STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0176	A. BUILDING: _____ B. WING _____	C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(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) COMPLETE DATE
L 006	.2104(C) REQUIREMENTS FOR LICENSE RENEWAL/CHANGE 10A-13D.2104 (c) The facility shall notify the Licensure and Certification Section of the Division of Facility Services within one working day following the occurrence of: (1) change in administration; (2) change in the director of nursing; (3) change in facility mailing address or telephone number; (4) changes in magnitude or scope of services; or (5) emergencies or situations requiring relocation of patients to a temporary location away from the facility. This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to notify the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation within one working day following the change of Director of Nursing. The findings included: Review of the facility's file indicated the current Director of Nursing (DON) was Nurse #1. Upon entrance to the facility on 06/09/19 at 10:15 AM the Weekend Supervisor (WS) stated that Nurse #1 had resigned as the facility's DON about a month ago, and the facility had a new DON. An interview with the DON was conducted on 06/09/19 at 12:23 PM. The DON confirmed that she became the DON on 05/13/19.	L 006	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. L006 " The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. The facility notified the Nursing Home Licensure and Certification Section of Health Service Regulation on 06/13/2019	7/9/19

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L 006	Continued From page 1 An interview was conducted with the Administrator on 06/13/19 at 11:34 AM. The Administrator confirmed that the current DON had been in that role since 05/13/19. She stated that she thought the corporation notified the Division of Health Service Regulation and the corporation believed she had completed the form for the facility's DON change. The Administrator stated it was miscommunication and she went ahead and completed the form. The Administrator stated that it was ultimately her responsibility to make the change and she should have completed the form within one working day.	L 006	" Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 1. No residents affected by deficient practice. " The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. On 7/5/2019 the Administrator was in serviced by the (RDO) Regional Director of Operations on completing DON notification and submitting within 24 hours. 2. Upon new hiring of a DON, the Administrator will submit change of notification and send a copy to the ROD to ensure the change has been submitted. " The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Administrator will report to the Quality Assurance and Performance Improvement Committee monthly for 3 months of any changes submitted for a new DON. " Date of compliance July 9, 2019	

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E 000	Initial Comments A recertification survey was conducted from 06/09/19 to 0/14/19 the facility was found in compliance with the requirements of CFR 483.73 Emergency Prepardness. Event ID 154X11	E 000		
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:	F 561		7/9/19

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

Electronically Signed | 07/04/2019

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F 561	Continued From page 1 Based on record review, staff and resident interviews, the facility failed to honor a resident's choice to not have showers scheduled on Sunday for 1 of 3 sampled residents reviewed for choices (Resident #16). The findings included: Resident #16 was admitted to the facility on 12/03/18 with diagnoses which included Parkinson's disease and hypertension. Resident #16's Admission Minimum Data Set (MDS) assessment dated 12/10/19 revealed it was very important for him to participate in religious services or practices. Resident #16's most recent quarterly MDS assessment dated 03/12/19 revealed, he had intact cognition and required supervision for bathing. Resident #16's Resident Care Specialists care guide dated 06/11/19 revealed, his showers were scheduled for first shift on Sundays and Thursdays. An interview with Resident #16 on 06/10/19 at 3:30 PM revealed, he was adamant that he did not want his showers scheduled on a Sunday because he attends church services at a church in the community and did not like to be rushed to get his shower completed before leaving the facility on Sunday morning. Resident #16 explained, he voiced this concern, about not wanting his showers scheduled on Sunday during the last resident council meeting (05/28/19) and a lady wrote his concern down and stated she would inform someone else about his concern.	F 561	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 561 Self Determination • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. On 06/28/2019 Resident # 16 was interviewed by the facility social worker regarding his preferences on which days he prefers to get his showers. Resident #16 care plan was updated on 07/03/2019 by the Minimum Data Set Nurse (MDS) to reflect the residents choice of shower days. • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. On 06/28/2019 Current residents with a BIM score 9 and higher were interviewed by the facility social worker to determine shower day preferences. The resident care plans were updated by the MDS nurse to reflect resident's choice of shower days 2. On 07/08/2019 the facility social worker will contact the responsible party	

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F 561	Continued From page 2 Resident #16 stated there had been no one to interview him about changing his shower days from Sundays since that resident council meeting. The resident stated he was still receiving showers on Sunday which was not his preference. On 06/13/19 at 3:12 PM during an interview with the Activity Director (AD), she explained that her responsibility during the resident council meetings was to document the minutes of the meetings and the Social Worker (SW) was the one who documented the residents' concern, so she may not have heard Resident #16 voice his concern. The AD stated Resident #16 attended nearly every resident council meeting and was quiet, but was vocal when he chose to be. She added she did not feel it was unrealistic for Resident #16 to receive his scheduled showers on a different day than Sunday because he attended church services every Sunday. On 06/14/19 at 9:55 AM an interview with Unit Manager (UM) #1 revealed, Resident #16 was alert and oriented and could voice his preferences for showers. The UM explained, she was aware that Resident #16 attended his church's service on Wednesdays but did not know about Sundays because she did not work on the weekends. An interview with the Social Worker on 06/14/19 at 12:12 PM revealed, her responsibility during the resident council meeting was to document the residents' concerns, but could not remember if Resident #16 voiced a specific concern during the last meeting. The SW explained if the residents preferred their bath days to be on certain days of the week then their preferences should be honored.	F 561	of residents with a BIMs of 9 or below to determine their shower preference. The residents care plans will be updated by the MDS nurse to reflect resident's choice of shower days. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. On 06/19/2019 the Director of Nursing and social worker began re-education with Licensed nurses, CNA's, and activity staff on resident self-determination and resident rights that residents have a choice of shower days. This re-education will be complete by 07/05/2019. After that date nursing and activity staff will not be allowed to work until re-education is complete. This re-education will be included in the orientation for new nursing or activity staff. 2. Systems altered is that each resident or resident representative upon admission will be asked shower preference days and times. This will reoccur a minimum of each quarter during the care plan meeting. 3. The RR will be contacted for those residents with a BIMS below 9 to determine if shower schedules need to be altered. This will be completed by 07/08/2019 4. Upon admission a resident or RR will be communicate and it will be documented in the care plan the resident's preference shower days and times	

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F 561	Continued From page 3 During an interview with the Director of Nursing on 06/14/19 at 2:34 PM, she explained that staff should have asked residents on admission and periodically after admission what days of the week they would prefer to receive showers. She stated it was not unreasonable for Resident #16 to have his shower days changed from Sundays to another day of the week.	F 561	• The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Social worker will interview 5 residents weekly for 12 weeks to ensure residents are being allowed a choice in what days their showers will be done. This audit will be documented on the choices audit tool. 2. The social worker will present to the monthly Quality Assurance Performance committee (QAPI) the results of the choices audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. • Date of compliance July 9, 2019	
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services;	F 576		7/9/19

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F 576	Continued From page 4 (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on Resident Council and staff interviews, the facility failed to deliver mail to residents on Saturdays. This had the potential to affect 91 of 91 residents in the facility. The findings included: An interview with members of the Resident Council on 06/13/19 at 10:14 AM, revealed they mail was not delivered to them on Saturdays. They reported it was not delivered on Saturdays due to the Activities Director not being in the	F 576	F 576 Rights to forms of communication with Privacy • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident mail that was delivered on June 8, 2019 was delivered to the residents on June 9, 2019 by the activity director.	

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F 576	Continued From page 5 building to deliver it and stated she was responsible for delivering the mail Monday through Friday. A member of the Resident Council reported her birthday was on 06/08/19 and she would have liked to have received her mail on 06/08/19 to receive a birthday card her family had mailed to her. They reported mail delivered on Saturday is typically delivered the following Monday. During an interview with the Activities Director on 06/13/19 at 10:23 AM, she reported she was responsible for delivering mail through the week and on weekends, when she was in the building. She reported on weekends when she was not working it was the responsibility of the weekend receptionist to deliver the mail when it arrived. She reported she came into the building on 06/09/19 and noted the mail that was delivered on 06/08/19 had not been delivered to the residents and stated she then passed it out to the residents on 06/09/19. She reported she did not know why it had not been delivered on 06/08/19. She stated mail was typically delivered by the post office between 1:00 PM and 2:00 PM on Saturday and the expectation was that mail was delivered the day it arrived at the facility. An interview with the Weekend Receptionist on 06/13/19 at 11:34 AM, revealed she was responsible for passing out mail to residents on the weekends. She reported she did not pass out the mail that was received on 06/08/19 because she was "too busy" to do it. She reported the mail delivered on 06/08/19 was delivered to the residents on 06/09/19. During an interview with the Director of Nursing on 06/13/19 at 12:37 PM, she reported it was her	F 576	• The facility will identify other residents having the potential to be affected by the same deficient practice: 1. Current residents that receive mail at the facility have the potential to be affected • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. As of 07/01/2019 Business office, activity director, and receptionist staff were re- educated by the Administrator on how to sort facility mail and ensure resident mail was delivered within twenty-four hours of receipt, including weekends. Newly hired staff for business office, receptionist, or activities will be educated during orientation. Any staff not educated by 07/09/2019 will not be allowed to work until reeducated. 2. A mail log was created to reflect what date a resident received mail and what date it was delivered. This log will be completed daily when the mail is delivered by the activity director, business office, or receptionist. The log will be initiated on 07/05/2019. 3. Administrator will review the log daily for 12 weeks to confirm resident mail delivery on the weekend. The review will begin on 07/08/2019 by the Administrator. The Administrator will interview 3 interviewable residents weekly for 1 month to ensure they are receiving mail timely and document on a log.	

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F 576	Continued From page 6 expectation that mail be delivered to residents on Saturdays by the staff member responsible, either the Activities Director or the Weekend Receptionist. She reported if a staff member was too busy to pass out the mail during their normal working hours, they should ensure another staff member was located to pass out the mail. She reported mail delivered on Saturday should be delivered on Saturday and should not be held until Sunday or Monday for delivery.	F 576	4. The activity director will document in the monthly resident council minutes if any issues with mail delivery reoccur. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Social Services Director will interview 5 residents weekly for 4 weeks then 3 times a week for 2 months to ensure mail is delivered on weekends. 2. The Administrator will present the results of the interviews and logs to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan. 3. Date of compliance July 9, 2019	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		7/9/19

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F 584	Continued From page 7 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to clean a seatbelt soiled with food debris which was attached to a resident's wheelchair for 1 of 2 residents who were sampled with seatbelts in wheelchairs (Resident #22). Findings included: Resident #22's most recent annual Minimum Data Set (MDS) dated 03/22/19 revealed he was severely impaired in cognition for daily decision	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Seatbelt for resident # 22 was cleaned on 06/14/2019 • The facility will identify other residents	

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F 584	Continued From page 8 making. The MDS further revealed Resident #22 required extensive assistance with activities of daily living except he only required supervision with eating. An observation on 06/10/19 at 1:05 PM revealed Resident #22 was seated in a wheelchair in the main lobby with a group of residents and visitors were coming in and out of the front door. Resident #22 had a seatbelt fastened at his waist and the belt and buckle were coated with multiple areas of dried food spills and numerous stains that were easily visible. An observation on 06/10/19 at 4:24 PM revealed Resident #22 was sitting in a wheel chair in the main lobby. Resident #22 had a seatbelt fastened at his waist and the belt and buckle were still coated with multiple areas of dried food spills and numerous stains that were easily visible. An observation on 06/11/19 at 8:26 AM revealed Resident #22 was sitting in a wheelchair in the hallway and had a seatbelt fastened around his waist. The seatbelt was observed to be soiled on either side of the buckle with multiple areas of dried food spills and numerous stains that were easily visible. An observation on 06/12/19 at 2:49 PM revealed Resident #22 was sitting in a wheelchair in the hallway and had a seatbelt fastened around his waist. The seatbelt was observed to be soiled on either side of the buckle with multiple areas of dried food spills and numerous stains that were easily visible. During an interview on 06/13/19 at 12:38 PM, the	F 584	having the potential to be affected by the same deficient practice: 1. Current residents with seatbelts were visually observed by the unit manger on 6/14/2019 and no other seatbelts were found to be soiled. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. On 07/03/2019 the cleaning schedule performed by the third shift CNA's was revised to include seatbelts. 2. On 07/03/2019 the director of nursing re-educated the licensed nurses, CNA's, and activity staff on the cleaning schedule and that if a seatbelt is observed soiled to notify the Director of nursing and or nursing supervisor so that someone can be directed to change and clean the seatbelt. 3. On 07/08/2019 an inspection by the Director of Nursing of residents with seatbelts will be performed 5x week for 4 weeks and 3 X a week for 8 weeks to ensure the seatbelts are not soiled. The DON will document these findings on an audit tool. • Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; 1. The Director of Nursing will report the findings of the observations to the Quality Assurance and Performance Committee	

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F 584	Continued From page 9	F 584		

Director of Nursing stated Resident #22's seatbelt should be cleaned when soiled. She further stated Resident #22's seatbelt should be cleaned when his wheelchair was cleaned and as needed if it was soiled.

During an interview 06/13/19 at 3:37 PM, the Account Manager for Housekeeping explained he had a schedule of when each resident's wheelchair was due to be cleaned each month and he placed a sign at the nurses' station to indicate when wheelchairs would be cleaned. He stated he assigned a Housekeeper to come in at 5:00 AM to clean wheelchairs and the Nurse Aides (NAs) on third shift took wheelchairs that were due to be cleaned to a back hallway and after the Housekeeper cleaned them the NAs took them back to resident rooms. He stated seatbelts on wheelchairs were also cleaned when the wheelchair was cleaned and confirmed Resident #22's wheelchair was last cleaned on Friday 06/07/19. He explained it was his expectation for NAs to let him know if the chair or anything on it such as the seatbelt was soiled.

During an interview on 06/13/19 at 3:56 PM, Unit Manager #2 explained Resident #22 was supposed to wear a seatbelt when he was up in this wheelchair. She confirmed he could unfasten his seatbelt when requested but he was at risk for falls and needed to wear it for safety. She explained Resident #22 would not let anyone feed him because that was the last independent thing he could do for himself. She further explained Resident #22 ate pureed food and he usually spilled food on his lap and on the seatbelt in his wheelchair. She stated it was her expectation for staff to clean the seatbelt when it was soiled. She further stated when Resident #22's wheelchair

for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.

- Date of compliance July 9, 2019

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	345128	A. BUILDING _____ B. WING _____	C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 584	Continued From page 10 was cleaned the seatbelt should also be cleaned. She explained it was everyone's responsibility to clean the seat belt when they saw it was soiled because it was not just housekeeping's responsibility. During a telephone interview on 06/14/19 at 8:54 AM with Nurse Aide #4 she confirmed she was assigned to care for Resident #22 on Sunday 06/09/19. She stated she had not been instructed to clean the seatbelt in Resident #22's wheelchair and did not recall he had a seatbelt in his wheelchair. During an interview on 06/14/19 at 3:04 PM, the Administrator stated it was her expectation that staff should clean the seatbelt in Resident #22's wheelchair when it was soiled.	F 584		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment,	F 640		7/9/19

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F 640	Continued From page 11 a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete and transmit a discharge tracker Minimum Data Set (MDS) assessment to the Centers for Medicare and Medicaid Services (CMS) system within the minimum required time frame for 1 of 3 residents reviewed for closed records (Resident #1).	F 640	F 640 Encoding/Transmitting Resident Assessments • The corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 640	Continued From page 12 The finding included: Resident #1 was admitted to the facility on 12/28/18 with diagnoses that included heart failure and diabetes mellitus. Resident #1 was discharged from the facility on 02/20/19. Review of the resident's discharge tracker MDS revealed, it was not completed or transmitted to CMS within the required 14-day timeframe. During an interview with the MDS Coordinator (MDSC) on 06/14/19 at 10:59 AM, she confirmed that Resident #1's 02/20/19 discharge tracker had not been completed or transmitted to CMS as of 06/14/19. The MDSC explained, she normally waited 24 hours after the resident was transferred out of the facility before she completed the discharge summary in the event the resident returned to the facility. The MDSC stated she apparently forgot to keep track of Resident #1 which caused her to miss the completion and transmission of the discharge tracker MDS. An interview with the Director of Nursing (DON) on 06/14/19 at 2:38 PM revealed, the MDSC probably waited to see if the resident would return from the hospital within 24 hours and lost track of the situation but regardless she should have completed and transmitted the discharge assessment in the appropriate 14-day timeframe.	F 640	1. Resident #1 had his discharge tracker completed and transmitted on 07/02/2019 by the facility Minimum Data Set (MDS) Coordinator. • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. The facility has conducted MDS audits for residents requiring a discharge assessment from 02/20/2019 through 07/01/2019 by the (IDT) Interdisciplinary Team to identify residents who needed to have a discharge assessment scheduled and completed. The results of the audits did not identify any other discharge trackers that were not completed or transmitted. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. The (MDS)Coordinator has been re-educated by the regional MDS consultant on 07/05/2019 on completion of the discharge assessment and verifying that these assessments are transmitted timely. Newly hired MDS staff will be educated during orientation. Any current staff not educated by 07/09/2019 will not be allowed to work until reeducated. 2. The alleged deficiency is isolated where education and quality assurance will achieve compliance 3. The MDS Coordinator will conduct a weekly audit to ensure all discharge	

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F 640	Continued From page 13	F 640	assessments have been scheduled beginning 07/08/2019. The MDS Coordinator will conduct audits weekly for 4 weeks and monthly for 2 months. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The director of nursing will be responsible to review the audits submitted by the MDS coordinator weekly of discharge assessments and Final Validation Report (transmittal log) that shows complete and timely filing of facility assessments weekly for 4 weeks and monthly for 2 months 2. The director of nursing will be review the results of the audits through monthly Quality Assessment and Performance Improvement (QAPI) and corrective actions taken as necessary and plan modified as needed. • Date of compliance July 9, 2019	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the Admission Minimum Data Set (MDS) assessment in active	F 641	F 641 Accuracy of Assessments • The corrective action will be	7/9/19

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F 641	Continued From page 14 diagnosis for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #84). The finding included: Resident #84 was admitted to the facility on 05/15/19 with diagnoses which included hip fracture, diabetes mellitus and dementia. Review of Resident #84's Physician Orders dated 02/20/19 revealed a handwritten order for Neudexta 20-10 milligram one capsule by mouth every 12 hours for Pseudobulbar affect. A review of Resident #84's admission Minimum Data Set (MDS) assessment dated 02/22/19 indicated Resident #84 had not been coded under Section I for Active Diagnosis for Pseudobulbar Affect. During an interview with the MDS Coordinator (MDSC) on 06/14/19 at 11:11 AM she explained, that she collected information from several different areas of the resident's medical record, including the physician's orders, to complete the resident assessments. The MDSC stated that since the order with the diagnosis was written after Resident #84 was admitted, the order could have been in circulation in medical records waiting to be filed on the resident's chart and therefore, it was not on Resident #84's chart when she completed the MDS. An interview with the Director of Nursing on 06/14/19 at 2:40 PM indicated, she felt human error was the reason the mental health diagnosis was not added to the MDS, and it should not have been left off.	F 641	accomplished for those residents found to have been affected by the deficient practice: 1. The admission comprehensive assessment for Resident # 84 has been modified on 06/14/2019 to reflect the diagnoses of Pseudobulbar Affect. The modification was transmitted on 06/14/2019. The Minimum Data Set (MDS) coordinator has been in-serviced and re-educated by the director of nursing on July 2, 2019 on importance of accuracy of her comprehensive assessments on section I (diagnosis). Failure to complete accurate assessments related to tobacco use by the MDS coordinator will result in further re-education and may result in disciplinary action up to and including termination of employment through the facility progressive disciplinary policy. • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. Section I of the most recently completed MDS as of June 1, 2019 for all current residents, will be audited for accuracy by the regional nurse consultant. Modifications if needed will be corrected and submitted by the MDS coordinator. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 641	Continued From page 15 During an interview with the Administrator on 06/14/19 at 3:24 PM she indicated she felt as if the MDSC was used to only looking in the progress notes for diagnoses, but in any case, the mental health diagnosis should have been on Resident #84's admission assessment.	F 641	1. MDS nurse was re-educated by the Regional MDS consultant on 07/02/2019 regarding the importance of accurately coding the MDS, specifically, section I. Newly hired MDS staff will be educated during orientation. Any MDS staff that has not been educated by 07/09/2019 will not be allowed to work until reeducated. 2. Beginning 07/08/2019 Regional MDS consultant will audit section I of 5 Minimum data sets per week x 12 weeks to ensure accuracy. After the 12 weeks the regional MDS consult will review section I of random completed MDS's during visits to ensure the facility maintains compliance • The facility plans to monitor its performance to make sure that solutions are sustained; 1. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by MDS coordinator monthly x 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. • Date of compliance July 9, 2019	

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F 644	Continued From page 16	F 644		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to request a Level 2 Preadmission Screening and Resident Review (PASRR) for a resident with a new mental health diagnosis for 1 of 1 resident reviewed for PASRR (Resident #74). The Findings Included: Resident #74 was admitted to the facility on 06/02/16. Resident #74 had diagnoses that included generalized anxiety disorder and major depressive disorder. A review of a progress note dated 04/02/18 revealed Resident #74 was given a new	F 644	F 644 Coordination of PASARR and Assessments • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. A level 2 PASARR screening was requested on 06/20/2019 for resident # 74 • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. On 07/03/2019 current residents were	7/9/19

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F 644	Continued From page 17 diagnosis of unspecified psychosis during a physician visit. A review of Resident #74's most recent comprehensive Minimum Data Set Assessment (MDS) dated 02/18/19 revealed Resident #74 to be cognitively intact for daily decision making with no psychosis, and no behaviors directed towards self or others. Resident #74 was coded as having active diagnoses that included anxiety disorder, depression, post traumatic stress disorder, and psychosis. Resident #74 was also coded as not having a level II PASRR. During an interview with the facility's Social Worker on 06/13/19 at 9:36 AM, she reported she did not have any responsibility for the review of PASRR numbers. She reported it was the responsibility of the Admissions Coordinator to request a review of a PASRR number, if warranted. During an interview with the Admission Coordinator on 06/13/19 at 9:39 AM, she reported she made sure a resident had a PASRR screening before admission into the facility. She explained she completed review requests when she was notified by the MDS Nurse of a significant change in condition, a new diagnosis or an exhibited behavior. She stated she could not remember when the last time Resident #74 had a PASRR review. She reported she would have expected MDS Nurse #1 to notify her when Resident #74 received a new diagnosis of unspecified psychosis. She also reported if she had been notified, she would have requested a PASRR review at that time. During an interview with MDS Nurse #1 on	F 644	audited by the Director of nursing and Unit Managers from April 1 to June 30 to determine if a new diagnosis was added during a physician visit that would require a Level 2 PASARR screening. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. On 07/03/2019 the Director of nursing re-educated the licensed nursing staff, MDS nurse and the nurse practitioner on Level 2 PASARR screening and what prompts the screening. Newly hired licensed nursing staff, MDS staff, and nurse practioner's will be educated during orientation. Any licensed nursing staff, MDS staff, and nurse practioner's that have not been educated by 07/09/2019 will not be allowed to work until reeducated. 2. Beginning on 07/08/2019 the unit manager and or the Director of nursing must initial progress noted by nurse practitioner, or medical doctor prior to going into the medical record to screen for diagnosis changes or additions. The progress notes that are reviewed will be kept on a log by the unit manger and or Director of Nursing. The log will be done weekly times 4 weeks then monthly times 2 months. 3. If a new diagnosis is added that requires a level 2 PASARR screening a log will be kept by the Director of Nursing who will communicate to the admissions	

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F 644	Continued From page 18 06/13/19 at 10:45 AM, she reported if she noted a resident to have a significant change in condition or a new significant mental health diagnosis, she should make a referral to the Admissions Coordinator for a PASSR review. She reported she did not complete a referral for Resident #74 because she did not feel it was a significant change in cognition, therefore it did not warrant a PASRR review. During an interview with Nurse Practitioner #1 on 06/14/19 at 9:23 AM, she reported a resident with a diagnosis of unspecified psychosis would be considered to have a significant mental health diagnosis and would require "ongoing and continuous mental health" therapy. During an interview with the Director of Nursing on 06/14/19 at 12:37 PM, she reported it was her expectation that PASRR reviews be requested if the criteria for a review was met. She reported she would have expected a resident with a new diagnosis of unspecified psychosis to have a PASRR review.	F 644	director if a level 2 PASARR screen needs to be referred. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. Beginning on 7/08/2019 the social worker will review 5 new Physician progress notes weekly for 12 weeks to determine if a new diagnosis was added that requires a level 2 PASARR screening and document these findings weekly for 4 weeks then monthly for 2 months. 2. The DON will review the PASARR screening log weekly for 12 with the IDT team. 3. The DON will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months • Date of compliance July 9, 2019	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655		7/9/19

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F 655	Continued From page 19	F 655		

that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:

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F 655	Continued From page 20 Based on record review and staff interview the facility failed to develop a baseline care plan that included minimum healthcare information to provide effective person-centered care for a resident with a urinary catheter (Resident #54) and a resident who was a fall risk (Resident #198) for 2 of 3 sampled residents. The finding included: 1. Resident #54 was initially admitted to the facility on 02/28/19 and most recently readmitted to the facility on 05/14/19. Resident #54's diagnoses included neuromuscular dysfunction of the bladder. Review of Resident #54's admission assessment dated 02/28/19 revealed that she had an indwelling urinary catheter and was signed by Unit Manager (UM) #2. Review of the comprehensive Minimum Data Set (MDS) dated 04/01/19 revealed that Resident #54 was moderately impaired for daily decision making and required total assistance of two staff members with toileting. The MDS further revealed that Resident #54 had an indwelling catheter and was always incontinent of bowel. Review of Resident #54's medical record revealed no base line care plan for the initial admission on 02/28/19 was present. An interview was conducted with UM #2 on 06/12/19 at 9:42 AM. UM #2 stated that either the floor nurse, UM, or MDS Coordinator would initiate the baseline care plans when a resident admitted to the facility. She added that the admitting nurse was responsible for completing	F 655	F 655 Baseline Care Plan • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. On 06/14/2019 Resident # 54 care plan was revised to reflect the presence of an indwelling catheter and the care required for the catheter 2. On 06/12/2019 Resident # 198 care plan was revised to reflect fall risk and interventions in place • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. On 07/02/2019 a review of baseline care plans for admissions starting June 1 of current residents with indwelling catheters and those that were a fall risk on admission to ensure the plan of care is reflective • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Beginning on 06/21/2019 the MDS nurse /DON re-educated the licensed nurses to start the base line care plan on admission. New hires will be educated on base line care plans during orientation. All licensed nursing staff that have not received education by 07/09/2019 will not be allowed to work until reeducated.	

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F 655	Continued From page 21 all the admission forms upon admission and this was included initiating baseline care plans but stated that the UMs would ensure that all the required assessments were completed. UM #2 could not explain why Resident #54 did not have a baseline care plan for indwelling urinary catheters but stated maybe it was an oversight. An interview was conducted with the MDS Coordinator on 06/12/19 at 2:30 PM. The MDS coordinator confirmed that no baseline care plans had been developed for Resident #54's indwelling urinary catheter. She added that she expected either the floor nurse or the UM to complete the baseline care plan upon admission to the facility so that the staff would know how to take care of the resident appropriately. An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:10 AM. The DON stated that she expected baseline care plan to be initiated upon admission to the facility either by the admission nurse or the UMs so that the direct care staff knew how to care for the resident. An interview was conducted with the Administrator on 06/14/19 at 3:04 PM. The Administrator stated that she expected baseline care plans to be initiated upon admission so that the staff was aware of how to care for the newly admitted resident. 2. Resident #198 was admitted to the facility on 06/03/19 with diagnoses that included unspecified dementia without behaviors, weakness, and repeated falls. The resident's admission physician orders revealed orders that included: behavior	F 655	2. The MDS nurse will bring the base line care plan to the clinical morning meeting beginning 07/08/2019 and will be placed on a log for review to ensure the base line is reflective of the resident's status. The MDS nurse will bring base line care plans to morning meeting daily for 12 weeks. 3. On 07/08/2019 the DON will audit the log for completion of all baseline care plans on admissions weekly for 12 weeks to ensure the care plan is reflective of those that have indwelling catheters and that are a fall risk. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The DON will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months • Date of compliance July 9, 2019	

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F 655	Continued From page 22	F 655		

monitoring for the use of anxiety agents, antidepressants, and antipsychotics; Temazepam Capsule 30 milligrams (mg) for insomnia; Mirtazapine 15 mg for dementia, and Seroquel (an antipsychotic) 50mg for anxiety.

A review of Resident #198's baseline care plan revealed no dementia care plan, no activities of daily living (ADL) care plan or antipsychotic use care plan. Additionally, a resident care guide for Resident #198 not been developed.

During an interview with Nurse Aide #3 on 06/12/19 at 2:12 PM, she reported she was made aware of care needs by looking at the resident's resident care guide. She reported she was unsure who developed or edited the resident care guides and stated if there was no resident care guide, it would be difficult to determine the care a resident required. She reported she was unsure the level of care Resident #198 required.

During an interview with Unit Manager #1 on 06/12/19 at 9:42 AM, she reported it was the responsibility of the admitting floor nurse to begin the baseline care plan once a resident was admitted to the facility. She reported it should be completed within the first 48 hours a resident was in the facility. She reported once the baseline care plans were completed they would be placed into the resident's electronic medical record. She stated she was unsure why Resident #198's baseline care plan had not been completed but reported it should have been completed.

During an interview with the Director of Nursing on 06/12/19 at 11:47 AM, she reported it was her expectation that baseline care plans be completed within 48 hours of a resident's

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F 655	Continued From page 23 admission to the facility. She reported without the completion of a baseline care plan, the floor staff would have difficulty determining what care Resident #198 required.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		7/9/19

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F 656	Continued From page 24 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to develop a comprehensive person-centered care plan for a resident with an indwelling urinary catheter (Resident #54) and failed to develop a comprehensive, individualized care plan for a resident that required assistance with bed mobility and toileting that included how much staff assistance was needed to care for the resident (Resident #298) for 2 of 3 sampled residents. The findings included: 1. Resident #54 was initially admitted to the facility on 02/28/19 and most recently readmitted to the facility on 05/14/19. Resident #54's diagnoses included neuromuscular dysfunction of the bladder. Review of Resident #54's admission assessment dated 02/28/19 revealed that she had an indwelling urinary catheter. Review of the comprehensive Minimum Data Set (MDS) dated 04/01/19 revealed that Resident #54 was moderately impaired for daily decision making and required total assistance of two staff members with toileting. The MDS further revealed	F 656	F 656 Develop/Implement Comprehensive Care Plan • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. On 06/12/2019 the Minimum Data Set nurse revised resident # 54 person-centered care plan in order that it may accurately reflect an indwelling catheter. 2. On 06/12/2019 the Minimum Data Set nurse revised resident # 298 Person-centered care plan in order that it may accurately reflect the assistance required by staff with bed mobility and toileting 3. The task segment in Point click care that communicates to the certified nursing assistant was updated to reflect resident # 54 indwelling catheter and resident # 298 amount of assistance required from staff for bed mobility and toileting. • The facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 656	Continued From page 25 that Resident #54 had an indwelling catheter and was always incontinent of bowel. Review of the Care Area Assessment (CAA) dated 04/07/19 and signed by the MDS Coordinator read in part, Resident #54 has an indwelling urinary catheter that was placed during her hospitalization. The catheter seemed to be patent and intact. Will proceed to care plan and monitor level of function and avoid complications as it pertains to the indwelling catheter. Review of Resident #54's medical record revealed no care plan for the indwelling urinary catheter. An observation of Resident #54 was made on 06/09/19 at 3:31 PM. Resident #54 was resting in bed with her eyes open and was alert and verbal. She was observed to have an indwelling urinary catheter that was draining clear yellow fluid into a collection bag that contained approximately 300 milliliters (ml) of the clear yellow fluid. An interview was conducted with the MDS Coordinator on 06/12/19 at 2:30 PM. The MDS coordinator confirmed that no care plan had been developed for Resident #54's indwelling urinary catheter. She could not explain why there was no care plan for the indwelling urinary catheter but stated it was just an oversight on her part. The MDS Coordinator stated that she should have proceeded to care plan for the indwelling urinary catheter as stated in the CAA. An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:10 AM. The DON stated that she expected indwelling urinary catheters to be care planned as part of the	F 656	1. On 07/02/2019, an audit of current residents with indwelling catheters and those residents that require assistance with bed mobility and toileting was completed by the director of nursing (DON) and/or unit manger to ensure that a resident's person -centered care plan accurately reflects indwelling catheters and the amount of staff assistance required with bed mobility and toileting. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. On 07/02/2019 the Regional MDS Consultant will provide re-education to the IDT (Interdisciplinary Team) which includes the MDS Coordinator, Social Worker, Activities Director, Dietary, Therapy Director and Nursing Management of the development of Person -centered comprehensive care plans. Ongoing, newly hired MDS and IDT staff will receive education during their orientation period by the Regional MDS Consultant. Any MDS staff or IDT staff that have not received education by 07/09/2019 will not be allowed to work until reeducated. 2. Beginning on 07/08/2019 the Regional MDS Consultant will review, audit, and document on a log 3 completed person -centered comprehensive care plans weekly for 12 weeks to ensure each care plan reflects an indwelling catheter if present and the amount of staff	

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F 656	Continued From page 26 comprehensive care planning process. 2. Resident #298 was initially admitted to the facility on 09/19/15 and most recently readmitted on 05/23/19. Resident #298's medical diagnoses included: weakness, hemiplegia, above knee amputation of lower extremity. Review of a care plan that was initiated on 02/10/17 read in part, Resident #298 has an Activity of Daily Living (ADL) self-care performance deficit related to right above knee amputation, impaired range of motion, and right sided hemiplegia/hemiparesis. The goal of the care plan read, Resident #298 will improve current level of function in ADLs through the review date. The interventions included: BED MOBILITY: the resident requires staff assistance, DRESSING: the resident requires staff assistance, PERSONAL HYGIENE: the resident requires staff assistance, and TOILETING: the resident requires staff assistance. Review of the quarterly Minimum Data Set (MDS) dated 04/18/19 revealed that Resident #298 was moderately impaired for daily decision making and required extensive assistance of two person with bed mobility, toileting, and personal hygiene. The MDS further revealed that Resident #298 had experienced no falls since the previous assessment. Review of a nurse's note dated 05/03/19 at 7:59 AM read in part, Nursing Assistant (NA) #2 reports that Resident #298 was on the floor. He fell to the floor while NA #2 was turning him to provide care. Nurse observed resident on the floor, supine lying on bedside mat. Blood under head and laceration with large amount of blood.	F 656	assistance that is required for bed mobility and toileting. The Regional MDS Consultant will complete a log for the audit. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months • Date of compliance July 9, 2019	

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Sent to Emergency Room (ER) for evaluation. Signed by Nurse #2.

An interview was conducted with Nurse #2 on 06/11/19 at 1:49 PM. Nurse #2 stated that on 05/03/19 Resident #298 was being turned in bed by NA #2 to provide incontinent care and once turned onto his side he kept going and fell to the floor. Nurse #2 stated that Resident #298 sustained a head injury and was sent to the ER. She added that she was not familiar with Resident #298 and that night was the first night she had cared for him. She stated that she was not aware of how many staff members it took to turn him in bed or to provide incontinent care and relied on the NAs to know that information. Nurse #2 confirmed she was not aware of the information in Resident #298's care plan but stated if she had any question about how much care or assistance that he needed she would refer to Resident #298's care plan.

An interview was conducted with the MDS Coordinator on 06/11/19 at 4:41 PM. The MDS Coordinator reviewed Resident #298's care plan and stated that she could not tell how much assistance he required for bed mobility or incontinence care. She stated that she expected the care plan to contain enough information to care for the resident but would also depend on the policy of the facility.

An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:16 AM. The DON reviewed Resident #298's care plan and confirmed that it did not contain the information of how much staff assistance Resident #298 required for bed mobility and incontinence care and stated that was a systemic breakdown in the

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F 656	Continued From page 28 facility. The DON stated she expected the care plan to have sufficient information, so the direct care staff could safely take care of Resident #298.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer medications ordered to be administered daily at bedtime to a resident who had returned to the facility from the hospital but did not receive bedtime doses on the day of his return to the facility for 1 of 6 residents sampled for unnecessary medications (Resident #34). Findings included: Resident #34 was admitted to the facility on 11/05/18 with diagnoses which included a urinary tract infection, Parkinson's disease, seizures, Alzheimer's disease, diabetes, dementia, depression and anxiety. A review of the most recent quarterly Minimum Data Set (MDS) dated 04/05/19 revealed Resident #34 was cognitively intact for daily decision making. The MDS also revealed Resident #34 required limited assistance for activities of daily living except he only required supervision with eating.	F 658	F 658 Services Provided to Meet Professional Standards • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 34 received medications as ordered on 06/05/2019. The facility completed a medication error report and notified the medical director. • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. Any resident(s) admitted since survey exit, until 6/30/19 were reviewed to ascertain ordered medications were transcribed to the medication administration record (MAR), medications were received from the pharmacy, and administered as ordered. No discrepancies found.	7/9/19

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F 658	Continued From page 29 A review of an incident report dated 05/30/19 at 6:00 PM indicated Resident #34 had a fall from a wheelchair in the dining room. The report further indicated family arrived at 7:15 PM and requested for Resident #34 to be sent to the hospital. A review of a Nurse's note dated 06/04/19 at 4:41 PM revealed Resident #34 returned to the facility from the hospital. A review of Physician's orders dated 06/04/19 indicated in part the following bedtime medications: Dilantin Extended Capsule 100 milligrams (mg) give 5 capsules by mouth at bedtime for seizures. Seroquel 25 mg give 1 tablet by mouth at bedtime for dementia with behaviors. A review of a Medication Administration Record (MAR) dated 06/04/19 revealed Dilantin Extended capsules 100 mg give 5 capsules by mouth at bedtime for seizures but the space to document the medication was blank. A review of a MAR dated 06/04/19 revealed Seroquel 25 mg by mouth at bedtime for dementia with behaviors but the space to document the medication was blank. During an interview on 06/12/19 at 3:33 PM, Nurse #3 stated she was not assigned to care for Resident #34 on 06/04/19 when he returned from the hospital but if there was no documentation on the MAR next to the medication it meant it wasn't given. During a telephone interview on 06/13/19 at 11:18 AM, Nurse #5 confirmed she worked on 06/04/19	F 658	• The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Beginning on 06/19/2019 the Licensed nurses were re-educated by the Director of Nursing which included Admission/readmission required procedures; verify all orders with the physician, orders verified with second nurse after medication orders were entered correctly into the facility electronic medical record medication administration record, fax all pharmacy orders to pharmacy as soon as they are received and put a copy of the faxed confirmation in the Director of Nursing (D.O.N.) box, call pharmacy for verification that orders were received and that they will be delivered with the next pharmacy run, document in nurses progress note who spoke to at the pharmacy with date and time. Newly hired licensed staff will be educated during the orientation process. Current licensed nursing staff will not be allowed to work after 07/09/2019 until reeducated. 2. New resident orders and any new admission/readmission charts will be reviewed starting 6/30/2019 during AM clinical meeting by the Interdisciplinary team (IDT) members that includes at a minimum the Director of Nursing (D.O.N.), Minimum Data Set (MDS) Nurse, and Administrator PRN, Monday-Friday, and weekends by the RN Weekend Supervisor. Review to include; new orders	

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F 658	Continued From page 30 during the evening shift. She stated she did not give Resident #34 medications that evening because some of his medications had changed when he came back from the hospital. She explained Unit Manager #1 had to go through the medication list and review them and Unit Manager #1 had told her the medications had to be sorted out. During an interview on 06/13/19 at 12:30 PM, the Director of Nursing explained she had taken report from a Nurse at the hospital before Resident #34 returned to the facility on 06/04/19. She verified a facsimile (fax) copy of the medication list from the hospital had been initialed by the Family Nurse Practitioner and once she had approved the medication list the medications could be entered into the computer system for the medications to be given. She further stated a blank space on the MAR meant medication was not given and it was her expectation Resident #34 should have received his bedtime medications on 06/04/19. During an interview on 06/14/19 at 9:15 AM, the Family Nurse Practitioner confirmed her initials on the medication list from the hospital for Resident #34 and stated her initials indicated she had seen the list. She further stated it was her expectation for residents to receive medications as ordered however she did not feel 1 missed bedtime dose of Dilantin and 1 missed bedtime dose of Seroquel would have caused harm for Resident #34 but if he missed the medications over several days it would be a problem. She further explained she would expect for staff to communicate missed medications with the providers.	F 658	and admission/readmission orders were properly faxed to the pharmacy, medication orders were entered correctly into the facility electronic medical record medication administration record, medications received as ordered and on the medication cart, and medications have been administered as ordered. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. Starting 07/01/2019 New order(s) and Admission/re-admission audits will be completed by the Director of Nursing (D.O.N.) and Minimum Data Set (MDS) Nurse, or a designated nurse administrator weekly M-F for 4 weeks, then 3x/week for 2 months. Audit to include; any new resident orders and admission/readmission orders were properly faxed to the pharmacy, medication orders were entered correctly into the facility electronic medical record medication administration record, medications received as ordered and on the medication cart, and medications have been administered as ordered. 2. Results of the audits will be presented by the D.O.N. at the monthly Quality Assurance Performance Improvement (QAPI) x3 months or until a timeframe determined by the QAPI members	

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F 658	Continued From page 31 During an interview on 06/14/19 at 10:01 AM, Unit Manager #1 explained when a resident was sent to the hospital and they were gone for more than 24 hours they were considered discharged. She stated all current Physician orders had to be discontinued and new orders were put into the computer system when the resident returned to the facility. She explained she recalled she put Resident #34's medications into the computer on 06/04/19 and Resident #34 should have received his bedtime doses of medications. She explained when she came to work the next day a Nurse asked her if Resident #34's medications had been discontinued. She stated she pulled them up on the computer and they were all active but were not showing up on the MAR. She stated she called computer support and was told the computer assigned the medications to the incorrect MAR. She stated it was her expectation that Nurse #5 should have questioned why she could not see Resident #34's medications on the MAR. An attempt to interview Resident #34 on 06/14/19 at 10:40 AM revealed he could say hello and ok and would only smile and nod his head up and down when asked questions. During an interview on 06/14/19 03:04 PM, the Administrator stated it was her expectation for residents to receive their medications at bedtime when they returned from the hospital.	F 658	• Date of compliance July 9, 2019	
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	F 677		7/9/19

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F 677	Continued From page 32 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to provide activities of daily living care to a dependent resident who was soiled with food left over from the breakfast meal before feeding the resident the lunch meal for 1 of 4 residents sampled for activities of daily living (Resident #75). The findings included: Resident #75 was admitted to the facility on 04/30/19 and readmitted on 05/22/19. Resident #75's diagnoses included: dementia, cerebral infarction, weakness, dysphagia, and others. Review of a care plan initiated on 05/14/19 read in part, Resident #75 has an Activity of Daily Living (ADL) self-care performance deficit related to decreased mobility and cognitive impairment. The goal read, Resident #75 will improve current level of function in ADLs through the review date. The interventions included: bathing/shower: the resident requires assistance, dressing: the resident requires assistance, eating: the resident is totally dependent on staff for eating. Review of the quarterly Minimum Data Set (MDS) dated 05/25/19 revealed that Resident #75 was moderately impaired for daily decision making and required extensive assistance of 1 staff member with eating and extensive assist of two person with dressing. The MDS further revealed that Resident #75 required extensive assistance of one person with personal hygiene. An observation of Resident #75 was made on	F 677	F 677 ADL Care Provided for Dependent Residents • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 75 was assisted with ADL care after lunch on 6/9/19 with no adverse effects to the resident. • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. Current residents that are dependent with ADLS are at risk for the deficient practice. Upon observations no other residents were found to have not received AM care prior to meals. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Beginning on 06/19/2019 the DON/ unit managers re-educated the CNA's and Licensed nursing staff on assisting dependent residents with ADL's, to include timely am care after breakfast and to ensure clothes are changed after meals if soiled with food. Newly hired CNAs and Licensed nursing staff will be educated during orientation. Any licensed staff and	

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F 677	Continued From page 33 06/09/19 at 11:57 AM. Resident #75 was resting in bed with his eyes open, he was alert but nonverbal. He was clothed in a hospital gown and was covered with a sheet. Resident #75 appeared unkempt. His hair had not been combed and and there was a towel laying partially on his chest and partially in the bed next to him that contained eggs and thick brown chunky material that resembled oatmeal. That same thick brown chunky material that resembled oatmeal was noted on the front of Resident #75's hospital gown and sheet that was covering him. An observation of Resident #75 was made on 06/09/19 at 12:57 PM. Resident #75 was resting in bed with his eyes open and was alert. He stated he was waiting on his lunch to come. Resident #75 remained clothed in a hospital gown and covered with a sheet. The towel that contained eggs and thick brown chunky material that resembled oatmeal remained partially laying on his chest and partially laying in bed with him. The same thick brown chunky material that resembled oatmeal remained on the front of Resident #75's gown and sheet that was covering him. An observation of Resident #75 and interview with Nursing Assistant (NA) #1 was conducted on 06/09/19 at 1:22 PM. NA #1 was feeding Resident #75 his lunch meal. The towel that contained eggs and thick brown chunky material that resembled oatmeal remained in bed with him. The thick brown chunky material that resembled oatmeal remained on the front of his gown and the sheet that was covering him. NA #1 stated that she fed Resident #75 breakfast and while assisting him she stepped out of the room to grab a towel and when she returned Resident #75 had	F 677	CNAs not educated by 07/09/2019 will not be allowed to work until reeducated. 2. The unit managers/supervisors will make rounds on all units 5 x week for 12 weeks during meal times to ensure that residents that require assistance with ADLS do not have on food soiled clothing prior to meals. The rounds will begin on 07/08/2019 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 2 months. Finding will be documented on a log and given to the DON for review. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Director of nursing will present the results of the visual round audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance. • Date of compliance July 9, 2019	

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grabbed his oatmeal and spilt it on his gown and sheet. NA #1 confirmed that she had not provided any ADL care to Resident #75. She stated that they facility was really short staffed and there was only 4 NAs in the building and after breakfast she had to assist one of the other NAs with a transfer and then started her round at the other end of the hall. NA #1 stated that she had not gotten to Resident #75 before the lunch trays arrived at the unit, so she had to stop and pass the lunch trays and then assist Resident #75 with his lunch. NA #1 stated that she would complete Resident #75's ADL care after lunch and get him cleaned up. NA #1 stated that Resident #75 should have been cleaned up after breakfast and should not have eaten lunch still soiled from the breakfast meal but added "it had been so busy" and she had just not had time.

An interview was conducted with the Weekend Supervisor (WS) on 06/12/19 at 9:25 AM. The WS confirmed that she was working on 06/09/19 and was aware of the staffing challenges but stated she was not permitted to make any schedules changes. The WS stated that it was unacceptable that Resident #75 was fed lunch while soiled with breakfast food. She added that she had not witnessed Resident #75 that day but was not aware that the staff had not been able to provide ADL care to him prior to the lunch meal. The WS stated that if there was not enough staff to complete the ADL care to Resident #75 then NA #1 should have notified the nurse. She added that she expected ADL to be provided to every resident when needed and it was "excessive to have no ADL care by lunch time."

An interview was conducted with the Unit Manager (UM) #2 on 06/12/19 at 9:58 AM. UM #2

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F 677	Continued From page 35 stated that the staff should have cleaned up Resident #75 and not fed him lunch while soiled from breakfast. UM #2 stated "no one would want to eat with food all over them." She added that morning ADL care should be completed by lunch time and Resident #75 should have been cleaned up prior to being served lunch. An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:07 AM. The DON stated that she expected ADL care to be provided as needed and Resident #75 should have been cleaned up prior to being served his lunch meal. An interview was conducted with the Administrator on 06/14/19 at 3:04 PM. The Administrator stated that she expected Resident #75 to be cleaned up prior to his lunch being served. She further stated that she expected ADL care to be provided when needed and certainly before lunch.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, and Nurse Practitioner interviews the facility failed to prevent a dependent resident from falling from bed and sustaining injuries during the provision of	F 689	F 689 Free of accident Hazards/Supervision/Devices • The corrective action will be	7/9/19

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F 689	Continued From page 36 care for 1 of 4 residents (Resident #298) reviewed for supervision to prevent accidents. One staff member was providing Resident #298 with incontinence care when the resident rolled out of bed and fell to the floor. Resident #298 received treatment at the hospital for injuries sustained as a result of this fall which included; a laceration to the head that required 3 sutures and a fractured clavicle. The findings included: Resident #298 was initially admitted to the facility on 09/19/15 and most recently readmitted on 05/02/19. Resident #298's medical diagnoses included: weakness, hemiplegia, above knee amputation of lower extremity, and others. Resident #298's care plan that was initiated on 02/10/17 read in part, Resident #298 has an Activity of Daily Living (ADL) self-care performance deficit related to right above knee amputation, impaired range of motion, and right sided hemiplegia/hemiparesis. The goal of the care plan read, Resident #298 will improve current level of function in ADLs through the review date. The interventions included: BED MOBILITY: the resident requires staff assistance, DRESSING: the resident requires staff assistance, PERSONAL HYGIENE: the resident requires staff assistance, and TOILETING: the resident requires staff assistance. The resident's Occupational Therapy (OT) evaluation and plan of treatment dated 12/14/18 read in part, Resident #298 was last evaluated by OT on 06/30/17. His current level of function read, hygiene and groom: patient requires assistance, however will not currently address in	F 689	accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 298 current interventions related to the incident on 5/3/19 are in place. The interventions included changing the bed and ensuring 2 CNA's were utilized when performing care in bed • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. Current residents that are at risk for falls or that have fallen are at risk for the deficient practice • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. An audit completed by the MDS coordinator on 07/03/2019 of care plans of residents with falls in the last 30 days to ensure that interventions are on the care plan and in place. 2. Beginning on 07/03/2019 the licensed nurses were re-educated by DON on the documentation and assessment required after a resident fall. New employees will receive this education during orientation. Any licensed nursing staff that have not received education by 07/09/2019 will not be allowed to work until after reeducated. 3. Beginning on 07/03/2019 the CNA's were re-educated by the DON on following the care plans for interventions related to preventing falls and on using	

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F 689	Continued From page 37 treatment plan, toileting: did not test (dependent at bed level), and dressing: continues to require extensive assistance with max assistance for upper body. The evaluation and plan of treatment did not indicate how much staff assistance was required for each task. The quarterly Minimum Data Set (MDS) dated 04/18/19 revealed that Resident #298 was moderately impaired for daily decision making and required extensive assistance of two person with bed mobility, toileting, and personal hygiene. The MDS further revealed that Resident #298 had experienced no falls since the previous assessment. A facility document titled "Resident Care Specialist Assignment Sheet" and dated 04/25/19 read in part, Resident #298 was scheduled to receive a shower on Tuesday and Sunday on second shift and was incontinent of bowel and bladder. Under transfer/ambulation it stated mechanical lift (2 assist) and under restraint/bedrails/positioning the column was blank and contained no information about mobility status. An incident report dated 05/03/19 at 6:14 AM read in part, Nursing Assistant (NA) #2 reported to Nurse #2 that Resident #298 was on the floor. He fell to the floor while NA #2 was turning him to provide care. Nurse #2 observed Resident #298 laying in the floor supine position on the bedside mat. There was blood noted under his head along with a cross necklace. Swelling noted to left frontal area above eyebrow with bleeding noted. Ice and pressure applied. Laceration noted to occipital (back of head), area with large amount of blood. Emergency Medical Services (EMS)	F 689	the Kardex. New employees will receive this education during orientation. Any CNAs that have not received education by 07/09/2019 will not be allowed to work until reeducated. 4. On 07/08/2019 the DON and IDT will complete a root cause analysis of each fall to ensure the intervention in place remains appropriate. The IDT will review root cause analysis daily as needed during clinical meeting beginning on 07/08/2019. 5. The care plan will be updated after each fall to reflect the review or addition of new interventions by the MDS coordinator. 6. Beginning 07/08/2019 the resident care sheets have been converted to the PCC Kardex and updated. The Kardex will be updated to reflect current level of assistance needed for activity of daily living and as needed to include intervention for a fall. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Director of Nursing will conduct an audit, which includes appropriate level of assistance while providing ADL care and document findings for all residents with falls weekly for 12 weeks to ensure the assessment, documentation are complete for 3 days and interventions updated on the care plan. 2. The Director of nursing will conduct and present the results of the audits,	

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F 689	Continued From page 38 called. Signed by Unit Manager #1. Review of a nurse's note dated 05/03/19 at 7:59 AM read in part, NA #2 reports that Resident #298 was on the floor. He fell to the floor while NA #2 was turning him to provide care. Nurse observed resident on the floor, supine lying on bedside mat. Blood noted under his head and laceration with large amount of blood. Sent to Emergency Room (ER) for evaluation. Signed by Nurse #2. Review of Emergency Room (ER) notes dated 05/03/19 read in part, per EMS the patient was in the usual state of health until this morning when the staff at the facility rolled the patient in bed and he rolled off the bed and landed face first on the ground. The patient sustained approximately a 2 foot fall out of bed and was unable to brace the landing. Initial evaluation found the patient to have a left brow hematoma that was bleeding as well as an obvious shoulder deformity. Imagining were notable for a left nondisplaced clavicular fracture. The patients scalp laceration was repaired and appeared appropriate and given the clavicle fracture was nondisplaced no acute/urgent intervention was deemed necessary will continue previously placed sling. The patient was deemed appropriate to return to the facility. Review of a statement provided by NA #2 with no date noted read in part, it was 5:00 AM and I was making my rounds and Resident #298 was soiled with fecal matter, so I gathered my linen and proceed to clean Resident #298 up. NA #2 wrote that she cleaned his front side then she rolled him to his right side to clean his back side. After he was clean on both the front and back side NA #2 indicated she gathered all her dirty linen and trash	F 689	which will include appropriate level of assistance while providing ADL care and fall interventions to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance • Date of compliance July 9, 2019	

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and bagged them up. NA #2 indicated she was then ready to put the clean brief and pad under Resident #298, so she again rolled him to his right side and he fell to the floor and it happened so fast "I did not have time to respond." The statement was signed by NA #2.

Attempts to speak to NA #2 were made on 06/11/19, 06/12/19, and 06/13/19 were unsuccessful.

An initial interview was conducted with Resident #298 on 06/09/19 at 12:37 PM. He stated that he recently received a new bed because the staff was washing him up and fell out of bed. Resident #298 could not explain how he fell out of bed but stated he was bleeding from his head and went to the hospital and they fixed him up and sent him back home. Another interview was conducted with Resident #298 on 06/12/19 at 10:41 AM. He stated that he could not recall the name of the staff member that was providing care to him on 05/03/19 but stated that was the first time he had seen her and the first time she had cared for him. Resident #298 stated that she was washing him up and rolled him off the bed. He added that on third shift usually one staff member would come to help him but when NA #5 was there she always had someone to help her. Resident #298 stated "he feels much safer if there are 2 people" helping but stated "they do a pretty good job of getting it done."

An interview was conducted with Nurse #2 on 06/11/19 at 1:49 PM. Nurse #2 stated that on 05/03/19 NA #2 stated that Resident #298 was on the floor. She stated she asked NA #2 how he got on the floor and NA #2 replied he fell out of bed. Nurse #2 stated she again asked NA #2 how that

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happened, and she replied she was providing care to him when she turned him on his side he kept going and fell to the floor. Nurse #2 stated that when she entered the room Resident #298 was laying on the floor face up between the 2 beds in the room and he was alert and verbal. She stated that there was a lot of blood coming from his head and noted a laceration with some swelling to his left eye area and she immediately applied ice to that area. She added that she was not familiar with Resident #298 and that night was the first night she had cared for him. She added she was not aware of how many staff members it took to turn him in bed or to provide incontinent care and relied on the NAs to know that information. Nurse #2 stated that Resident #298 denied any complaints to her but when EMS arrived he did complain of some arm pain. She added that she notified the on call medical provider and the family and sent Resident #298 out to the ER for evaluation and completed the required paperwork. Nurse #2 stated that Resident #298 wore a gold cross necklace on his neck and she believed that the cross may have caused the laceration because it was directly under his head and was covered with blood. She stated that when she left after her shift Resident #298 had not yet returned from the hospital.

An interview was conducted with the Administrator and the Corporate Nurse Consultant (CNC) on 06/11/19 at 2:17 PM. The CNC stated that after the incident with Resident #298 they called NA #2 to come back to the facility and they re-enacted the event, so they would know what occurred. The CNC stated that what they learned was that Resident #298 had 2 large loose bowel movements through the night and had a 3rd one which was why NA #2 was

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providing care to him. She stated that they determined that when NA #2 turned Resident #298 on his right side he threw his left stump (amputation site) over the edge of the bed and that threw him out of the bed to the floor. She added that his bed at the time had no side rails and there was, nothing to grab and he just fell to the floor. The CNC confirmed that NA #2 was providing care to Resident #298 by herself on 05/03/19. The CNC stated they believe the laceration came from the cross pendant he wore around his neck. The Administrator stated that after the event they changed Resident #298 to a 2 person assist and added positioning rails to his bed. She stated that the facility used the Resident Care Specialist Assignment Sheet to communicate resident mobility status to the direct care staff. The Administrator stated that the mobility status would come from the therapy department and Unit Manager #1 would place that information on the Resident Care Specialist Assignment Sheet and the staff would pick one up each time they came to work and have the information. When the Administrator and CNC reviewed the Resident Care Specialist Assignment Sheet for Resident #298 that was in place when the resident fell on 05/03/19 they agreed that it did not contain the information that would be required to take care of Resident #298. The Administrator stated that she expected the Resident Care Specialist Assignment sheet to contain information on how to care for the resident including how many staff members were needed to safely care for the resident.

An observation of NA #5 and #6 providing care to Resident #298 was conducted on 06/12/19 at 10:31 AM. NA #5 was on the left side of the bed and NA #6 was on the right side of the bed. They

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were able to complete his bed bath and incontinence care without incident. NA #5 stated that she took care of Resident #298 regularly and was familiar with his care needs. She stated that she always had 2 people in the room even prior to his fall on 05/03/19 when providing care because of his right sided weakness.

An interview was conducted with the Director of Rehab on 06/12/19 at 4:32 PM. The Director of Rehab stated that the last time Resident #298 was on OT caseload was December of 2018 which was an evaluation only. He stated that in the facility's morning meeting they have an in-house communication form that they gave to the Unit Managers that was responsible for the resident. That form would include mobility and functional status and the Unit Manager would place that information on the Resident Care Specialist Assignment Sheet and then give to the NAs, so they knew how to safely and properly care for the resident. The Director of Rehab stated that if the resident was re-evaluated by therapy that process would start over again. If no therapy had occurred, then the resident functional status from the last therapy involvement would still be accurate.

An interview was conducted with Unit Manager (UM) #1 on 06/12/19 at 4:53 PM. UM #1 stated that she was not at the facility when Resident #298 fell from bed but was told about it. She stated that she was told that NA #2 was providing care to him and rolled him out of bed. UM #1 stated that Resident #298 has always and still required 2-person assistance and to her knowledge the Resident Care Specialist Assignment Sheet indicated that. UM #1 stated that NA #2 should have had another person with

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F 689	Continued From page 43	F 689		

her that night and that would have prevented Resident #298 from falling out of bed.

An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:16 AM. The DON stated she was not the DON when the fall occurred but stated she had since been made aware of the incident. The DON reviewed Resident #298's Resident Care Specialist Assignment sheet that was in place on 05/03/19 when the resident fell and confirmed that it did not indicate how many staff members were needed that night to take care of Resident #298. She added that since assuming the role of DON she had identified the need to restructure the Resident Care Specialist Assignment sheet and planned to start using the Kardex that was a part of the electronic medical record which in her mind would be clearer to the staff of how to properly take care of the resident. The DON again confirmed that the staff did not know how much assistance Resident #298 required and stated, "we had a systemic breakdown."

An interview was conducted with the Nurse Practitioner (NP) on 06/14/19 at 9:15 AM. The NP stated that when she arrived at the facility on 05/03/19 UM #1 informed her of the fall and stated they had called the on-call provider and sent Resident #298 to the ER. The NP stated that she was told that the NA was providing care and she rolled him to his side and he fell from the bed. The NP stated that when he went to the ER they noted a fractured clavicle as a result of the fall from bed on 05/03/19 and we sent him to orthopedic doctor, but no surgery was necessary. The NP stated that she expected the staff to do everything they could to keep the resident safe and secure.

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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 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 690	F 690 Bowel Bladder Incontinence	7/9/19

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F 690	Continued From page 45 interview the facility failed to secure a indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 2 residents reviewed for urinary indwelling catheter care (Resident #54). The findings included: Resident #54 was initially admitted to the facility on 02/28/19 and most recently readmitted to the facility on 05/14/19. Resident #54's diagnoses included neuromuscular dysfunction of the bladder. Review of the comprehensive Minimum Data Set (MDS) dated 04/01/19 revealed that Resident #54 was moderately impaired for daily decision making and required total assistance of two staff members with toileting. The MDS further revealed that Resident #54 had an indwelling catheter and was always incontinent of bowel. An observation of Resident #54 was made on 06/09/19 at 3:31 PM. Resident #54 was resting in bed with her eyes open and was alert and verbal. She was observed to have an indwelling urinary catheter that was draining clear yellow fluid into a collection bag that contained approximately 300 milliliters (ml) of the clear yellow fluid. The indwelling urinary catheter was not anchored or secured to Resident #54's leg and was noted to be pulled across the front of her brief and connected to the drainage bag that was hanging on the side of the bed. Resident #54 denied pain or discomfort at this time. An observation of Resident #54 was made on 06/10/19 at 11:29 AM. Resident #54 was resting in bed with her eyes open. Resident #54's indwelling urinary catheter was draining clear	F 690	Catheter UTI • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 54 indwelling catheter was secured on 06/14/2019to prevent tugging or pulling • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. On 06/14/2019 the DON and/or unit manager conducted a visual audit of current residents with indwelling catheters to ensure they are secured. Any findings of un secured indwelling catheters will be secured immediately. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Beginning on 06/19/2019 the licensed nursing staff and the CNA's will be re-educated by the DON on the policy and procedures for proper anchoring/securing of catheter tubing. Newly hired licensed nursing staff and CNAs will be educated in orientation. Current staff not educated by 07/09/2019 will not be allowed to work until reeducated. 2. New employees will receive this	

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F 690	Continued From page 46 yellow fluid into a drainage bag hanging on the side of the bed. The indwelling urinary catheter was not anchored or secured to Resident #54's leg and again was pulled across the front of her brief and connected to the drainage bag on the side of the bed. Resident #54 verbalized general discomfort but not specific to her indwelling urinary catheter. An observation of Resident #54 was made on 06/11/19 at 8:08 AM. Resident #54 was resting in bed with her eyes open. Resident #54's indwelling urinary catheter was draining clear yellow fluid. The indwelling urinary catheter was not anchored or secured to Resident #54's leg and was running out the side of her brief into the collection bag that was hanging on the side of the bed. An observation of Resident #54 was made on 06/12/19 at 12:03 PM. Resident #54 was resting in bed with her eyes open. She had an indwelling urinary catheter that was not anchored or secured to her leg. The indwelling urinary catheter was pulled up over the side of her brief and then connected to the drainage bag that hung on the side of the bed. The catheter was draining clear yellow fluid and Resident #54 denied any complaints. An interview was conducted with Nursing Assistant (NA) #3 on 06/12/19 at 1:38 PM. NA #3 confirmed that she was caring for Resident #54 and was familiar with her needs. NA #3 stated that she performed catheter care every day, emptied the catheter bag, and reported to the nurse how much output Resident #54 had. She stated that the nurse was responsible for anchoring or securing the catheter tubing and if she would have noticed that her catheter tubing	F 690	education during orientation. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. Beginning on 07/08/2019 the DON and/or Unit manager will conduct weekly audits for 12 weeks of all indwelling catheters to ensure compliance with anchoring of tubing and place on an audit log. 2. The Director of nursing will present the results of the audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance. • Date of compliance July 9, 2019	

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was not anchored or secured she would have notified the nurse. NA #3 confirmed that she had not noticed that Resident #54's catheter tubing was not anchored and therefore had not reported it to the nurse.

An observation of Resident #54 and interview with Nurse #3 were conducted on 06/12/19 at 2:11 PM. Resident #54 was resting in bed with her eyes open. Her indwelling urinary catheter was pulled through the right side of her brief and pulled across the front of her brief and connected to the drainage bag hanging on the left side of the bed. Nurse #3 confirmed that the indwelling urinary catheter tubing was not anchored and was pulling across the front of Resident #54's brief. She stated that all indwelling catheter tubing should be anchored to her leg and it was the responsibility of the nurse to ensure that it was anchored appropriately. Nurse #3 stated that she would immediately anchor the resident's catheter tubing.

An interview was conducted with Unit Manager #2 on 06/12/19 at 2:19 PM. Unit Manager #2 stated that it would be a good idea to anchor or secure the indwelling urinary catheter tubing to Resident #54's leg. She added that the tubing should be fed through her brief and hung on the same side of the bed to ensure it drained properly and did not pull and cause discomfort to Resident #54.

An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:10 AM. The DON confirmed that Nurse #3 would be responsible for anchoring or securing the indwelling urinary catheter tubing for Resident #54. The DON stated that she expected the indwelling urinary catheter tubing to be secured at all times to prevent pulling

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F 690	Continued From page 48 or tugging on the resident. An interview was conducted with the Administrator on 06/14/19 at 3:04 PM. The Administrator stated that she expected indwelling catheter tubing to be anchored or secured at all times to prevent pulling or tugging on the resident.	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 staff interviews, the facility failed to obtain a physician's order for administration of oxygen for a resident who received oxygen through a nasal cannula from an oxygen concentrator (Resident #86) and also failed to administer oxygen according to a physician's order (Resident #89) for 2 of 3 residents sampled for respiratory care. Findings included: 1. Resident #86 was admitted to the facility on 09/24/15 with diagnoses which included Alzheimer's disease, chronic obstructive pulmonary (lung) disease, depression and anxiety.	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #86 discharged on 06/10/2019 • Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 1. An audit of all residents with oxygen orders to ensure that oxygen is provided	7/9/19

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F 695	Continued From page 49 The resident's most recent annual Minimum Data Set (MDS) dated 05/08/19 revealed Resident #86 was severely impaired in cognition for daily decision making. The MDS also revealed Resident #86 required extensive assistance with activities of daily living and oxygen was not indicated. A review of Resident #86's monthly Physician's orders dated 06/07/19 revealed there was not an order for the resident to receive oxygen. Further review of Physician's orders dated 06/07/19 through 06/09/19 revealed there were no orders for oxygen. During an observation on 06/09/19 at 12:14 PM Resident #86 was lying in bed with a nasal cannula in her nose and the oxygen tubing was connected to an oxygen concentrator next to her bed. The oxygen concentrator was turned on to 2 liters per minute. During an observation on 06/10/19 at 2:55 PM Resident #86 was lying in bed with a nasal cannula in her nose and the oxygen tubing was connected to an oxygen concentrator next to her bed. The oxygen concentrator was turned on at 1.5 liters per minute. A review of a Physician's order with a revised date of 06/11/19 indicated to send to Resident #86 to the emergency room for a peripheral inserted central catheter (PICC) line placement. A review of a Nurse's progress note dated 06/11/19 at 9:16 AM by Unit Manager #2 indicated Resident #86 was hospitalized.	F 695	as ordered by the physician. Audit completed on 07/05/2019 by Director of Nursing 2. A Visual audit of residents was completed by the DON on 07/05/2019 to validate a resident that is receiving oxygen has an order and those residents with an order for oxygen are receiving it. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. On 07/05/2019 Licensed staff educated by DON/UM regarding the importance of following physician orders for oxygen, ensuring those residents with orders for oxygen are receiving it, prior to administering oxygen an order must be obtained, and documentation is completed in the MAR/TAR. New hires will receive education during orientation. As of 07/09/2019 licensed staff not re-educated will not be allowed to work until reeducation is received. 2. Beginning on 07/08/2019 audits will be conducted by Director of Nursing/Nurse Managers to monitor residents with oxygen to ensure oxygen is provided and with an order by the physician. This audit will be conducted on all residents with oxygen 5 x per week x 12 weeks. The DON/UM will audit the MAR 3 times a week for 12 weeks to ensure residents are receiving oxygen as ordered.	

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F 695	Continued From page 50 During a telephone interview on 06/12/19 at 9:22 AM, the weekend Nursing Supervisor stated she did not recall seeing a Physician's order for oxygen for Resident #86. She further stated residents who received oxygen should have an order it. During an interview on 06/12/19 at 9:35 AM with Unit Manager #2 she explained Resident #86 was diagnosed with pneumonia a few days ago after she had a chest x-ray. She stated when a resident needed oxygen staff were supposed to get a Physician's order to administer oxygen. After review of Resident #86's physician orders she stated an order should have been obtained for Resident #86's oxygen. She further stated someone had put oxygen on Resident #86, but she was not sure who had put the oxygen on or when they had placed it on Resident #86. She confirmed Resident #86 had gone to the emergency room for a PICC line placement on 06/11/19 and had not returned to the facility During an interview on 06/13/19 at 12:38 PM with the Director of Nursing she stated it was her expectation Resident #86 should have had an order for oxygen. She explained it was her guess that the Nurse forgot to enter the order. During a telephone interview on 06/14/19 at 8:54 AM with Nurse Aide (NA) #4 she stated she was assigned to Resident #86 last Sunday on 06/09/19 and recalled Resident #86 had oxygen on. She stated Resident #86 was always telling her she needed to put water in the container on the oxygen concentrator, but she was not allowed to do anything with that. She explained Resident #86 had received oxygen ever since she had	F 695	• The facility plans to monitor its performance to make sure that solutions are sustained; 1. The director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance • Date of compliance July 9, 2019	

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F 695	Continued From page 51	F 695		

been coming to the facility since April 2019 as an agency NA.

During an interview on 06/14/19 at 3:04 PM with the Administrator she stated it was her expectation for there to be and oxygen order for Resident #86. She further expected for staff to follow Physician's orders and administer oxygen according to the Physician's order.

2. Resident #89 was admitted to the facility on 07/12/18 and most recently readmitted on 04/02/19. Resident #89's medical diagnoses included: respiratory failure, heart failure, chronic obstructive pulmonary disease, and others.

Review of a Minimum Data Set (MDS) dated 03/21/19 revealed that Resident #89 was moderately impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that Resident #89 had no shortness of breath and no oxygen was used during the assessment reference period.

Review of a Medical Doctor (MD) order dated 06/06/19 read, oxygen at 2 liters per minute via nasal cannula.

An observation of Resident #89 was conducted on 06/09/19 at 11:34 AM. Resident #89 was resting in bed with his eyes closed and had oxygen in his nose. The oxygen concentrator was sitting next to the bed and was set to deliver 5 liters per minute.

An observation of Resident #89 was conducted on 06/10/19 at 9:11 AM. Resident #89 was resting in his bed with his eyes closed. There was

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F 695	Continued From page 52	F 695		

oxygen in his nose. The oxygen concentrator was sitting next to the bed and was set to deliver 4 liter per minute.

An observation and interview with Resident #89 were conducted on 06/11/19 at 8:09 AM. Resident #89 was in resting in bed with his eyes open. He was alert and verbal. He had oxygen in his nose. The oxygen concentrator was sitting next to his bed and was set to deliver 4 liters per minute. Resident #89 denied any cough or shortness of breath and stated he has worn oxygen off and on over the years. He stated that the nurses would set the concentrator next to his bed and make sure it was set to the right amount which he thought was 2 liters per minute.

An observation of Resident #89 was conducted on 06/12/19 at 11:57 AM. Resident #89 was resting in his bed with his eyes closed. There was oxygen in his nose. The oxygen concentrator was sitting next to the bed and was set to deliver 4 liter per minute.

An interview was conducted with Nursing Assistant (NA) #7 on 06/12/19 at 1:52 PM. NA #7 confirmed that she was taking care of Resident #89 and was familiar with his care needs. She stated that Resident #89 wore his oxygen at all times and she would reapply it if it came off, but the nurse was responsible for the setting the flow rate. NA #7 stated that each time she was it the room with Resident #89 she would make sure he had his oxygen in place.

An interview was conducted with Nurse #3 on 06/12/19 at 2:04 PM. Nurse #3 stated that Resident #89 had been on oxygen ever since she had been coming to the facility for 2 months. She

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added that he wore the oxygen continuously and per the MD order on 06/06/19 he should be receiving 2 liters of oxygen per minute. Nurse #3 confirmed that she was taking care of Resident #89 and confirmed that he was on 4 liters per minute and stated, "he should not be on 4 liters he should be on 2 liters." Nurse #3 adjusted the flow rate to 2 liters per minute and stated that each nurse should be checking the oxygen rate every day and stated that she had not noticed the flow rate when she was in the room earlier.

An interview was conducted with Unit Manager #2 on 06/12/19 at 2:22 PM. Unit Manager #2 stated that Resident #89 has been on oxygen since hid most readmission. She stated that the nurses should be checking the oxygen flow rate every shift and making sure it was at the correct flow rate. Unit Manger #2 stated that if flow rate was changed she would expect to see a new order and a nurse note explaining why the order had changed. Unit Manager #2 stated she expected Resident #89 to be on the correct dose of oxygen as ordered by the MD.

An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:14 AM. The DON stated that oxygen should be checked by the nurse every shift to ensure the oxygen was being delivered at the correct flow rate. She would expect Resident #89 to be on 2 liters of oxygen per the MD order.

An interview was conducted with the Nurse Practitioner (NP) on 06/14/19 at 9:15 AM. The NP stated that she expected all medications including oxygen to be given as ordered by the medical provider.
An interview was conducted with the

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F 695	Continued From page 54 Administrator on 06/14/19 at 3:04 PM. The Administrator stated that she expected oxygen to be delivered to the resident at the rate that was ordered by the MD.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to provide sufficient	F 725	F 725 Sufficient nursing staff	7/9/19

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F 725	Continued From page 55 nursing staff to provide Activity of Daily Living to a dependent resident that was soiled with food left over from the breakfast meal This affected 1 of 4 sampled residents (Resident #75). The finding included: This tag is cross referred to F677: Based on observations, record review, and staff interview the facility failed to provide activities of daily living care to a dependent resident who was soiled with food left over from the breakfast meal before feeding the resident the lunch meal for 1 of 4 residents sampled for activities of daily living (Resident #75). An interview was conducted with the Scheduling Coordinator (SC) on 06/13/19 at 3:02 PM. The SC stated that she completed the assignment sheet 5 weeks at a time. She added that she has one agency that she used to fill any open spots on the schedule. The SC stated that currently she only had one nurse on the facility's staff and the rest were agency nurses. She added that they currently had no vacancies for NAs and she very rarely had to uses agency NAs. The facility policy was for staff to call out 4 hours prior to their shift and the SC stated that most staff did not follow that policy and left the staff scrambling to find coverage. She stated that when staff called out she would call around to find coverage either with the facility staff or the agency staff. She confirmed that weekends and holidays had more call outs and it was more difficult to find coverage for those times. The SC stated that normal staffing patterns for the facility were 2 nurses and 8 NAs for first and second shift. She added that this pattern included the weekends as well. The SC confirmed that she was not aware that on	F 725	" The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 75 was assisted with ADL care after lunch on 6/9/19 with no adverse effects to the resident. " The facility will identify other residents having the potential to be affected by the same deficient practice: 1. Current residents that are dependent with ADLS are at risk for the deficient practice. Upon observations no other residents were found to have not received AM care prior to meals. " The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Beginning on 06/19/2019 the DON/ unit managers re-educated the CNA□s and Licensed nursing staff for any call outs notify the supervisor, unit manager, and/or DON to ensure adequate staffing. If unable to get coverage with facility staff including prn staff, then reach out to agency to assist with coverage. An admin nurse will be appointed by the Administrator to come in if coverage is unsuccessful, on assisting dependent residents with ADL□s, to include timely am care after breakfast and to ensure clothes are changed after meals if soiled with food. Newly hired CNAS and	

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F 725	Continued From page 56 06/09/19 there were only 4 NAs in the building. She added that when she left on Friday 06/07/19 the schedule was fully staffed, and she has no further involvement until Monday morning. She stated that she has requested two times to have remote access, so she could manage the schedule and call in and both times have been denied. The SC stated that it would fall to the Weekend Supervisor (WS) to handle any staffing concerns. The SC stated that it concerned her that there were only 4 NAs in the building on 06/09/19 because "that was not enough to take care of the residents." She added that the WS has the authority to call agency staff to call the facility staff to get help if it is needed. She further stated that if there were only 4 NAs in the building then the Nurses and WS should be helping on the floor and the DON should be made aware. An interview was conducted with the DON on 06/13/19 at 8:07 AM. The DON stated that she had only been the DON since 05/13/19 and really did not have a clear picture of the staffing in the facility yet. She stated that the Certified Medication Aides (CMAs) were instructed to help on the floor when they have completed their medication pass. The DON stated that if there was a call in the WS had the ability to reach out to the staff and to the agency for support. The DON stated she made it clear to the WS that she if needed to call the staff or the agency to get support to please just let her know so that she was aware. The DON stated that she expected there to be enough staff to meet the needs of each of the residents. An interview was conducted with the Administrator on 06/14/19 at 3:04 PM. The Administrator stated that if there were only 4 NAs	F 725	Licensed nursing staff will be educated during orientation. Any licensed staff or CNAs that have not been educated by 07/09/2019 will not be allowed to work until reeducated. 2. Beginning on 07/08/2019 the staffing coordinator will notify the DON of any callouts during Monday through Friday and the weekend supervisor will notify the DON of any callouts Saturday and Sunday. If unable to obtain coverage the DON will notify the Administrator so that the Admin Nurse is notified to report to the facility. 3. The facility will staff according to the staffing pattern which is determined by the resident acuity. The facility will continue to recruit and hire for open positions via utilizing the company recruiter and sign on bonus. All call outs for nursing staff will go through the DON and the DON will assist with replacement. Agency will be utilized until staffing patterns are stable and reliable. The DON will be responsible for maintaining staffing patterns, reviewing the staffing pattern sheets(assignment sheets), and documenting on a log that the facility is staffing according to the staffing pattern which is determined by the resident acuity beginning on 07/08/2019. " The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Director of nursing will present the results of staffing pattern sheets to the quality assurance performance committee (QAPI) monthly for 3 months for any	

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F 725	Continued From page 57 in the building on 06/09/19 the WS should have made phone calls to get some help in the facility and if she was unable to find some help then she should have reached out to the DON and herself, so we could help in making sure the residents were taken care of.	F 725	recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance. " Date of compliance July 9, 2019	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		7/9/19

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F 732	Continued From page 58 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post the required daily staffing information on weekends for 2 of the prior 7 days. Findings included: An observation on 06/09/19 at 10:15 AM during the initial tour of the facility revealed the posted staffing was located on the wall next to the Director of Nursing (DON) office and was dated Friday 06/07/19. During a telephone interview on 06/12/19 at 9:22 AM, the weekend Nursing Supervisor stated she had not been told who was responsible for posting the daily staffing on weekends. An interview on 06/13/19 at 8:44 AM with the DON revealed the Scheduling Coordinator posted the daily staffing Monday through Friday. She stated she was not sure who was responsible for posting the daily staffing on the weekends. She further stated she did not know if anyone had communicated with weekend staff to post the daily staffing. An interview on 06/13/19 at 3:00 PM with the Scheduling Coordinator revealed she had just taken the job as Scheduler in April 2019. She	F 732	F 732 Posting Staffing • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. The staffing coordinator was re-educated by the Administrator on 07/03/2019 regarding the daily posting of licensed, unlicensed staff and census. 2. Daily staffing information is posted daily as of 6/14/19 • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. No residents have the potential to be affected • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Licensed staff will be re-educated on 07/03/2019 by the Director of nursing on checking the daily posting of nurse	

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F 732	Continued From page 59 confirmed she posted the daily staffing information Monday through Friday each week because she did not work weekends. She explained she completed the daily posting sheets from the weekend when she returned to work on Monday morning and she gave the weekend numbers to the Administrator. She stated she did not know who was supposed to post the daily staffing on the weekend because no one had told her who was supposed to post the staffing on weekends. She further stated the daily staffing had not been posted on weekends since she had taken the job as Scheduling Coordinator in April and as far as she knew the posted staffing had not been done on weekends since the new company took over on 02/01/19. She explained she thought it would be the Nurse Manager on duty to do that, but it had never been discussed with her. An interview on 06/14/19 at 3:04 PM with the Administrator revealed it was her expectation to post the daily staffing information on a daily basis which included weekends. She stated it was her expectation for the weekend Nursing Supervisor to post the daily staffing on the weekends.	F 732	staffing form, each shift to ensure proper census, licensed and unlicensed hours are correct. Newly hired licensed staff will be educated during orientation. Any licensed staff not educated by 07/09/2019 will not be allowed to work until reeducated. 2. Beginning 07/08/2019 the daily staffing form from prior day will be reviewed daily by Director of Nursing/ unit coordinators/ scheduler or weekend supervisor to ensure accurate care hours were posted for licensed and unlicensed staff to ensure regulatory compliance. The DON will review the daily staffing form daily for the previous day, and the weekend RN Supervisor will review Friday and Saturdays for four weeks then 3 times a week for 2 weeks, then weekly for 2 weeks, then monthly for 1 month. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. Copies of the daily nurse staffing posting will be submitted to the Quality Assurance Performance Improvement committee by the staffing coordinator monthly for 3 months, for recommendations or modifications until compliance is achieved. • Date of compliance July 9, 2019	

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		7/9/19

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F 758	Continued From page 61 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to obtain a baseline Abnormal Involuntary Movement Scale (AIMs) assessment for a resident who received antipsychotic medication for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #84). The findings included: Resident #84 was admitted to the facility on 05/15/19 with diagnoses which included anxiety and pseudobulbar affect. Review of Resident #84's admission Minimum Data Set (MDS) assessment dated 05/22/19 revealed, his cognition was intact, and he received antipsychotic medication during the assessment period. Review of Resident #84's care plan dated 05/27/19 revealed, he received an antipsychotic medication for behavior management. The goal was to remain free of adverse side effects of the medication included monitoring for side effects of the antipsychotic which included performing an AIMS assessment, a tool used to indicate extrapyramidal symptoms, a drug induced condition often caused by using antipsychotic	F 758	F 758 Free from Unnecessary Psychotropic Meds/PRN Use • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #84 had an AIMS completed on 06/10/2019 by the unit manager • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. An audit was completed on 06/10/2019 by the director of nursing on current residents receiving antipsychotic medications. 100% of residents receiving antipsychotic medications had Abnormal involuntary movement (AIMS) completed by July 5, 2019 • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 758	Continued From page 62 medications. Review of the physician orders dated 05/15/19 for Resident #84 revealed, an order for Seroquel, an antipsychotic medication, 75 milligrams by mouth twice a day. Review of Pharmacy Recommendations dated 05/29/19 revealed a recommendation for an AIMS assessment to be completed. Review of Resident #84's medical record indicated there had not been an AIMS assessment completed for Resident #84. On 06/14/19 at 9:55 AM during an interview with the Unit Manager (UM) #1 she explained, she was unsure if the AIMS assessment automatically triggered as a part of the admission assessments for all new admissions but stated if it was not, the MDS Coordinator would manually upload the AIMS assessment for the nurses to complete as she completed the MDS assessment. Interview with the MDS Coordinator on 06/14/19 at 11:11 AM revealed, she did not set up any assessments that may have been missed during Resident #84's admission which included the AIMS assessments. The MDS explained, she did not audit the medical record for missing assessments as she completed the MDS assessments. During an interview with the Pharmacy Consultant on 06/14/19 at 2:11 PM she explained, she reviewed Resident #84's medical record when she was at the facility on 05/29/19. The Consultant stated she recommended a baseline AIMS assessment be conducted due to Resident	F 758	1. On 07/03/2019 the Director of nursing re-educated the licensed nurses on how and when to complete an AIMS on residents taking anti-psychotic medications. Newly hired licensed nursing staff will be educated during orientation. Licensed nursing staff that have not been educated will not be allowed to work after 07/09/2019 until reeducated. 2. Beginning on 07/08/2019 the UM will be responsible for completing the base line AIMS for residents on psychotropic medications within 48 hours. 3. Beginning 07/08/2019 new orders will be monitored in the daily clinical meeting for new antipsychotic medication orders and documented on the log by the UM. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. On 07/08/2019 the director of nursing will audit all residents receiving any antipsychotics monthly for 3 months to ensure that AIMS are being completed timely 2. The Director of nursing will present the results of the audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance. • Date of compliance July 9, 2019	

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F 758	Continued From page 63 #84 being on an antipsychotic medication. The Pharmacy Consultant stated she emailed her recommendation to the Director of Nursing (DON) after her visits, but the recommendation had not been completed. Interview with the DON on 06/14/19 at 2:40 PM revealed, she was aware of the Pharmacy Consultants recommendations on 05/29/19 had not been completed. The DON confirmed the AIMS should have been completed on admission especially since Resident #84 had been admitted on an antipsychotic medication and after she received the recommendation from the pharmacist. The DON gave the explanation of human error as to why the AIMS assessment was not completed on admission but added she had already completed an audit to assure the AIMS assessment was completed on admissions.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		7/9/19

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F 842	Continued From page 64 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 65 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document an assessment for a change in condition for a resident who was sent to the hospital for a change in condition (Resident #34). The facility also failed to document pulse oximetry percentages for a resident who received oxygen (Resident #86). This affected 2 of 2 residents whose medical records were reviewed for hospitalization. Findings included: 1. Resident #34 was admitted to the facility on 11/05/18 with diagnoses which included Parkinson's disease, seizures, Alzheimer's disease, diabetes, dementia, depression and anxiety. A review of a care plan with a revised date of 01/16/19 revealed Resident #34 was at risk for falls related to decreased mobility, history of falls and a history of seizure activity. The goal indicated Resident #34 would be free from injury from falls and the interventions were listed in part to anticipate and meet the resident's needs, provide frequent safety checks and monitor for seizure activity.	F 842	F 842 Resident Records – Identifiable Information • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 34 had an assessment completed for change in condition on 6/14/2019. 2. Resident #86 is no longer in facility was discharged on 06/10/2019 • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. Current residents that have a change in condition have the potential to be affected. The 24-hour report will be reviewed daily by the DON/UM/Supervisor to identify any change of condition to ensure proper notification and assessments has been completed. 2. All residents receiving oxygen have been reviewed to ensure they have an order for administration 3. New orders will be reviewed in the	

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F 842	Continued From page 66 A review of the most recent quarterly Minimum Data Set (MDS) dated 04/05/19 revealed Resident #34 was cognitively intact for daily decision making. The MDS also revealed Resident #34 required limited assistance for activities of daily living except he only required supervision with eating. A review of an incident report dated 05/30/19 at 6:00 PM indicated Resident #34 was lying face down on the floor around 5:53 PM in front of his wheelchair in the dining room. The report revealed Resident #34 had a laceration above his right eyebrow and 2 lacerations on the right side of the bridge of his nose. The report further revealed family arrived at 7:15 PM and requested for Resident #34 to be sent to the hospital. A review of a Nurse's progress note dated 05/30/19 at 6:40 PM revealed Resident #34 was found lying face down on the floor at 5:53 PM with 2 lacerations to his face. Further review of Nurse's progress notes revealed there was no assessment documented for Resident #34 when family expressed concerns about his condition and requested he be sent to the hospital. A review of a hospital history and physical dated 05/30/19 at 10:36 PM revealed Resident #34 had been transported to the hospital today on 05/30/19. The document indicated family had reported Resident #34 had fallen face first out of a wheelchair and they arrived sometime later and noted that Resident #34's mouth was slightly drawn, and his leg was jerking, and they felt this was indicative of his seizures. The document further indicated family reported Resident #34 had been urinating frequently and had a small cough. A section labeled Diagnosis, Impression	F 842	daily clinical meeting starting 7/8/19 M-F and by the supervisor S-S to ensure oxygen orders are in place. Documentation of this review will be completed daily and kept by the DON In addition rounds are completed daily starting 7/8/19 by the DON/UM/Supervisor to ensure that each resident receiving oxygen has a physician order. Documentation of the rounds will be kept by the DON. 4. DON/UM/Supervisor will review the previous 24hr progress notes to determine if a change of condition is documented and to ensure if an assessment was completed and if notifications of RP and MD were completed. Documentation of this review will be kept by the DON on a log • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Beginning on 06/19/2019 the DON/ unit managers re-educated the CNAs and Licensed nursing staff on documentation, including change of conditions in residents, notifying MD and Responsible Party of change in condition, and pulse oximetry percentages on residents receiving oxygen. Newly hired CNAs and Licensed nursing staff will be educated during orientation. Any licensed staff not re-educated by 07/09/2019 will not be allowed to work until the re-education has occurred.	

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F 842	Continued From page 67 and Plan revealed broad-spectrum antibiotics had been initiated for suspicion of a urinary tract infection, possible breakthrough seizure and hyperglycemia (high blood sugar). The report further revealed Resident #34 had a high blood sugar reading of 539 and he was treated in the emergency room with intravenous fluids and insulin with improvement of symptoms. During an interview on 06/13/19 at 9:27 AM, Nurse #3 explained when a resident had a change in condition, Nurses were expected to call the Physician and document the change in condition in the resident's medical record. During a telephone interview on 06/13/19 at 9:52 AM, Nurse #4, confirmed she worked on second shift on 05/30/19, and recalled Resident #34's fall in the dining room. She explained she called Resident #34's family to inform them of the fall and about an hour later 3 family members came to the facility and stated Resident #34 was not acting right and they wanted him sent to the hospital. She stated she called the on-call number and was told to send Resident #34 to the hospital because of the family request. She further stated she had assessed Resident #34 before he went to the hospital, but she did not know much about Resident #34 because it was her first night of work in the facility. She explained she completed the incident report the next day when she returned to the facility and thought she had documented on a change in condition form and a progress note before Resident #34 went to the hospital, but she couldn't recall what she had documented. During an interview on 06/13/19 at 12:30 PM, the Director of Nursing verified there was an incident	F 842	2. Beginning on 07/08/2019 the unit managers/supervisors will conduct an audit to review documentation 5 x week for 12 weeks to ensure that residents that have a change of condition or require pulse oximetry checks have been documented accurately. Finding will be given to the DON daily. 3. New orders will be reviewed in the daily clinical meeting starting 7/8/19 M-F and by the supervisor S-S to ensure oxygen orders are in place. Documentation of this review will be completed daily and kept by the DON In addition rounds are completed daily starting 7/8/19 by the DON/UM/Supervisor to ensure that each resident receiving oxygen has a physician order. Documentation of the rounds will be kept by the DON. 4. DON/UM/Supervisor will review the previous 24hr progress notes to determine if a change of condition is documented and to ensure if an assessment was completed and if notifications of RP and MD were completed. Documentation of this review will be kept by the DON on a log • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The Director of nursing will present the results of the audits to the quality assurance performance committee (QAPI) monthly for 3 months for any	

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F 842	Continued From page 68 report for Resident #34's fall on 05/30/19 but there were no progress notes documented and there was no change in condition form completed prior to Resident #34 being sent to the hospital. She stated she would have expected to see a Nurse's progress note or a change in condition form completed regarding Resident #34's condition prior to being sent to the hospital. During an interview on 06/14/19 at 10:01 AM, Unit Manager #1 stated it was the expectation for the Nurse to complete a change in condition form when a resident was sent to the hospital. During an interview on 06/14/19 at 3:04 PM, the Administrator stated it was her expectation for there to be a progress note and a change in condition form prior to a resident being sent to the hospital. 2. Resident #86 was admitted to the facility on 09/24/15 with diagnoses which included Alzheimer's disease, chronic obstructive pulmonary (lung) disease, depression and anxiety. A review of the most recent annual Minimum Data Set (MDS) dated 05/08/19 revealed Resident #86 was severely impaired in cognition for daily decision making. The MDS also revealed Resident #86 required extensive assistance with activities of daily living. A review of a Medication Administration Record dated 06/01/19 through 06/10/19 revealed there were no pulse oxygenation percentages documented. During an observation on 06/09/19 at 12:14 PM	F 842	recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance. • Date of compliance July 9, 2019	

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F 842	Continued From page 69	F 842		

Resident #86 was lying in bed with a nasal cannula in her nose and the oxygen tubing was connected to an oxygen concentrator next to her bed. The oxygen concentrator was turned on to 2 liters per minute.

During an observation on 06/10/19 at 2:55 PM Resident #86 was lying in bed with a nasal cannula in her nose and the oxygen tubing was connected to an oxygen concentrator next to her bed. The oxygen concentrator was turned on at 1.5 liters per minute.

During an interview on 06/12/19 at 2:26 PM, Unit Manager #2 stated residents who required oxygen should have oxygen saturation percentages checked and documented every shift and as needed. She confirmed there had been no oxygen saturation percentages documented since 05/17/19 for Resident #86.

During an interview on 06/13/19 at 12:38 PM, the Director of Nursing stated it was her expectation that pulse oximetry percentages should be documented each shift. She further stated pulse oximetry percentages should have been documented for Resident #86.

During an interview on 06/14/19 03:04 PM, the Administrator stated it was her expectation for pulse oximetry percentages to be documented for resident's who received oxygen.

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F 000	INITIAL COMMENTS On June 14, 2019, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an on-site revisit. The facility remains out of complainace.	F 000		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	{F 656}		7/8/19

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

Electronically Signed | 07/04/2019

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{F 656}	Continued From page 1 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to develop a comprehensive person-centered care plan for a resident with an indwelling urinary catheter (Resident #54) and failed to develop a comprehensive, individualized care plan for a resident that required assistance with bed mobility and toileting that included how much staff assistance was needed to care for the resident (Resident #298) for 2 of 3 sampled residents. The findings included: 1. Resident #54 was initially admitted to the facility on 02/28/19 and most recently readmitted to the facility on 05/14/19. Resident #54's diagnoses included neuromuscular dysfunction of the bladder. Review of Resident #54's admission assessment dated 02/28/19 revealed that she had an indwelling urinary catheter. Review of the comprehensive Minimum Data Set (MDS) dated 04/01/19 revealed that Resident #54 was moderately impaired for daily decision making and required total assistance of two staff	{F 656}	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 656 Develop/Implement Comprehensive Care Plan • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. On 06/12/2019 the Minimum Data Set nurse revised resident # 54 person-centered care plan in order that it may accurately reflect an indwelling catheter. 2. On 06/12/2019 the Minimum Data Set nurse revised resident # 298 Person-centered care plan in order that it may accurately reflect the assistance required by staff with bed mobility and toileting	

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{F 656}	Continued From page 2 members with toileting. The MDS further revealed that Resident #54 had an indwelling catheter and was always incontinent of bowel. Review of the Care Area Assessment (CAA) dated 04/07/19 and signed by the MDS Coordinator read in part, Resident #54 has an indwelling urinary catheter that was placed during her hospitalization. The catheter seemed to be patent and intact. Will proceed to care plan and monitor level of function and avoid complications as it pertains to the indwelling catheter. Review of Resident #54's medical record revealed no care plan for the indwelling urinary catheter. An observation of Resident #54 was made on 06/09/19 at 3:31 PM. Resident #54 was resting in bed with her eyes open and was alert and verbal. She was observed to have an indwelling urinary catheter that was draining clear yellow fluid into a collection bag that contained approximately 300 milliliters (ml) of the clear yellow fluid. An interview was conducted with the MDS Coordinator on 06/12/19 at 2:30 PM. The MDS coordinator confirmed that no care plan had been developed for Resident #54's indwelling urinary catheter. She could not explain why there was no care plan for the indwelling urinary catheter but stated it was just an oversight on her part. The MDS Coordinator stated that she should have proceeded to care plan for the indwelling urinary catheter as stated in the CAA. An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:10 AM. The DON stated that she expected indwelling urinary	{F 656}	3. The task segment in Point click care that communicates to the certified nursing assistant was updated to reflect resident # 54 indwelling catheter and resident # 298 amount of assistance required from staff for bed mobility and toileting. • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. On 07/02/2019, an audit of current residents with indwelling catheters and those residents that require assistance with bed mobility and toileting was completed by the director of nursing (DON) and/or unit manger to ensure that a residents person -centered care plan accurately reflects indwelling catheters and the amount of staff assistance required with bed mobility and toileting. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. On 07/02/2019 the Regional MDS Consultant will provide re-education to the IDT (Interdisciplinary Team) which includes the MDS Coordinator, Social Worker, Activities Director, Dietary, Therapy Director and Nursing Management of the development of Person -centered comprehensive care plans. Ongoing, newly hired MDS and IDT staff will receive education during their orientation period by the Regional	

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{F 656}	Continued From page 3 catheters to be care planned as part of the comprehensive care planning process. 2. Resident #298 was initially admitted to the facility on 09/19/15 and most recently readmitted on 05/23/19. Resident #298's medical diagnoses included: weakness, hemiplegia, above knee amputation of lower extremity. Review of a care plan that was initiated on 02/10/17 read in part, Resident #298 has an Activity of Daily Living (ADL) self-care performance deficit related to right above knee amputation, impaired range of motion, and right sided hemiplegia/hemiparesis. The goal of the care plan read, Resident #298 will improve current level of function in ADLs through the review date. The interventions included: BED MOBILITY: the resident requires staff assistance, DRESSING: the resident requires staff assistance, PERSONAL HYGIENE: the resident requires staff assistance, and TOILETING: the resident requires staff assistance. Review of the quarterly Minimum Data Set (MDS) dated 04/18/19 revealed that Resident #298 was moderately impaired for daily decision making and required extensive assistance of two person with bed mobility, toileting, and personal hygiene. The MDS further revealed that Resident #298 had experienced no falls since the previous assessment. Review of a nurse's note dated 05/03/19 at 7:59 AM read in part, Nursing Assistant (NA) #2 reports that Resident #298 was on the floor. He fell to the floor while NA #2 was turning him to provide care. Nurse observed resident on the floor, supine lying on bedside mat. Blood under	{F 656}	MDS Consultant 2. The Regional MDS Consultant will review and audit 3 completed person -centered comprehensive care plans weekly for 12 weeks to ensure each care plan reflects an indwelling catheter if present and the amount of staff assistance that is required for bed mobility and toileting. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. the Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months • Date of compliance July 8, 2019	

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{F 656}	Continued From page 4	{F 656}		

head and laceration with large amount of blood. Sent to Emergency Room (ER) for evaluation. Signed by Nurse #2.

An interview was conducted with Nurse #2 on 06/11/19 at 1:49 PM. Nurse #2 stated that on 05/03/19 Resident #298 was being turned in bed by NA #2 to provide incontinent care and once turned onto his side he kept going and fell to the floor. Nurse #2 stated that Resident #298 sustained a head injury and was sent to the ER. She added that she was not familiar with Resident #298 and that night was the first night she had cared for him. She stated that she was not aware of how many staff members it took to turn him in bed or to provide incontinent care and relied on the NAs to know that information. Nurse #2 confirmed she was not aware of the information in Resident #298's care plan but stated if she had any question about how much care or assistance that he needed she would refer to Resident #298's care plan.

An interview was conducted with the MDS Coordinator on 06/11/19 at 4:41 PM. The MDS Coordinator reviewed Resident #298's care plan and stated that she could not tell how much assistance he required for bed mobility or incontinence care. She stated that she expected the care plan to contain enough information to care for the resident but would also depend on the policy of the facility.

An interview was conducted with the Director of Nursing (DON) on 06/13/19 at 8:16 AM. The DON reviewed Resident #298's care plan and confirmed that it did not contain the information of how much staff assistance Resident #298 required for bed mobility and incontinence care

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{F 656}	Continued From page 5 and stated that was a systemic breakdown in the facility. The DON stated she expected the care plan to have sufficient information, so the direct care staff could safely take care of Resident #298.	{F 656}		
{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 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	{F 690}		7/8/19

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{F 690}	Continued From page 6 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to secure indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 2 residents reviewed with urinary indwelling catheters (Resident #54). The findings included: Resident #54 was initially admitted to the facility on 02/28/19 and most recently readmitted to the facility on 05/14/19. Resident #54's diagnoses included neuromuscular dysfunction of the bladder. Review of the comprehensive Minimum Data Set (MDS) dated 04/01/19 revealed that Resident #54 was moderately impaired for daily decision making and required total assistance of two staff members with toileting. The MDS further revealed that Resident #54 had an indwelling catheter and was always incontinent of bowel. An observation of Resident #54 was made on 06/09/19 at 3:31 PM. Resident #54 was resting in bed with her eyes open and was alert and verbal. She was observed to have an indwelling urinary catheter that was draining clear yellow fluid into a collection bag that contained approximately 300 milliliters (ml) of the clear yellow fluid. The indwelling urinary catheter was not anchored or secured to Resident #54's leg and was noted to be pulled across the front of her brief and connected to the drainage bag that was hanging	{F 690}	F 690 Bowel Bladder Incontinence Catheter UTI • The corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident # 54 indwelling catheter was secured on 06/14/2019to prevent tugging or pulling • The facility will identify other residents having the potential to be affected by the same deficient practice: 1. On 06/14/2019 the DON and/or unit manager conducted a visual audit of current residents with indwelling catheters to ensure they are secured. Any findings of un secured indwelling catheters will be secured immediately. • The following measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Beginning on 06/19/2019 the licensed nursing staff and the CNA's will be re-educated by the DON on the policy and procedures for proper	

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{F 690}	Continued From page 7 on the side of the bed. Resident #54 denied pain or discomfort at this time. An observation of Resident #54 was made on 06/10/19 at 11:29 AM. Resident #54 was resting in bed with her eyes open. Resident #54's indwelling urinary catheter was draining clear yellow fluid into a drainage bag hanging on the side of the bed. The indwelling urinary catheter was not anchored or secured to Resident #54's leg and again was pulled across the front of her brief and connected to the drainage bag on the side of the bed. Resident #54 verbalized general discomfort but not specific to her indwelling urinary catheter. An observation of Resident #54 was made on 06/11/19 at 8:08 AM. Resident #54 was resting in bed with her eyes open. Resident #54's indwelling urinary catheter was draining clear yellow fluid. The indwelling urinary catheter was not anchored or secured to Resident #54's leg and was running out the side of her brief into the collection bag that was hanging on the side of the bed. An observation of Resident #54 was made on 06/12/19 at 12:03 PM. Resident #54 was resting in bed with her eyes open. She had an indwelling urinary catheter that was not anchored or secured to her leg. The indwelling urinary catheter was pulled up over the side of her brief and then connected to the drainage bag that hung on the side of the bed. The catheter was draining clear yellow fluid and Resident #54 denied any complaints. An interview was conducted with Nursing Assistant (NA) #3 on 06/12/19 at 1:38 PM. NA #3 confirmed that she was caring for Resident #54	{F 690}	anchoring/securing of catheter tubing. 2. New employees will receive this education during orientation. • The facility plans to monitor its performance to make sure that solutions are sustained; 1. The DON and/or Unit manager will conduct weekly visual audits for 12 weeks of all indwelling catheters to ensure compliance with anchoring of tubing 2. The Director of nursing will present the results of the audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance. • Date of compliance July 8, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	R-C 06/14/2019

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{F 690}	Continued From page 8	{F 690}		

and was familiar with her needs. NA #3 stated that she performed catheter care every day, emptied the catheter bag, and reported to the nurse how much output Resident #54 had. She stated that the nurse was responsible for anchoring or securing the catheter tubing and if she would have noticed that her catheter tubing was not anchored or secured she would have notified the nurse. NA #3 confirmed that she had not noticed that Resident #54's catheter tubing was not anchored and therefore had not reported it to the nurse.

An observation of Resident #54 and interview with Nurse #3 were conducted on 06/12/19 at 2:11 PM. Resident #54 was resting in bed with her eyes open. Her indwelling urinary catheter was pulled through the right side of her brief and pulled across the front of her brief and connected to the drainage bag hanging on the left side of the bed. Nurse #3 confirmed that the indwelling urinary catheter tubing was not anchored and was pulling across the front of Resident #54 ' s brief. She stated that all indwelling catheter tubing should be anchored to her leg and it was the responsibility of the nurse to ensure that it was anchored appropriately. Nurse #3 stated that she would immediately anchor the catheter tubing.

An interview was conducted with Unit Manager #2 on 06/12/19 at 2:19 PM. Unit Manager #2 stated that it would be a good idea to anchor or secure the indwelling urinary catheter tubing to Resident #54's leg. She added that the tubing should be fed through her brief and hung on the same side of the bed to ensure it drained properly and did not pull and cause discomfort to Resident #54.

An interview was conducted with the Director of

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{F 690}	Continued From page 9 Nursing (DON) on 06/13/19 at 8:10 AM. The DON confirmed that Nurse #3 would be responsible for anchoring or securing the indwelling urinary catheter tubing for Resident #54. The DON stated that she expected the indwelling urinary catheter tubing to be secured at all times to prevent pulling or tugging on the resident. An interview was conducted with the Administrator on 06/14/19 at 3:04 PM. The Administrator stated that she expected indwelling catheter tubing to be anchored or secured at all times to prevent pulling or tugging on the resident.	{F 690}		