STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	R-C 01/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	**3195 OLD MURPHY ROAD FRANKLIN, NC 28734**

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F 000	INITIAL COMMENTS On January 5, 2019 The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While the deficiency cited on the complaint investigation on 11/28/18 was corrected effective 12/07/18 the facility remains out of compliance.	F 000		

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

Electronically Signed | 01/21/2019

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

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F 000	INITIAL COMMENTS On January 5, 2019 The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the complaint investigation on 10/23/18 were corrected effective 12/05/18 the facility remains out of compliance.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		2/4/19

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

Electronically Signed | 01/28/2019

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to treat residents in a dignified manner by not covering an exposed resident, entering resident rooms without obtaining permission from the resident to enter and not verifying which resident required assistance for 3 of 6 sampled residents reviewed for dignity (Resident #28, #15 and #6). The findings included: 1. Resident #28 was admitted to the facility on 11/04/17 with diagnoses of seizure disorder and major brain injury. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/22/18 revealed Resident #28 had severe cognitive impairment and required extensive assistance with her activities of daily living. The MDS also indicated Resident #28 had no behaviors of rejecting care. On 01/05/19 at 3:56 PM an observation was made from the hallway of Resident #28 lying on her right side in her unmade bed sleeping with the bottom half of her body exposed and uncovered. Resident #28 was wearing a gown	F 550	F550 Resident Rights/Exercise of Rights How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #6 and #15 have no further concerns. Resident #28 was provided privacy upon observation by the facility staff. Staff member identified during survey by resident #15 is no longer is employed. How will facility identify other residents having potential to be affected by the same deficient practice? Residents residing in the facility were interviewed regarding resident rights. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and non-licensed facility staff	

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F 550	Continued From page 2 that was positioned above her waist and a brief that was visible from the hallway. Observations of Resident #28 from the hallway revealed on 01/05/19 at 4:00 PM, at 4:07 PM, at 4:14 PM, at 4:19 PM and at 4:20 PM revealed she was lying in bed with her lower torso uncovered and exposed. During these observations, the resident's exposed legs and her brief were observed from the hallway. During observations on 01/05/19 from 4:00 PM to 4:20 PM, three staff members and one resident were observed to pass by Resident #28's opened door while she was lying in her bed uncovered and with her lower torso and brief exposed. The three staff members who passed by the resident's room did not intervene to cover the resident to protect her from being exposed to others. On 01/05/19 at 4:20 PM observed the Corporate Quality Assurance Nurse (CQAN) knocked on Resident #28's door and entered the room. During an interview with the CQAN on 01/05/19 at 4:22 PM she stated she pulled Resident #28's privacy curtain because from the hallway she observed that the resident was exposed. During an interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM she stated she expected the staff to look into each resident's room as they passed to monitor for issues like exposures. The DON stated the staff was expected to pull Resident #28's privacy curtain to prevent her from being exposed. During an interview with Nurse Aide (NA) #5 on 01/05/19 at 5:43 PM she stated on 01/05/19 she noticed that Resident #28 was lying in her bed	F 550	were re-educated by 2/4/2019 regarding the F550 Resident Rights/Exercise of Rights specific to treating residents in a dignified manner; maintaining their dignity by ensured they are covered, knocking and asking to enter residents room(s) by the corporate clinical nurse consultants and the Staff Development Director. Education included hands on scenarios and interactive training sessions. How the facility plans to monitor its performance to make sure that solutions are sustained? The Department Managers and/or designee began monitoring resident rights on 1/21/2019 with a Compliance Monitoring Tool that includes observations of resident privacy, knocking on the resident doors, and maintaining resident□s dignity by covering if exposed. Monitoring includes 10% of the census 3x/week times 4 weeks, then weekly x 8 weeks. Results of the monitoring tool will be brought to the stand-down meeting 5 times/weekly x 4 weeks, then weekly x 8 weeks, the administrator will discuss the findings with the Manager and/or Designee. Results of the audits will be presented to the QAPI meeting monthly x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are	

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F 550	Continued From page 3 exposed and uncovered but she wanted to take the vital sign machine that she was using back to the dayroom before she provided care to Resident #28. The NA stated when she went back to Resident #28's room someone had already closed her door. During an interview with Nurse #7 on 01/05/19 at 5:35 PM she stated she was not aware that Resident #28 was exposed and uncovered while lying in her bed, but she would have expected the staff to cover her up if they were aware of it. 2. Resident #15 was admitted to the facility on 02/12/18 with diagnoses which included diabetic neuropathy and cataracts and blindness in both eyes. The most recent quarterly Minimum Data Set (MDS) assessment dated 10/08/18 revealed he was cognitively intact, required limited assistance with most of his activities of daily living and his vision was severely impaired. On 01/02/19 at 5:50 PM Resident #15 was overheard to holler loudly "get this d--- food out of here" and "she yells at me every time she comes in here."Several staff member were observed to rush to Resident #15's room. During an interview with Resident #15 on 01/03/19 at 10:05 AM he explained that he became upset during the previous evening because "the girl"(did not know her name) who delivered his supper tray to his room "just banged it down on my table and said here is your food." Resident #15 stated the girl did not knock on his door before she came into his room and that was the third time that day that she had "done me that way." The Resident continued to state the staff came into his room all the time uninvited and it	F 550	responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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F 550	Continued From page 4	F 550		

was disrespectful to him as a person because his room was his home.

On 01/05/19 at 12:18 PM an interview was conducted with the facility's "Scheduler" who was one of the staff members that went into Resident #15's room on the evening of 01/02/19. The Scheduler stated Resident #15 told the Director of Nursing (DON) (who went into the room at the same time as she did) that the girl was too loud when she came into his room and that she did not even knock on his door before she entered. The Scheduler stated she did not know who the staff person was that Resident #15 referred to.

During an interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM, she explained the staff member that Resident #15 referred to who entered his room unannounced on the evening of 01/02/19 in a loud manner was a new employee. The DON stated she expected that all employees would knock on Resident #15's door and all resident's doors and wait for an invitation before they entered a resident's room.

3. Resident #6 was admitted to the facility 4/21/09. The quarterly Minimum Data Set dated 10/08/18 revealed Resident #6 had mild cognitive impairment and required supervision to limited assistance for all activities of daily living (ADL's).

During an interview on 01/03/19 beginning at 11:18 AM, Resident #6 stated she had a headache and was observed to use her call light at 11:21 AM. While continuing the interview with Resident #6, Nurse Aide (NA) #10 opened the door and entered the room without knocking or announcing her presence and went directly to the roommate's bed. NA #10 was overheard telling

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F 550	Continued From page 5	F 550		

Resident #6's roommate that she was going to get another NA to help her and she would be right back. NA #10 exited the room without speaking to or acknowledging Resident #6. NA #10 returned to the room with a second NA and went to the call light station on the wall and turned it off. Resident #6 then stated she had used the call light for herself not her roommate.

During an interview on 01/03/19 at 11:31 AM, NA #10 stated she had been told by a housekeeper that Resident #6's roommate needed assistance, so she entered the room and went directly to the roommate's bed. NA #10 stated she entered the room assuming the light was for Resident #6's roommate. NA #10 also stated the proper protocol was to knock on the door before entering but she just forgot to do it.

During an interview on 01/03/19 at 11:45 AM, the housekeeper stated she had seen the light on in the hallway for Resident #6's room and told the NA that assistance was needed in that room. The housekeeper stated she did not specify which person needed help because she did not know that information.

During an interview on 01/05/19 at 9:27 AM, Resident #6 stated the NA's often entered her room without knocking. Resident #6 further stated it irritated her that the NA's did not take the time to knock on the door before they entered her room. She also stated she hardly ever used her call light, but when she did it was usually for pain medication. Resident #6 further stated when she does use her call light the staff usually assume it's for her roommate because her roommate used it multiple times throughout the day to request assistance from staff.

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F 550	Continued From page 6 During an interview on 01/05/19 at 1:17 PM, the Director of Nursing (DON) stated her expectation was for all staff to knock before entering a resident's room and wait for a response or an invitation to enter and all staff should verify which resident needs assistance when entering a resident's room.	F 550		
{F 561} SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	{F 561}		2/4/19

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{F 561}	Continued From page 7 facility. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and resident interviews the facility failed to honor the choice of having ice water at bedside for 1 of 4 sampled residents reviewed for choices (Resident #21). The findings included: Resident #21 was admitted to the facility on 05/28/18 with diagnoses which included chronic obstructive pulmonary disease (COPD). The most recent quarterly Minimum Data Set (MDS) assessment dated 11/30/18 revealed Resident #21 had intact cognition and required supervision with most of her activities of daily living. The MDS also indicated Resident #21 received oxygen. On 01/05/19 at 3:23 PM during an interview with Resident #21 she stated that due to the medications required to treat her COPD and the fact that she used continuous oxygen, her mouth stayed dry and she had requested ice water be kept at her bedside. Resident #21 explained that the Geriatric Care Aides (GCA's) were supposed to pass out ice water but she ended up having to ask for ice water almost every day because it was not being done and that it was "par for the course." Resident #21 stated that eairler in the day she had to ask Nurse Aide (NA) #4 to get her some ice water because there were no GCA's on her hall today. Interview with NA #4 on 01/05/19 at 3:51 PM confirmed Resident #21 had asked him to get her some ice water just before dinner. The NA stated her water pitcher was approximately ¼ full with	{F 561}	561 Self-Determination How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #21 was provided fresh ice water upon notification. How will facility identify other residents having potential to be affected by the same deficient practice? Facility residents were observed to ensure they had fresh ice water and/or fluids at their bedside as ordered; services provided accordingly. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and unlicensed staff were re-educated by 2/4/2019 regarding F561 Self-Determination, specific to providing water at resident□s bedside by the corporate nurse consultants and the Staff Development Director. New hires will receive the education during their orientation to the facility. Education included hands on scenarios and interactive training sessions. How the facility plans to monitor its performance to make sure that solutions are sustained?	

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{F 561}	Continued From page 8 water and there was maybe two pieces of melted ice left in her water pitcher. The NA explained that he was assigned to float halls when he came into work on 01/05/19 at 11:00 AM and did not know if the ice water had been passed on Resident #21's hall or not. An interview conducted with NA #5 on 01/05/19 at 4:00 PM revealed she worked on Resident #21's hall on the 7-3 shift and admitted they did not pass out ice water to all of the residents because they got behind in their work and ended up completing their tasks late. The NA stated the GCAs usually passed out the ice water, but they did not have a GCA on the hall that day. Interview with NA #6 on 01/05/19 at 4:07 PM stated the GCAs usually passed out ice water but they did not have a GCA on the hall today. The NA admitted Resident #21 was "big on having ice water" but they could not pass out the ice water because they got behind on the hall tasks and could not get to it. The NA stated she should have informed the nurse that they were not going to be able to pass out ice water. Observation of the Daily Assignment Sheet 7-3 Shift 01/05/19 revealed no Geriatric Care Aides (GCAs) were scheduled. Interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM revealed, it was the responsibility of the GCAs to pass out the ice water and it should be done at the beginning of the shift. The DON explained that in the event there were no GCAs assigned to the hall then it was the NAs responsibility to pass the ice water out and if they knew they were unable to get it done then they should have informed the Nurse	{F 561}	The Department Managers and/or designee began monitoring on 1/21/2019 monitoring 10% of the resident census for Ice Water at bedside and within reach, 5x/weekly x4 weeks, then weekly x8 weeks. Results of the monitoring tool will be brought to stand-down meeting 5x/weekly x4 weeks, then weekly x8 weeks. Results of the on-going audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	

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{F 561}	Continued From page 9 and if it still did not get done they should inform the oncoming shift.	{F 561}		
{F 607} SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to operationalize abuse policies and procedures in the area of staff reporting of an allegation of abuse when staff did not immediately report the resident's allegations of staff abuse during care to the administrator which resulted in a delay in the facility's investigation of an allegation of abuse for 1 of 3 sampled residents reviewed for abuse and neglect (Resident #18). Findings included: A review of the facility Abuse, Neglect, or Misappropriation of Resident Property Policy dated 01/2009 with a revised date of 03/10/17 revealed in part: The facility believes that residents have the right to be free from abuse, neglect, involuntary seclusion, exploitation, or	{F 607}	F607 Develop/Implement Abuse/Neglect Policies How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #18 received a head-to-toe skin evaluation and was interviewed regarding the allegation. How will facility identify other residents having potential to be affected by the same deficient practice? Facility residents were interviewed by the Social Worker regarding any allegations of staff mistreatment.	2/4/19

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{F 607}	Continued From page 10 misappropriation of property. Any employee who witnesses or suspects that abuse, neglect, exploitation, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Failure to report any concern related to neglect, exploitation, abuse, or misappropriation of property will result in disciplinary action and possible termination of employment. The Administrator is responsible to ensure that complaints of abuse, neglect, exploitation, or misappropriation of property and injuries of unknown origin are investigated. Resident #18 was admitted to the facility on 05/11/18 with diagnoses which included heart failure, peripheral vascular disease (poor circulation in legs), diabetes, respiratory failure and dementia. A review of a care plan dated 06/10/18 revealed a focus statement that Resident #18 had acts characterized by inappropriate behavior and was resistive to care and treatment and the goals were listed in part Resident #18 would receive care within his choices and preferences. The interventions were listed in part to report behaviors to Nurse and Physician. A review of the quarterly Minimum Data Set (MDS) dated 11/09/18 revealed Resident #18 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #18 required extensive assistance for bed mobility, transfers, dressing, toileting and hygiene and no rejection of care or behaviors were indicated. A review of an initial 24 Hour Report indicated the	{F 607}	Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and unlicensed staff were re-educated regarding Development/Implementation of F607 Abuse/Neglect Policies specifically related to reporting allegations of abuse; who is the abuse coordinator, procedures of reporting, and timeframes required by the corporate nurse consultants and the Staff Development Coordinator. Education included hands on scenarios and interactive training sessions. Education will be completed by 2/04/2019, staff members will not be allowed after the date without receiving the education prior to reporting for their shift. New hires will receive the education during their orientation to the facility. How the facility plans to monitor its performance to make sure that solutions are sustained? Department managers and/or designee will monitor abuse prevention and notification utilizing a compliance monitoring tool. The monitoring tool includes interview questions for the th staff regarding abuse prevention and reporting. On 1/21/2019 the monitoring began and will continue 3x/weekly times 4 weeks, then weekly for 8 weeks. Results of the monitoring tool will be brought to the stand down meeting 5x/weeks times 4 weeks, and weekly	

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{F 607}	Continued From page 11 facility became aware of an incident which related to Resident #18 on 12/07/18 at 11:45 PM. A section labeled Allegation Details revealed "Resident allegation of abuse." A section labeled Details of Physical or Mental Injury/Harm revealed a handwritten statement "No harm or change in affect." and the report was signed by the Administrator and dated 12/10/18. A review of a handwritten statement by Nurse #10 which was included with documents in a file with the initial 24 hour report dated 12/07/18, revealed Resident #18 made accusations to Nurse #10 on 12/07/18 about NAs and stated he was hurt by them and "they were being mean" and "kicked me." The statement further revealed Nurse #10 witnessed Resident #18 from the hallway during medication pass and did not observe NAs to be mean or to kick Resident #18 on 12/07/18 at 8:30 PM. The statement also revealed Nurse #10 went into Resident #18's room on 12/08/18 at 5:45 AM to check his blood sugar and he had no complaints. An attempt to contact Nurse #10 on 01/05/19 at 10:45 AM was unsuccessful. A review of a handwritten statement by Nurse Aide (NA) #7 with no date or time but was included in a folder with the initial 24 hour report dated 12/07/18 revealed she went in Resident #18's room and no one "kicked" or hit the resident. An attempt to contact NA #7 on 01/05/19 at 10:48 AM was unsuccessful. A review of a handwritten statement by NA #8 with no date or time but was included with	{F 607}	times 8 weeks. Results of the audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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documents in a file with the initial 24 hour report dated 12/07/17 revealed she worked on 12/07/18 and did not kick Resident #18.

During a telephone interview on 01/05/19 at 11:02 AM, NA #8 explained she had only worked at the facility for a couple of months and had received abuse and neglect training during her orientation by the Director of Nursing. She stated she was aware she was supposed to report allegations of abuse to the Nurse immediately. She explained she did not recall details of the incident when Resident #18 had accused NAs of being mean and kicked him but she did recall a Nurse was in the hallway when it had happened and NA #8 stated she had written a statement because she had been asked to write one.

A review of the documents in the folder revealed there was no statement or interview notes with Resident #18 as part of the facility's investigation regarding his allegation of staff abuse.

During an interview on 01/03/19 at 10:48 AM Resident #18 stated a NA had been rough with him in the past but he did not recall her name and did not recall if he reported it to anyone but he had not seen the NA in a while. He further stated he did not recall the details of the incident on 12/07/18.

A review of a facsimile (fax) confirmation report revealed the initial 24 hour report was submitted to the state agency on 12/10/18 at 8:43 PM and the report was signed by the Administrator on 12/10/18.

A review of a 5 Working Day Report with fax confirmation date of 12/16/18 at 4:30 PM in a

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section labeled Original Allegation Details revealed Resident #18 alleged abuse from a staff member during resident care. The report further revealed several staff were in the room helping with resident care and no witnesses saw any abuse however, a section labeled Witness Information indicated Nurse #10 was listed as a witness.

During an interview on 01/05/19 at 5:53 PM, the Administrator confirmed she was the Abuse Cordinator. She explained it was reported to her during the day on Monday 12/10/18 that Resident #18 had behaviors during care and he reported staff had been mean and had kicked him. She stated when she received the report she started asking quesitons and gathered information and started an investigation. She explained she filed the 24 hour report because it had not been submitted to the state agency within 24 hours after Resident #18 alleged staff had abused him. She further stated staff should have reported an allegation of abuse on the day it happened on 12/07/18. She explained Nurse #10 did not follow facility policy and procedures to report allegations of abuse and Nurse #10 who was employed by a staffing agency no longer worked at the facility. She stated it was her expectation staff should have reported the incident as an allegation of abuse when it happened so an investigation could have been started right away. She further stated the facility policies and procedures were very regulatory and were written in regulatory language. She explained she felt the facility staff needed to do a better job of reporting allegations of abuse and neglect and they needed to put training at a level that their workers could understand better and practice in their daily routines.

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{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to report an allegation of abuse to the state agency within 24 hours when a resident reported an allegation of staff abuse during care for 1 of 3 residents reviewed for abuse and neglect (Resident #18).	{F 609}	F609 Reporting of Alleged Violations How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #18 received a head to toe skin	2/4/19

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{F 609}	Continued From page 15 Findings included: Resident #18 was admitted to the facility on 05/11/18 with diagnoses which included heart failure, peripheral vascular disease (poor circulation in legs), diabetes, respiratory failure and dementia. A review of the quarterly Minimum Data Set (MDS) dated 11/09/18 revealed Resident #18 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #18 required extensive assistance for bed mobility, transfers, dressing, toileting and hygiene. A review of an initial 24 Hour Report revealed the facility became aware of an incident which related to Resident #18 on 12/07/18 at 11:45 PM. A section labeled Allegation Details revealed "Resident allegation of abuse." A section labeled Details of Physical or Mental Injury/Harm revealed a handwritten statement "No harm or change in affect." A review of a handwritten statement by Nurse #10 which was included with documents in a file with the initial 24 hour report dated 12/07/18, revealed Resident #18 made accusations to Nurse #10 on 12/07/18 about NAs and stated he was hurt by them and "they were being mean" and "kicked me." The statement further revealed Nurse #10 witnessed Resident #18 from the hallway during medication pass and did not observe NAs to be mean or to kick Resident #18 on 12/07/18 at 8:30 PM. The statement also revealed Nurse #10 went into Resident #18's room on 12/08/18 at 5:45 AM to check his blood sugar and he had no complaints.	{F 609}	evaluation and was interviewed regarding the allegation. How will facility identify other residents having potential to be affected by the same deficient practice? Facility residents were interviewed by the facility Social Worker regarding any allegations of staff mistreatment. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? The Administrator or Designee will submitting the Initial Allegation Reports to Health Care Personnel. Licensed and unlicensed staff were re-educated by 2/04/2019 regarding F609 Reporting allegations of Abuse timely, and within the required timeframes. Staff members that have not completed education by 2/4/2019 will be educated before able to work their next scheduled shift. Newly hired staff will receive the education during their facility orientation. Education included hands on scenarios and interactive training sessions. How the facility plans to monitor its performance to make sure that solutions are sustained? The Administrator and Director of Nursing will audit each other regarding the initial submission of allegations reports to the	

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{F 609}	Continued From page 16 An attempt to contact Nurse #10 on 01/05/19 at 10:45 AM was unsuccessful. A review of a handwritten statement by Nurse Aide (NA) #7 with no date or time but was included with documents in a file with the initial 24 hour report dated 12/07/18 revealed she went in Resident #18's room and no one "kicked" or hit the resident. An attempt to contact NA #7 on 01/05/19 at 10:48 AM was unsuccessful. A review of a handwritten statement by NA #8 with no date or time but was included with documents in a file with the initial 24 hour report dated 12/07/17 revealed she worked on 12/07/18 and did not kick Resident #18. During an interview on 01/05/19 at 11:02 AM, NA #8 explained she had only worked at the facility for a couple of months and had received abuse and neglect training during her orientation by the Director of Nursing. She stated she was aware she was supposed to report allegations of abuse to the Nurse immediately. She explained she did not recall details of the incident when Resident #18 had accused NAs of being mean and kicked him but she recalled a Nurse was in the hallway when it had happened but did not remember who the Nurse was. A review of the documents revealed there was no statement or interview notes with Resident #18 as part of the facility's investigation regarding his allegation of staff abuse. During an interview on 01/03/19 at 10:48 AM Resident #18 stated a NA had been rough with	{F 609}	Health Care Personnel Registry. The Department Managers and/o designee will monitor Abuse Prevention and notification with targeted questions specific to reporting requirements utilizing the compliance monitoring tool. The monitoring tool includes staff interview questions regarding reporting o f allegations initiated 1/21/2019, to include 2 staff members 3x weekly x 4 weeks, then weekly x 8 weeks. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	

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{F 609}	Continued From page 17	{F 609}		

him in the past but he did not recall her name and did not recall if he reported it to anyone but he had not seen the NA in a while. He further stated he did not recall the details of the incident on 12/07/18.

A review of a facsimile (fax) confirmation report revealed the initial 24 hour initial report was submitted to the state agency on 12/10/18 at 8:43 PM and the report was signed by the Administrator on 12/10/18.

A review of a 5 Working Day Report with fax confirmation date 12/16/18 at 4:30 PM in a section labeled Original Allegation Details revealed Resident #18 alleged abuse from a staff member during resident care. The report further revealed several staff were in the room helping with resident care and no witnesses saw any abuse.

During an interview on 01/05/19 at 5:53 PM, the Administrator explained she received a report on Monday 12/10/18 that Resident #18 had reported staff had been mean and had kicked him. She stated when she received the report on Monday 12/10/18 she started asking questions and started an investigation. She further stated she realized an initial 24 hour report had not been submitted to the state agency so she submitted the initial 24 hour report the day she was informed to cover the facility. She explained when she had questioned staff about the incident they stated Resident #18 had behaviors during care and they did not think to report it as abuse. She further stated staff should have reported an allegation of abuse on the day it happened on 12/07/18 and the 24 hour initial report should have been submitted to the state agency at that

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{F 609}	Continued From page 18 time. She explained Nurse #10 did not follow facility policy and procedures to report allegations of abuse to the Administrator and Nurse #10 who was employed by a staffing agency no longer worked at the facility. She stated it was her expectation staff should have reported the incident as an allegation of abuse when it happened so the initial 24 hour report could have been faxed within 24 hours of the incident.	{F 609}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	{F 656}		2/4/19

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{F 656}	Continued From page 19 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to develop and implement a care plan for vision care for 1 of 3 residents (Resident #17) and failed to follow the care plan for 1 of 4 residents (Resident #14) reviewed for comprehensive care plans. The findings included: 1. Resident #17 was admitted to the facility on 10/06/18 with diagnoses including cataracts, glaucoma and macular degeneration. The admission Minimum Data Set (MDS) dated 10/13/18 indicated Resident #17 had impaired vision and had corrective lenses. The MDS further indicated Resident #17 had mild cognitive impairment and required extensive assistance with most activities of daily living. Review of the admission Care Area Assessment (CAA) for visual function revealed the resident wore eye glasses and had a diagnosis of a cataract. The CAA further indicated a care plan	{F 656}	F656 Develop/Implement Comprehensive Care Plans How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #14 care plan was updated and no longer requires Intake and Output. The IDT Members reviewed resident #14 care plan and determined he did not warrant monitoring intake and output. Resident #17 care plan was updated to reflect her glasses. How will facility identify other residents having potential to be affected by the same deficient practice? The facility consultant reviewed past 90 days of Comprehensive Assessments; included were 11 residents identified that	

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{F 656}	Continued From page 20 would be initiated to begin addressing vision concerns for Resident #17. Record review of the care plans revealed no care plan had been created to address vision for Resident #17. Record review of the Physician's admission History and Physical (H&P) revealed Resident #17 had decreased visual acuity and visual field deficit. The H&P also revealed Resident #17 stated she "needed eyeglasses to see." During an observation on 01/03/19 at 11:14 AM, Resident #17 was observed sitting in her room with her glasses on. Resident #17 was unable to state how long she had been wearing her glasses or whether she was able to see out of them. During an interview on 01/03/19 at 1:11 PM, Nurse Assistant (NA) #11 revealed Resident #17 had glasses and wore them regularly. During an interview on 01/03/19 at 4:28 PM, the MDS Coordinator reviewed the admission MDS and CAA for Resident #17 and stated there should have been a care plan. The MDS Coordinator also reviewed all previously written care plans for Resident #17 to verify if a care plan had been created and resolved but did validate no care plan had been created for vision problems. During an interview on 01/03/19 at 4:35 PM, MDS Coordinator #2 stated after the CAA was completed in an area she would go ahead and create a care plan. MDS Coordinator #2 verified she had written the CAA for Resident #17 but could not explain why a care plan was not written,	{F 656}	triggered for the Visual CAA. 2 of the 11 assessments reviewed required correction according to the RAI Manual. Care plans were updated accordingly. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? The Interdisciplinary Team Members that contribute to the MDS assessment were re-educated by the Corporate AVP of Clinical Quality and Reimbursement on 1/18/19 and 1/22/19 regarding appropriate documentation and care planning based on the comprehensive assessment, to include development and implementation of the care plan for vision care following the care plans as developed. How the facility plans to monitor its performance to make sure that solutions are sustained? The Interdisciplinary Team Members and/or designee will monitor changes of condition and/or concerns utilizing the change of condition audit tool to include care plan revision, and implementation of interventions to maintain the residents highest practical, physical, mental, and psychosocial well-being. Residents that will be monitored through this process as indicated by care plan revisions. Results of the audit tool will be reviewed in stand down meeting 5x weekly times 4 weeks, then weekly times 8 weeks. Results of the on-going audits will be	

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{F 656}	Continued From page 21 but thought it was just an accidental oversight. During an interview on 01/05/19 at 1:17 PM, the Director of Nursing (DON) stated her expectations were for care plans to be comprehensive, up to date, and reflect the resident in his or her current state. 2. Resident #14 was admitted to the facility on 06/13/15 with a recent readmission after a hospitalization on 09/21/18. The admission Minimum Data Set (MDS) dated 09/28/18 indicated Resident #14 had mild cognitive deficits and required assistance with all activities of daily living. The MDS further revealed Resident #14 had an indwelling urinary catheter due to Benign Prostatic Hypertrophy (BPH) as well as urine retention. Review of the admission Care Area Assessment (CAA) for urinary incontinence indicated Resident #14 had a urinary catheter and required staff assistance with toileting. Review of the admission care plan revealed Resident #14 had an "altered pattern of urinary elimination with indwelling cath (foley) at risk for infection - urinary retention, BPH." Goals listed on the care plan indicated for Resident #14 to be clean, dry and free from odor or skin breakdown and to be free of urinary tract infections. One of the interventions was "empty drainage bag at end of shift observe and record output." Review of urinary output for the most recent 30 days revealed five instances of 12 hours or greater time when urinary output was not recorded. These days included 12/04/18, 12/07/18, 12/14/18, 12/19/18 and 12/27/18.	{F 656}	presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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{F 656}	Continued From page 22	{F 656}		

During an observation on 01/02/19 at 6:04 PM, Resident #14 was observed eating dinner in the dining room while sitting in his wheelchair. His catheter was observed in a privacy bag and the catheter and tubing were off the floor.

During an interview on 01/03/19 at 6:09 PM, the Director of Nursing (DON) reviewed the urinary output sheets for Resident #14 for the past 30 days. The DON stated her expectation was for the NA's to document on each shift what the total urinary output was for Resident #14.

During an interview on 01/04/19 at 1:39 PM, Nurse Assistant (NA) #6 stated Resident #14 had a catheter that had to be emptied at least once a shift unless it seemed overly full and you might empty it a second time during the shift. NA #6 also stated that she may have forgotten to document his output on occasion but she's not sure. NA #6 further stated she can remember emptying his catheter at end of shift at least once recently when there was not a lot of urinary output.

During an interview on 01/04/19 at 1:52 PM, NA #3 stated Resident #14 had a catheter and it stayed in a privacy bag off the floor along with the catheter tubing. NA #3 also stated he looked at the catheter bag when he first comes on his shift and then checks it again before he leaves his shift. NA #3 stated he didn't think he ever forgot to document the urine output for Resident #14, but it was possible it had happened.

During an interview on 01/04/19 at 2:02 PM, NA #12 stated Resident #14 had a catheter and usually had an output of 800-1000 cc's per shift.

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{F 656}	Continued From page 23 NA #12 stated he emptied his catheter bag every shift and documented what the output was. NA #12 also stated he may have emptied the bag and forgotten to document Resident #14's output, but he wasn't sure. During an interview on 01/04/19 at 2:18 PM, MDS Coordinator #2 stated that much of the information put into the care plan flowed over to the kardex (system NA's use to view resident care needs) but some of it had to be manually put in. MDS Coordinator #2 stated the information that was listed on the care guide had not reflected for the NA's to "observe and record output" at the end of each shift nor did it indicate the catheter bag was to be emptied at the end of each shift.	{F 656}		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide fingernail care and keep the fingernails clean for 2 of 5 dependent residents reviewed for activities of daily living (Resident #18 and #5). The findings included: 1. Resident #18 was admitted to the facility 05/11/18 with diagnoses which included diabetes and heart failure. The quarterly Minimum Data Set (MDS) dated	{F 677}	F677 ADL Care Provided for Dependent Residents How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #5 and #18 were provided nail care by the facility staff. How will facility identify other residents having potential to be affected by the same deficient practice?	2/4/19

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{F 677}	Continued From page 24 12/23/18 revealed Resident #18 had cognitive deficits and required extensive to total assistance for most Activities of Daily Living (ADL's). The MDS also revealed Resident #18 had no rejection of care. Review of the care plan revealed no rejection of care, however there were some behavioral issues that were directed toward others during the lookback period. During an observation on 01/02/19 at 5:47 PM, Resident #18 was observed to have long fingernails on both hands with brown debris under each fingernail. During an observation on 01/03/19 at 10:48 AM, Resident #18 was observed to have long fingernails on both hands with brown debris under each fingernail. During an observation on 01/04/19 at 5:53 PM, Resident #18 was observed to have long fingernails on both hands with brown debris under each fingernail. During an observation on 01/05/19 at 2:57 PM, Resident #18 was observed to have long fingernails on both hands with brown debris under each fingernail. An interview on 01/05/19 beginning at 2:57 PM with Nurse Aide (NA) #13 revealed she had not offered to clean the fingernails of Resident #18 today or requested that the nurse cut his fingernails. NA #13 also stated that Resident #18 did not like showers and was only given bed baths. Resident #18 was asked in the presence of NA #13 about his fingernails. Resident #18	{F 677}	On 1/8/19 The Treatment Nurse completed 100% observation of dependent residents for nail care and care provided accordingly. Care Plans were updated to reflect resident interventions based on resident preferences and care requirements. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Nursing Staff were re-educated by 2/4/2019 regarding F677 ADL Care for Dependent Residents by the corporate clinical nurses and staff development coordinator. Education included hands on scenarios and interactive training sessions including fingernail care and cleanliness of fingernails. How the facility plans to monitor its performance to make sure that solutions are sustained? The Department Managers and/or designee will monitor ADL Care delivery specifically related to fingernail care and cleanliness of fingernails for 10% of the current census 3x a week x4 weeks, then weekly times 8 weeks utilizing the compliance Monitoring Tool. Results of the monitoring tool will be brought to stand-down meeting 5 times weekly times for 4 weeks, then weekly for 8 weeks. Results of the on-going audits will be presented to the QAPI meeting	

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{F 677}	Continued From page 25 stated his nails were too long and they were dirty, and he could no longer care for them because of his arthritis. NA #13 proceeded to clean the fingernails of Resident #18 and stated she would report to her nurse that his fingernails needed to be cut. An interview on 01/05/19 at 3:44 PM with Nurse #9 revealed he had only given Resident #18 insulin this morning since there was a Certified Medication Aide (CMA) on the unit and he had not noticed his fingernails were long and dirty. An interview on 01/05/19 at 4:17 PM with CMA #6 revealed he gave Resident #18 his oral meds and completed 2 capillary blood glucose (CBG) checks and he did not notice his fingernails. CMA #6 also stated he probably got task oriented and did not notice Resident #18's fingernails, but he should be looking at fingernails when he gives medication or any type of care. An interview on 01/05/19 at 3:59 PM with the Director of Nursing (DON) revealed her expectations were during delivery of care a nurse should observe a resident's fingernails and provide nail care as needed when the resident is diabetic. 2. Resident #5 was admitted to the facility on 02/18/13 with diagnoses which included peripheral vascular disease and dementia. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/16/18 revealed Resident #5 had severe cognitive impairment and required extensive assistance with personal hygiene. The MDS also indicated Resident #5 had no behaviors of rejecting care.	{F 677}	x3months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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{F 677}	Continued From page 26	{F 677}		

A Care Plan revised on 12/17/18 indicated Resident #5 required assistance with personal hygiene and would be neat, clean and odor free on a daily basis. Interventions included the staff would provide intermittent supervision with cues and guidance and would discuss with Resident #5 the portions of the task that he would be willing to attempt.

Observation of Resident #5 on 01/02/19 at 3:21 PM revealed he was sitting in the hallway with brown debris under the fingernails on both of his hands.

Subsequent observations of Resident #5 on 01/02/19 at 6:43 PM, 01/03/19 at 2:14 PM, 01/03/19 at 5:00 PM, 01/04/19 at 9:33 AM, 01/04/19 at 1:00 PM and 01/04/19 2:50 PM revealed the fingernails on both of his hands continued to be unclean with brown debris underneath them.

Interview with Bather #1 on 01/03/19 at 12:08 PM revealed Resident #5 was bathed twice a week which included nail care. The Bather stated Resident #5 was not one to refuse his bath and was cooperative to his nails being trimmed and cleaned.

Interview with Nursing Assistant (NA) #3 on 01/04/19 at 10:46 AM revealed Resident #5 was bathed twice a week and received nail care during his baths and daily as needed.

Interview with NA #3 on 01/04/19 at 2:50 PM revealed he had worked on Resident #5's hall all day and he had not cleaned Resident #5's fingernails. At this time Resident #5's fingernails were observed with NA #3 and he continued to

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{F 677}	Continued From page 27 have brown debris underneath all of his fingernails. NA #3 stated "I will see if he will let me clean his nails". Interview with Nurse #8 on 01/04/19 at 2:56 PM revealed she expected Resident #5's fingernails to be trimmed and cleaned on his bath days and his fingernails particularly needed cleaned every shift. At this time, Nurse #8 observed the condition of Resident #5's fingernails while NA #3 was in the process of cleaning his fingernails. Nurse #8 stated "I would say they needed to be cleaned". During an interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM she stated she expected Resident #5's nails to be kept clean.	{F 677}		
{F 690} SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an 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	{F 690}		2/4/19

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{F 690}	Continued From page 28 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, staff and physician interviews, the facility failed to clarify the diagnosis for an indwelling urinary catheter on admission and to assess the resident for the possible removal of the catheter for 1 of 3 residents reviewed for urinary catheters (Resident #12). The findings included: Resident #12 was originally admitted to the facility on 11/15/18 with diagnoses that included diabetes and renal failure. Review of the discharge summary from the hospital did not have a diagnosis for urinary retention or any other diagnosis for the urinary catheter. Review of physician's orders upon admission revealed no order for an indwelling urinary	{F 690}	F690 Bowel/Bladder Incontinence, Catheter, UTI How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #12'□s catheter was discontinued. How will facility identify other residents having potential to be affected by the same deficient practice? On 1/8/19 the RN Consultant completed 100% audit of residents with catheters to validate appropriate diagnosis for use of indwelling foley catheters, and continued rationale for use. Measures to be put into place or systemic	

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{F 690}	Continued From page 29 catheter. Review of the care plan for Resident #12 dated 11/16/18 indicated 1) an altered pattern of urinary elimination with indwelling catheter and 2) at risk for infection due to urinary retention. Review of the physician's History and Physical (H&P) dated 11/16/18 revealed no diagnoses present for the use of an indwelling urinary catheter. The H&P further revealed the following "patient is continent of both bowel and bladder," "no dysuria" (painful urination), and "frequency and urgency normal." A second follow-up visit dated 11/19/18 revealed "patient is continent of both bowel and bladder," "no dysuria," and "frequency and urgency normal." For both 11/16/18 and 11/19/18 the physical examination for genitourinary was deferred. The 5-day admission Minimum Data Set (MDS) dated 11/22/18 revealed Resident #12 had some cognitive impairment and had been admitted from the hospital with an indwelling urinary catheter. The admission Care Area Assessment (CAA) revealed Resident #12 took medications that could cause incontinence but gave no specific information to address the catheter or assessment and monitoring for the catheter's use and possible removal. The 14-day MDS dated 11/29/18 also revealed the resident had some cognitive impairment along with an indwelling catheter and diagnoses of diabetes and renal failure. No other related diagnoses were listed. Review of nurse's notes dated 11/28/18 revealed Resident #12 had a diagnosis of urinary retention and continued to have a urinary catheter.	{F 690}	changes made to ensure that the deficient practice will not recur? The Director of Nursing and/or designee will monitor new orders starting on 1/21/2019 for catheters utilizing a catheter audit tool upon admission, residents with indwelling urinary catheters will be reviewed for appropriate diagnosis and rationale for continued use or discontinuance. The results of the review will be reviewed with the attending physician if an appropriate diagnosis is not available. Results of the auditing tool will be reviewed in stand down meeting 5x weekly times 4 weeks, then weekly times 8 weeks. How the facility plans to monitor its performance to make sure that solutions are sustained? Results of the audits tool will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Plan of Correction 2/04/2019.	

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{F 690}	Continued From page 30	{F 690}		

Review of laboratory results dated 12/10/18 revealed a urinalysis had indicated Resident #12 was positive for a Urinary Tract Infection (UTI).

Review of the physician's progress note dated 12/10/18 revealed Resident #12 had a urinary catheter secondary to urinary retention.

Review of nurse's notes dated 01/02/19 revealed the catheter was in place with clear yellow drainage.

Review of nurse's notes and assessments revealed no assessment had been completed or monitoring to assess the need for catheter removal prior to 01/02/19.

During an interview with Resident #12 on 01/02/19 at 5:47 PM, he shook his head to the left and right indicating "no" when asked if he knew why he had a urinary catheter. The catheter and tubing were observed during this interview to be sitting in a pink basin wrapped in a clear plastic bag underneath his bed.

Review of nurse's notes dated 01/03/19 revealed a late entry note to discontinue the catheter and to monitor for urination and residual. A second nurse's note dated 01/03/19 revealed no voiding had occurred yet, the bladder was non-distended and oral fluids were being pushed.

Review of nurse's notes dated 01/04/19 revealed Resident #12 was incontinent of urine. A second note from skin wound treatment dated 01/04/19 revealed Resident #12 was voiding freely.

During an interview with the MDS Coordinator on 01/05/19 at 11:40 AM, she reviewed the

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{F 690}	Continued From page 31	{F 690}		

admission MDS and verified there was no diagnosis listed for the use of Resident #12's catheter but wanted to look back at his admission file to verify if there was a diagnosis present.

During a second interview with the MDS Coordinator on 01/05/19 at 12:09 PM, she stated she was must have overlooked that he did not have a diagnosis for a catheter when she put it in the assessment. She further stated if she had recognized it she would have requested a diagnosis from the physician.

During an interview with the physician on 01/05/19 at 12:45 PM, he reviewed his notes and stated Resident #12 did not have a diagnosis for a urinary catheter. The physician further stated if a resident has a urinary catheter there needs to be a diagnosis and if not, they need to remove the catheter. The physician also stated a catheter could be removed if everything was going well with the resident within 2 weeks in a best-case scenario and 4 weeks if there were extenuating circumstances. Technically there was a diagnosis of urinary retention according to the physician, however he stated often things fall through the cracks when a resident is transferred from setting to setting and he often had to try to pick up the pieces and in this case the diagnosis for the catheter fell through the cracks.

During an interview with the Director of Nursing (DON) on 01/05/19 at 2:57 PM, she revealed her expectations were for the nurse to notify the physician upon a resident's admission to the facility if there was no diagnosis for an indwelling catheter and request a diagnosis for the catheter or an order to remove the catheter.

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{F 725}	Continued From page 32	{F 725}		
{F 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff, resident and Physician interviews the facility failed to provide sufficient nursing staffing to perform assessment and take vital signs, to provide fingernail care or provide ice water at the bedside for 4 of 11 sampled residents reviewed for respiratory care, provision of activities of daily	{F 725}	F725 Sufficient Nursing Staff How will corrective action be accomplished for those resident(s) found to be affected by the deficient practice? Resident #2 remains in the facility and	2/4/19

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MACON VALLEY NURSING AND REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734

(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 725}	Continued From page 33 living (ADL) care to dependent residents and choices (Residents #2, #21, #18 and #5). This citation is crossed reference to: 1a. F-0695: Based on observations, record reviews and resident, Physician and staff interviews the facility failed to perform assessments and vital signs for a resident who received oxygen and was sent to the hospital with respiratory distress for 1 of 4 residents reviewed for respiratory care (Resident #2). An interview with Nurse Aide (NA) #9 conducted on 01/03/19 at 4:47 PM revealed she observed Resident #2 having a hard time breathing and the resident told her that she could not breathe. The NA stated she informed the Nurse about Resident #2 having difficulty breathing but did not go back and check on her afterwards because she had thirty other residents to take care of and did not have time. b. F-0677: Activities of Daily Living Skills: Based on observation, record review, resident and staff interviews, the facility failed to provide fingernail care and keep the fingernails clean for 2 of 5 dependent residents reviewed for activities of daily living (Resident #18 and #5). c. F-0561: Self Determination: Based on observation, record reviews, staff and resident interviews the facility failed to honor the choice of having ice water at bedside for 1 of 4 sampled residents reviewed for choices (Resident #21). An interview with Bather #1 on 01/03/19 at 12:08 PM revealed there were days when she was pulled to the hall to work with just herself and	{F 725}	remains stable. Resident #5 and #18 were provided nail care by the facility staff. Resident #21 was provided fresh ice water upon notification. How will facility identify other residents having potential to be affected by the same deficient practice? Residents who are dependent were audited regarding care and services, interventions provided accordingly. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? A Wage Analysis was completed; as a result wage adjustments were made, implementation of a sign-on bonus and recruitment bonus to facilitate staff recruitment in all departments. The Administrator and the Director of Nursing will meet staffing patterns and shift assignments for appropriate coverage weekly and prior to the weekend based on needs in conjunction with on-boarding process. Director of Nursing will ensure adequate staffing is provided daily for performance of assessments including vital signs, provision of nail care, and provision of ice water at the bedside. How the facility plans to monitor its performance to make sure that solutions are sustained?	

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{F 725}	Continued From page 34 another aide who was newly hired. The Bather explained that made it difficult to complete resident care rounds as often as needed because the newly hired aide was not familiar with the residents and could not work on their own as she could. The Bather stated some resident care tasks like toileting, providing incontinent care and turning had to be put off because there was not enough time to get all of the resident care done, and she had to pass on to the oncoming shift what resident care was not completed. During an interview with Bather #2 on 01/03/19 at 12:51 PM she stated the facility had hired a lot of new staff recently which was a good thing but when they were assigned to a hall with only a new staff member that made it difficult to provide all of the resident's daily care needs in a timely manner because the new staff member doesn't know the residents like she does. The Bather stated when she and a new hire was assigned to work by themselves, she felt that she had to provide the resident's basic care needs and what resident care she could not get done she passed on to the next shift. The Bather stated she knew for a fact that the Administration knew how hard it was to work with only a new hire and be expected to get all of the resident care tasks done. During an interview with Nurse #3 on 01/03/19 at 4:41 PM she stated it was difficult for the aides (which was usually a facility aide and an agency aide) to be as thorough as they needed to be with providing resident care such as toileting, checking, changing and feeding the residents but she helped them out as much as she could with answering the call lights in order to free the aides up to be able to provide more resident care.	{F 725}	Results of the monitoring tool which include ADL Care, Call Light response time, and passing water at the bedside, will be brought to stand-down meeting 5x/week times 4 weeks, then weekly times 8 weeks for discussion with the IDT Members and to the monthly QAPI meeting. Results of the audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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{F 725}	Continued From page 35	{F 725}		

During an interview with Nursing Assistant (NA) #3 on 01/04/19 at 10:46 AM he explained it was difficult at times to complete the daily care needs that the residents required when he worked the hall with a newly hired aide because he was tasked to orient the aide and provide the resident's basic activities of daily living. The aide stated when he was unable to complete the tasks he passed what was undone on to the oncoming shift.

During an interview with NA #6 on 01/05/19 at 4:07 PM she stated today she had to work Gray/300 hall with a new hire and they were behind with their hall tasks the whole shift. The NA stated they had two meals to feed, answer call lights, and try to provide as much resident care as they could but could not seemed to get caught up with their tasks. The NA stated she had all intentions to pass out ice water but was unable to do so before she had to go to the other hall to work another eight hours on second shift.

During an interview with NA #17 on 01/05/19 at 9:55 AM she explained she was a newly hired employee that was given eight hours of orientation on first shift then was expected to work the following second shift on a hall by herself. The aide stated that although that was not her ideal orientation she felt that she had no choice to work the hall by herself. The aide stated she did the best she could to provide the residents basic care needs considering how little she knew about them.

On 01/05/19 at 12:58 PM during an interview with the "Scheduler" she explained she was aware of the facility's current staffing situation and estimated a percentage of 80 percent of agency

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{F 725}	Continued From page 36 staff that currently worked at the facility. The Scheduler stated the facility had initiated several new programs such as offering both referral and hire on bonuses, offering shift differential pay, and had adjusted the pay scale to hire new facility staff. On 01/05/19 at 4:42 PM during an interview with the Director of Nursing (DON) she explained that because the facility was cited for insufficient staffing on the last complaint investigation her focus had been on getting agency staff in the facility. The DON stated she was aware that the majority of the facility was staffed with agency staff but that there was a core of the long term staff that remained at the facility and the majority of them worked on first shift which left second and third shift to be staffed with agency staff and that made it difficult to provide a sufficient orientation to the agency staff and to the newly hired facility staff. The DON stated she needed to get over one hurdle at a time and the biggest one was bringing staff into the facility.	{F 725}		
{F 760} SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews, the facility failed to prevent a significant medication error by not following physician orders to administer an anticoagulant for 1 of 3 residents (Resident #18) reviewed for anticoagulant therapy.	{F 760}	F760 Residents are Free of Significant Med Errors How will corrective action be accomplished for those resident(s) found to be affected by the deficient practice?	2/4/19

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{F 760}	Continued From page 37 The findings included: Resident #18 was readmitted to the facility on 12/03/18 with diagnoses which included acute embolism and thrombosis of deep veins of upper extremity, peripheral vascular disease (PVD), long term use of anticoagulants and others. A review of Resident #18's most recent quarterly minimum data set (MDS) dated 11/19/18 revealed the resident was moderately impaired for daily decision making, had an open lesion on his foot and received dressings to his feet. The MDS also revealed the resident had received anticoagulants for 7 days during the look back period. A review of Resident #18's care plan dated 12/17/18 revealed the resident had a care plan for potential for bleeding related to anticoagulant therapy. The goal was the resident would be free of signs/symptoms of bleeding. The interventions included in part, administer medications as ordered by the physician. Review of Resident #18's monthly January 2019 physician orders revealed an order for the resident to receive a 5 milligram tablet of Eliquis (an anticoagulant medication) twice a day by mouth. A review of Resident #18's Medication Administration Record (MAR) for January of 2019, revealed in part, the resident had an order for the following medication in the morning: Eliquis 5 milligram (mg) tablet - 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. On 01/04/19 Resident #18 was scheduled for a	{F 760}	Resident 18'□s Eliquis was administered for his PM dose on the given date. How will facility identify other residents having potential to be affected by the same deficient practice? Residents on anticoagulants were audited to ensure administration occurred per orders. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Unit Managers and/or designee are responsible for reviewing appointments for the next day and notifying the physician to obtain orders for holding or administering medications before appointments. Measures to be put Into place or systemic changes made to ensure that the deficient practice will not recur? Licensed Nurses and Medication Aides were re-educated by 2/4/2019 regarding Medication Administration/Safety specifically related to anticoagulants and anticoagulant administration based on physician orders. Education included hands on scenarios and interactive training sessions. The Director of Nursing and/or designee will monitor new medication orders, medications available on cart and medication administration including	

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{F 760}	Continued From page 38 physician appointment and was scheduled to leave the facility between 7:00 AM and 7:30 AM. Review of the residents MAR revealed on 01/04/19 the resident had not received his Eliquis prior to leaving for his appointment. The MAR revealed the medication had not been given and the medication was circled by Certified Medication Aide (CMA) #1. An interview on 01/05/19 at 10:01 AM with CMA #1 revealed she had not given the Eliquis to Resident #18 because she had not counted narcotics with the off going nurse. CMA #1 stated she could not give any medications until she was able to count with the nurse that had worked the previous night shift. A telephone interview on 01/05/19 at 2:16 PM with Nurse #6 who had worked the night shift on 01/04/19 revealed she had not given Resident #18 his Eliquis because it was scheduled later than her medication pass. Nurse #6 stated Resident #18 left the facility at 7:00 AM and Nurse #9 and CMA #1 knew she had not given his medications prior to him leaving. Nurse #6 stated Resident #18 had an early breakfast before he left and had a bagged lunch to take with him to his appointment. Nurse #6 stated Resident #18 had left before she had counted medications with Nurse #9 or CMA #1 and she probably should have given his medications to him prior to him leaving the facility. An interview on 01/05/19 at 7:53 PM with the Medical Director (MD) revealed he would not have wanted Resident #18 to have gone out of the facility to an appointment without receiving his morning medications. The MD stated Resident #18 not getting his Eliquis was a "significant	{F 760}	anticoagulants beginning 1/28/2019 for 10% of residents on anticoagulants 3x weekly times 4 weeks, and weekly times 8 weeks utilizing the Compliance Monitoring Tool. How the facility plans to monitor its performance to make sure that solutions are sustained? Results of the monitoring tool will be brought to stand-down meeting 5x week for 4 weeks, and weekly for 8 weeks for discussion with the IDT Members and to the monthly QAPI meeting. Results of the on-going audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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{F 760}	Continued From page 39 medication error" and he "could not go without the medication due to the risk of having a blood clot." An interview on 01/05/19 at 8:01 PM with the Director of Nursing (DON) revealed she would have expected Nurse #6 to have given Resident #18 his medications prior to him leaving the facility for his appointment, especially his Eliquis.	{F 760}		

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		2/4/19

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

Electronically Signed | 01/28/2019

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to treat residents in a dignified manner by not covering an exposed resident, entering resident rooms without obtaining permission from the resident to enter and not verifying which resident required assistance for 3 of 6 sampled residents reviewed for dignity (Resident #28, #15 and #6). The findings included: 1. Resident #28 was admitted to the facility on 11/04/17 with diagnoses of seizure disorder and major brain injury. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/22/18 revealed Resident #28 had severe cognitive impairment and required extensive assistance with her activities of daily living. The MDS also indicated Resident #28 had no behaviors of rejecting care. On 01/05/19 at 3:56 PM an observation was made from the hallway of Resident #28 lying on her right side in her unmade bed sleeping with the bottom half of her body exposed and uncovered. Resident #28 was wearing a gown that was positioned above her waist and a brief that was visible from the hallway. Observations of Resident #28 from the hallway revealed on 01/05/19 at 4:00 PM, at 4:07 PM, at 4:14 PM, at 4:19 PM and at 4:20 PM revealed she was lying in bed with her lower torso uncovered and exposed. During these observations, the resident's exposed legs and her	F 550	F550 Resident Rights/Exercise of Rights How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #6 and #15 have no further concerns. Resident #28 was provided privacy upon observation by the facility staff. Staff member identified during survey by resident #15 is no longer is employed. How will facility identify other residents having potential to be affected by the same deficient practice? Residents residing in the facility were interviewed regarding resident rights. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and non-licensed facility staff were re-educated by 2/4/2019 regarding the F550 Resident Rights/Exercise of Rights specific to treating residents in a dignified manner; maintaining their dignity by ensured they are covered, knocking and asking to enter residents room(s) regulation by the corporate clinical nurse consultants and the Staff Development Director. Education included hands on	

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F 550	Continued From page 2 brief were observed from the hallway. During observations on 01/05/19 from 4:00 PM to 4:20 PM, three staff members and one resident were observed to pass by Resident #28's opened door while she was lying in her bed uncovered and with her lower torso and brief exposed. The three staff members who passed by the resident's room did not intervene to cover the resident to protect her from being exposed to others. On 01/05/19 at 4:20 PM observed the Corporate Quality Assurance Nurse (CQAN) knocked on Resident #28's door and entered the room. During an interview with the CQAN on 01/05/19 at 4:22 PM she stated she pulled Resident #28's privacy curtain because from the hallway she observed that the resident was exposed. During an interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM she stated she expected the staff to look into each resident's room as they passed to monitor for issues like exposures. The DON stated the staff was expected to pull Resident #28's privacy curtain to prevent her from being exposed. During an interview with Nurse Aide (NA) #5 on 01/05/19 at 5:43 PM she stated on 01/05/19 she noticed that Resident #28 was lying in her bed exposed and uncovered but she wanted to take the vital sign machine that she was using back to the dayroom before she provided care to Resident #28. The NA stated when she went back to Resident #28's room someone had already closed her door. During an interview with Nurse #7 on 01/05/19 at 5:35 PM she stated she was not aware that	F 550	scenarios and interactive training sessions. All new hires will receive education during their orientation to facility. How the facility plans to monitor its performance to make sure that solutions are sustained? The Department Managers and/or designee began monitoring resident□s rights 1/21/2019 with a Compliance Monitoring Tool that includes observations of resident privacy, knocking on the resident doors, and maintaining residents dignity by covering if exposed. Monitoring 10% of the census 3x/week times 4 weeks, then weekly times 8 weeks. Results of the monitoring tool will be brought to the stand-down meeting 5 times/weekly x 4 weeks, then weekly x 8 weeks. Results of the audits will be presented to the QAPI meeting monthly x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	

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Resident #28 was exposed and uncovered while lying in her bed, but she would have expected the staff to cover her up if they were aware of it.

2. Resident #15 was admitted to the facility on 02/12/18 with diagnoses which included diabetic neuropathy and cataracts and blindness in both eyes. The most recent quarterly Minimum Data Set (MDS) assessment dated 10/08/18 revealed he was cognitively intact, required limited assistance with most of his activities of daily living and his vision was severely impaired.

On 01/02/19 at 5:50 PM Resident #15 was overheard to holler loudly "get this d--- food out of here" and "she yells at me every time she comes in here."Several staff member were observed to rush to Resident #15's room.

During an interview with Resident #15 on 01/03/19 at 10:05 AM he explained that he became upset during the previous evening because "the girl"(did not know her name) who delivered his supper tray to his room "just banged it down on my table and said here is your food." Resident #15 stated the girl did not knock on his door before she came into his room and that was the third time that day that she had "done me that way." The Resident continued to state the staff came into his room all the time uninvited and it was disrespectful to him as a person because his room was his home.

On 01/05/19 at 12:18 PM an interview was conducted with the facility's "Scheduler" who was one of the staff members that went into Resident #15's room on the evening of 01/02/19. The Scheduler stated Resident #15 told the Director of Nursing (DON) (who went into the room at the

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F 550	Continued From page 4	F 550		

same time as she did) that the girl was too loud when she came into his room and that she did not even knock on his door before she entered. The Scheduler stated she did not know who the staff person was that Resident #15 referred to.

During an interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM, she explained the staff member that Resident #15 referred to who entered his room unannounced on the evening of 01/02/19 in a loud manner was a new employee. The DON stated she expected that all employees would knock on Resident #15's door and all resident's doors and wait for an invitation before they entered a resident's room.

3. Resident #6 was admitted to the facility 4/21/09. The quarterly Minimum Data Set dated 10/08/18 revealed Resident #6 had mild cognitive impairment and required supervision to limited assistance for all activities of daily living (ADL's).

During an interview on 01/03/19 beginning at 11:18 AM, Resident #6 stated she had a headache and was observed to use her call light at 11:21 AM. While continuing the interview with Resident #6, Nurse Aide (NA) #10 opened the door and entered the room without knocking or announcing her presence and went directly to the roommate's bed. NA #10 was overheard telling Resident #6's roommate that she was going to get another NA to help her and she would be right back. NA #10 exited the room without speaking to or acknowledging Resident #6. NA #10 returned to the room with a second NA and went to the call light station on the wall and turned it off. Resident #6 then stated she had used the call light for herself not her roommate.

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F 550	Continued From page 5	F 550		

During an interview on 01/03/19 at 11:31 AM, NA #10 stated she had been told by a housekeeper that Resident #6's roommate needed assistance, so she entered the room and went directly to the roommate's bed. NA #10 stated she entered the room assuming the light was for Resident #6's roommate. NA #10 also stated the proper protocol was to knock on the door before entering but she just forgot to do it.

During an interview on 01/03/19 at 11:45 AM, the housekeeper stated she had seen the light on in the hallway for Resident #6's room and told the NA that assistance was needed in that room. The housekeeper stated she did not specify which person needed help because she did not know that information.

During an interview on 01/05/19 at 9:27 AM, Resident #6 stated the NA's often entered her room without knocking. Resident #6 further stated it irritated her that the NA's did not take the time to knock on the door before they entered her room. She also stated she hardly ever used her call light, but when she did it was usually for pain medication. Resident #6 further stated when she does use her call light the staff usually assume it's for her roommate because her roommate used it multiple times throughout the day to request assistance from staff.

During an interview on 01/05/19 at 1:17 PM, the Director of Nursing (DON) stated her expectation was for all staff to knock before entering a resident's room and wait for a response or an invitation to enter and all staff should verify which resident needs assistance when entering a resident's room.

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F 561	Continued From page 6	F 561		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and resident interviews the facility failed to honor the choice of having ice water at bedside for 1 of 4 sampled residents reviewed for choices (Resident #21).	F 561	561 Self-Determination How will corrective action be accomplished for those residents found to be affected by the deficient practice?	2/4/19

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F 561	Continued From page 7 The findings included: Resident #21 was admitted to the facility on 05/28/18 with diagnoses which included chronic obstructive pulmonary disease (COPD). The most recent quarterly Minimum Data Set (MDS) assessment dated 11/30/18 revealed Resident #21 had intact cognition and required supervision with most of her activities of daily living. The MDS also indicated Resident #21 received oxygen. On 01/05/19 at 3:23 PM during an interview with Resident #21 she stated that due to the medications required to treat her COPD and the fact that she used continuous oxygen, her mouth stayed dry and she had requested ice water be kept at her bedside. Resident #21 explained that the Geriatric Care Aides (GCA's) were supposed to pass out ice water but she ended up having to ask for ice water almost every day because it was not being done and that it was "par for the course." Resident #21 stated that eairler in the day she had to ask Nurse Aide (NA) #4 to get her some ice water because there were no GCA's on her hall today. Interview with NA #4 on 01/05/19 at 3:51 PM confirmed Resident #21 had asked him to get her some ice water just before dinner. The NA stated her water pitcher was approximately ¼ full with water and there was maybe two pieces of melted ice left in her water pitcher. The NA explained that he was assigned to float halls when he came into work on 01/05/19 at 11:00 AM and did not know if the ice water had been passed on Resident #21's hall or not. An interview conducted with NA #5 on 01/05/19 at 4:00 PM revealed she worked on Resident #21's	F 561	Resident #21 was provided fresh ice water upon notification. How will facility identify other residents having potential to be affected by the same deficient practice? Facility residents were observed to ensure they had fresh ice water and/or fluids at their bedside as ordered; services provided accordingly. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and unlicensed staff were re-educated by 2/4/2019 regarding F561 Self-Determination, specific to providing water at resident□s bedside by the corporate nurse consultants and the Staff Development Director. New hires will receive the education during their orientation to the facility. Education included hands on scenarios and interactive training sessions. How the facility plans to monitor its performance to make sure that solutions are sustained? The Department Managers and/or designee began monitoring on 1/21/2019 monitoring 10% of the resident census for Ice Water at bedside and within reach for 3x/weekly x4 weeks, then weekly x8 weeks. Results of the monitoring tool will be	

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F 561	Continued From page 8 hall on the 7-3 shift and admitted they did not pass out ice water to all of the residents because they got behind in their work and ended up completing their tasks late. The NA stated the GCAs usually passed out the ice water, but they did not have a GCA on the hall that day. Interview with NA #6 on 01/05/19 at 4:07 PM stated the GCAs usually passed out ice water but they did not have a GCA on the hall today. The NA admitted Resident #21 was "big on having ice water" but they could not pass out the ice water because they got behind on the hall tasks and could not get to it. The NA stated she should have informed the nurse that they were not going to be able to pass out ice water. Observation of the Daily Assignment Sheet 7-3 Shift 01/05/19 revealed no Geriatric Care Aides (GCAs) were scheduled. Interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM revealed, it was the responsibility of the GCAs to pass out the ice water and it should be done at the beginning of the shift. The DON explained that in the event there were no GCAs assigned to the hall then it was the NAs responsibility to pass the ice water out and if they knew they were unable to get it done then they should have informed the Nurse and if it still did not get done they should inform the oncoming shift.	F 561	brought to stand-down meeting 5x/weekly x4 weeks, then weekly x8 weeks. Results of the on-going audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2018.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical	F 583		2/4/19

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F 583	Continued From page 9 records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to protect private health information on 3 of 4 units (Orange hall, Green hall and SPARK) by leaving confidential medical information unattended in an area accessible to the public on 3 of 4 medication carts.	F 583	F583 Personal Privacy/Confidentiality of Records How will corrective action be accomplished for those residents found to be affected by the deficient practice? On 1/5/2019 the licensed staff were	

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F 583	Continued From page 10 The findings included: 1. A continuous observation on 01/03/19 of the Orange hall medication cart from 11:51 AM to 11:54 AM revealed the Medication Administration Record (MAR) book was open and a resident's (Resiident #29) information visible on the medication cart on the Orange hall. Nurse #2 was observed to leave the MAR opened to a resident's information on the medication cart and then left the cart unattended when she went to the supply room to get tubing for a resident's oxygen. An interview on 01/05/19 at 1:16 PM with Nurse #2 revealed she had not realized she had left the MAR opened but knew it should be covered so no resident information was visible. An interview on 01/05/19 at 6:00 PM with the Director of Nursing (DON) revealed it was her expectation that MARs be covered any time the nurse or Certified Medication Aide (CMA) was not standing at the medication cart. The DON stated she had made colored sheets to cover the resident information when the nurse was giving medications and had to step away, so they would not lose their place in the book. 2. A continuous observation on 01/03/19 of the Green hall medication cart from 4:08 PM until 4:13 PM revealed the Medication Administration Record (MAR) book was open and a resident's information (Resident #26) was visible on the medication cart on the Green hall. Nurse #4 was observed to leave the MAR opened to a resident's information while she left the medication cart unattended to go the supply room to get intravenous fluids for a resident.	F 583	provided with privacy cover sheets to utilize during med pass for maintaining confidentiality. How will facility identify other residents having potential to be affected by the same deficient practice? Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and unlicensed staff were re-educated by 2/4/2019 regarding the F583 Personal Privacy/Confidentiality of Records specifically protecting private health information by the corporate clinical nurse consultants and the Staff Development Director. Education included hands on scenarios and interactive training sessions. How the facility plans to monitor its performance to make sure that solutions are sustained? The Department Managers and/or designee will monitor personal privacy/confidentiality of records utilizing Compliance Monitoring Tool initiated 1/21/2019, the monitoring will include observation of the protection of confidential medical information on the medication carts 3x/week times 4 weeks, then weekly x 8 weeks at various medication pass times. Results of the monitoring tool will be brought to stand-down meeting for	

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F 583	Continued From page 11 Another continuous observation on 01/03/19 of the Green hall medication cart from 4:43 PM until 4:48 PM revealed both MAR books were left opened with residents' (Resident #s 31 and 32) information was visible on the medication cart. Nurse #4 was observed to leave both MARs opened to residents' information when she left the medication cart to administer medications in a resident's room. An interview on 01/03/19 at 4:43 PM with the Unit Manager (UM) who walked up to the medication cart on Green hall, revealed resident MAR's should be covered at all times when the nurse is not at the medication cart to protect the resident's private health information. The UM manager reminded Nurse #4 to keep her MARs covered when she was away from the medication cart and the nurse quickly covered the information. An interview on 01/05/19 at 6:00 PM with the Director of Nursing (DON) revealed it was her expectation that MARs be covered any time the nurse was not standing at the medication cart. The DON stated she had made colored sheets to cover the resident information when the nurse was giving medications and had to step away, so they would not lose their place in the book. 3. A continuous observation on 01/05/19 of the SPARK medication cart from 4:48 PM to 5:12 PM revealed the Medication Administration Record (MAR) book was open and a resident's (Resident # 30) information visible on the medication cart in the SPARK unit. Certified Medication Aide (CMA) #1 was observed to leave the MAR opened and the medication cart was unattended while he was in the medication prep room.	F 583	discussion 5x/week times 4 weeks, then weekly x 8 weeks. Results of the audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	

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F 583	Continued From page 12 An interview with CMA #1 on 01/05/19 at 5:15 PM revealed he did not realize he had left the MAR open but knew it should be covered so the resident information was not visible. An interview on 01/05/19 at 6:00 PM with the Director of Nursing (DON) revealed it was her expectation that MARs be covered any time the nurse or Certified Medication Aide (CMA) was not standing at the medication cart. The DON stated she had made colored sheets to cover the resident information when the nurse was giving medications and had to step away, so they would not lose their place in the book.	F 583		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to operationalize abuse policies and procedures in the area of staff reporting of an allegation of abuse when staff did not immediately report the resident's allegations of staff abuse during care to the administrator which	F 607	F607 Develop/Implement Abuse/Neglect Policies How will corrective action be accomplished for those residents found to be affected by the deficient practice?	2/4/19

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F 607	Continued From page 13 resulted in a delay in the facility's investigation of an allegation of abuse for 1 of 3 sampled residents reviewed for abuse and neglect (Resident #18). Findings included: A review of the facility Abuse, Neglect, or Misappropriation of Resident Property Policy dated 01/2009 with a revised date of 03/10/17 revealed in part: The facility believes that residents have the right to be free from abuse, neglect, involuntary seclusion, exploitation, or misappropriation of property. Any employee who witnesses or suspects that abuse, neglect, exploitation, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Failure to report any concern related to neglect, exploitation, abuse, or misappropriation of property will result in disciplinary action and possible termination of employment. The Administrator is responsible to ensure that complaints of abuse, neglect, exploitation, or misappropriation of property and injuries of unknown origin are investigated. Resident #18 was admitted to the facility on 05/11/18 with diagnoses which included heart failure, peripheral vascular disease (poor circulation in legs), diabetes, respiratory failure and dementia. A review of a care plan dated 06/10/18 revealed a focus statement that Resident #18 had acts characterized by inappropriate behavior and was resistive to care and treatment and the goals were listed in part Resident #18 would receive	F 607	Resident #18 received a head-to-toe skin evaluation and was interviewed regarding the allegation. How will facility identify other residents having potential to be affected by the same deficient practice? Facility residents were interviewed by the Social Worker regarding any allegations of staff mistreatment. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and unlicensed staff were re-educated regarding Development/Implementation of F607 Abuse/Neglect Policies specifically related to reporting allegations of abuse; who is the abuse coordinator, procedures of reporting, and timeframes required by the corporate nurse consultants and the Staff Development Coordinator. Education included hands on scenarios and interactive training sessions. Education will be completed by 2/04/2019, staff members will not be allowed after the date without receiving the education prior to reporting to shift. New hires will receive the education during their orientation to the facility. How the facility plans to monitor its performance to make sure that solutions are sustained?	

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F 607	Continued From page 14 care within his choices and preferences. The interventions were listed in part to report behaviors to Nurse and Physician. A review of the quarterly Minimum Data Set (MDS) dated 11/09/18 revealed Resident #18 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #18 required extensive assistance for bed mobility, transfers, dressing, toileting and hygiene and no rejection of care or behaviors were indicated. A review of an initial 24 Hour Report indicated the facility became aware of an incident which related to Resident #18 on 12/07/18 at 11:45 PM. A section labeled Allegation Details revealed "Resident allegation of abuse." A section labeled Details of Physical or Mental Injury/Harm revealed a handwritten statement "No harm or change in affect." and the report was signed by the Administrator and dated 12/10/18. A review of a handwritten statement by Nurse #10 which was included with documents in a file with the initial 24 hour report dated 12/07/18, revealed Resident #18 made accusations to Nurse #10 on 12/07/18 about NAs and stated he was hurt by them and "they were being mean" and "kicked me." The statement further revealed Nurse #10 witnessed Resident #18 from the hallway during medication pass and did not observe NAs to be mean or to kick Resident #18 on 12/07/18 at 8:30 PM. The statement also revealed Nurse #10 went into Resident #18's room on 12/08/18 at 5:45 AM to check his blood sugar and he had no complaints. An attempt to contact Nurse #10 on 01/05/19 at 10:45 AM was unsuccessful.	F 607	Department managers and/or designee will monitor abuse prevention and notification utilizing a compliance monitoring tool, the monitoring tool includes interview questions for the staff regarding abuse prevention and reporting. On 1/21/2019 the monitoring began and will continue 3x/weekly times 4 weeks, then weekly for 8 weeks. Results of the monitoring tool will be brought to the stand down meeting 5x/weeks times 4 weeks, and weekly times 8 weeks. Results of the audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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A review of a handwritten statement by Nurse Aide (NA) #7 with no date or time but was included in a folder with the initial 24 hour report dated 12/07/18 revealed she went in Resident #18's room and no one "kicked" or hit the resident.

An attempt to contact NA #7 on 01/05/19 at 10:48 AM was unsuccessful.

A review of a handwritten statement by NA #8 with no date or time but was included with documents in a file with the initial 24 hour report dated 12/07/17 revealed she worked on 12/07/18 and did not kick Resident #18.

During a telephone interview on 01/05/19 at 11:02 AM, NA #8 explained she had only worked at the facility for a couple of months and had received abuse and neglect training during her orientation by the Director of Nursing. She stated she was aware she was supposed to report allegations of abuse to the Nurse immediately. She explained she did not recall details of the incident when Resident #18 had accused NAs of being mean and kicked him but she did recall a Nurse was in the hallway when it had happened and NA #8 stated she had written a statement because she had been asked to write one.

A review of the documents in the folder revealed there was no statement or interview notes with Resident #18 as part of the facility's investigation regarding his allegation of staff abuse.

During an interview on 01/03/19 at 10:48 AM Resident #18 stated a NA had been rough with him in the past but he did not recall her name and

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F 607	Continued From page 16	F 607		

did not recall if he reported it to anyone but he had not seen the NA in a while. He further stated he did not recall the details of the incident on 12/07/18.

A review of a facsimile (fax) confirmation report revealed the initial 24 hour report was submitted to the state agency on 12/10/18 at 8:43 PM and the report was signed by the Administrator on 12/10/18.

A review of a 5 Working Day Report with fax confirmation date of 12/16/18 at 4:30 PM in a section labeled Original Allegation Details revealed Resident #18 alleged abuse from a staff member during resident care. The report further revealed several staff were in the room helping with resident care and no witnesses saw any abuse however, a section labeled Witness Information indicated Nurse #10 was listed as a witness.

During an interview on 01/05/19 at 5:53 PM, the Administrator confirmed she was the Abuse Cordinator. She explained it was reported to her during the day on Monday 12/10/18 that Resident #18 had behaviors during care and he reported staff had been mean and had kicked him. She stated when she received the report she started asking quesitons and gathered information and started an investigation. She explained she filed the 24 hour report because it had not been submitted to the state agency within 24 hours after Resident #18 alleged staff had abused him. She further stated staff should have reported an allegation of abuse on the day it happened on 12/07/18. She explained Nurse #10 did not follow facility policy and procedures to report allegations of abuse and Nurse #10 who was employed by a

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F 607	Continued From page 17 staffing agency no longer worked at the facility. She stated it was her expectation staff should have reported the incident as an allegation of abuse when it happened so an investigation could have been started right away. She further stated the facility policies and procedures were very regulatory and were written in regulatory language. She explained she felt the facility staff needed to do a better job of reporting allegations of abuse and neglect and they needed to put training at a level that their workers could understand better and practice in their daily routines.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		2/4/19

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F 609	Continued From page 18 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to report an allegation of abuse to the state agency within 24 hours when a resident reported an allegation of staff abuse during care for 1 of 3 residents reviewed for abuse and neglect (Resident #18). Findings included: Resident #18 was admitted to the facility on 05/11/18 with diagnoses which included heart failure, peripheral vascular disease (poor circulation in legs), diabetes, respiratory failure and dementia. A review of the quarterly Minimum Data Set (MDS) dated 11/09/18 revealed Resident #18 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #18 required extensive assistance for bed mobility, transfers, dressing, toileting and hygiene. A review of an initial 24 Hour Report revealed the facility became aware of an incident which related to Resident #18 on 12/07/18 at 11:45 PM. A section labeled Allegation Details revealed "Resident allegation of abuse." A section labeled Details of Physical or Mental Injury/Harm revealed a handwritten statement "No harm or change in affect."	F 609	F609 Reporting of Alleged Violations How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #18 received a head to toe skin evaluation and was interviewed regarding the allegation. How will facility identify other residents having potential to be affected by the same deficient practice? Facility residents were interviewed by the facility Social Worker regarding any allegations of staff mistreatment. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed and unlicensed were re-educated by 2/4/2019 regarding F609 Reporting allegations of abuse timely, and within the required timeframes. Staff members that have not completed education by 2/4/2019 will be educated before able to work their next scheduled shift. Newly hired staff will receive the education during their facility orientation. Education included hands on scenarios	

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F 609	Continued From page 19 A review of a handwritten statement by Nurse #10 which was included with documents in a file with the initial 24 hour report dated 12/07/18, revealed Resident #18 made accusations to Nurse #10 on 12/07/18 about NAs and stated he was hurt by them and "they were being mean" and "kicked me." The statement further revealed Nurse #10 witnessed Resident #18 from the hallway during medication pass and did not observe NAs to be mean or to kick Resident #18 on 12/07/18 at 8:30 PM. The statement also revealed Nurse #10 went into Resident #18's room on 12/08/18 at 5:45 AM to check his blood sugar and he had no complaints. An attempt to contact Nurse #10 on 01/05/19 at 10:45 AM was unsuccessful. A review of a handwritten statement by Nurse Aide (NA) #7 with no date or time but was included with documents in a file with the initial 24 hour report dated 12/07/18 revealed she went in Resident #18's room and no one "kicked" or hit the resident. An attempt to contact NA #7 on 01/05/19 at 10:48 AM was unsuccessful. A review of a handwritten statement by NA #8 with no date or time but was included with documents in a file with the initial 24 hour report dated 12/07/17 revealed she worked on 12/07/18 and did not kick Resident #18. During an interview on 01/05/19 at 11:02 AM, NA #8 explained she had only worked at the facility for a couple of months and had received abuse and neglect training during her orientation by the Director of Nursing. She stated she was aware	F 609	and interactive training sessions. The Administrator or Designee is responsible for submitting initial allegations reports to the Health Care Personnel Registry. How the facility plans to monitor its performance to make sure that solutions are sustained? The Administrator and Director of Nursing will audit the other regarding the initial submission of initial allegations. The Department Managers and/or designee will monitor Abuse Prevention and notification with targeted questions specific to reporting requirements utilizing the Compliance Monitoring Tool. The monitoring tool includes staff interview questions regarding reporting of allegations initiated 1/21/2019, to include 2 staff members 3x weekly x 4 weeks, then weekly times 8 weeks. Results of the monitoring tool will be brought to stand-down meeting 5x weekly times 4 weeks, then weekly times 8 weeks. Results of audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator responsible sustained compliance.	

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F 609	Continued From page 20	F 609	Date of Compliance 2/04/2019.	

she was supposed to report allegations of abuse to the Nurse immediately. She explained she did not recall details of the incident when Resident #18 had accused NAs of being mean and kicked him but she recalled a Nurse was in the hallway when it had happened but did not remember who the Nurse was.

A review of the documents revealed there was no statement or interview notes with Resident #18 as part of the facility's investigation regarding his allegation of staff abuse.

During an interview on 01/03/19 at 10:48 AM Resident #18 stated a NA had been rough with him in the past but he did not recall her name and did not recall if he reported it to anyone but he had not seen the NA in a while. He further stated he did not recall the details of the incident on 12/07/18.

A review of a facsimile (fax) confirmation report revealed the initial 24 hour initial report was submitted to the state agency on 12/10/18 at 8:43 PM and the report was signed by the Administrator on 12/10/18.

A review of a 5 Working Day Report with fax confirmation date 12/16/18 at 4:30 PM in a section labeled Original Allegation Details revealed Resident #18 alleged abuse from a staff member during resident care. The report further revealed several staff were in the room helping with resident care and no witnesses saw any abuse.

During an interview on 01/05/19 at 5:53 PM, the Administrator explained she received a report on Monday 12/10/18 that Resident #18 had reported

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F 609	Continued From page 21 staff had been mean and had kicked him. She stated when she received the report on Monday 12/10/18 she started asking questions and started an investigation. She further stated she realized an initial 24 hour report had not been submitted to the state agency so she submitted the initial 24 hour report the day she was informed to cover the facility. She explained when she had questioned staff about the incident they stated Resident #18 had behaviors during care and they did not think to report it as abuse. She further stated staff should have reported an allegation of abuse on the day it happened on 12/07/18 and the 24 hour initial report should have been submitted to the state agency at that time. She explained Nurse #10 did not follow facility policy and procedures to report allegations of abuse to the Administrator and Nurse #10 who was employed by a staffing agency no longer worked at the facility. She stated it was her expectation staff should have reported the incident as an allegation of abuse when it happened so the initial 24 hour report could have been faxed within 24 hours of the incident.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		2/4/19

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F 656	Continued From page 22 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to develop and implement a care plan for vision care for 1 of 3 residents (Resident #17) and failed to follow the care plan for 1 of 4 residents (Resident #14) reviewed for comprehensive care plans. The findings included:	F 656	F656 Develop/Implement Comprehensive Care Plans How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #14 care plan was revised to	

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F 656	Continued From page 23 1. Resident #17 was admitted to the facility on 10/06/18 with diagnoses including cataracts, glaucoma and macular degeneration. The admission Minimum Data Set (MDS) dated 10/13/18 indicated Resident #17 had impaired vision and had corrective lenses. The MDS further indicated Resident #17 had mild cognitive impairment and required extensive assistance with most activities of daily living. Review of the admission Care Area Assessment (CAA) for visual function revealed the resident wore eye glasses and had a diagnosis of a cataract. The CAA further indicated a care plan would be initiated to begin addressing vision concerns for Resident #17. Record review of the care plans revealed no care plan had been created to address vision for Resident #17. Record review of the Physician's admission History and Physical (H&P) revealed Resident #17 had decreased visual acuity and visual field deficit. The H&P also revealed Resident #17 stated she "needed eyeglasses to see." During an observation on 01/03/19 at 11:14 AM, Resident #17 was observed sitting in her room with her glasses on. Resident #17 was unable to state how long she had been wearing her glasses or whether she was able to see out of them. During an interview on 01/03/19 at 1:11 PM, Nurse Assistant (NA) #11 revealed Resident #17 had glasses and wore them regularly. During an interview on 01/03/19 at 4:28 PM, the	F 656	reflect no longer requiring Intake and Output. IDT members reviewed care plan and determined resident #14 did not warrant monitoring Intake and Output. Resident #17 care plan was updated to reflect her glasses. How will facility identify other residents having potential to be affected by the same deficient practice? The facility consultant reviewed past 90 days of Comprehensive Assessments; included were 11 residents identified that triggered for the Visual CAA. 2 of the 11 assessments reviewed required correction according to the RAI Manual. Care plans were updated accordingly. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? The Interdisciplinary Team Members that contribute to the MDS assessment were re-educated by the Corporate AVP of Clinical Quality and Reimbursement on 1/18/19 and 1/22/19 regarding appropriate documentation and care planning based on the comprehensive assessment, to include development and implementation of the care plan for vision care and following the care plans as developed. How the facility plans to monitor its performance to make sure that solutions are sustained? The Interdisciplinary Team Members and/or designee will monitor changes of	

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F 656	Continued From page 24 MDS Coordinator reviewed the admission MDS and CAA for Resident #17 and stated there should have been a care plan. The MDS Coordinator also reviewed all previously written care plans for Resident #17 to verify if a care plan had been created and resolved but did validate no care plan had been created for vision problems. During an interview on 01/03/19 at 4:35 PM, MDS Coordinator #2 stated after the CAA was completed in an area she would go ahead and create a care plan. MDS Coordinator #2 verified she had written the CAA for Resident #17 but could not explain why a care plan was not written, but thought it was just an accidental oversight. During an interview on 01/05/19 at 1:17 PM, the Director of Nursing (DON) stated her expectations were for care plans to be comprehensive, up to date, and reflect the resident in his or her current state. 2. Resident #14 was admitted to the facility on 06/13/15 with a recent readmission after a hospitalization on 09/21/18. The admission Minimum Data Set (MDS) dated 09/28/18 indicated Resident #14 had mild cognitive deficits and required assistance with all activities of daily living. The MDS further revealed Resident #14 had an indwelling urinary catheter due to Benign Prostatic Hypertrophy (BPH) as well as urine retention. Review of the admission Care Area Assessment (CAA) for urinary incontinence indicated Resident #14 had a urinary catheter and required staff assistance with toileting.	F 656	condition and/or concerns utilizing the change of condition audit tool to include care planned revision, and implementation of interventions to maintain the residents highest practical, physical, mental, and psychosocial well-being. Residents that will be monitored include through this process as indicated by care plan revisions. Results of the audit tool will be reviewed in stand down meeting 5x weekly times 4 weeks, then weekly times 8 weeks. Results of the on-going audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2018.	

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Review of the admission care plan revealed Resident #14 had an "altered pattern of urinary elimination with indwelling cath (foley) at risk for infection - urinary retention, BPH." Goals listed on the care plan indicated for Resident #14 to be clean, dry and free from odor or skin breakdown and to be free of urinary tract infections. One of the interventions was "empty drainage bag at end of shift observe and record output."

Review of urinary output for the most recent 30 days revealed five instances of 12 hours or greater time when urinary output was not recorded. These days included 12/04/18, 12/07/18, 12/14/18, 12/19/18 and 12/27/18.

During an observation on 01/02/19 at 6:04 PM, Resident #14 was observed eating dinner in the dining room while sitting in his wheelchair. His catheter was observed in a privacy bag and the catheter and tubing were off the floor.

During an interview on 01/03/19 at 6:09 PM, the Director of Nursing (DON) reviewed the urinary output sheets for Resident #14 for the past 30 days. The DON stated her expectation was for the NA's to document on each shift what the total urinary output was for Resident #14.

During an interview on 01/04/19 at 1:39 PM, Nurse Assistant (NA) #6 stated Resident #14 had a catheter that had to be emptied at least once a shift unless it seemed overly full and you might empty it a second time during the shift. NA #6 also stated that she may have forgotten to document his output on occasion but she's not sure. NA #6 further stated she can remember emptying his catheter at end of shift at least once recently when there was not a lot of urinary

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F 656	Continued From page 26 output. During an interview on 01/04/19 at 1:52 PM, NA #3 stated Resident #14 had a catheter and it stayed in a privacy bag off the floor along with the catheter tubing. NA #3 also stated he looked at the catheter bag when he first comes on his shift and then checks it again before he leaves his shift. NA #3 stated he didn't think he ever forgot to document the urine output for Resident #14, but it was possible it had happened. During an interview on 01/04/19 at 2:02 PM, NA #12 stated Resident #14 had a catheter and usually had an output of 800-1000 cc's per shift. NA #12 stated he emptied his catheter bag every shift and documented what the output was. NA #12 also stated he may have emptied the bag and forgotten to document Resident #14's output, but he wasn't sure. During an interview on 01/04/19 at 2:18 PM, MDS Coordinator #2 stated that much of the information put into the care plan flowed over to the kardex (system NA's use to view resident care needs) but some of it had to be manually put in. MDS Coordinator #2 stated the information that was listed on the care guide had not reflected for the NA's to "observe and record output" at the end of each shift nor did it indicate the catheter bag was to be emptied at the end of each shift.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		2/4/19

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F 677	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide fingernail care and keep the fingernails clean for 2 of 5 dependent residents reviewed for activities of daily living (Resident #18 and #5). The findings included: 1. Resident #18 was admitted to the facility 05/11/18 with diagnoses which included diabetes and heart failure. The quarterly Minimum Data Set (MDS) dated 12/23/18 revealed Resident #18 had cognitive deficits and required extensive to total assistance for most Activities of Daily Living (ADL's). The MDS also revealed Resident #18 had no rejection of care. Review of the care plan revealed no rejection of care, however there were some behavioral issues that were directed toward others during the lookback period. During an observation on 01/02/19 at 5:47 PM, Resident #18 was observed to have long fingernails on both hands with brown debris under each fingernail. During an observation on 01/03/19 at 10:48 AM, Resident #18 was observed to have long fingernails on both hands with brown debris under each fingernail. During an observation on 01/04/19 at 5:53 PM, Resident #18 was observed to have long fingernails on both hands with brown debris under	F 677	F677 ADL Care Provided for Dependent Residents How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #5 and #18 were provided nail care by the facility staff. How will facility identify other residents having potential to be affected by the same deficient practice? On 1/8/19 The Treatment Nurse completed 100% observation of dependent residents for nail care and care provided accordingly. Care Plans were updated to reflect resident interventions based on resident preferences and care requirements. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Nursing Staff were re-educated by 2/4/2019 regarding F677 ADL Care for Dependent Residents by the corporate clinical nurses and staff development coordinator. Education included hands on scenarios and interactive training sessions including fingernail care and cleanliness of fingernails. How the facility plans to monitor its performance to make sure that solutions are sustained?	

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F 677	Continued From page 28 each fingernail. During an observation on 01/05/19 at 2:57 PM, Resident #18 was observed to have long fingernails on both hands with brown debris under each fingernail. An interview on 01/05/19 beginning at 2:57 PM with Nurse Aide (NA) #13 revealed she had not offered to clean the fingernails of Resident #18 today or requested that the nurse cut his fingernails. NA #13 also stated that Resident #18 did not like showers and was only given bed baths. Resident #18 was asked in the presence of NA #13 about his fingernails. Resident #18 stated his nails were too long and they were dirty, and he could no longer care for them because of his arthritis. NA #13 proceeded to clean the fingernails of Resident #18 and stated she would report to her nurse that his fingernails needed to be cut. An interview on 01/05/19 at 3:44 PM with Nurse #9 revealed he had only given Resident #18 insulin this morning since there was a Certified Medication Aide (CMA) on the unit and he had not noticed his fingernails were long and dirty. An interview on 01/05/19 at 4:17 PM with CMA #6 revealed he gave Resident #18 his oral meds and completed 2 capillary blood glucose (CBG) checks and he did not notice his fingernails. CMA #6 also stated he probably got task oriented and did not notice Resident #18's fingernails, but he should be looking at fingernails when he gives medication or any type of care. An interview on 01/05/19 at 3:59 PM with the Director of Nursing (DON) revealed her	F 677	The Department Managers and/or designee will monitor ADL Care delivery specifically related to fingernail care and cleanliness of fingernails for 10% of the current census 3x times a week x4, then weekly times 8 weeks utilizing the Compliance Monitoring Tool. Results of the monitoring tool will be brought to stand-down meeting 5 times weekly times for 4 weeks, then weekly for 8 weeks. Results of the on-going audits will be presented to the QAPI meeting x3months or until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	

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F 677	Continued From page 29	F 677		

expectations were during delivery of care a nurse should observe a resident's fingernails and provide nail care as needed when the resident is diabetic.

2. Resident #5 was admitted to the facility on 02/18/13 with diagnoses which included peripheral vascular disease and dementia. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/16/18 revealed Resident #5 had severe cognitive impairment and required extensive assistance with personal hygiene. The MDS also indicated Resident #5 had no behaviors of rejecting care.

A Care Plan revised on 12/17/18 indicated Resident #5 required assistance with personal hygiene and would be neat, clean and odor free on a daily basis. Interventions included the staff would provide intermittent supervision with cues and guidance and would discuss with Resident #5 the portions of the task that he would be willing to attempt.

Observation of Resident #5 on 01/02/19 at 3:21 PM revealed he was sitting in the hallway with brown debris under the fingernails on both of his hands.

Subsequent observations of Resident #5 on 01/02/19 at 6:43 PM, 01/03/19 at 2:14 PM, 01/03/19 at 5:00 PM, 01/04/19 at 9:33 AM, 01/04/19 at 1:00 PM and 01/04/19 2:50 PM revealed the fingernails on both of his hands continued to be unclean with brown debris underneath them.

Interview with Bather #1 on 01/03/19 at 12:08 PM revealed Resident #5 was bathed twice a week

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F 677	Continued From page 30 which included nail care. The Bather stated Resident #5 was not one to refuse his bath and was cooperative to his nails being trimmed and cleaned. Interview with Nursing Assistant (NA) #3 on 01/04/19 at 10:46 AM revealed Resident #5 was bathed twice a week and received nail care during his baths and daily as needed. Interview with NA #3 on 01/04/19 at 2:50 PM revealed he had worked on Resident #5's hall all day and he had not cleaned Resident #5's fingernails. At this time Resident #5's fingernails were observed with NA #3 and he continued to have brown debris underneath all of his fingernails. NA #3 stated "I will see if he will let me clean his nails". Interview with Nurse #8 on 01/04/19 at 2:56 PM revealed she expected Resident #5's fingernails to be trimmed and cleaned on his bath days and his fingernails particularly needed cleaned every shift. At this time, Nurse #8 observed the condition of Resident #5's fingernails while NA #3 was in the process of cleaning his fingernails. Nurse #8 stated "I would say they needed to be cleaned". During an interview with the Director of Nursing (DON) on 01/05/19 at 4:24 PM she stated she expected Resident #5's nails to be kept clean.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		2/4/19

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F 690	Continued From page 31 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, staff and physician interviews, the facility failed to clarify the diagnosis for an indwelling urinary catheter on admission and to assess the resident for the possible removal of the catheter for 1 of 3 residents reviewed for urinary catheters (Resident	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI How will corrective action be accomplished for those residents found to be affected by the deficient practice?	

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F 690	Continued From page 32 #12). The findings included: Resident #12 was originally admitted to the facility on 11/15/18 with diagnoses that included diabetes and renal failure. Review of the discharge summary from the hospital did not have a diagnosis for urinary retention or any other diagnosis for the urinary catheter. Review of physician's orders upon admission revealed no order for an indwelling urinary catheter. Review of the care plan for Resident #12 dated 11/16/18 indicated 1) an altered pattern of urinary elimination with indwelling catheter and 2) at risk for infection due to urinary retention. Review of the physician's History and Physical (H&P) dated 11/16/18 revealed no diagnoses present for the use of an indwelling urinary catheter. The H&P further revealed the following "patient is continent of both bowel and bladder," "no dysuria" (painful urination), and "frequency and urgency normal." A second follow-up visit dated 11/19/18 revealed "patient is continent of both bowel and bladder," "no dysuria," and "frequency and urgency normal." For both 11/16/18 and 11/19/18 the physical examination for genitourinary was deferred. The 5-day admission Minimum Data Set (MDS) dated 11/22/18 revealed Resident #12 had some cognitive impairment and had been admitted from the hospital with an indwelling urinary catheter.	F 690	Resident #12'□s catheter was discontinued. How will facility identify other residents having potential to be affected by the same deficient practice? On 1/8/19 the RN Consultant completed 100% audit of residents with catheters to validate appropriate diagnosis for use of indwelling foley catheters, and continued rationale for use. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? The Director of Nursing and/or designee will monitor new orders for catheters utilizing a catheter audit tool beginning 1/21/2019, upon admission residents with indwelling urinary catheters will be reviewed for appropriate diagnosis and rationale for continued use or discontinuance. The results of the review will be reviewed with the attending physician if an appropriate diagnosis not available. Results of the auditing tool will be reviewed in stand down meeting 5x weekly times 4 weeks, then weekly times 8 weeks. How the facility plans to monitor its performance to make sure that solutions are sustained? Results of the audits tool will be presented	

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F 690	Continued From page 33 The admission Care Area Assessment (CAA) revealed Resident #12 took medications that could cause incontinence but gave no specific information to address the catheter or assessment and monitoring for the catheter's use and possible removal. The 14-day MDS dated 11/29/18 also revealed the resident had some cognitive impairment along with an indwelling catheter and diagnoses of diabetes and renal failure. No other related diagnoses were listed. Review of nurse's notes dated 11/28/18 revealed Resident #12 had a diagnosis of urinary retention and continued to have a urinary catheter. Review of laboratory results dated 12/10/18 revealed a urinalysis had indicated Resident #12 was positive for a Urinary Tract Infection (UTI). Review of the physician's progress note dated 12/10/18 revealed Resident #12 had a urinary catheter secondary to urinary retention. Review of nurse's notes dated 01/02/19 revealed the catheter was in place with clear yellow drainage. Review of nurse's notes and assessments revealed no assessment had been completed or monitoring to assess the need for catheter removal prior to 01/02/19. During an interview with Resident #12 on 01/02/19 at 5:47 PM, he shook his head to the left and right indicating "no" when asked if he knew why he had a urinary catheter. The catheter and tubing were observed during this interview to be sitting in a pink basin wrapped in a clear plastic bag underneath his bed.	F 690	to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Plan of Correction 2/04/2019.	

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Review of nurse's notes dated 01/03/19 revealed a late entry note to discontinue the catheter and to monitor for urination and residual. A second nurse's note dated 01/03/19 revealed no voiding had occurred yet, the bladder was non-distended and oral fluids were being pushed.

Review of nurse's notes dated 01/04/19 revealed Resident #12 was incontinent of urine. A second note from skin wound treatment dated 01/04/19 revealed Resident #12 was voiding freely.

During an interview with the MDS Coordinator on 01/05/19 at 11:40 AM, she reviewed the admission MDS and verified there was no diagnosis listed for the use of Resident #12's catheter but wanted to look back at his admission file to verify if there was a diagnosis present.

During a second interview with the MDS Coordinator on 01/05/19 at 12:09 PM, she stated she was must have overlooked that he did not have a diagnosis for a catheter when she put it in the assessment. She further stated if she had recognized it she would have requested a diagnosis from the physician.

During an interview with the physician on 01/05/19 at 12:45 PM, he reviewed his notes and stated Resident #12 did not have a diagnosis for a urinary catheter. The physician further stated if a resident has a urinary catheter there needs to be a diagnosis and if not, they need to remove the catheter. The physician also stated a catheter could be removed if everything was going well with the resident within 2 weeks in a best-case scenario and 4 weeks if there were extenuating circumstances. Technically there was a diagnosis

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F 690	Continued From page 35 of urinary retention according to the physician, however he stated often things fall through the cracks when a resident is transferred from setting to setting and he often had to try to pick up the pieces and in this case the diagnosis for the catheter fell through the cracks. During an interview with the Director of Nursing (DON) on 01/05/19 at 2:57 PM, she revealed her expectations were for the nurse to notify the physician upon a resident's admission to the facility if there was no diagnosis for an indwelling catheter and request a diagnosis for the catheter or an order to remove the catheter.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, Physician and staff interviews the facility failed to perform assessments and vital signs for a resident who received oxygen and was sent to the hospital with respiratory distress (Resident #2) and the facility failed to connect oxygen tubing to an oxygen tank on the back of a resident's wheelchair who was ordered to receive oxygen to keep oxygen saturation percentages above 90 percent (Resident #25) for 2 of 4	F 695	F695 Respiratory/Tracheostomy Care and Suctioning How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #2 was assessed upon return to the facility and orders verified. Resident stable at time of survey.	2/4/19

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F 695	Continued From page 36 sampled residents reviewed for respiratory care. Findings included: 1. Resident #2 was admitted to the facility on 11/12/18 with diagnoses which included chronic respiratory failure with hypoxia (oxygen deficiency), obstructive sleep apnea (breathing stops during sleep), COPD (chronic obstructive pulmonary (lung) disease), atelectasis (partial or complete collapse of a lung), shortness of breath and dementia. A Review of Physician's orders dated 11/12/18 revealed the following respiratory orders: Albuterol 0.083 percent nebulizer every 6 hours Duoneb inhaler 3 milliliters 4 times a day Advair 250-50 microgram inhaler 1 puff 2 times a day Oxygen 2 liters per minute via nasal cannula continuous to maintain oxygen saturation percentage above 90 percent. A review of a care plan with a created date of 11/14/18 indicated Resident #2 had the potential for or actual ineffective breathing pattern related to COPD and the goal was Resident #2's airway would be maintained. The interventions were listed in part to assess and monitor for signs or symptoms of insufficient breathing pattern, rapid heartbeat, anxiety, restlessness, shortness of breath, rapid breathing followed by decreased breathing rate, sudden decrease in activity tolerance, blueness of lips, fingers and face, increased confusion or pleuritic chest pain in the lung areas. A review of an admission Minimum Date Set (MDS) dated 11/19/18 indicated Resident #2 was	F 695	On 1/3/19 Resident #25's Oxygen was reconnected to concentrator and current orders verified. How will facility identify other residents having potential to be affected by the same deficient practice? Residents with oxygen ordered were reviewed and verified for appropriate order vs. oxygen administered. No further residents were identified to have a variance from orders. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Nursing Staff were re-educated by 2/4/2019 regarding Respiratory Care specifically respiratory assessments to include vital signs and ensuring oxygen is being delivered per physician orders and oxygen tubing connected as ordered. Education included hands on scenarios and interactive training sessions. Newly hired staff will receive education during facility orientation. The Director of Nursing and/or Designee will monitor respiratory care delivery and appropriate orders utilizing the change of condition audit, to include assessment completion and documentation of the assessment to begin1/21/2019 5x week for 4 weeks then weekly times 8 weeks. How the facility plans to monitor its	

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moderately impaired in cognition for daily decision making. The MDS further indicated Resident #2 required extensive assistance for dressing and toileting but required limited assistance for bed mobility, transfers and locomotion off the unit and required supervision for locomotion on the unit and eating. The MDS also revealed oxygen was indicated.

A review of a nurse's progress note dated 11/26/18 at 2:11 PM documented by Nurse #2 revealed Resident #2's respirations were even and unlabored. The notes further revealed Resident #2 had no shortness of breath and had oxygen on at 2 liters per minute per physician's orders but got short of breath with exertion.

A review of a nurse's progress note dated 11/26/18 at 9:09 PM documented by Nurse #1 revealed around 8:45 PM a receptionist called Nurse #1 and informed her that 911 was on the phone because Resident #2 had called them. The note further revealed when Nurse #1 arrived in Resident #2's room she appeared to have a lot of anxiety but there was no documentation of an assessment of Resident #2 which included lung sounds or vital signs. The notes also revealed Resident #2 was transferred to the hospital by Emergency Medical Services (EMS) for evaluation and treatment.

A review of an EMS report dated 11/26/18 revealed EMS personnel arrived at Resident #2's bedside at 8:38 PM. A section labeled History of Present Illness indicated EMS was called to the facility at Resident #2's request because of breathing difficulties. The report revealed Resident #2 was sitting in a wheelchair beside her bed and was alert but in obvious distress.

performance to make sure that solutions are sustained?

Results of the monitoring tool will be brought to stand-down 5x week for 4 weeks then weekly times 8 weeks for discussion with the IDT Members and to the monthly QAPI meeting. Results of the audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance.

The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.

Date of Compliance 2/04/2018.

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The report indicated EMS personnel asked Nurse #1 if Resident #2 had received a breathing treatment and Nurse #1 stated she had given Resident #2 a breathing treatment "about 5:30 PM." The report further indicated Resident #2 had respiratory wheezes and little air movement in the bases of her lungs. The report revealed Resident #2 had oxygen on at 3 liters per minute, her blood pressure was 203/84, heart rate was 130, respirations were 30 and labored and temperature was 98.8 degrees Fahrenheit. The report further revealed EMS personnel administered Duoneb 3 milligram (mg) nebulizer treatment at 8:48 PM, Solumedrol (steroid) 125 mg intravenously at 8:52 PM, left the facility with Resident #2 at 8:56 PM and arrived at the emergency room at 9:04 PM.

A review of an Emergency Room report dated 11/26/18 revealed Resident #2 presented to the emergency room with severe shortness of breath. The notes further revealed Resident #2 was short of breath and was hard to understand due to her breathlessness. A section labeled Assessment/Plan revealed a chest x-ray revealed a fairly large pleural effusion (excess fluid in the lung) on the left that was much changed from a previous x-ray dated 11/09/18. A section labeled Diagnosis/Disposition revealed COPD exacerbation, worsening pleural effusion and debility.

A review of a hospital discharge summary dated 11/29/18 revealed Resident #2 had a left pleural effusion with a thoracentesis (procedure to remove fluid from the lung) and a liter of bloody fluid was obtained, oxygen saturation was 94 percent on 2 liters of oxygen, she was clinically improved and was discharged back to the facility.

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During an interview on 01/02/19 at 5:33 PM, Nurse #1 who was assigned to care for Resident #2 during second shift on 11/26/18 explained she received report on 11/26/18 from day shift Nurse #2 that Resident #2 had increased anxiety but reported no other concerns. Nurse #1 explained Resident #2 requested a breathing treatment to help her breathe better before her regularly scheduled breathing treatment at 6:00 PM. She stated she gave Resident #2 a breathing treatment and thought she had listened to Resident #2's lungs but did not recall what she had heard. She explained later while she was giving medications to other residents NA #9 reported Resident #2 had requested another breathing treatment because she was having breathing problems and then a receptionist told her Resident #2 had called 911. She stated she went to Resident #2's room but by the time she got there EMS had arrived at the facility and they took Resident #2 to the hospital. After review of Resident #2's medical record Nurse #1 confirmed she documented a pulse oxygenation percentage of 92 in the electronic medical record on 11/26/18 at 5:47 PM and confirmed there was no pulse oxygenation percentage or vital signs documented after that time or before Resident #2 was transported to the hospital by EMS after 8:30 PM. She confirmed there were no other notes to describe Resident #2's respiratory condition because she had not documented assessments of Resident #2 in the nurse's notes. Nurse #1 stated she did not recall getting a pulse oxygenation percentage after 5:47 PM and did not recall checking Resident #2's vital signs.

During a telephone interview on 01/03/19 at 11:10 AM with the EMS Lead Supervisor, he confirmed

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he responded to the facility on 11/26/18 after Resident #2 called 911 because it was his routine to respond with the EMS crew on that type of call. He stated when he arrived in Resident #2's room she was sitting in a wheelchair by her bed and was having obvious respiratory distress with difficulty breathing. He described her as leaning forward trying to breathe and she was emotionally upset because she felt she had not gotten treatment she needed. He stated Resident #2 was hooked to an oxygen concentrator with oxygen on at 3 liters per minute and a Nurse was in the room but he could not recall her name. He further stated he asked the Nurse if Resident #2 had received a breathing treatment for her current episode and the Nurse reported she had given Resident #2 a breathing treatment at 5:00 PM. He explained EMS personnel treated Resident #2 according to their protocols for COPD and Asthma excerbation and transported her to the emergency room for evaluation and treatment.

During a telephone interview on 01/03/19 at 9:13 PM, Nurse #2 stated Resident #2 wore oxygen all the time and had been fine during day shift on 11/26/18. She explained Nurse's were expected to document assessments in the nurse's notes when a resident had respiratory problems. She further explained Nurses were expected to listen to the resident's lungs, check vital signs and oxygen saturation percentages and document them in the resident's medical record.

During a telephone interview on 01/03/19 at 12:22 PM, the Physician who was also the facility Medical Director stated it was his expectation for Nurse's to evaluate the resident and investigate when a resident had respiratory problems. He

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further stated there should be documentation as to what the Nurse's evaluation revealed and the documentation should be a footprint with the assessments to indicate what the Nurse did.

During a telephone interview on 01/03/19 at 4:47 PM, NA #9 who was assigned to care for Resident #2 during second shift on 11/26/18 stated after supper Resident #2 told her she was having difficulty breathing and wanted a breathing treatment. She explained she told Resident #2 she would tell Nurse #1 but when she went to the nurse's station Nurse #1 stated Resident #2 had called 911. She further explained she did not recall if she checked or documented Resident #2's vital signs on 11/26/18 because everything had happened so fast.

During an interview on 01/04/19 at 9:54 AM, the Director of Nursing stated after review of Resident #2's medical record Nurse #1 failed to document assessments of Resident #2. She explained it was her expectation for Nurses to document any assessments they did and vital signs were supposed to be taken at the first of the shift and were supposed to be documented at the point of care when taken. She stated apparently documentation of assessments and vital signs had not occurred on 11/26/18 before Resident #2 called 911. She further stated she could not explain what had happened with Resident #2's condition because there were no assessments documented. She explained Nurses were supposed to document as care was rendered and if a Nurse went into a resident's room and the resident was having respiratory distress the Nurse should make quick decisions and listen to lung sounds, get vital signs and all of the information should be documented in the

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resident's medical record.

2. Resident #25 was re-admitted to the facility on 01/12/18 with diagnoses which included anemia, chronic lung disease, history of pneumonia, depression and dementia.

A review of a care plan dated 10/18/18 indicated the potential for or actual ineffective breathng pattern related to pneumonia and the goal was Resident #25's airway would be maintained. The interventions were listed in part to monitor for signs or symptoms of insufficient breathing pattern, notify Physician of signs or symptoms of insufficient breathing pattern and provide oxygen therapy as ordered.

A review of the most recent significant change Minimum Data Set (MDS) dated MDS 10/26/18 revealed Resident #25 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #25 required extensive assistance for med mobility and transfers but required limited assistance with locomotion on the unit and oxygen was indicated.

A review of the monthly Physician's orders dated 01/01/19 through 01/31/19 revealed Resident #25 was to wear oxygen to keep his oxygen saturation percentages above 90.

During continuous observations on 01/03/19 which started at 11:28 AM Resident #25 was sitting in a wheelchair and propelled himself out of his room into the hallway. The observations revealed Resident #25 had an oxygen tank on the back of the wheelchair, he had a nasal cannula in his nose and he was holding oxygen tubing in his lap but the tubing was not connected to the

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oxygen tank. Resident #25 was then observed to propel himself in the wheelchair around the nurse's station and next to Nurse #2 who was giving medications to residents. Resident #25 was asked by the surveyor if he was having trouble breathing while seated in his wheelchair next to Nurse #2 and he stated "no, I just have old lungs." The observations revealed Nurse #2 continued to pull medications out of a medication cart and did not speak to Resident #25. The observations continued and Resident #25 propelled himself down a hallway and back to his room while holding the disconnected oxygen tubing in his lap then came back out of his room and passed Nurse Aide (NA) #10 in the hallway. Observations revealed NA #10 walked by Resident #25 but did not stop or speak to Resident #25. Resident #25 then propelled himself in the wheelchair inside of a dayroom and continued to hold the oxygen tubing in his lap which was not connected to the oxygen tank on the back of his wheelchair. The observations continued until 11:53 AM when the MDS Coordinator walked into the day room and looked at Resident #25's oxygen tank and connected the oxygen tubing to the oxygen tank on the back of Resident #25's wheelchair. The observations further revealed the MDS Coordinator did not check Resident #25's oxygen saturation percentage before or after she connected the oxygen tubing to the oxygen tank.

During a telphone interview on 01/03/19 at 12:22 PM, the facility Medical Director stated it was his expectations for Nurses to follow Physician's orders. He futher stated it was his expectation for Nurses to assess a resident's respiratory status and if a resident was ordered to have oxygen they should receive oxygen as ordered by the

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Physician.

During a telephone interview on 01/05/19 at 11:02 AM, NA #10 stated she had only worked at the facility for about 3 months. She further stated she was familiar with Resident #25 and was aware he wore oxygen. She stated she recalled seeing Resident #25 in the hallway on 01/03/19 and saw he had his oxygen tubing in his lap but did not realize it was not connected to the oxygen tank because she was on her way to another unit.

During an interview on 01/05/19 at 11:38 AM, the MDS Coordinator stated she recalled a couple of days ago she saw Resident #25 holding oxygen tubing in his lap. She confirmed she was walking by the day room and she went into the room and adjusted the nasal cannula in his nose and connected the oxygen tubing to the tank on the back of his wheelchair. She stated Resident #25 said his oxygen machine was in his room but she reminded him he had an oxygen tank on the back of his wheelchair. She explained then Resident #25 asked if he was supposed to tell someone when he went out of his room to put his oxygen on and the MDS Coordinator stated she told him his oxygen tubing needed to be connected to the oxygen tank on the back of his wheelchair when he was out of his room. She further stated Resident #25 did not refuse for her to connect the oxygen tubing and she was not sure why other staff did not make sure his oxygen tubing was connected to the oxygen tank on the back of his wheelchair.

During an interview on 01/05/19 at 1:17 PM, Nurse #2 confirmed she was giving resident medications during her medication pass on 01/03/19 but did not realize Resident #25 did not

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F 695	Continued From page 45 have his oxygen tubing connected to the oxygen tank on the back of his wheelchair. She stated she did recall hearing someone ask Resident #25 if he was having trouble breathing and he had stated he just had old lungs. She further stated she should have looked at Resident #25's oxygen and should have made sure the oxygen tubing was connected to the oxygen tank on the back of Resident #25's wheelchair. During an interview on 01/05/19 at 3:25 PM, the Director of Nursing stated it was her expectation if a resident was in the hall or day room with oxygen tubing that was disconnected from the oxygen tank staff should connect the resident's oxygen tubing and make sure the oxygen was turned on to the liter flow ordered by the physician.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		2/4/19

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F 725	Continued From page 46 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff, resident and Physician interviews the facility failed to provide sufficient nursing staffing to perform assessment and take vital signs, to provide fingernail care or provide ice water at the bedside for 4 of 11 sampled residents reviewed for respiratory care, provision of activities of daily living (ADL) care to dependent residents and choices (Residents #2, #21, #18 and #5). This citation is crossed reference to: 1a. F-0695: Based on observations, record reviews and resident, Physician and staff interviews the facility failed to perform assessments and vital signs for a resident who received oxygen and was sent to the hospital with respiratory distress for 1 of 4 residents reviewed for respiratory care (Resident #2). An interview with Nurse Aide (NA) #9 conducted on 01/03/19 at 4:47 PM revealed she observed Resident #2 having a hard time breathing and the resident told her that she could not breathe. The NA stated she informed the Nurse about Resident #2 having difficulty breathing but did not go back and check on her afterwards because she had	F 725	F725 Sufficient Nursing Staff How will corrective action be accomplished for those resident(s) found to be affected by the deficient practice? Resident #2 remains in the facility and remains stable. Resident #5 and #18 were provided nail care by the facility staff. Resident #21 was provided fresh ice water upon notification. How will facility identify other residents having potential to be affected by the same deficient practice? Residents who are dependent were audited regarding care and services, interventions provided accordingly. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? A wage analysis was completed as a result wage adjustments made,	

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F 725	Continued From page 47 thirty other residents to take care of and did not have time. b. F-0677: Activities of Daily Living Skills: Based on observation, record review, resident and staff interviews, the facility failed to provide fingernail care and keep the fingernails clean for 2 of 5 dependent residents reviewed for activities of daily living (Resident #18 and #5). c. F-0561: Self Determination: Based on observation, record reviews, staff and resident interviews the facility failed to honor the choice of having ice water at bedside for 1 of 4 sampled residents reviewed for choices (Resident #21). An interview with Bather #1 on 01/03/19 at 12:08 PM revealed there were days when she was pulled to the hall to work with just herself and another aide who was newly hired. The Bather explained that made it difficult to complete resident care rounds as often as needed because the newly hired aide was not familiar with the residents and could not work on their own as she could. The Bather stated some resident care tasks like toileting, providing incontinent care and turning had to be put off because there was not enough time to get all of the resident care done, and she had to pass on to the oncoming shift what resident care was not completed. During an interview with Bather #2 on 01/03/19 at 12:51 PM she stated the facility had hired a lot of new staff recently which was a good thing but when they were assigned to a hall with only a new staff member that made it difficult to provide all of the resident's daily care needs in a timely manner because the new staff member doesn't know the residents like she does. The Bather stated when	F 725	implementation of sign-on bonus and recruitment bonus to facilitate staff recruitment in all departments. The Administrator and Director of Nursing will meet staffing patterns and shift assignments for appropriate coverage weekly and prior to the weekend based on needs in conjunction with on-boarding process. Director of Nursing will ensure adequate staffing is provided daily for performance of assessments including vital signs, provision of nail care, and provision of ice water at the bedside. How the facility plans to monitor its performance to make sure that solutions are sustained? Results of the monitoring tool which includes ADL Care, Call Light Response time, and passing water to the residents will be brought to stand-down meeting 5x/week times 4 weeks, then weekly times 8 weeks for discussion with the IDT Members and to the monthly QAPI meeting. Results of the audits will be presented to the QAPI meeting x months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	

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she and a new hire was assigned to work by themselves, she felt that she had to provide the resident's basic care needs and what resident care she could not get done she passed on to the next shift. The Bather stated she knew for a fact that the Administration knew how hard it was to work with only a new hire and be expected to get all of the resident care tasks done.

During an interview with Nurse #3 on 01/03/19 at 4:41 PM she stated it was difficult for the aides (which was usually a facility aide and an agency aide) to be as thorough as they needed to be with providing resident care such as toileting, checking, changing and feeding the residents but she helped them out as much as she could with answering the call lights in order to free the aides up to be able to provide more resident care.

During an interview with Nursing Assistant (NA) #3 on 01/04/19 at 10:46 AM he explained it was difficult at times to complete the daily care needs that the residents required when he worked the hall with a newly hired aide because he was tasked to orient the aide and provide the resident's basic activities of daily living. The aide stated when he was unable to complete the tasks he passed what was undone on to the oncoming shift.

During an interview with NA #6 on 01/05/19 at 4:07 PM she stated today she had to work Gray/300 hall with a new hire and they were behind with their hall tasks the whole shift. The NA stated they had two meals to feed, answer call lights, and try to provide as much resident care as they could but could not seemed to get caught up with their tasks. The NA stated she had all intentions to pass out ice water but was unable to

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do so before she had to go to the other hall to work another eight hours on second shift.

During an interview with NA #17 on 01/05/19 at 9:55 AM she explained she was a newly hired employee that was given eight hours of orientation on first shift then was expected to work the following second shift on a hall by herself. The aide stated that although that was not her ideal orientation she felt that she had no choice to work the hall by herself. The aide stated she did the best she could to provide the residents basic care needs considering how little she knew about them.

On 01/05/19 at 12:58 PM during an interview with the "Scheduler" she explained she was aware of the facility's current staffing situation and estimated a percentage of 80 percent of agency staff that currently worked at the facility. The Scheduler stated the facility had initiated several new programs such as offering both referral and hire on bonuses, offering shift differential pay, and had adjusted the pay scale to hire new facility staff.

On 01/05/19 at 4:42 PM during an interview with the Director of Nursing (DON) she explained that because the facility was cited for insufficient staffing on the last complaint investigation her focus had been on getting agency staff in the facility. The DON stated she was aware that the majority of the facility was staffed with agency staff but that there was a core of the long term staff that remained at the facility and the majority of them worked on first shift which left second and third shift to be staffed with agency staff and that made it difficult to provide a sufficient orientation to the agency staff and to the newly

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F 725	Continued From page 50 hired facility staff. The DON stated she needed to get over one hurdle at a time and the biggest one was bringing staff into the facility.	F 725		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to administer medications with a 5 per cent (%) or less error rate as evidenced by 5 medication administration errors out of 25 opportunities for a medication error rate of 20% for 4 of 14 residents (Resident #s 11, 9, 27, and 26) during medication pass. The findings included: 1. Resident #11 was readmitted to the facility on 10/17/18 with diagnoses which included type 2 diabetes mellitus. A review of his January 2019 Medication Administration Record (MAR) revealed he was on finger stick blood sugars (FSBS) before meals and at bedtime with sliding scale insulin (SSI) for coverage and was on scheduled insulin as well. On 01/02/19 at 11:45 AM during the observation of a medication pass, Nurse #1 was giving medications to Resident #11 which included 6 units of Novolog insulin for a FSBS of 280 and a scheduled dose of Novolog 10 units before lunch for a total of 16 units of Novolog. Nurse #1 drew	F 759	F759 Free of Medication Error Rate 5% or More How will corrective action be accomplished for those resident(s) found to be affected by the deficient practice? Resident□s #9 and #27 remain in the facility and are stable. Resident #11 was administered the correct dose of insulin. Resident #26□s Flonase was obtained from the pharmacy. How will facility identify other residents having potential to be affected by the same deficient practice? Resident medication orders were reviewed to ensure all medications were available as written by 2/4/2019. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?	2/4/19

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F 759	Continued From page 51 up the insulin in an insulin syringe and showed the syringe that was read at 10 units of Novolog. Nurse #1 locked the medication cart and was getting ready to take the medication to Resident #11 when she was stopped and asked to verify the amount of insulin in the syringe. Nurse #1 looked at the syringe again and saw that it only had 10 units in the syringe. An interview on 01/03/19 at 11:34 AM with Nurse #1 revealed she had drawn up the wrong amount of insulin and was thankful it was corrected before it was given. Nurse #1 stated she had "looked at the bottom of the plunger in the syringe instead of the top of the plunger. Nurse #1 stated she should have double checked the syringe before leaving the cart to give the medication. An interview on 01/05/19 at 3:00 PM with the Director of Nursing (DON) revealed she expected the staff administering medications to follow the 5 rights of medication administration including right person, right medication, right dose, right route and right time. 2. Resident #9 was readmitted to the facility on 03/28/18 with diagnoses which included type 2 diabetes mellitus. A review of her January MAR revealed she was scheduled insulin prior to lunch. The order was for Resident #9 to receive Novolog 6 units subcutaneously (SQ) before lunch. Nurse #2 drew up the insulin in an insulin syringe and showed the syringe that was read at 6 units of Novolog. On 01/03/19 at 12:00 PM during the observation of a medication pass, Nurse #2 went in to Resident #9's room and cleaned an area around her belly button on her stomach and gave the	F 759	Licensed Nurses and Medication Aides were re-educated regarding Medication Administration/Safety specifically medication administration of insulin prep and administration, medication omission, common mistakes to avoid, and transcription of medications to medication administration record by the corporate clinical nurses, the Staff Development Director, and the Consultant Pharmacist by 2/4/2019. Education included hands on scenarios and interactive training sessions. The Director of Nursing and/or Designee will monitor new medication orders, medications available on cart, and medication administration including insulin. The monitoring began 1/28/2019 and will include transcription of new orders to the Medication administration record and treatment administration record, availability of new medications ordered, and resident's medication schedules when out on appointments utilizing the Compliance Monitoring Tool. Insulin administration will be reviewed utilizing the monitoring tool, including observation of administration. 10% of resident census will be monitored 3x week for 4 weeks, then weekly for 8 weeks. The consultant pharmacist will perform medication pass observation on her monthly visits. How the facility plans to monitor its performance to make sure that solutions are sustained?	

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F 759	Continued From page 52 insulin holding the syringe sideways and parallel to the stomach instead of at a 90 degree angle to the stomach. The insulin was administered intradermal at a 5 degree angle instead of SQ at a 90 degree angle. There was no noted induration of the skin at the injection site. An interview on 01/05/19 at 1:16 PM with Nurse #2 revealed she had given the insulin "sideways." Nurse #2 stated that was the way that she was taught to do insulin injections and that was the way she had always done them. An interview on 01/05/19 at 3:00 PM with the Director of Nursing (DON) revealed she was not aware that Nurse #2 was giving insulin intradermal at a 5 degree angle to the stomach. The DON stated the facility did have skills checklists on the nurses and giving injections was a part of the skills checklist; however, she could not locate a skills checklist for Nurse #2. The DON stated she expected the staff administering medications to follow the 5 rights of medication administration including right person, right medication, right dose, right route and right time. The DON demonstrated she expected the nurses to give insulin injections with an insulin syringe at a 90 degree angle with the needle going straight in to the stomach or body part. 3. Resident #27 was readmitted to the facility on 04/26/18 with diagnoses which included type 2 diabetes mellitus. A review of his January 2019 MAR revealed he was on FSBS before meals and at bedtime with SSI for coverage. His FSBS prior to lunch on 01/03/19 was 166 and according to his orders he was to receive 2 units of Novolog insulin for coverage. Nurse #2 drew up the insulin and it was verified as 2 units of Novolog.	F 759	Results of the monitoring tool will be brought to stand-down meeting 5x week times 4 weeks, then weekly times 8 weeks for discussion with the IDT Members and to the monthly QAPI meeting. Results of the on-going audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	

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F 759	Continued From page 53	F 759		

On 01/03/19 at 12:20 PM during the observation of a medication pass, Nurse #2 went in to Resident #27's room and cleaned an area around his belly button on his stomach and gave the insulin holding the syringe sideways and parallel to the stomach instead of at a 90 degree angle to the stomach. The insulin was administered intradermal at a 5 degree angle instead of SQ at a 90 degree angle. There was no noted induration of the skin at the injection site.

An interview on 01/05/19 at 1:16 PM with Nurse #2 revealed she had given the insulin "sideways." Nurse #2 stated that was the way that she was taught to do insulin injections and that was the way she had always done them.

An interview on 01/05/19 at 3:00 PM with the Director of Nursing (DON) revealed she was not aware that Nurse #2 was giving insulin intradermal at a 5 degree angle to the stomach. The DON stated the facility did have skills checklists on the nurses and giving injections was a part of the skills checklist; however, she could not locate a skills checklist for Nurse #2. The DON demonstrated she expected the nurses to give insulin injections with an insulin syringe at a 90 degree angle with the needle going straight in to the stomach or body part.

4. Resident #26 was readmitted to the facility on 12/22/18. A review of his January 2019 MAR revealed the physician had written an order on 01/02/19 for Flonase nasal spray 2 sprays in each nostril twice a day (bid) for 4 weeks for allergic rhinitis.

On 01/03/19 at 9:00 AM, during the observation

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F 759	Continued From page 54	F 759		

of a medication pass, Certified Medication Aide (CMA) #5 was not able to administer Resident #26's Flonase nasal spray because it was not received from the pharmacy so the medication was omitted; however, there was not a physician's order to hold the medication until received from the pharmacy. CMA #5 did not administer the medication because it was not available from the pharmacy and simply circled the administration time as not given.

An interview on 01/03/19 at 9:15 AM with CMA #5 revealed she had not given the medication because it was not available and was not one of the medications in the Emergency Medication Box (EMB). CMA #5 stated she would report the absence of the medication to her supervising nurse.

An interview on 01/04/19 at 10:00 AM with the Unit Manager revealed she had written an order on 01/03/19 sometime (could not remember time) on 2nd shift to hold the Flonase until received from pharmacy. The UM stated it was written after she realized the medication was not available to be given to Resident #26. The UM stated there had been a delay in getting the medication because the original order had not been faxed to the pharmacy promptly after it had been written.

An interview on 01/05/19 at 3:00 PM with the Director of Nursing (DON) revealed she was not aware there had been a delay in getting Resident #26's medication and stated it should have been called in to the pharmacy for delivery. The DON stated she expected the staff administering medications to follow the 5 rights of medication administration including right person, right

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F 759	Continued From page 55	F 759		

medication, right dose, right route and right time.

5. Resident #26 was readmitted to the facility on 12/22/18. A review of his January 2019 MAR revealed the physician had written an order on 01/02/19 for Flonase nasal spray 2 sprays in each nostril twice a day (bid) for 4 weeks for allergic rhinitis.

On 01/03/19 at 4:06 PM, during the observation of a medication pass, Nurse #4 was not able to administer Resident #26's Flonase nasal spray because it was not received from the pharmacy so the medication was omitted; however there was not a physician's order to hold the medication until received from the pharmacy. Nurse #4 did not administer the medication because it was not available and simply circled the administration time as not given.

An interview on 01/03/19 at 4:10 PM with Nurse #4 revealed she would have to contact the pharmacy to find out where the resident's nasal spray was and when it would be delivered.

An interview on 01/04/19 at 10:00 AM with the Unit Manager revealed she had written an order on 01/03/19 sometime (could not remember time) on 2nd shift to hold the Flonase until received from pharmacy. The UM stated it was written after she realized the medication was not available to be given to Resident #26. The UM stated there had been a delay in getting the medication because the original order had not been faxed to the pharmacy promptly after it had been written.

An interview on 01/05/19 at 3:00 PM with the Director of Nursing (DON) revealed she was not

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F 759	Continued From page 56 aware there had been a delay in getting Resident #26's medication and stated it should have been called in to the pharmacy for delivery. The DON stated she expected the staff administering medications to follow the 5 rights of medication administration including right person, right medication, right dose, right route and right time.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews, the facility failed to prevent a significant medication error by not following physician orders to administer an anticoagulant for 1 of 3 residents (Resident #18) reviewed for anticoagulant therapy. The findings included: Resident #18 was readmitted to the facility on 12/03/18 with diagnoses which included acute embolism and thrombosis of deep veins of upper extremity, peripheral vascular disease (PVD), long term use of anticoagulants and others. A review of Resident #18's most recent quarterly minimum data set (MDS) dated 11/19/18 revealed the resident was moderately impaired for daily decision making, had an open lesion on his foot and received dressings to his feet. The MDS also revealed the resident had received anticoagulants for 7 days during the look back period.	F 760	F760 Residents are Free of Significant Med Errors How will corrective action be accomplished for those resident(s) found to be affected by the deficient practice? Resident 18'□s Eliquis was administered for his PM dose on the given date. How will facility identify other residents having potential to be affected by the same deficient practice? Residents on anticoagulants were audited to ensure administration occurred per orders. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Unit Managers and/or designee are responsible for reviewing appointments	2/4/19

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F 760	Continued From page 57 A review of Resident #18's care plan dated 12/17/18 revealed the resident had a care plan for potential for bleeding related to anticoagulant therapy. The goal was the resident would be free of signs/symptoms of bleeding. The interventions included in part, administer medications as ordered by the physician. Review of Resident #18's monthly January 2019 physician orders revealed an order for the resident to receive a 5 milligram tablet of Eliquis (an anticoagulant medication) twice a day by mouth. A review of Resident #18's Medication Administration Record (MAR) for January of 2019, revealed in part, the resident had an order for the following medication in the morning: Eliquis 5 milligram (mg) tablet - 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. On 01/04/19 Resident #18 was scheduled for a physician appointment and was scheduled to leave the facility between 7:00 AM and 7:30 AM. Review of the residents MAR revealed on 01/04/19 the resident had not received his Eliquis prior to leaving for his appointment. The MAR revealed the medication had not been given and the medication was circled by Certified Medication Aide (CMA) #1. An interview on 01/05/19 at 10:01 AM with CMA #1 revealed she had not given the Eliquis to Resident #18 because she had not counted narcotics with the off going nurse. CMA #1 stated she could not give any medications until she was able to count with the nurse that had worked the previous night shift.	F 760	for the next day and notifying the physician to obtain orders for Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed Nurses and Medication Aides were re-educated by 2/4/2019 regarding Medication Administration/Safety specifically related to anticoagulants and anticoagulant administration based on physician orders. Education included hands on scenarios and interactive training sessions. The Director of Nursing and/or designee will monitor new medication orders, medications available on cart and medication administration including anticoagulants beginning 1/28/2019 for 10% of residents on anticoagulants 3x weekly times 4 weeks, and weekly times 8 weeks utilizing the Compliance Monitoring Tool. How the facility plans to monitor its performance to make sure that solutions are sustained? Results of the monitoring tool will be brought to stand-down meeting 5x week for 4 weeks, and weekly for 8 weeks for discussion with the IDT Members and to the monthly QAPI meeting. Results of the on-going audits will be presented to the QAPI meeting x3 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for	

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F 760	Continued From page 58 A telephone interview on 01/05/19 at 2:16 PM with Nurse #6 who had worked the night shift on 01/04/19 revealed she had not given Resident #18 his Eliquis because it was scheduled later than her medication pass. Nurse #6 stated Resident #18 left the facility at 7:00 AM and Nurse #9 and CMA #1 knew she had not given his medications prior to him leaving. Nurse #6 stated Resident #18 had an early breakfast before he left and had a bagged lunch to take with him to his appointment. Nurse #6 stated Resident #18 had left before she had counted medications with Nurse #9 or CMA #1 and she probably should have given his medications to him prior to him leaving the facility. An interview on 01/05/19 at 7:53 PM with the Medical Director (MD) revealed he would not have wanted Resident #18 to have gone out of the facility to an appointment without receiving his morning medications. The MD stated Resident #18 not getting his Eliquis was a "significant medication error" and he "could not go without the medication due to the risk of having a blood clot." An interview on 01/05/19 at 8:01 PM with the Director of Nursing (DON) revealed she would have expected Nurse #6 to have given Resident #18 his medications prior to him leaving the facility for his appointment, especially his Eliquis.	F 760	the Plan of Correction and the Administrator is responsible for sustained compliance. Plan of Compliance 2/04/2019.	