was able to use his wheelchair independently for ambulation.

An observation on 07/09/18 at 2:38 PM revealed Resident #33 coming out of his room in his wheelchair with cigarettes and a dark green lighter sitting in his lap. An interview with the resident revealed he kept his cigarettes and lighter in his room. Resident #33 stated he kept them separated in his room so another resident could not come in his room and find both of them.

An observation on 07/11/18 at 1:43 PM revealed Resident #33 rolling out of his room in his wheelchair going out to smoke with cigarettes and a lighter in his hand.

An interview was conducted on 07/11/18 at 3:17 PM with Nurse Aide (NA) #1 who worked on the hall where Resident #33 lived. NA #1 stated the independent smokers could go out anytime and get their smoking materials from the Activities Director or the Activities Assistant. NA #1 stated if it was after 5:00 PM the smoker's box was locked up in the medication room and the independent smokers could get their materials from the nurses.

An interview on 07/11/18 at 3:54 PM with the Activities Director (AD) revealed the residents' smoking materials.
An interview with the DON revealed it was his expectation for all smokers to abide by the smoking policies and procedures. He stated it was also his expectation for the nurse to monitor the independent smokers and assure they turn in their smoking materials to be secured and locked up.
The systemic failure was due to not monitoring the return of smoking materials. Two different departments had parts of the process to insure residents comply with the smoking policy. Nursing and Activities both assumed the other department was responsible for monitoring smoking compliance. In addition, both departments have acknowledged that the residents involved did not return smoking materials and staff failed to ensure the return of smoking materials.
2. Staff and resident education was provided by the Director of Nursing /Unit Manager/Activities Director/Administrator. The initial staff in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included smoking safety and smoking policy and procedures.
A monitoring tool has been put in-place by the Director of Nursing/Unit Manager to document and monitor resident compliance with the smoking policy and procedure. A minimum of 5 audits will be conducted each week for a minimum of four weeks. Staff will be monitored by the

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F 689	Continued From page 27 materials were marked with their name and kept in a box and locked in the activities' office or after hours locked in the medication room. She stated each person's cigarettes were marked with their name on them and the facility provided the lighters. If the resident's family brought cigarettes in they were locked up in the medication room until we could mark their name on them. The AD stated they were not having any problems with any of the smokers and frequently go over the rules with them. An interview on 07/11/18 at 4:21 PM with Nurse #1 revealed he was aware the smokers' materials had to be monitored. Nurse #1 stated the guys came to the nurses after the AD and her assistant were gone for the day to get their cigarettes and lighter and stated they relinquished them after they were done smoking. Nurse #1 stated they had not had any incidents with the smokers since he had worked at the facility. An interview on 07/12/18 at 9:26 AM with the Director of Nursing (DON) revealed his expectation was for the nurses to monitor the smokers and make sure the cigarettes and lighter were returned and locked up. An interview on 07/13/18 at 10:23 AM with the DON and Unit Manager revealed they had not yet checked Resident #33's room for cigarettes and a lighter. The Unit Manager stated she was not aware she needed to check his room for cigarettes and a lighter. An observation on 07/13/18 at 10:23 AM revealed Resident #33 out in the gazebo smoking with staff members that were out smoking.	F 689	Director of Nursing/Unit Manager and/or designee. Monitoring will continue to be conducted for three months. After the first month 3 observations will be conducted randomly each week for at least two months and until the QAPI committee determines that the issue is in compliance. 3. The Director of Nursing will notify the administrator weekly on the progress of the audits. The Director of Nursing will present the results of the audits monthly at the QAPI meeting for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The Activity Director will be responsible for monitoring the audits being completed. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	

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An observation on 07/13/18 at 11:32 AM revealed Resident #33 rolled in from outside with the staff member. During continuous observation he rolled past the AD office and down the hallway past the nurse's station and into his room, partially closed the door and was observed transferring himself into the bed.

An interview on 07/13/18 at 11:32 AM with the AD revealed she was not aware Resident #33 had been out to smoke and stated they had not given him cigarettes or a lighter to go out and had not known that he had been out already. The AD stated he must have kept his cigarettes after he went out last evening. She stated he had gone out before late at night and he must not have turned his cigarettes and lighter to the nurse when he came back in last evening. The AD and assistant stated they felt Resident #33 was a safe smoker and followed the procedures out in the gazebo when he went out and smoked. The AD stated the department heads had done rounds and when they do them, they are looking at everything in the room and making sure the resident had what they need, within reach and looked in their closets to make sure they could reach everything. She stated they also checked oxygen, call lights and room lights but they had not looked at personal items in their drawers. The AD stated it was hard for them to monitor the independent smokers to make sure their cigarettes and lighter were returned.

An interview on 07/13/18 at 11:50 AM with NA #2 revealed she had worked at the facility for a short time but was out in the gazebo when Resident #33 was out smoking earlier. She stated he was already out there when she went out for a short break. NA #2 stated the resident told her he

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would go in with her when she got ready to go back in and stated she opened the door for him to come back in the facility. NA #2 stated the residents were not supposed to have cigarettes and lighter in their rooms and was not sure if any of the residents kept either in their rooms.

An interview on 07/13/18 at 3:05 PM with Resident #33 revealed he was aware he had signed a smoking contract and he was not supposed to share smoking materials. The resident stated if someone needed a cigarette he would always help them out by giving them one and stated they would be foolish not to smoke it. Resident #33 stated he didn't care who asked, if they wanted a cigarette he was going to give them one. He stated he would try to be more careful and not give out cigarettes and would try to remember to turn his in to the nurse.

An interview on 07/13/18 at 3:42 PM with the DON revealed the Unit Manager had not seen a pack of cigarettes or lighter in Resident #33's room but had not looked through his drawers or his personal things. The DON stated his expectation was for the independent smokers to return their smoking materials to the nurses to be locked up. The DON stated he expected the nurses to monitor the smokers so they would know where the residents were when they were off the unit.

An interview on 07/13/18 at 4:42 PM with Nurse #2 revealed she had worked the night before from 7:00 PM to 7:00 AM. She stated the independent smokers went out and required assistance getting back in the building and ring the bell for someone to let them in. Nurse #2 stated one of the residents always turned his

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cigarettes and lighter back in to be locked up but Resident #33 had not always turned his in to her. She stated she honestly had not asked Resident #33 for his cigarettes and lighter last evening and he probably kept them after coming in from smoking.

2. Resident #34 was admitted to the facility on 09/08/16 with diagnoses which included cerebral infarction, Parkinson's disease, muscle weakness, hemiplegia, impulsiveness and chronic pain.

A review of the Smoking Policy, evaluation and contract dated 11/02/16 revealed the facility had assessed Resident #34 as a supervised smoker and was only allowed to smoke at designated times with assistance from facility staff. The assessment stated Resident #34 required supervision due to falling asleep with cigarette held close to her face, flicked ashes on the ground instead of ash trays, and veered from the sidewalk on her way to the gazebo and could not get her wheelchair back on the sidewalk.

An observation on 07/11/18 at 11:59 AM revealed Resident #34 at the end of the hall with Resident #33, talking and Resident #34 was observed reaching in her zippered purse in her wheelchair taking out a cigarette and lighter and giving them to Resident #33. Resident #33 was observed trying to give the cigarette and lighter back to Resident #34 and she stated to him "no, you take it because I have not had a chance to go out to smoke it." Resident #33 rolled away with the cigarette and lighter in his hand.

An observation on 07/11/18 at 1:03 PM revealed

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the resident was out smoking at the gazebo with facility staff assistance. Resident #34 placed her smoking apron on with assistance from the Activities Assistant (AA). The resident was given her cigarette and it was lighted for her. She and 2 other supervised smokers were out to smoke. Resident #34 was observed laying her head back with her hand holding the cigarette close to her hair and flicked her ashes on the ground instead of in the ash trays. The staff member encouraged the resident to put her ashes in the ash trays instead of flicking them on the concrete.

An interview on 07/12/18 at 3:01 PM with Resident #34 revealed she had lived at the facility for 5 years and was admitted after suffering a stroke. She stated she knew she shouldn't but still smoked. Resident #34 stated she had to be supervised and could only go out to smoke at 9:30 AM, 1:00 PM and 4:30 PM. She stated the cigarettes and lighters are kept in a box with everybody's name on theirs and they are locked up in the Activities office or the medication room. Resident #34 stated she had a cigarette and lighter that Resident #33 had given her but she had not had the chance to go out and smoke it so she gave it back to him because it was his. Resident #34 stated she knew she was not supposed to take smoking materials from another resident and she had given it back to Resident #33 because it was his. She also stated they helped each other out if one was out of cigarettes another resident would offer them one of theirs. Resident #34 stated the smokers were willing to help each other with cigarettes. Resident #34 stated she did not think Resident #33 knew he was not supposed to give her cigarettes and a lighter.

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F 689	Continued From page 32 An interview on 07/12/18 at 3:33 PM with Nurse #3 revealed she was not aware that Resident #34 had cigarettes and a lighter in her purse. She stated the supervised smokers were supposed to have their cigarettes and lighter locked up in the AD's office and after she is gone in the medication room at the nurse's station. Nurse #3 stated none of the supervised smokers should have smoking materials on their person. An interview on 07/13/18 at 3:05 PM with Resident #33 revealed he was aware he had signed a smoking contract and he was not supposed to share smoking materials. The resident stated if someone needed a cigarette he would always help them out by giving them one and stated they would be foolish not to smoke it. Resident #33 stated he didn't care who asked, if they wanted a cigarette he was going to give them one. Resident #33 stated he had given Resident #34 a cigarette and lighter and knew that he was not supposed to but she had given it back and had not smoked it. He stated he would try to be more careful and not give out cigarettes and would try to remember to turn his in to the nurse. An interview on 07/13/18 at 3:45 PM with the DON revealed it was his expectation for all smokers to abide by the smoking policies and procedures. He stated it was also his expectation for the nurses to monitor the independents smokers and assure they turn in their smoking materials to be secured and locked up.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		8/6/18

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F 690	Continued From page 33 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide catheter care by positioning the catheter bag and tubing in such a way they were directly touching the floor	F 690	1. On 07/13/2018 the annual survey was conducted by DHHS. Based on observations, record review and staff interviews the facility failed to provide	

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F 690	Continued From page 34 for 2 of 2 residents reviewed for bowel/bladder incontinence, catheter, and urinary tract infection (Resident #259, Resident #9). Findings Included: 1.Resident #259 was admitted to the facility 08/17/17 and readmitted 05/10/18 after an unplanned discharge to the hospital. Diagnoses included dementia without behavioral disturbance, enlarged prostate gland with lower urinary tract symptoms, and cystitis. Review of the discharge Minimum Data Set (MDS) dated 05/15/18 assessed Resident #259 to be independent with daily decision making. The MDS included the functional status of activities of daily living and assessed Resident #259 needed extensive assistance by 1 person for bed mobility, dressing, and personal hygiene. Limited assistance by 1 person for toilet use and extensive assistance by 2 persons for transfers. Bowel and bladder assessed an indwelling catheter with urine not rated and always incontinent of bowel. Review of the care plan dated 05/14/18 identified the problem of an indwelling catheter with the goal to not experience complications with catheter. The interventions included catheter care as necessary, ensure drainage bag does not touch floor, and remains below the level of resident's bladder. During an observation on 07/10/18 at 11:14 AM, Resident #259 was in the therapy room with a catheter bag attached below the seat of a wheelchair. The catheter bag and tubing were directly touching the floor. Resident #259 was	F 690	catheter care by positioning the catheter bag and tubing in such a way they were directly touching the floor for 2 of 2 residents reviewed for bowel and bladder incontinence, catheter and urinary infection. During an observation on 07/10/18 resident #259 was in the therapy room with a catheter bag attached below the seat of the wheelchair. Catheter bag and tubing were directly touching the floor. Resident #259 was assisted by the COTA from therapy to room. Resident #259 was left in the resident's room with the catheter bag and tubing in the same position directly touching the floor. During a second observation the resident was resting in bed and the catheter bag and tubing were directly touching a fall mat. During a third observation on 07/12/18 resident #259 was self-propelling while being encouraged by the COTA. The catheter bag and tubing were directly touching the carpeted floor During an interview with COTA he stated it was not a good practice to allow the catheter bag and tubing to touch the floor. During an interview with the DON he explained the expectation was for the catheter bag and tubing to be off the floor at all times. An observation and interview with resident #9 on 07/10/18 revealed she was in bed resting with the catheter bag sitting with the bottom of bag touching the floor. After an observation of wound care for resident #9 revealed two C.N.A.s left the room with the bottom of the catheter bag	

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F 690	Continued From page 35 assisted with mobility and propelled by a Certified Occupational Assistant (COTA) from the therapy room, down the hallway, to the resident's room. Resident #259 was left in the room with the catheter bag and tubing in the same position directly touching the floor and attached underneath the seat of the wheelchair. During a second observation on 07/11/18 at 6:46 AM, Resident #259 was resting in a bed that was positioned low to the floor. The catheter bag and tubing were directly touching a fall mat placed on the floor beside the bed. During a third observation on 07/12/18 at 11:26 AM, while working with therapy Resident #259 was self-propelling up and down the hallway and receiving encouragement from a COTA. The catheter bag and tubing were directly touching the carpeted floor. The catheter bag was attached under the wheelchair seat. During an interview on 07/12/18 at 11:33 AM, the COTA explained he didn't notice the catheter bag and tubing touching the floor. He explained it wasn't good practice to allow the catheter bag and tubing to touch the floor, it could create a hole in the bag, and wasn't best practice in preventing infection. He repositioned the catheter bag and tubing so they were no longer touching the floor. During an interview on 07/12/18 at 9:37 AM, the Director of Nursing explained he expectations was for the catheter bag and tubing to be off the floor at all times from an infection control perspective. 2. Resident #9 was admitted to the facility on	F 690	touching the floor. An observation on 07/11/18 with C.N.A. #1 revealed she had not noticed the catheter bag had been resting on the floor. An interview with the DON revealed the expectation was for all urinary draining bags to be off the floor at all times. An analysis of the events revealed a systemic failure by nursing and therapy staff. The catheter bag should never be placed where it is allowed to touch the floor or a fall mat. Both departments failed to identify this as an infection control concern. 2. Staff education was provided by the Director of Nursing /Unit Manager. The initial staff in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included caring for residents with catheters in a manner that aide in the prevention of urinary tract infections. A monitoring tool has been put in-place by the Director of Nursing/Unit Manager to document and monitor compliance with catheter care in a way that prevents urinary tract infections. A minimum of 5 audits will be conducted each week for four weeks. Staff will be monitored by the Director of Nursing/Unit Manager. Monitoring will continue to be conducted for three months. After the first month 3 observations will be conducted randomly each week for two months. 3. The Director of Nursing will notify the	

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F 690	Continued From page 36 11/23/09 with diagnoses which included multiple sclerosis (MS), muscle weakness, contractures of the right and left hip, and neuromuscular dysfunction of the bladder. A review of Resident #9's most recent annual Minimum Data Set (MDS) dated 04/23/18 revealed she was moderately impaired for daily decision making and required extensive to total assistance with most activities of daily living (ADL) except eating which she required only setup and supervision. The MDS also revealed she was always incontinent of bowel and had an indwelling urinary catheter. A review of Resident #9's most recent annual Care Area Assessment (CAA) summary dated 05/02/18 revealed the resident had a catheter due to her diagnosis of neurogenic bladder, and her recurrent urinary tract infections (UTIs) both resulting from the progression of her MS. Resident #9 was incontinent of bowel and was dependent on staff for all aspects of incontinence and catheter care. A review of Resident #9's care plan dated 05/02/18 revealed she was care planned for an indwelling urinary catheter due to her neurogenic bladder, MS, bowel incontinence and recurrent rash to her buttocks. The goal was that Resident #9 would be a clean and dry as possible daily through the next review. The interventions included: 1. Dignity bag for the catheter drainage bad, 2. Perform routine catheter care, 3. Monitor for signs and symptoms of urinary infection, such as cloudy, foul or bloody urine, elevation in temperature, abdominal distention and update medical doctor (MD), 4. Change catheter per orders, .	F 690	administrator weekly on the progress of the audits. The Director of Nursing will present the results of the audits monthly at the QAPI meeting for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The Director of Nursing will be responsible for monitoring the audits being completed to ensure that catheter bag placement is being completed properly. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	

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F 690	Continued From page 37	F 690		

An observation and interview with Resident #9 on 07/10/18 at 9:59 AM revealed she was in bed with night clothes on, pleasant and smiling and answering questions appropriately. The resident stated she had had her urinary catheter for some time due to her progression of her disease and that it did not really bother her or cause her any discomfort. She described it as a necessary evil. The catheter bag had a leaf cover for privacy and was below the level of her bladder and the bag was positioned on the right side of her bed, sitting with the bottom of it touching and resting on the floor.

After an observation of wound care on 07/11/18 at 2:54 PM, Nurse Aide (NA) #1 and NA #2 repositioned the resident in the bed and stated they had already provided catheter care and NA #1 stated the catheter bag did not need to be emptied yet and when both NAs left the room the catheter bag was on the right side of the resident's bed and the bottom of the bag was resting on the floor.

An observation and interview with Resident #9 on 07/11/18 at 5:37 PM revealed she was resting in bed, dressed neatly with her hair combed and her covers pulled up over her. The resident stated she had eaten her dinner and that it was good. She stated she had plenty to drink and there were beverages on her bedside table. Her bed was up in a high position and her urinary catheter bag was on the right side of her bed, sitting with the bottom of the bag touching and resting on the floor.

An interview on 07/11/18 at 5:55 PM with NA #1 revealed she had not noticed the urinary catheter

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F 690	Continued From page 38 bag had been resting on the floor when she left Resident #9's room. NA #1 stated the catheter bag was supposed to remain below the level of the bladder and was not supposed to be in contact with the floor. An interview on 07/12/18 at 9:37 AM with the Director of Nursing (DON) revealed his expectation was for all urinary drainang bags to be off the floor at all times from an infection control perspective.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		8/6/18

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F 758	Continued From page 39 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to provide a 14 day stop date for a psychotropic medication ordered as needed for 1 of 2 residents reviewed for psychotropic medications (Resident #22). The findings included: Resident #22 was admitted to the facility 08/29/17 with diagnoses which included unspecified psychosis with hallucinations and delusions, unspecified dementia with behavioral disturbance and anxiety disorder. A quarterly Minimum Data Set (MDS) dated	F 758	1. Based on record review and staff and physician interviews the facility failed to provide a 14 day stop date for a psychotropic medication ordered as needed for 1 of 2 residents reviewed for psychotropic medications. Resident #22 was admitted to the facility 08/29/17 with diagnoses which included unspecified psychosis with hallucinations and delusions, unspecified dementia with behavioral disturbances and anxiety disorder. A review of resident #22's medical record revealed physician's order initiated by the facilities medical director and dated	

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F 758	Continued From page 40 05/18/18 indicated the resident's cognition was highly impaired. The MDS described Resident #22 with inattention and disorganized thinking that was continuously present and required extensive staff assist with all activities of daily living except for eating which required staff supervision. A review of Resident #22's medical record revealed a physician's order initiated by the facility's Medical Director (MD) and dated 04/21/18. The order specified Xanax (an antianxiety medication considered a psychotropic drug) 0.5 milligrams (mg) every 4 hours as needed (prn). No 14 day stop date was written for this medication. Continued medical record review revealed 5 psych consult progress notes dated 04/30/18, 05/07/18, 05/21/18, 05/28/18 and 06/11/18. Each consult was signed by a Nurse Practitioner who was certified in psychiatric medicine (NP-C). Each consult listed Xanax 0.5 mg every 4 hours as needed. The consult dated 04/30/18 noted Xanax was available for use. The consult dated 05/21/18 noted the prn Xanax was used 6 times in the past 2 weeks and was effective when used. The consult dated 06/11/18 noted the prn Xanax was used 8 times in the past 2 weeks and was generally effective when used. No recommendations for medication changes pertaining to Xanax were documented on any consult. On each progress note, the NP-C specified no side effects from psychotropic medications were noted on any visit and to continue medications as ordered. A care plan last revised 07/09/18 described Resident #22 with a long history of dementia,	F 758	04/21/18. The order specified Xanax every 4 hours as needed (prn). No 14 day stop date was written for this medication. An interview with the NP-C was conducted on 07/13/18. During the interview NP-C stated the Xanax was ordered before she started seeing resident #22. She added if she did not write the order she did not notice there was no stop date. NP-C confirmed that Xanax was classified as a psychotropic medication and should have a 14 day stop order. An interview with the DON was conducted on 07/12/18 revealed the DON understood that Xanax was a psychotropic and should have a 14 day stop order. An interview with the medical director was conducted on 07/13/18. MD stated he was aware of the 14 day stop order for Xanax. MD explained he ordered the psych consult for resident #22 to handle the administration of psychotropic medications which included Xanax. 2. Staff education was provided by the Director of Nursing /Unit Manager to the physician and nurse practitioner. The education was provided on 8/23/2018 and included the requirements for a stop date on all PRN orders for psychotropic medication are limited to 14 days, and if extended beyond 14 days the practitioner should document their rationale in the resident's medical record and indicate the duration for the PRN order. A monitoring tool has been put in-place by the Director of Nursing. The Director of Nursing along with the IDT will conduct	

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F 758	Continued From page 41 hallucinations and was at risk of complications related to psychotropic medication use. The care plan goal specified the resident would be free from complications related to medication use through the next review. Approaches included give medications as ordered and monitor for effect of medication and update physician with any unrelieved behaviors such as anxiety. An interview with the Director of Nursing (DON) was conducted 07/12/18 at 11:30 AM. The DON stated Xanax should have a 14 day stop dated unless specified by the NP-C. An interview with the NP-C was conducted via phone on 07/13/18 at 9:09 AM. The NP-C stated the Xanax was ordered before she started seeing Resident #22. She added if she did not write an order, she did not notice there was no stop date. The NP-C confirmed Xanax was classified as a psychotropic medication and should have a 14 day stop date if ordered prn. She stated she would correct the order on her next visit which would be 07/16/18. An additional interview was conducted with the DON on 07/13/18 at 12:18 PM. The DON stated the prn Xanax should have a stop date. He added he was unable to find a recommendation from the pharmacy consultant noting no stop date for the prn medication. The DON stated the pharmacy consultant was unavailable for interview this week. An interview was conducted with the MD on 07/13/18 at 3:05 PM. The MD stated he was aware of the prn Xanax order written in April for Resident #22. The MD added he was aware of the rules for 14 day stop dates for prn	F 758	weekly audits for PRN psychotropic medications, at the Risk meeting. The process of weekly audits will be ongoing. The IDT team conducted an audit of all PRN psychotropic medications on 8/2/2018, during the weekly RISK meeting. 3. The Director of Nursing will report to the administrator weekly on the progress of auditing the use of psychotropic medications and any non-compliance issues until the QAPI committee determines that the concern is in compliance. The DON will report the compliance of the audits being completed within the prescribed time frame as established by policy to the QAPI committee monthly issues until the QAPI committee determines that the concern is in compliance. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	

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F 758	Continued From page 42 psychotropic medications. The MD explained he ordered the psych consult for Resident #22 to handle the administration of psychotropic medications which included Xanax.	F 758		
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 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 discard a box of expired medication from 1 of 2 medication storage rooms and failed to discard cards of expired medications from 2 of	F 761	1. Based on observations and staff interviews, the facility failed to discard a box of expired medication from 1 of 2 medication storage rooms and failed to	8/6/18

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F 761	Continued From page 43 4 medication carts. The findings included: 1. Observation of the Medication Storage Room on the 100/200 hall on 07/10/18 at 2:58 PM revealed an unopened box of Symbicort 160/4.5 inhalation aerosol (an inhaler that contains a steroid to reduce inflammation and a bronchodilator that relaxes airways and makes it easier to breath) with 60 inhalants in the package. The pharmacy label stated the medication was prescribed for Resident #20 and filled on 06/17/2017 and expired on 06/2018. Nurse #1 was interviewed when the box of expired medication was discovered on 07/10/18 at 2:58 PM and stated the medication was expired and should have been removed from the Medication Room on 06/01/18. During an interview on 07/12/18 at 9:25 AM with the Unit Manager and the Director of Nursing (DON), the DON stated the pharmacist had just audited their medication carts and Medication Rooms and missed the expired medications. Additionally, he stated all the nurses were responsible for assuring all medications in the Medication Rooms and on the carts were within date. 2. Observation of the medication cart on the 100 Hall Cart 1 on 07/10/18 at 4:01 PM revealed expired medications prescribed for Resident #15. The medication was Memantine HCl (a drug used to treat the symptoms of Alzheimer's disease) 10 milligram (mg) tablets and there was one card with 25 tablets that expired 03/31/18 and one card with 27 tablets that expired 05/31/18.	F 761	discard cards of expired medications from 2 of 4 medication carts. Observation of the medication storage room on the 100/200 hall on 07/10/18revealed an unopened box of Symbicort. The pharmacy label stated the medication was prescribed for resident #20 and filled on 06/17/17 and expired on 06/18. Observation of the medication cart on 100/200 revealed expired medications prescribed for resident #15 had expired on 03/31/18 and another had expired on05/31/18. Observation of the medication cart on 300/400 hall revealed there were 4 expired medications cards. During an interview with the DON it was revealed that the pharmacist had just audited facility medication carts and the medication storage rooms and missed the expired medications. Additionally, he stated all the nurses were responsible for assuring all medications in the medication storage rooms and on the carts were within date. An analysis of the events revealed that nurse failed to ensure that all medications in the medication storage rooms and on carts were within date. This failure was a result of not following the facility policies. The pharmacy which had conducted an audit failed to provide the check needed to verify that all medications were within date. It is the responsibility of the nurses to check for expired medications. Proper inventory management of medications was not followed. 2. Staff education was provided by the	

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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 761	Continued From page 44 Nurse #1 was interviewed when the expired cards of medications were discovered on 07/10/18 at 4:01 PM and stated the medications were expired and should have been removed on 03/31/18 and 05/31/18 when they expired. 3. Observation of the medication cart on the 300/400 Hall on 07/10/18 at 4:08 PM revealed expired medications prescribed for Resident #19. There was 1 card of Atorvastatin Calcium (a drug used to treat bad cholesterol) 10 mg tablets with 9 tablets left on the card which expired 06/30/18. In addition, another medication prescribed for Resident #19 was expired. There were 2 cards of Hydrochlorothiazide (a drug used to treat high blood pressure) 25 mg tablets with one card with 7 tablets that expired on 05/31/18 and one card with 24 tablets that expired on 06/30/18. Nurse #6 was interviewed when the expired cards of medications were discovered on 07/10/18 at 4:08 PM and stated the medications were expired and should have been removed on 05/31/18 and 06/30/18 when they expired. During an interview on 07/12/18 at 9:25 AM with the Unit Manager and the Director of Nursing (DON), the DON stated the pharmacist had just audited their medication carts and Medication Storage Rooms and missed the expired medications. Additionally, he stated all the nurses were responsible for assuring all medications in the Medication Storage Rooms and on the carts were within date.	F 761	Director of Nursing /Unit Manager to the floor nurses and medication aides. The initial staff in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included expectations of discarding expired drugs and biologicals as they expire. A monitoring tool has been put in-place by the Director of Nursing to document and monitor compliance with ensuring that all expired drugs and biologics are removed from inventory and returned to the pharmacy for destruction. A minimum of a weekly audit, for each medication/treatment cart, will be conducted by the unit manager for a minimum of four weeks and until the QAPI committee determines that the issue is resolved. Monitoring will continue to be conducted for at least three months. After the first month 1 observation, for each medication/treatment cart, will be conducted every two weeks for at least two months. The unit manager will be responsible for auditing the medication storage rooms. Monitoring will be conducted weekly for a minimum of four weeks and until the QAPI committee determines that the issue is resolved. Monitoring will continue to be conducted for at least three months. After the first month 1 observation, for each medication storage room will be conducted every two weeks for at least two months. 3. The Director of Nursing will notify the	

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F 761	Continued From page 45	F 761	administrator weekly on the progress of the audits. The Director of Nursing will present the results of the audits monthly at the QAPI meeting for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The Director of Nursing will be responsible for monitoring the audits being completed by nurses and pharmacy. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to provide thickened liquids as ordered by the physician for 1 of 2 residents reviewed with orders for thickened liquids. (Resident #56) The findings included: Resident #56 was admitted to the facility 06/18/18 with diagnoses which included encephalopathy, acute mastoiditis, myocardial infarction, acute respiratory failure with hypoxia, essential hypertension, dysphagia, jaundice, altered mental state, nutritional anemia and hypothyroidism.	F 805	1. Based on medical record review, observations and staff interviews the facility failed to provide thickened liquids as ordered by the physician for 1 of 2 residents reviewed with orders for thickened liquids. Review of the admission care plan dated 06/28/18 for resident #56 noted the following problem area and approaches: Resident has impaired cognitive skills as evidenced deficits in short and long term memory. Communication and cognition vacillate. Resident's ability to complete ADLs has	8/6/18

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F 805	Continued From page 46 The admission Minimum Data Set for Resident #56 dated 06/25/18 assessed him with severe cognitive impairment. The Care Area Assessment associated with the admission MDS for Resident #56 included a review of the following problem areas: Nutrition-Resident is ordered puree diet with nectar thickened liquids due to dysphagia and recent aspiration pneumonia. He requires assistance with meals. He is currently on Speech Therapy caseload. Other diagnoses include chronic encephalopathy, vitamin deficiency, hypothyroidism, respiratory failure, hypertension, anemia and congestive heart failure. Will monitor intake, weight and pertinent labs. Dehydration-Resident is a recent admit from the hospital with diagnoses of acute hypoxemic respiratory failure, pleural effusion related to thoracentesis. Resident developed aspiration pneumonia while in the hospital and had a diagnosis of mastoiditis prior to admission to hospital. Resident has diagnosis of congestive heart failure and occasional lower extremity edema. Resident has diet of nectar thickened liquids, oral fluids should be encouraged throughout the shift. Review of the admission care plan dated 06/28/18 for Resident #56 noted the following problem areas and approaches: -Resident's ability to complete activities of daily living (transfer, locomotion, dress, eat, toilet, maintain personal hygiene) has deteriorated related to recent hospitalization for acute hypoxemic respiratory failure, pleural effusion related to thoracentesis, and aspiration pneumonia.	F 805	deteriorated related to recent hospitalization for acute hypoxemic respiratory failure, pleural effusion related to thoracentesis and aspiration pneumonia. The physician diet order in place for resident #56 since admission was for puree with nectar thick liquids. Observations and interviews were made of resident #56 throughout the four days of the survey. Resident #56 was provided liquids that did not contain nectar thickener throughout the four days. The speech therapist stated the need for thickened liquids including water should be noted on the tray card as well as the C.N.A.'s electronic care guide. On 07/13/18 the physician of resident #56 stated if a resident had orders for thickened liquids he expected all liquids to be thickened. The facility failed to restrict resident #56 liquids to thickened liquids. This failure was caused by the tray card system not being updated properly and the C.N.A.'s electronic care guide was not followed by the C.N.A.'s. Resident #56 does not want thickened liquids so the C.N.A.'s chose to comply with resident request and not follow the orders for thickened liquids. 2. Staff education was provided by the Director of Nursing /Unit Manager. The initial staff in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included ensuring that each resident receives food and beverages in a form/consistency to meet	

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F 805	Continued From page 47 Approaches to this problem area included to follow speech therapy plan of care and recommendations. -Resident has impaired cognitive skills as evidenced by deficits in short and long term memory. Communication and cognition vacillate. Approaches to this problem area included to determine if decisions made by the resident endanger the resident or others and to intervene if necessary. -Resident at risk for decline in nutrition/hydration related to recent pneumonia, acute renal failure, encephalopathy, impaired cognition, general weakness and dysphagia. Approaches to this problem area included to follow the Speech Therapist recommendations and to offer oral fluids throughout shift with ordered consistency. The physician diet order in place for Resident #56 since admission was puree with nectar thick liquids. The following observations and interviews were made of Resident #56 throughout the four days of the survey: On 07/10/18 at 8:45 AM Resident #56 was observed in his room, seated at bedside, with his breakfast tray on the overbed table in front of him. A pitcher of unthickened water was on the bedside table, beside the bed of Resident #56. A Certified Occupational Therapy Assistant (COTA) was seated in the room with Resident #56 providing therapy. A cup of unthickened coffee was included with the breakfast meal and did not appear to have been touched. A tray card included with the breakfast meal indicated Resident #56 should have nectar thick coffee. Resident #56 had eaten all the food served with	F 805	their individual needs. A monitoring tool has been put in-place by the Director of Nursing to document and monitor compliance of each resident receiving food and beverages consistent with each resident's needs. A minimum of 5 audits will be conducted each week for four weeks. After the first month 3 observations will be conducted randomly each week for at least two months. Staff will be monitored by the Unit Manager 3. The Director of Nursing will notify the administrator weekly on the progress of the audits. The Director of Nursing will present the results of the audits monthly at the QAPI meeting for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The Director of Therapy will be responsible for monitoring the audits being completed. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	

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the breakfast meal. The COTA stirred the coffee with a spoon and verified it had not been thickened. The COTA stated a nursing assistant had delivered the tray to the room and it included the food as well as the coffee. The COTA looked at the tray card and verified Resident #56 should have been served nectar thick coffee, took the coffee out of the room and returned with a cup of nectar thick coffee. On 07/10/18 at 8:55 AM Nursing Assistant #3 stated she delivered the breakfast tray to the room of Resident #56 and included a cup of coffee on the tray. Nursing Assistant #3 stated she put the coffee on the breakfast tray of Resident #56 because it was listed as a preference but missed that the coffee should have been nectar thick.
On 07/10/18 at 9:13 and 11:40 AM a water pitcher with unthickened water and ice remained on the bedside table in the room of Resident #56.
On 07/10/18 at 2:20 PM, 3:45 PM and 4:55 PM a water pitcher with unthickened water remained on the bedside table in the room of Resident #56.
On 07/11/18 at 8:30 AM a water pitcher with unthickened water and ice was observed on the bedside table in the room of Resident #56.
On 07/11/18 at 11:30 AM Resident #56 was observed in the main dining room, seated at a table with 2 other residents. Three staff members were observed in the room at the time of the observation assisting residents with putting on clothing protectors and providing beverages before the start of the lunch meal. A tablemate (at the table where Resident #56 was seated) was observed to propel himself to the beverage counter, pour coffee into a maroon plastic mug and serve the mug of unthickened coffee to Resident #56. At 11:50 AM Medication Aide #2 came in to the dining room and gave Resident #56 some medications. Resident #56 was

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F 805	Continued From page 49	F 805		

holding the maroon mug and sipping coffee at the time the medications were given by Medication Aide #2. After giving the medications, Medication Aide #2 came back with some wipes and wiped the hands of Resident #56. Medication Aide #2 did not say anything to Resident #56 about his coffee as he continued to sip from the maroon mug. At 12:06 PM the maroon cup containing unthickened coffee had been consumed by Resident #56. Medication Aide #2 stated she was aware Resident #56 was supposed to have thickened liquids and did not notice the coffee in the maroon cup was not thickened when she administered medications to him at 11:50 AM.
Nursing Assistant #3 (who had been present in the dining room since 11:30 AM and provided a clothing protector to Resident #56) stated she was aware Resident #56 should have nectar thick liquids and didn't notice the coffee in the maroon cup was not thickened when she offered a clothing protector. Both Nursing Assistant #3 and Medication Aide #2 stated they often have problems with the tablemate of Resident #56 giving Resident #56 a cup of unthickened coffee and they tried to intervene.
On 07/11/18 at 2:55 PM a water pitcher with unthickened water was on the bedside table in the room of Resident #56.
On 07/12/18 at 9:05 AM a water pitcher with unthickened water was observed on the bedside table in the room of Resident #56.
On 07/12/18 at 11:45 AM the Speech Language therapist that had treated Resident #56 was interviewed and stated all liquids offered to Resident #56 should be thickened, including water. The Speech Language therapist stated the need for thickened liquids should be noted on the resident's tray card as well as the nursing assistant electronic care guide.

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F 805	Continued From page 50 On 07/12/18 at 12:00 PM Nurse #4 stated she was familiar with Resident #56 and often worked with him on day shift. Nurse #4 stated there should not be unthickened water in the room of Resident #56, noting he had orders for nectar thick liquids. Nurse #4 stated the nursing assistants provide the water pitchers and water for residents and she was not aware a pitcher of unthickened water was left at bedside in the room of Resident #56. On 07/12/18 at 3:00 PM a water pitcher with unthickened water was observed on the bedside table in the room of Resident #56. On 07/13/18 at 8:00 AM a water pitcher with unthickened water was observed on the bedside table in the room of Resident #56. On 07/13/18 at 10:00 AM a water pitcher with unthickened water was observed on the bedside table in the room of Resident #56. The Director of Nursing (DON) was present at the time of the observation and stated a water pitcher should not be in the room of residents with orders for thickened liquids. The DON stated staff should obtain pre-thickened beverages from the nourishment refrigerator between meals to offer to residents that required thickened liquids. The DON stated day shift nursing assistants typically put water pitchers in the rooms of residents. The DON stated nursing assistants would know if a resident required thickened liquids from the tray card, nursing assistant electronic care guide and care plan. The DON stated nursing assistants should be knowledgeable of residents that required thickened liquids and should monitor liquids provided to these residents throughout the day. At the time of the interview the DON accessed the nursing assistant electronic care guide and the care plan and noted the need for nectar thick liquids had not been included. The	F 805		

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F 805	Continued From page 51 DON stated the need for thickened liquids should have been included in the resident's medical record either at the time of the order or when the care plan was reviewed. On 07/13/18 at 12:00 PM the Minimum Data Set Nurse (that did the initial care plan dated 06/28/18 for Resident #56) stated she could not explain why the need for nectar thick liquids had not been included in the nursing assistant electronic care guide or care plan for Resident #56. On 07/13/18 at 3:00 PM (in a phone interview) the physician of Resident #56 stated if a resident had orders for thickened liquids he expected all liquids to be thickened. On 07/13/18 at 4:12 PM Nursing Assistant #5 stated she could not explain why a water pitcher would be left in the room of Resident #56 and indicated she was aware of the order for all liquids provided to him should be served nectar thick. . On 07/13/18 at 4:25 PM Nursing Assistant #6 could not explain why a water pitcher would be left in the room of Resident #56 and indicated she was aware of the order for all liquids provided to him should be served nectar thick. On 07/13/18 at 5:30 PM Nurse #4 stated the nursing assistants "change out" the water pitchers on Tuesday and Friday on the hall Resident #56 resided. Nurse #4 stated she suspected it was an oversight that water pitchers were placed in all resident rooms by nursing assistants without thinking about the residents with orders for thickened liquids.	F 805		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		8/6/18

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F 867	Continued From page 52 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor those interventions that the committee put into place November of 2017, December of 2017, and April of 2018. The deficiencies were in the areas of activities of daily living and supervision to prevent accidents. Activities of daily living was originally cited as a result of complaint investigations conducted November of 2017 and March of 2018. Supervision to prevent accidents was cited as a result of a complaint investigation conducted September of 2017. The continued failure of the facility during 4 federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referred to: 1. a. F677 483.24(a)(2) Activities of daily living: Based on observations, record review, and staff interviews the facility failed to provide perineal care for 1 of 2 residents reviewed for incontinence care (Resident #44) and failed to assist 2 of 4 dependent residents (Resident #2, Resident #27) with tray set up and feeding assistance. This tag was cited in December of 2017 for failing	F 867	1. Based on observations, record review and staff and resident interviews the facility's QAPI committee failed to maintain implemented procedures and monitor those interventions that the committee put into place December 2017 and April 2018. The deficiencies were in the area of ADLs and supervision to prevent accidents. Based on observations, record review and staff interviews the facility failed to provide perineal care for 1 of 2 residents reviewed for incontinence care and failed to assist 2 of residents with tray set up and feeding assistance. Based on observations, record review and staff interviews the facility failed to secure smoking materials for 1 of 2 residents and monitor 1 of 4 residents to ensure that she did not have any smoking materials secured from another resident. During an interview with the administrator he stated the facility failed because the facility did not put into place the communication that was needed to maintain compliance. 2. The QAPI committee will receive prior to the meeting the results of all audits and monitoring within the facility. The QAPI committee will discuss monthly the results of the audits and monitoring and determine when it is appropriate to reduce the amount of reporting. The committee's	

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F 867	Continued From page 53 to provide thorough incontinence care and again in March of 2018 for failing to provide incontinence care for greater than 3 hours including before a lunch meal. This deficiency was cited again on the current survey for failing to provide peri care with incontinence care and failing to assist dependent residents with meal tray set up and feeding assistance. b. F689 483.25(d)(1)(2) Supervision to prevent accident: Based on observations, record review and staff and resident interviews, the facility failed to secure smoking materials for 1 of 2 independent smoking residents (Resident #33) and monitor 1 of 4 supervised smoking residents (Resident #34) to ensure that she did not have smoking materials secured from another resident. This tag was cited in November of 2017 from failing to provide a tabs alarm to assist with supervision to prevent falls. This deficiency was cited again on the current survey for failure to monitor residents that smoked independently and monitor smoking materials. During an interview on 07/13/18 at 4:47 PM, the Administrator stated the facility had gotten rid of tabs alarms for residents at risk for falls. He added the failure to maintain compliance with activities of daily living was most concerning. The Administrator stated the system failed because the facility did not put into place the communication that was needed to maintain compliance.	F 867	decision to reduce the amount of monitoring will be based on compliance, observations and medical record review where appropriate. The QAPI committee will discuss the results of the auditing with the regional director of the department prior to reducing the frequency of monitoring. The QAPI committee may increase the frequency of monitoring without the regional director involvement. 3. The Administrator will report the results of monitoring/audits to the Chief Operating Officer or designee. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		8/6/18

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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 55 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to maintain infection control procedures by not containing Clostridium difficile (C. Diff) soiled clothing in the confines of the room and placing it in the correct bag to be laundered for 1 of 1 sampled resident (Resident #33) on contact precautions. The facility also failed to maintain infection control procedures by not performing hand hygiene and changing gloves after providing incontinence care and prior to touching personal items in the resident room for 1 of 2 residents (Resident #259) reviewed for incontinence care.	F 880	1. Based on observations, record review, physician and staff interviews the facility failed to maintain infection control procedures by not containing soiled clothing in the confines of the room and placing it in the correct bag to be laundered for 1 of 1 sampled resident. The facility also failed to maintain infection control procedures by not performing hand hygiene and changing gloves after providing incontinence care and prior to touching personal items in the resident room for 1 of 2 residents reviewed for	

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	345302	A. BUILDING _____ B. WING _____	C 07/13/2018

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F 880	Continued From page 56 The findings included: A review of the facility's Infection Prevention and Control Policy and Procedure, Isolation - Categories of Transmission-Based Precautions and Clostridium Difficile policies revealed the proper procedures for hand washing, personal protective equipment and caring for residents on contact precautions for Clostridium difficile (C. diff). 1. An observation on 07/11/18 at 3:30 PM revealed Resident #33 was at the nurse's station with his soiled laundry in his lap. He was observed dropping some of the soiled clothing on the carpet, handing it to Nurse #1 to mark his name in the soiled clothing with a marker. Nurse #1 marked Resident #33's name in each piece of clothing (on the stone wall) and placed the clothing into a regular linen bag instead of the water soluble bags on the isolation cart. Nurse #1 stated he was putting the resident's name in his soiled clothing so that it could be laundered and returned to him. An interview on 07/11/18 at 3:37 PM revealed Nurse #1 knew Resident #33 was on contact precautions and his clothing should have been bagged in his room but stated the resident had brought the clothing out to the nurse's station for Nurse #1 to put his name in them so he would get them back after laundering. Nurse #1 stated he had not thought about redirecting the resident with his clothing back to his room but was just trying to get the clothing laundered because it was soiled from diarrhea. Nurse #1 stated he would have "housekeeping blast the wall and clean it up good." Nurse #1 stated he was not	F 880	incontinence care. A review of the facility's infection prevention and control policy and procedures – isolation revealed the proper procedures for hand washing, personal protective equipment and caring for residents on contact precautions for C. diff. An observation on 07/11/18 revealed resident #33 was at the nurse's station with his soiled laundry in his lap. He was observed dropping some of the soiled clothing on the carpet, handing it to nurse #1to mark his name in the soiled clothing with a marker. Nurse #1 marked resident #33s name in each piece of clothing and place clothing into a regular linen bag instead of the water soluble bags on the isolation cart. An interview with nurse #1 revealed he knew resident #33 was on contact precautions and his clothing should have been bagged in his room and placed in the proper clothing bag. An interview on 07/13/18 with the housekeeping supervisor revealed that there were water soluble bags available for the soiled linen of resident's on precautions. An interview on 07/13/18 with the DON revealed his expectations would have been for Nurse #1 to have marked resident #33 clothing with his name in the resident's room and then bagged the clothing in his room and then bagged the clothing in his room in a water soluble bag and taken to laundry. During an observation of fecal incontinence care on 07/11/18 revealed	

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F 880	Continued From page 57 sure how they would clean the carpet the clothing had fallen on but he would ask housekeeping about cleaning it. An interview on 07/13/18 at 3:14 PM with the medical director via phone revealed he would have expected the staff to bag soiled linen of a resident with C. diff in the resident's room and not out at the nursing station. The medical director stated he would consider it a problem for soiled linen to be bagged out at the nursing station. An interview on 07/13/18 at 4:52 PM with the housekeeping supervisor revealed that there were water soluble bags available for the soiled linen of resident's on precautions. She stated the clothing was placed in the water soluble bags which were marked with an orange stripe and these clothes were laundered separately from the other clothing and returned to the resident. The supervisor stated the water soluble bags were more transparent than the regular bags and dissolved in the washing machine. An interview on 07/13/18 at 5:00 PM with the Director of Nursing revealed his expectation would have been for Nurse #1 to have marked Resident #33's clothing with his name in the resident's room and then bagged the clothing in his room in a water soluble bag and taken to laundry. 2. Review of the facility's infection control policy and procedure guidelines in preventing resident exposure to feces during incontinence care included the following steps: Remove soiled items. Place into designated container. Remove gloves and discard into designated container. Wash and dry hands thoroughly. Clean overhead table and return to proper position. Lower the bed	F 880	C.N.A. #4 donned gloves and began to clean feces off the buttocks of resident #259. She placed the soiled linen and clothes directly on the floor at the bedside. Wearing the same gloves used to clean feces touched the bedside control and lowered the bed. She moved the resident's wheelchair to the foot of the bed by touching both handles. She touched two corners of the overbed table and the call light button to position then within reach of resident #259. She bagged the soiled linen and clothes in plastic bags. She was observed to wear the same gloves after providing fecal incontinence care and touch frequently used items. She removed her gloves and disposed of them in a waste container and washed her hands with soap and water before leaving the room. During an interview on 07/11/18 C.N.A. #4 explained she should have removed her gloves after providing fecal incontinence care and before touching the items in the room to ensure those were not contaminated with feces. During an interview on 07/12/18with the DON revealed his expectation was for C.N.A. to remove her gloves and wash her hands before touching frequently used items. He also expected her not to place soiled linen directly on the floor, but use the designated container. An analysis of the events revealed that failure to follow infection control policies and procedures as well as acceptable standards of practice by the nurse and C.N.A. was the cause of unacceptable handling of infectious waste.	

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F 880	Continued From page 58 into lowest position. Place the call light within easy reach. Wash and dry hands thoroughly. During an observation of fecal incontinence care on 07/11/18 at 10:56 AM, NA #4 donned gloves and began to clean feces off the buttocks of Resident #259. She placed the soiled linen and clothes directly on the floor at the bedside. Wearing the same gloves used to clean feces, NA #4 touched the bed remote control and lowered the bed. She moved the resident's wheel chair to the foot of the bed by touching both handles. She touched two corners of the overhead table and the call light button to position them within reach of Resident #259. She bagged the soiled linen and clothes in plastic bags. She was observed to wear the same gloves after providing fecal incontinence care and touch frequently used items. She removed her gloves and disposed of them in a waste container and washed her hands with soap and water before leaving the room. During an interview on 07/11/18 at 12:39 PM, NA #4 explained she should have removed her gloves after providing fecal incontinence care and before touching the items in the room to ensure those were not contaminated with feces. She explained she washes her hands between residents. During an interview on 07/12/18 at 9:28 AM, the Director of Nursing revealed his expectation was for NA #4 to remove her gloves and wash her hands before touching frequently used items. He also expected her not to place soiled linen directly on the floor, but use the designated container.	F 880	2. Staff education was provided by the Director of Nursing and Unit Manager. The initial in-services were conducted on 7/13/2018-7/14/2018 on each shift. Additional in-services were conducted on 8/3/2018-8/6/2018 and continue to be on-going. In-services included use of appropriate infection control procedures at all time. A monitoring tool has been put in-place by the Director of Nursing to document and monitor staff compliance with infection control policies and procedures as well as acceptable standards of practice. CNAs will be monitored by the nurse in charge. The nurses providing incontinence care will be observed by the unit manager. A minimum of 10 observations will be conducted each week for four weeks. After the first month, 5 observations will be conducted randomly each week for the next two months. 3. The Director of Nursing will notify the administrator weekly on the progress of the audits. The Director of Nursing will present the results of the audits monthly at the QAPI meeting for review and recommendations for a minimum of three months or until substantial compliance is achieved and quarterly, thereafter, to ensure the POC is sustained. The Director of Nursing will be responsible for monitoring the audits being completed. 4. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	