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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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E 000	Initial Comments An unannounced Recertification survey was conducted on 12/2/19 through 12/6/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 2XMJ11.	E 000		
F 000	INITIAL COMMENTS A recertification with complaint investigation survey was conducted from 12/2/19 through 12/6/19. 1 of the 1 complaint allegation was substantiated resulting in a deficiency at F689. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) CFR 483.35 at tag F726 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/22/19 and was removed on 12/5/19. An extended survey was conducted.	F 000		
F 584 SS=E	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-	F 584		12/26/19

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

Electronically Signed | 12/24/2019

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F 584	Continued From page 1 §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 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 observation and staff interview the facility failed to maintain double doors utilized for smoking residents and repair a hole in 1 of 12 resident bathroom doors.	F 584	F584 The bathroom door on Resident 302□s room was repaired on December 5, 2019 by the Maintenance Supervisor. The exit/entrance door to the smoking	

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F 584	Continued From page 2 The findings included: 1. A. Observation of resident room #302 on 12/5/19 at 1:30pm revealed the bathroom door to have hole. The bathroom door further had marring with splintered wood. B. Observation of exit and entrance door to the resident smoking area on 12/5/19 at 2:00pm revealed the double doors to be missing weather stripping exposing 16 nail heads. The door was further observed as not closing securely as evidenced by the exterior of the building begin observed when the double doors were closed. Residents entering the facility from the smoking area were observed to use the doors with exposed nail heads to assist in propelling their wheelchairs into the building. Observation and interview with the Maintenance Director on 12/5/19 at 3:00pm reveled he was kept abreast of maintenance concern by staff and residents. He indicated that each nursing department had a notebook with maintenance request forms inside. During the observation he indicated he was unaware of the hole with splintering to resident room #302. He further indicated he was unaware of the exposed nails on the exit door to the resident smoking area. He indicated that the doors did not close fully, and they nail heads were exposed due to missing weather stripping. Interview with the Director of Nursing (DON) on 12/6/19 at 1:25pm revealed all maintenance need should be logged into the maintenance request books located on halls. In the instance maintenance was unable to fix something it should be reported to the DON or the Administrator. In the instance the resident	F 584	area was repaired on December 5, 2019 by the Maintenance Supervisor. Environmental rounds to assess for splintered wood doors, holes in doors or exposed nails or other dangerous conditions were conducted by The Maintenance Supervisor. The environmental rounds started on December 5th and were completed on December 6th. Any environmentally unsafe issues were addressed and needed repairs made starting on December 5 and completed by December 6th. The Maintenance Director was assigned to repair any issues identified. Education was provided during the clinical stand up meeting on December 6th by the Administrator on what to observe during daily rounds (5x/week) in their assigned community areas. Managers will assess resident□s spaces for splintered wood, exposed nails and all other situations that could be potentially dangerous to residents and/or staff. A list will be given to the Maintenance Director daily x 5 days with the expectation all repairs will be completed as quickly as possible after identification. Rounds will occur 5 x/week for 4 weeks, 3 x week x 4 weeks and then weekly x 4 weeks. The Administrator will present issues found with dates of repair at the monthly QAPI meetings x 3 months or sustained compliance is achieved.	

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F 584	Continued From page 3 smoking area doors could not be immediately corrected the smoking area should have been temporarily relocated until the repairs could be made.	F 584		
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		12/26/19

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F 656	Continued From page 4 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to follow care plan interventions for 1 of 3 residents (Resident #121) reviewed for positioning. The findings included: Resident #121 was admitted to the facility on 3/15/16 with a diagnosis that included stage 4 pressure ulcer of the left buttock, contracture of knee, gastrostomy status and tracheostomy status. The Minimum Data Set (MDS) assessment dated 11/7/19 revealed Resident #121 was cognitively impaired and totally dependent on staff for activities of daily living (ADL's). The MDS further indicated Resident #121 had upper and lower extremity impairments and 1 stage 4 pressure ulcer. Review of Resident #121 Care Plan indicated an onset date of 1/8/19 of "I have actual skin impairment" (stage 4 left buttock). The goal stated his pressure ulcer would show signs of healing. The interventions included air mattress to bed and supplements to promote wound healing. Observation of Resident #121 on 12/3/19 at	F 656	F656 The specialty mattress for Resident #121 was plugged into the wall and found to be working properly on December 5th by the charge nurse. All residents with specialty mattresses are at risk of their bed becoming accidentally unplugged. Each resident with a specialty bed was observed by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and Unit Managers (UM) on December 5th. All other specialty beds were found to be functioning properly. The DON and Administrator educated all staff (licensed and unlicensed nursing staff, housekeeping staff, maintenance staff and dietary staff) to observe for non-functioning specialty beds when entering resident rooms and during daily rounds that are held Monday through Friday by the department managers. The education started on December 6th and was completed on December 7th. The DON addressed the problem of accidently unplugging specialty beds with the transport company that was responsible for unplugging the bed during transfer of Resident #121. This was completed by	

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F 656	Continued From page 5 2:52pm revealed the resident to laying supine in bed. The electric air mattress system was observed to not be operating. The electronic air mattress system had no lights indicting the comfort level of the pressure reliving mattress. Observation of Resident #121 on 12/4/19 at 8:43am revealed the resident to be laying in bed. The Residents electric air mattress was observed as not functioning and not plugged in. Observation and interview with Nurse #5 on 12/4/19 at 10:05am Revealed she was responsible for checking the function of resident care equipment to include air mattresses. She indicated that the electric air mattress system had a security feature that would alarm if there was a malfunction. She stated the electric air mattress system was unplugged at the time of the observation. She further stated she recalled the device being unplugged due to Resident #121 having an outside medical appointment the day prior. Due the device not alarming she assumed it was operating. Interview with the Director of Nursing (DON) on 12/6/19 at 1:25pm revealed care plan interventions should have been in place. She further revealed it was the responsibility of the assigned nurse to ensure resident care equipment was operational.	F 656	phone on December 7th. Audits of resident rooms will take place 5x/week x 4 weeks by Department Managers as assigned by the Administrator, then 3x/week x 4 weeks and then weekly x 4 weeks. The results of the audit will be recorded on the round sheet completed by each Department manager assigned to a location within the community. If a bed is found to be non-functioning, the department manager will connect the bed to the electrical outlet. If the bed is connected to the electrical outlet and non-functional, the department manager will report immediately to the DON and/or the Maintenance Supervisor. The non-functioning bed will be reported immediately to the durable medical equipment provider for repair and the resident will be transferred to another bed. Results of the audits will be presented to the QAPI committee by the Administrator or DON monthly x 3 or until sustained compliance is achieved.	
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-	F 658		12/26/19

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F 658	Continued From page 6 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff members, physician, and a pharmacy representative, the facility failed to accurately transcribe an antipsychotic medication ' s dosage and the correct dosage formulation as ordered by the physician for 1 of 6 residents reviewed for unnecessary medications (Resident #383). The findings included: 1) Resident #383 was admitted to the facility on 11/22/19 from a hospital. Her cumulative diagnoses included psychosis with delusions. A review of the resident ' s 11/22/19 admission orders included the following medications, in part: --25 milligrams (mg) Seroquel (an antipsychotic medication) to be given as 1.5 tablets (37.5 mg) by mouth every night at bedtime; and, --25 mg Seroquel to be given as 0.5 tablets (12.5 mg) every 8 hours. This order was clarified on 11/23/19 for the 12.5 mg dose of Seroquel to be given on an "as needed" (PRN) basis only for a period of 14 days. On 11/23/19, a physician ' s order was received to increase the scheduled Seroquel to 25 mg every 12 hours and to discontinue the 37.5 mg dose at bedtime. Further review of the resident ' s medical record included a physician ' s order dated 11/24/19 to increase the scheduled Seroquel with instructions to give 50 mg Seroquel by mouth every 12 hours.	F 658	F658 Clarification of Resident #383□s Seroquel order was obtained on December 5 2019 by the (DON) Director of Nurses. The previous order was discontinued, and the DON transcribed the correct order into the Electronic Medical Record (EMR). All residents receiving antipsychotic medications are at risk of having errors when licensed staff transcribe physician□s orders into the EMR. A list of residents receiving antipsychotic medications were compiled by the DON, ADON and UM on December 5, 2019. The DON/ADON and/or the UM compared the physician□s order to the transcribed medication in the EMR. There were no further errors in transcription found. The DON/ADON and/or UM educated the licensed nursing staff on the policy for transcribing new orders. The nurse obtaining the order from the MD will enter the order into the EMR and sign the order as transcribed. A second nurse will verify the medication order was transcribed correctly and cosign/initial the order to verify the second check has been completed. Education was completed on December 5th. No nurse will be allowed to work until the education has been completed. The process for verification of orders will be added to the orientation process for all newly hired nurses and be presented by the Staff Development Coordinator and/or the DON/ADON during	

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F 658	Continued From page 7 On 11/27/19, a physician ' s order was received to continue the morning dose of Seroquel (50 mg) and to increase the bedtime dose to 100 mg Seroquel. A review of Resident #383 ' s November 2019 Medication Administration Record (MAR) revealed when the bedtime dose of Seroquel was increased to 100 mg on 11/27/19, the resident also continued to receive 50 mg Seroquel XR (an extended release formulation) at bedtime. The total dose of Seroquel and Seroquel XR provided at bedtime was 150 mg. A review of the resident ' s admission Minimum Data Set (MDS) assessment dated 11/29/19 revealed she had moderately impaired cognitive skills for daily decision making. Section E of the MDS reported the resident experienced psychosis with delusions and rejected care on 1 - 3 days out of the previous 7 days. Resident #383 required supervision with eating; limited assistance for bed mobility, transfers, walking in her room and locomotion on/off the unit; and extensive assistance for dressing, toileting, and personal hygiene. Section N of the MDS assessment indicated Resident #383 received an antipsychotic medication on a routine basis for 7 out of 7 days during the look back period. A review of Resident #383 ' s December 2019 MAR indicated the resident continued to receive both the 100 mg Seroquel and 50 mg Seroquel XR at bedtime (through the evening of 12/4/19). An interview was conducted on 12/5/19 at 8:40 AM with Resident #383 ' s Medical Doctor (MD). During this interview, the resident ' s MARs and administration of 50 mg Seroquel XR in addition	F 658	orientation. A third check will be held 5x/week during morning clinical meeting. The DON/ADON and/or UM will compare the copy of the order to the transcribed order in the EMR. Any errors will be corrected immediately. An audit of new orders will be completed by the DON/ADON and/or UM 5x/wk x 4 weeks, then 3x/wk x 4 weeks and then weekly x 4 weeks. The results of the audit will be recorded on a Transcription of Orders Record. Results of the audit will be presented to the QAPI team monthly or until substantial compliance is achieved by the DON or ADON.	

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to Seroquel 100 mg was discussed. Upon inquiry, the physician reported he intended for the resident to receive only 100 mg of regular Seroquel for the evening dose.

An interview was conducted on 12/5/19 at 11:30 AM with the facility's Director of Nursing (DON). During the interview, the DON described the facility's process of order transcription. She reported once a physician's order was written out, the nurse would typically enter the order into the facility ' s computer system using a drop down box. The nurse would then electronically transmit the medication order to the pharmacy. At that time, Resident #383's Seroquel orders and MARs were reviewed. The DON also reviewed the resident ' s electronic orders and identified Nurse #5 as having input the 11/27/19 order which increased the bedtime dose of Seroquel to 100 mg. It was noted the 50 mg dose of Seroquel XR previously given to Resident #383 at bedtime had not been discontinued. When asked, the DON reported she would expect medication orders to be transcribed into the facility ' s electronic system as ordered by the physician.

An interview was conducted on 12/5/19 at 12:00 PM with Nurse #5. During the interview, Nurse #5 reviewed Resident #383's physician orders (from the paper chart) and the electronic medication orders from 11/27/19. The nurse confirmed the initials on the 11/27/19 physician ' s order were her initials. Upon review of the electronic orders, the nurse also confirmed she had input the 11/27/19 order written for 100 mg Seroquel to be administered at bedtime for Resident #383. Nurse #5 reported the 50 mg Seroquel XR dose previously given to the resident at bedtime should have been

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discontinued when the 100 mg Seroquel dose was initiated.

A follow-up interview was conducted on 12/5/19 at 2:30 PM with the facility ' s DON. During the interview, the DON confirmed Resident #383 had received both 50 mg Seroquel XR and 100 mg Seroquel at bedtime in error. The DON reported she had talked with the MD and he indicated only 100 mg Seroquel was intended to be given to Resident #383 at bedtime.

2) Resident #383 was admitted to the facility on 11/22/19 from a hospital. Her cumulative diagnoses included psychosis with delusions.

A review of the resident ' s 11/22/19 admission orders included the following medications, in part:
--25 milligrams (mg) Seroquel (an antipsychotic medication) to be given as 1.5 tablets (37.5 mg) by mouth every night at bedtime; and,
--25 mg Seroquel to be given as 0.5 tablets (12.5 mg) every 8 hours. This order was clarified on 11/23/19 for the 12.5 mg dose of Seroquel to be given on an "as needed" (PRN) basis only for a period of 14 days.

On 11/23/19, a physician ' s order was received to increase the scheduled Seroquel to 25 mg every 12 hours and to discontinue the 37.5 mg dose at bedtime.

A review of the resident ' s medical record included a physician ' s order dated 11/24/19 which indicated Seroquel should be increased and given as 50 mg Seroquel by mouth every 12 hours.

A review of Resident #383 ' s November 2019

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Medication Administration Record (MAR) revealed when Seroquel was increased to 50 mg on 11/24/19, the resident was administered 50 mg of Seroquel XR (an extended release formulation) instead of the regular Seroquel formulation.

A review of the resident ' s admission Minimum Data Set (MDS) assessment dated 11/29/19 revealed she had moderately impaired cognitive skills for daily decision making. Section E of the MDS reported the resident experienced psychosis with delusions and rejected care on 1 - 3 days out of the previous 7 days. Resident #383 required supervision with eating; limited assistance for bed mobility, transfers, walking in her room and locomotion on/off the unit; and extensive assistance for dressing, toileting, and personal hygiene. Section N of the MDS assessment indicated Resident #383 received an antipsychotic medication on a routine basis for 7 out of 7 days during the look back period.

An observation of the hall medication cart conducted on 12/3/19 at 3:17 PM confirmed the only 50 mg dosage form of Seroquel available on the medication cart was the XR formulation (not regular Seroquel) for Resident #383.

A review of Resident #383 ' s December 2019 MAR indicated the resident continued to receive 50 mg of Seroquel XR through the morning of 12/5/19.

An interview was conducted with Resident #383 ' s Medical Doctor (MD) on 12/5/19 at 8:00 AM. During the interview, the Seroquel formulation provided to the resident was discussed. Upon inquiry, the MD reported he never prescribes

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Seroquel XR for a resident. He stated he intended for Resident #383 to receive the regular Seroquel formulation, not Seroquel XR.

An interview was conducted on 12/5/19 at 11:30 AM with the facility's Director of Nursing (DON). During the interview, the DON described the facility's process of order transcription. She reported once a physician's order was written out, the nurse would typically enter the order into the facility ' s computer system using a drop down box. The nurse would then electronically transmit the medication order to the pharmacy. At that time, Resident #383's Seroquel orders and MARs were reviewed. The DON also reviewed the electronic medication orders and identified Nurse #6 as having input the order for 50 mg Seroquel XR into the electronic system on 11/24/19. She stated the medication order should have been input for 50 mg Seroquel (the regular formulation). When asked, the DON reported she would expect the medication orders to be transcribed into the system as ordered by the physician.

An interview was conducted on 12/5/19 at 12:17 PM with Nurse #6. Upon request, the nurse reviewed Resident #383 ' s physician orders for Seroquel and confirmed her initials were on the 11/24/19 order written to increase the dose to 50 mg every 12 hours. When asked, the nurse stated if she signed the order, she would also have been the nurse who put the order into the electronic system.

A telephone interview was conducted on 12/5/19 at 12:25 PM with a representative from the dispensing pharmacy. The pharmacy confirmed Nurse #6 had input the medication order for 50

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F 658	Continued From page 12 mg Seroquel XR on 11/24/19. The pharmacy representative also reported there had been no modifications to that order since it had been input into the electronic system on 11/24/19. A follow-up interview was conducted on 12/5/19 at 2:30 PM with the facility ' s DON. During the interview, the DON reported she had talked with the MD and confirmed Resident #383 had received the XR formulation of Seroquel by mistake. The DON stated the resident should have received the regular Seroquel formulation as ordered by the physician.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to provide an on-going activity program as scheduled and that met the individual interest and needs for 1 of 5 cognitively impaired residents reviewed for activities (Residents #79). The findings included:	F 679	F679 Resident #79 does attend group activities. Due to her mental capacity, Resident #79 wanders in and out of activities at will. Activities she attends includes musical activities and religious/spiritual activities. Due to the resident□s mental capacity, she is unable to concentrate long enough to read books, magazines and the	12/26/19

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F 679	Continued From page 13 Resident #79 was admitted to the facility on 10/2/19. The diagnoses included cognitive impairment and dementia. Resident #79 was coded on the admission Minimum Data Set(MDS) dated 10/9/19 as having cognition impairment and she needed assistance with activities. The MDS also coded Resident #79 ' s activity interest as very important to participate in group activities to include music, religious/spiritual, exercise and reading the newspaper, magazines and books. Review of the care plan dated 10/9/19, identified the problem as Resident #79 would benefit from group activities at least 3 times weekly with reminders prior to the activity and assistance provided with transporting to the activity room. The goal included Resident #79 would participate in at least 3 activities per week, show a physical sign of enjoyment following at least one activity. Maintain appropriate interaction with others. The interventions included staff would engage resident in group activities, all staff introduce self to resident before each interaction, staff will offer activities programs director toward specific interest of resident. Staff will place resident in appropriate psychosocial activities. I need assistance with activities of daily living related to muscle weakness and severe cognitive impairment of dementia. Review of the facility ' s planned activity calendar revealed the following activities were scheduled for 12/02/19 and 12/04/19. Observation on 12/2/19 at 10:43 AM, revealed the scheduled activity was a movie and exercise. There were 16 residents that participated. Resident #79 was observed seated at the nursing station, walking around in/out of other resident	F 679	newspaper. Resident #79□s care plan was revised on 12/20/19 by the Activity Director to reflect the resident□s current status and mental capacity. The family of Resident #79 will be interviewed in order to obtain other interest of the resident. This will occur on 12/20/19. The Activity Director and/or the Assistant will provide one on one activities for Resident #79 at least twice weekly to include music, reading scripture or spiritual literature. Other residents with altered mental capacity are at risk. The Director of Nursing (DON) and the Activity Director (AD) reviewed a list of current residents. Those residents identified with cognitive deficient, and the inability to actively participate in group activities or a limited attention span will be identified. Those residents will be highlighted on a current census form. This was completed on 12/20/19. Family members of those identified as having limited cognitive abilities or limited attention spans will be interviewed to determine activities the residents may enjoy. Interviews will be conducted by the AD and the AA starting on 12/20/19 and completed by 12/27/19. The AD, Activity Assistant (AA) or community volunteers will attempt to provide at least 2 activities per week to those individuals. The activities will consist of those activities that family have indicated are of interest to the resident either past or present. The Administrator and the Regional Clinical Consultant will educate the AD and the AA on providing activities of interest (prior or present) to those	

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F 679	Continued From page 14 rooms. Staff did not encourage or escort Resident #79 to the scheduled activity. Observation on 12/2/19 at 2:30 PM, revealed the scheduled activity was minster/religious activity. Resident #79 was observed in front of nursing station wandering in out of other resident rooms and unit staff attempting to redirect residents to return to seat while assisting other residents with care. Staff did not encourage or escort Resident #79 to the scheduled activity. Observation on 12/3/19 at 10:30 AM, revealed the scheduled activity was family feud. Resident #79 was observed in front of nursing station wandering in/out of other resident rooms and unit staff attempting to redirect resident to return to seat while assisting other residents with care. Staff did not encourage or escort Resident #79 to the scheduled activity. Observation on 12/3/19 at 2:30 PM, revealed the scheduled activity was bingo. Resident #79 was observed in front of nursing station wandering in/out of other resident rooms. Staff did not encourage or escort Resident #79 to the scheduled activity. Observation on 12/3/19 at 3:00 PM, Resident #79 was observed resident sitting in front of nursing station, getting up periodically going to stand in other resident's door way. Staff did not encourage or escort Resident #79 to any activity. Observed on 12/4/19 at 10:30 AM, revealed the scheduled activity was snack/movie. Resident #79 was sitting in front of the nursing station, 13 residents watching movie, movie ended at 11:00 AM. Resident #79 remained at nursing station.	F 679	residents with a lack of mental capacity or limited attention span. The AD and AA will be educated on admission and at least yearly to review with family members any interest the resident previously had or seems to receive enjoyment in the present. Education will also include accurately recording, for each resident, any activities provided or attended. This education will be provided on 12/20/19. The activity list for residents with decreased mental capacity or decreased attention span will be previewed by the first day of the new month by the Administrator and/or the DON for inclusion of those residents with decreased capacity or decreased attention span to assure residents are scheduled to receive activities identified as those they enjoy. The Administrator and/or the DON will request and view 10% of the activity participation logs for residents lacking mental capacity or short attention spans 5x week x 2 weeks during the morning stand up meeting. This will continue for 3 x week x 2 weeks and then weekly x 4 weeks or until the AD and AA can maintain sustained compliance. Results of the activity audits will be entered on an activity log daily. The AD or AA will present the results of the audit to the QAPI committee monthly x 3 or until sustained compliance is achieved.	

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Observation at 12/4/19 at 2:30 PM, revealed the scheduled activity was horse racing and Resident #79 was sitting a nursing station, periodically getting up and wandering in/out of other resident rooms. Staff did not encourage or escort Resident #79 to the scheduled activity.

Interview on 12/4/19 at 2:40 PM, the Activity Assistant stated she attempts to get as many people as possible to the activity, once the activity starts unit staff were expected to bring residents to the activity. The AA indicated the resident did not participate in the scheduled activities for the week.

Review of Resident #79 ' s activity participation record for October 2019 and November 2019, revealed there was no documentation of the activities that Resident #79 participated in for the month. Reviewed of the activity participation record for 12/2/19- 12/4/19 documented Resident #79 had participated in the exercise, movie, bingo, religious/minister and snack/movie activities during the times Resident #79 was observed in other resident rooms and/or at nursing station.

Interview on 12/5/19 at 9:15 AM, the Activities Director stated Resident #79's dementia level limits her attention span to participate in activities for long periods of time. The resident would also wander around in the facility but not directly participate in an activity. The staff should encourage resident to attend and participate.

Interview on 12/5/19 at 9:20 AM, NA#8 stated the aides try to assist with getting residents to activities, but if they were providing care to other

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F 679	Continued From page 16 residents, they would be unable take residents to activities. Resident #79 was confused but would participate in activities when she was directed to the activities. Interview on 12/5/19 at 8:20 AM, NA #9 stated staff were expected to assist residents to activities, but if the aides were doing care, they would be unable to get residents to activities at the start of the activities and they may only get the resident to the end of the activity. Interview on 12/5/19 at 2:45 PM, the Director of Nursing stated the staff should be encouraging/offering and assisting residents to preferred activities of interest daily activity daily.	F 679		
F 689 SS=J	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 record review and staff interviews, the facility failed to follow manufacturer ' s recommendations to use two people for safe bed to chair transfer of a dependent resident and cross the sling straps before transferring the resident. This resulted in the resident ' s fall during transfer, causing the resident to have severe head trauma, hospitalization and death. This occurred for 1 of 3 sampled residents	F 689	F689 Resident #50 was transferred via Hoyer lift from the bed to the wheelchair by a nursing assistant (NA) #1 on November 22, 2019 at approximately 1:00 PM. The resident slid out of the sling and fell to the floor sustaining a laceration and was sent to the hospital for further evaluation. Resident #50 was found to have a brain	12/26/19

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F 689	Continued From page 17 reviewed for accidents (Resident #50). Immediate Jeopardy (IJ) began on 11/22/19, when Nurse Aide #1 operated the mechanical lift without assistance of another staff member, transferred Resident #50 from the bed to the chair and did not cross the lift sling straps, which resulted in the resident' s fall during the transfer with severe head trauma, hospitalization and death. The IJ was removed on 12/5/19, when the facility provided and implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put into place are effective to prevent accidents. The findings included: The manufacturer ' s manual, dated 2010, for the lift, which was used for Resident 50 ' s transfer, included a warning: "Although [the manufacturer] recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case." The manual recommended to place the sling straps "around, crossed between or underneath the patient ' legs." Resident #50 was admitted to the facility on 4/8/16. Resident 50 ' s lift assessment, dated 2/23/19, revealed that she required mechanical lift for	F 689	bleed and subsequently expired. Statements were obtained from the NA #1 who had transferred the resident. NA #1 acknowledged to the Director of Nursing (DON) that she had placed the resident in the lift sling, had not placed the lift sling under the resident□s legs or between her legs and had transferred the resident without the help of another staff member. Resident #50 slid out of the sling, hitting her head on the legs of the mechanical lift. NA #1 informed the DON that she had requested help from the 2 NAs on her hall, but had not received the requested help. Beginning on 11/22/19, NA #1 was not allowed to work with residents in the skilled unit or residents requiring transfer with a Hoyer lift until she was retrained on lift sling selection by weight and girth as included in the Owner□s Operators Maintenance Manual for Patient Slings, the proper technique for transferring the resident and the need to use 2 staff members to transfer a resident. The Owner□s Operators Maintenance Manual for Patient Slings indicate the lift sling can be crossed between the legs or underneath the resident□s legs. The NA was educated by the DON and the Staff Development Coordinator to complete this step when transferring residents. The NA was instructed on where to find lift slings and what she should do if she received an assignment in which she felt uncomfortable. NA #1 was also educated where to locate the care cards that would identify which lift pad to use and how many staff were needed to transfer a	

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transfer.
The Quarterly Minimum Data Set assessment, dated 10/15/19, revealed she had severely impaired cognition. Resident #50 ' s diagnoses included Alzheimer ' s disease, dementia, osteopenia (reduced bone structure), and bilateral hand contractures. She required total assistance with activities of daily living (ADL), including two people assistance for transfer. She did not have steady balance during transitions.

Resident #50 ' s plan of care, dated 10/15/19, revealed she was at risk for falls, due to muscle weakness and impaired mobility. The goal was to prevent serious injury. The interventions were to provide total ADL care, including transfer via mechanical lift. The Nurse Aide Information Sheet for Resident #50 revealed she required mechanical lift for bed to chair/recliner transfer.

The skills checklist of Nurse Aide #1 for 11/7/19 - 11/19/19, indicated review and return demonstration for "Hoyer, Sit-to-Stand" lifts and two-person transfer on 11/19/19 were observed by the nurse-trainer. The checklist did not specify the lift sling/strap application procedure.

The Skill Checklist Resident Lift, completed by Nurse Aide #1 on 11/19/19, indicated "all lift transfers require assistance of two staff members."

The incident report, dated 11/22/19, indicated that on 11/22/19 at 1:00 PM, Nurse #1 was called by the staff to Resident 50 ' s room. She observed Resident #50 on the floor, next to the mechanical lift, with blood around her head. Nurse Aide #1 stated that during the transfer, she was lifting the resident to place her in her chair via mechanical

resident via mechanical lift. NA #1 was also instructed when transferring residents to ask for help from the NAs and nurse on her hall. If these staff were not available, she was instructed to request help from the Unit Manager, DON or Assistant Director of Nursing (ADON). If for some reason, no staff member was available at the moment, the NA was educated to wait to transfer residents when staff became available.
Expectations that she, NA #1, would follow the instructions when providing care for residents was explained. NA #1 was able to verbalize expectations in following the care card, how to select the proper lift sling and provided a return demonstration to the administrative nursing team starting on 11/22/19 and ended on 12/4/19. NA #1 returned to work with residents requiring the use of mechanical lifts on 11/28/19.
During orientation, NA #1 had signed the form during orientation that documented she knew the community policy was to have 2 staff members when transferring residents per Hoyer lift. Her ability to correctly use a Hoyer lift was observed and documented by the NA on the floor with whom she trained dated 11/19/19.
On 11/22/19, the DON and ADON conducted interviews with the nurse that had been assigned to care for Resident #50 and the other 2 NAs working on the hall where Resident #50 lived. The nurse and the NAs denied that NA #1 had requested assistance in transferring Resident #50.
The Community□s Maintenance Director inspected both the sling and mechanical

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lift, when the resident slipped out the lift on the floor, hitting her head. The assessment revealed about 1.6 inches laceration on the back of resident ' s head. A dressing was applied. The resident was transferred to bed via mechanical lift by three assistants and prepared for transfer to Emergency Room (ER).

Hospital records revealed that Resident #50 arrived to the ER on 11/22/19 at 1:45 PM after witnessed fall in the nursing home. Per EMS (Emergency Medical Service) report, patient slid out of the mechanical lift and fell, hitting her head. Upon assessment, patient ' s mental status was at baseline and there was 1.5 inches laceration on her posterior scalp. Per family report, the patient slid forward from the lift, fell out of the sling and hit her head on the lift. Review of the CT (Computer Tomography) scan, dated 11/22/19 at 4:00 PM, revealed the multicompartmental acute intracranial bleeding (massive brain bleeding). The scalp laceration was repaired with staples. The resident was admitted for observation.

On 12/2/19 at 9:50 AM, during the phone interview, Resident 50 ' s family member indicated that the resident passed away on 11/28/19.

On 12/2/19 at 3:15 PM, during an interview, Nurse Aide #1 indicated that on 11/22/19 at 1:00 PM, she came into Resident 50 ' s room on 300 hall to provide bed to chair transfer. Nurse Aide #1 stated that she was aware of the requirements to use the mechanical lift by two assistants. The other staff members were not available at the time. Nurse Aide #1 began to transfer Resident #50 from bed to chair via mechanical lift alone. During the transfer, Resident #50 slid out of lift that had been used to transfer Resident #50. No defects were found on either the lift or the lift sling. This was completed on 11/22/19.

Residents requiring the use of a mechanical lift are at risk. On 11/25/19, the DON, ADON and other administrative nurses compiled a list of residents that required a mechanical lift for transfers. Observations were made by the DON, ADON and other administrative nurses of all residents requiring mechanical lifts to assure the residents were being transferred using the correct lift sling, correct technique and with the use of 2 staff members. Observations of transfers of all residents requiring a mechanical lift was completed on 11/25/19. Return demonstrations of all nursing assistants performing mechanical lifts were completed on 11/25/19 and will again be required of all staff to be completed by 12/5/19. Care cards were reviewed by the DON, the ADON and other administrative nurses to assure the proper information, to include size of lift sling required in accordance with the Owner□s Operators Maintenance Manual for Patient Slings and number of staff required for transfer, were included on the care card. Revision of care cards was started on 11/22/19 and was completed by 12/5/19.

Staff that includes NAs, licensed staff, physical therapists (PT) and occupational therapists (OT) will receive re-education on choosing the correct lift pad by the instructions in the Owner□s Operators

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mechanical lift sling, hit her head on the lift leg and fell to the floor. The nurse aide called for help. The floor nurse came immediately, assessed the resident, notified the physician, family and within one hour after the incident sent the resident to the hospital evaluation. Nurse Aide #1 confirmed she did not cross the straps during the lift sling application.

On 12/4/19 at 2:40 PM, during an interview, Nurse Aide #1 indicated she was aware that on 11/22/19, two other nurse aides worked on 300 hall, but at 1:00 PM, she did not see them. She was not comfortable to use mechanical lift, because she did not receive enough training in the facility. No staff members offered help to her with resident ' s transfer on 11/22/19 at 1:00 PM.

On 12/2/19 at 12:40 PM, during an interview, Nurse Aide #3 indicated that on 11/22/19, she worked on 300 hall and was not assigned for Resident #50. She remembered that approximately at lunchtime, she was called to Resident 50 ' s room for help. Nurse Aide #3 observed the Resident #50 on the floor near lift, with small amount of blood around the head. The aide confirmed that the staff completed competency training annually, including the lift/transfer, and always have two people for mechanical lift operation.

On 12/2/19 at 1:10 PM, during the phone interview, Nurse #1 indicated that on 11/22/19 after 1:00 PM, she was called to Resident 50 ' s room. In resident ' s room, she observed Nurse Aide #1 near the mechanical lift and Resident #50 on the floor, with small amount of blood around her head. Upon assessment, the resident had 1-1.5 inches laceration on the back of her head

Maintenance Manual for Patient Slings. The education started on 11/22/19 and will be presented again with completion by December 5, 2019. Those NAs, licensed staff, PTs and OTs not receiving the re-education by December 5, 2019 will not be allowed to provide resident care until the education is obtained. Re-education will be presented by the DON, ADON and other administrative nurses. Education includes using a navy sling (Small) for residents between 55-100 pounds, a purple sling (medium) for residents between 90-200 pounds, a green sling (large) for residents between 175-285 pounds, a blue sling (extra large) for residents that weight between 265-500 pounds and a black sling (2 extra large) for residents weighing from 265-600 pounds. Re-education will also instruct staff on the correct technique for using a sling to include crossing the straps between or underneath the resident□s legs. While the manufacturer□s instructions indicate the Invacare Reliant 450 RHL450-I lift can be safely operated by one person, the NAs, licensed staff, PTs and OTs will be re-educated on the facility□s lift policy to assure 2 NAs and/or staff are present during transfers using a lift. The NAs, licensed staff, PTs and OTs will also be trained that the slings will be kept in the Community Spas. A size chart will be posted above the rack holding the slings. After each use the slings are to be wiped with an antimicrobial wipe/spray and returned to the community spa. During education, NAs, licensed staff, PTs and OTs will be instructed to find the

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F 689	Continued From page 21 with small amount of blood. The nurse notified the physician, the DON and sent the resident to the hospital evaluation within one hour. The nurse aide reported she operated the lift alone. Nurse #1 completed the incident report and re-educated the nurse aide about requirements of two people for lift transfer. On 11/22/19, there were two more nurse aides, Nurse Aide #2 and Nurse Aide #3, on the floor and Nurse #1 did not know why Nurse Aide #1 used the mechanical lift without other nurse aides. The nurse continued that it was part of the training for all the staff to have two assistants for lift transfer. On 12/4/19 at 2:45 PM, during an interview, Nurse #2, Staff Development Coordinator, indicated that she provided the training for the staff, including the training for lift/transfer. During the education/training, she discussed with staff the policy requirements of two assistants for transfer, different kind of lifts and slings, available in facility. The practical, demonstration part, was separately provided by experienced nurse aides on the floor, which included the appropriate sling application, with placing straps crossed between legs. On 12/2/19 at 12:30 PM, during an interview, the Director of Nursing (DON), indicated that on 11/22/19 after 1:00 PM, she was notified by the staff that Resident #50 was dropped from mechanical lift to the floor during bed to chair transfer, provided by Nurse Aide #1 alone, and hit her head. Nurse Aide #1 confirmed she used the mechanical lift without assistance. The DON stated that Nurse Aide #1 successfully completed the lift/transfer training few weeks ago as part of her orientation process. The DON completed the investigation, which revealed that Nurse Aide #1	F 689	Resident Care Cards for each hall at the nurse□s station. The NAs, licensed nurses, PTs and OTs will be educated to look at the care cards prior to their shift starting to identify which resident needs a total lift and if a total lift is required what lift sling is to be used based on weight and girth. At the end of the training each NA, licensed nurse, PT and OT will be required to provide a return demonstration to the DON/ADON or other administrative nurse that proves they can choose the correct sling based on weight and girth, properly apply the sling and correctly lift the resident using 2 staff members. NAs will be re-educated to notify the nurse on the hall if they are given an assignment for which they are not comfortable. If the nurse does not respond, the NAs have been educated to notify the ADON or the DON. The ADON/DON will reassign if needed or place the orientee with another NA for additional training. If there is no one to immediately assist with the transfer, the staff were instructed to wait until other staff became available. The re-education and return demonstration will be documented on individual Lift Assessment Sheets and on Community In-Service sheets. Education on where to find the lift slings, how to choose the correct size of sling, correct technique for applying the sling to the resident and following the community□s policy will be included in orientation for all new nursing assistants, licensed staff, PTs and OTs. This initial training will be provided by the Staff Development Coordinator, DON or	

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F 689	Continued From page 22 did not follow the lift/transfer procedure: she did not have second assistant for mechanical lift and did not cross the sling strap during the transfer. Nurse Aide #1 was returned to the orientation/training to receive re-education about the lift transfer safety. The DON and administration completed mandatory in-service training with return demonstration for all the staff in regard to lift transfer, and re-assessed all the resident, received lift assistance for transfer. On 12/5/19 at 8:00 AM, during an interview, the Administrator indicated that the facility provided training, education, re-education and in-services in different aspects of care, included the lift/transfer. It was mandatory for the staff to have completed skills checklist prior to provide care. The Administrator and DON were notified of Immediate Jeopardy on 12/4/19 at 3:10 PM. On 12/5/19 at 5:00 PM, the facility provided the following credible allegation of Immediate Jeopardy removal: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Beginning on 11/22/19, Nurse Aide #1 was not allowed to work with residents in the skilled unit or residents requiring transfer with a mechanical lift until she was retrained on lift sling selection by weight and girth as included in the Owner ' s Operators Maintenance Manual for Patient Slings, the proper technique for transferring the resident and the need to use two staff members to transfer a resident. Nurse Aide #1 was able to verbalize expectations in following the care card, how to select the proper lift sling and provided a	F 689	another licensed nurse designated by the DON. Prior to working with residents that require transfer via Hoyer lift, the NA, licensed staff, PT or OT in orientation will demonstrate to the Staff Development Coordinator (SDC), DON or another licensed nurse appointed by the DON that he/she is capable of safely transferring residents via Hoyer lift using the correct sling, correctly applying the sling prior to transferring the resident and with the assistance of another staff member. The NA, licensed nurse, PT or OT in orientation will verbalize where to find the slings, how to care for the slings between resident use, how to use the resident care card and what he/she should do if not comfortable with an assignment. The SDC will maintain a skills check list for all newly hired nursing assistants and licensed staff. The check list will be completed by the DON, SDC or another licensed nurse and will document staff members□ ability to find the care cards, interpret the information related to lift sling size, correctly applying the sling and safely transfer the resident. Each year, each actively employed nursing assistant and licensed staff will re-demonstrate their ability to find the appropriate lift sling based on weight and girth, properly apply the sling prior to lifting the resident, be able to refer to the community□s policy on having 2 staff present during transfers with the Hoyer lift, will be able to verbalize where to find the information on the resident□s care card. NAs were instructed if they were unable to find another NA or nurse on the hall to assist	

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F 689	Continued From page 23 return demonstration to the administrative nursing team starting on 11/22/19 and ended on 12/4/19. The Community ' s Maintenance Director inspected both the sling and mechanical lift that had been used to transfer Resident #50. Residents requiring the use of a mechanical lift are at risk. On 11/25/19, the DON, Assistant DON (ADON), and other administrative nurses compiled a list of residents that required a mechanical lift for transfers. Return demonstrations of all nursing assistants performing mechanical lifts were completed on 11/25/19 and will again be required of all staff to be completed by 12/5/19. Care cards were reviewed by the DON, the Assistant DON and other administrative nurses by 12/5/19 to assure the proper information. 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The non-compliance resulted from failure to maintain safety for resident ' s lift transfer by Nurse Aide #1. Staff that includes nurse aides, licensed staff, physical therapists (PT) and occupational therapists (OT) will receive re-education, with completion on 12/5/19, on choosing the correct lift pad by the instructions in the Owner ' s Operators Maintenance Manual for Patient Slings. The slings will be kept in the Community Spas, and a size chart of the lift slings will be posted above the rack holding the slings. The re-education and return demonstration will be documented on individual Lift Assessment Sheets and on	F 689	with transfers to seek out the DON, ADON or other administrative nurse to assist with the transfer. Instruction included that under no circumstance was a transfer to be completed by 1 staff person. All lifts and slings were checked by the Maintenance Director. This began on 11/22/19 and was completed on 12/4/19. There has not been any other accidents or incidents involving the lifts that are used currently in the building. The lifts and slings are inspected monthly for wear and tear. Visual observations will be conducted each day of the week by the DON, ADON, SDC, RN Supervisor of staff using lifts. They will evaluate if the right sling is being selected, that there are at least 2 staff members involved in the lift, and where the slings are stored and disinfected. These observations will occur daily for 3 weeks and then twice per week for 1 month and once per month thereafter if no problems are noted. The results of this observation will be brought to the monthly QAPI meeting each month for 3 months and then every 6 months for the next year The Administrator, DON, ADON and other Administrative nurses are responsible for the implementation of the credible allegation of immediate jeopardy removal. The date of the community□s alleged removal of the immediate jeopardy is 12/5/19.	

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F 689	Continued From page 24 Community In-Service sheets. Education on where to find the lift slings, how to choose the correct size of sling, correct technique for applying the sling to the resident and following the community ' s policy will be included in orientation for all new nursing assistants, licensed staff, PTs and OTs. The SDC will maintain a skills checklist for all newly hired nursing assistants and licensed staff. The nurse aides were instructed that under no circumstance was a transfer to be completed by one staff person. The Administrator, DON, ADON and other Administrative nurses are responsible for the implementation of the credible allegation of immediate jeopardy removal. The date of the community ' s alleged removal of the immediate jeopardy is 12/5/19. The credible allegation was verified on 12/6/19 as evidenced by licensed and non-licensed nursing staff interviews on each of the halls. The staff had been re-educated on the implementation of appropriate procedure of residents ' lift transfer by two staff members at all the time, completed in-service/training in regards to location of residents ' care cards and lift slings and proper technique of the lift sling application. Interviews with the licensed and unlicensed staff confirmed they were in-serviced prior to working on the floor. The facility's credible allegation of immediate jeopardy removal was verified as having been implemented as of 12/5/19.	F 689		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		12/26/19

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F 726	Continued From page 25 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observation, the facility failed to train staff on safe transfer of residents using the mechanical lift per manufacturer's recommendation and the facility's lift/transfer training procedure, specifically, to use two people during transfer, to correctly use the straps to secure the resident during transfer and to use the correct sling. Five of 12 of nurse aides interviewed revealed they had insufficient training	F 726	726 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance Resident #50 was transferred via Hoyer lift from the bed to the wheelchair by a nursing assistant (NA) #1 on November 22, 2019 at approximately 1:00 PM. The	

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F 726	Continued From page 26	F 726		

with using the lift, sling sizes and type of lift for residents' transfer (Nurse Aide #1, Nurse Aide #2, Nurse Aide #4, Nurse Aide #5 and Nurse Aide #6). This resulted in the resident's fall during the transfer, causing the resident to have severe head trauma, hospitalization and death.

Immediate Jeopardy (IJ) began on 11/22/19, when Resident #50 was transferred from the bed to the chair with a mechanical lift using a technique that was not in line with the manufacturer's recommendation and the facility's lift/transfer training procedure. The nurse aide operated the mechanical lift without assistance of another staff member and did not cross the lift sling straps, which resulted in the resident's fall during the transfer with severe head trauma, hospitalization and death. Other aides were not clear about the training on the sling sizes and color-coding and indicated other staff were not always available to participate in the mechanical lift transfer and had to perform the transfer alone, even though they were aware of the policy on lifting with two people. The IJ was removed on 12/5/19, when the facility provided and implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance at a lower scope and severity of E (pattern with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put into place are effective to prevent accidents.

The findings included:

The manufacturer ' s manual, dated 2010, for the lift, which was used for Resident 50 ' s transfer, included a warning: "Although [the manufacturer]

resident slid out of the sling and fell to the floor sustaining a laceration and was sent to the hospital for further evaluation. Resident #50 was found to have a brain bleed and subsequently expired.
Statements were obtained from the NA #1 who had transferred the resident. NA #1 acknowledged to the Director of Nursing (DON) that she had placed the resident in the lift sling, had not placed the lift sling under the resident□s legs or between her legs and had transferred the resident without the help of another staff member. Resident #50 slid out of the sling, hitting her head on the legs of the mechanical lift. NA #1 informed the DON that she had requested help from the 2 NAs on her hall, but had not received the requested help.
Beginning on 11/22/19, NA #1 was not allowed to work with residents in the skilled unit or residents requiring transfer with a Hoyer lift until she was retrained on lift sling selection by weight and girth as included in the Owner□s Operators Maintenance Manual for Patient Slings, the proper technique for transferring the resident and the need to use 2 staff members to transfer a resident. The Owner□s Operators Maintenance Manual for Patient Slings indicate the lift sling can be crossed between the legs or underneath the resident□s legs. The NA was educated by the DON and the Staff Development Coordinator to complete this step when transferring residents. The NA was instructed on where to find lift slings and what she should do if she received an assignment in which she felt

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F 726	Continued From page 27 recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case." The manual recommended to place the sling straps "around, crossed between or underneath the patient ' legs." The manufacturer recommended to use the Lift Sling Sizing Chart, indicated five different sizes of the lift slings, from small to extra-extra-large, corresponding to color codes. Resident #50 was admitted to the facility on 4/8/16. The Quarterly Minimum Data Set assessment, dated 10/15/19, revealed she had severely impaired cognition. Resident #50 required total assistance with activities of daily living (ADL), including two people assistance for transfer. She did not have steady balance during transitions. The Nurse Aide Information Sheet for Resident #50 revealed she required mechanical lift for bed to chair/recliner transfer. This document did not specify the size or color of the lift sling to use for the resident. The skills checklist of Nurse Aide #1 for 11/7/19 - 11/19/19, indicated review and return demonstration for mechanical lift, Sit-to-Stand lifts and two-person transfer on 11/19/19 were observed by the nurse-trainer. The checklist did not specify the lift sling/strap application procedure. This skills checklist was signed by the nurse. The Skill Checklist Resident Lift, completed by Nurse Aide #1 on 11/19/19, indicated multiple	F 726	uncomfortable. NA #1 was also educated where to locate the care cards that would identify which lift pad to use and how many staff were needed to transfer a resident via mechanical lift. NA #1 was also instructed when transferring residents to ask for help from the NAs and nurse on her hall. If these staff were not available, she was instructed to request help from the Unit Manager, DON or Assistant Director of Nursing (ADON). If for some reason, no staff member was available at the moment, the NA was educated to wait to transfer residents when staff became available. Expectations that she, NA #1, would follow the instructions when providing care for residents was explained. NA #1 was able to verbalize expectations in following the care card, how to select the proper lift sling and provided a return demonstration to the administrative nursing team starting on 11/22/19 and again on 12/4/19. NA #1 returned to work with skilled residents requiring the use of mechanical lifts on 11/28/19. During orientation, NA #1 had signed the form during orientation that documented she knew the community policy was to have 2 staff members when transferring residents per Hoyer lift. Her ability to correctly use a Hoyer lift was observed and documented by the NA on the floor with whom she trained dated 11/19/19. Specify the action the entity will take to	

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F 726	Continued From page 28 steps of transfer from bed, transfer to chair procedures, including correct sling position and straps application. The checklist did not specify the way to place the straps around, crossed between or underneath the resident ' s legs. The checklist showed the warning: "all lift transfers require assistance of two staff members!" This checklist was signed by the Nurse Aide #3. The incident report, dated 11/22/19, indicated that on 11/22/19 at 1:00 PM, Nurse #1 was called by the staff to Resident 50 ' s room. She observed Resident #50 on the floor, next to the mechanical lift, with blood around her head. Nurse Aide #1 stated that during the transfer, she was lifting the resident to place her in her chair via mechanical lift, when the resident slipped out the lift on the floor, hitting her head. The assessment revealed about 1.6 inches laceration on the back of resident ' s head. A dressing was applied. The resident was transferred to bed via mechanical lift by three assistants and prepared for transfer to Emergency Room (ER). Hospital records revealed that Resident #50 arrived to the ER on 11/22/19 at 1:45 PM after witnessed fall in the nursing home. Per EMS (Emergency Medical Service) report, patient slid out of the mechanical lift and fell, hitting her head. The CT (Computer Tomography) scan, dated 11/22/19 at 4:00 PM, revealed massive brain bleeding. The resident was admitted for observation. Review of the Certificate of Death, dated 11/28/19, revealed Resident 50 ' s immediate cause of death was multicompartmental intracranial bleeding (massive brain bleeding). The condition, leading to the cause of death was	F 726	alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Staff that includes NAs, licensed staff, physical therapists (PT) and occupational therapists (OT) will receive re-education on choosing the correct lift pad by the instructions in the Owner□s Operators Maintenance Manual for Patient Slings. The education started on 11/22/19 and will be presented again with completion by December 5, 2019. Those NAs, licensed staff, PTs and OTs not receiving the re-education by December 5, 2019 will not be allowed to provide resident care until the education is obtained. Re-education will be presented by the DON, ADON and other administrative nurses. Education includes using a navy sling (Small) for residents between 55-100 pounds, a purple sling (medium) for residents between 90-200 pounds, a green sling (large) for residents between 175-285 pounds, a blue sling (extra large) for residents that weight between 265-500 pounds and a black sling (2 extra large) for residents weighing from 265-600 pounds. Re-education will also instruct staff on the correct technique for using a sling to include crossing the straps between or underneath the resident□s legs. While the manufacturer□s instructions indicate the Invacare Reliant 450 RHL450-I lift can be safely operated by one person, the NAs, licensed staff, PTs and OTs will be re-educated on the facility□s lift policy to assure 2 NAs and/or	

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F 726	Continued From page 29 the fall from the lift. On 12/2/19 at 3:15 PM, during an interview, Nurse Aide #1 indicated that on 11/22/19 at 1:00 PM, she came into Resident 50 ' s room on 300 hall to provide bed to chair transfer. Nurse Aide #1 stated that she was aware of the requirements to use the mechanical lift by two assistants. The other staff members were not available at the time. Nurse Aide #1 began to transfer Resident #50 from bed to chair via mechanical lift alone. During the transfer, Resident #50 slid out of mechanical lift sling, hit her head on the lift leg and fell to the floor. The nurse aide called for help. The floor nurse came immediately, assessed the resident, notified the physician, family and within one hour after the incident sent the resident to the hospital evaluation. Nurse Aide #1 confirmed she did not cross the straps during the lift sling application. On 12/4/19 at 2:40 PM, during an interview, Nurse Aide #1 indicated she was aware that on 11/22/19, two other nurse aides worked on 300 hall, but at 1:00 PM, she did not see them and did not have other staff members to help. Nurse Aide #1 mentioned that she worked with the Resident #50 first time and did not read the Nurse Aide ' s Information Sheet for Resident #50 prior to resident ' s transfer. She was not comfortable to use mechanical lift, because she did not receive enough training in the facility. No staff members offered help to her with resident ' s transfer on 11/22/19 at 1:00 PM. On 12/2/19 at 12:40 PM, during an interview, Nurse Aide #3 indicated that she provided the training for lift transfer procedures, completed and signed the Skill Checklist Resident Lift for	F 726	staff are present during transfers using a lift. The NAs, licensed staff, PTs and OTs will also be trained that the slings will be kept in the Community Spas. A size chart will be posted above the rack holding the slings. After each use the slings are to be wiped with an antimicrobial wipe/spray and returned to the community spa. During education, NAs, licensed staff, PTs and OTs will be instructed to find the Resident Care Cards for each hall at the nurse□s station. The NAs, licensed nurses, PTs and OTs will be educated to look at the care cards prior to their shift starting to identify which resident needs a total lift and if a total lift is required what lift sling is to be used based on weight and girth. At the end of the training each NA, licensed nurse, PT and OT will be required to provide a return demonstration to the DON/ADON or other administrative nurse that proves they can choose the correct sling based on weight and girth, properly apply the sling and correctly lift the resident using 2 staff members. NAs will be re-educated to notify the nurse on the hall if they are given an assignment for which they are not comfortable. If the nurse does not respond, the NAs have been educated to notify the ADON or the DON. The ADON/DON will reassign if needed or place the orientee with another NA for additional training. If assistance cannot be found to assist with the transfer using the mechanical lift, the staff have been educated to contact the DON, ADON or another administrative nurse to assist. If assistance is not found at that moment, the staff were educated to wait	

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nurse aides on the floor. She trained Nurse Aide #1 for lift transfer during her orientation. The training included discussion, demonstration and return demonstration of sling placement and straps application. Nurse Aide #3 mentioned that she always taught to cross the straps to increase the safety of transfer.

On 12/2/19 at 1:10 PM, during the phone interview, Nurse #1 indicated that on 11/22/19 after 1:00 PM, she was called to Resident 50 ' s room. In resident ' s room, she observed Nurse Aide #1 near the mechanical lift and Resident #50 on the floor. The nurse aide reported she operated the total lift alone. Nurse #1 completed the incident report and re-educated the nurse aide about requirements of two people for lift transfer. On 11/22/19, there were two more nurse aides, Nurse Aide #2 and Nurse Aide #3, on the floor and Nurse #1 did not know why Nurse Aide #1 used the total lift without other nurse aides. The nurse continued that it was part of the training for all the staff to have two assistants for lift transfer.

On 12/3/19 at 9:10 AM, during an interview, Nurse Aide #2 indicated that she worked in this facility three months and received training with lift transfer during the orientation. She remembered that the lift transfer required two staff members. Nurse Aide #2 used the lift slings, which were available in the resident ' s room at the time of transfer. For residents of different weight and height, she could use the same size of the lift slings. She did not know if the lift slings were color-coded.

On 12/3/19 at 10:10 AM, during an interview, Nurse Aide #8 indicated that she had many years

until help was available before transferring a resident with the lift. Documentation of Education and return demonstration has been recorded on individual Lift Assessment Sheets and on Community In-Service sheets.
Education on where to find the lift slings, how to choose the correct size of sling, correct technique for applying the sling to the resident and following the community□s policy will be included in orientation for all new nursing assistants, licensed staff, PTs and OTs. This initial training will be provided by the Staff Development Coordinator, DON or another licensed nurse designated by the DON. Prior to working with residents that require transfer via Hoyer lift, the NA, licensed staff, PT or OT in orientation will demonstrate to the Staff Development Coordinator (SDC), DON or another licensed nurse appointed by the DON that he/she is capable of safely transferring residents via Hoyer lift using the correct sling, correctly applying the sling prior to transferring the resident and with the assistance of another staff member. The NA, licensed nurse, PT or OT in orientation will verbalize where to find the slings, how to care for the slings between resident use, how to use the resident care card and what he/she should do if not comfortable with an assignment. The NA will be able to verbalize what to do if needed assistance with a transfer is not immediately available. The SDC will maintain a skills check list for all newly hired nursing assistants and licensed staff. Each year, each actively employed

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of experience as nurse aide and provided the training for other nurse aides on the floor in the lift transfer. During the training, she demonstrated the position of the straps crossed between resident ' s legs and the application of the sling, according to the Nurse Aide Information Sheet, available at the nurses ' station. She stressed it one more time that she always demonstrated the crossed between legs straps position to promote safety of transfer. Nurse Aide #8 did not provide practical lift transfer training for Nurse Aide #1.

On 12/3/19 at 10:15 AM, during an interview, Nurse Aide #4 indicated that she used long sling for mechanical lift and short sling for Sit-to-Stand lift transfer. She was not aware of different sizes of the slings for mechanical lift and used what was available in the residents ' room at the time of transfer.

On 12/3/19 at 12:00 PM, during an interview, Nurse Aide #5 indicated that she worked about one year in the facility. She could not recall the lift transfer training during her orientation period and learned how to use the lift from other employees. Nurse Aide #5 was aware of two people requirements to operate the lift for transfer. At times, the second assistant was not available on the floor for transfer and the nurse aide had to operate mechanical lift alone. After the incident on 11/22/19, Nurse Aide #5 worked three shifts per week and tried to participate in mandatory re-education in the area of lift transfer. She did not have an opportunity to demonstrate how she used the lift because the supervisor was not available.

On 12/3/19 at 3:10 PM, during an interview, Nurse Aide #6 indicated that for resident ' s lift

nursing assistant and licensed staff will re-demonstrate their ability to find the appropriate lift sling based on weight and girth, properly apply the sling prior to lifting the resident, be able to refer to the community□s policy on having 2 staff present during transfers with the Hoyer lift, will be able to verbalize where to find the information on the resident□s care card. NAs were instructed if they were unable to find another NA or nurse on the hall to assist with transfers to seek out the DON, ADON or other administrative nurse to assist with the transfer. Instruction included that under no circumstance was a transfer to be completed by 1 staff person.
Visual observations will be conducted each day of the week by the DON, ADON, SDC, RN Supervisor of staff using lifts. They will evaluate if the right sling is being selected, that there are at least 2 staff members involved in the lift, and where the slings are stored and disinfected. These observations will occur daily for 3 weeks and then twice per week for 1 month and once per month thereafter if no problems are noted.
The results of this observation will be brought to the monthly QAPI meeting each month for 3 months and then every 6 months for the next year

The Administrator, DON, ADON and other Administrative nurses are responsible for the implementation of the credible allegation of immediate jeopardy removal. The date of the community□s alleged removal of the immediate jeopardy is

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transfer, there was only large size of the lift sling available in the facility. In order to transfer the resident with the lift, Nurse Aide #6 "looked on resident ' s approximate size, mobility" and chose to use mechanical or Sit-to-Stand lift. If the resident already had the lift sling on the bed, Nurse Aide #6 would use it for lift transfer. He was not aware of documentation about the type of the lift or size of the lift sling for each resident.

On 12/4/19 at 2:45 PM, during an interview, the Staff Development Coordinator indicated that she provided the training for the staff, including the training for lift transfer. During the education/training, she discussed with staff the policy requirements of two assistants for transfer, different kind of lifts and slings, available in facility. The practical, demonstration part, was separately provided by experienced nurse aides on the floor, which included the appropriate sling application, with placing straps crossed between legs. The Staff Development Coordinator mentioned that the facility did not require additional certification/training for experienced nurse aides to be a preceptor for other nurse aides.

On 12/2/19 at 12:30 PM, during an interview, the Director of Nursing (DON), indicated that on 11/22/19 after 1:00 PM, she was notified by the staff that Resident #50 was dropped from mechanical lift to the floor during bed to chair transfer, provided by Nurse Aide #1 alone, and hit her head. Nurse Aide #1 confirmed she used the mechanical lift without assistance. The DON stated that Nurse Aide #1 successfully completed the lift/transfer training few weeks ago as part of her orientation process. The DON completed the investigation, which revealed that Nurse Aide #1

12/5/19.

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did not follow the lift/transfer procedure. She did not have second person to assist her in using the mechanical lift and did not cross the sling strap during the transfer. Nurse Aide #1 was returned to the orientation/training to receive re-education about the lift transfer safety. After the incident on 11/22/19, the DON and administration completed mandatory in-service training with return demonstration for all the staff in regard to lift transfer, and re-assessed all the residents, received lift assistance for transfer.

On 12/5/19 at 8:00 AM, during an interview, the Administrator indicated that the facility provided training, education, re-education and in-services in different aspects of care, included the lift/transfer. It was mandatory for the staff to have completed skills checklist prior to provide care.

The Administrator and DON were notified of Immediate Jeopardy on 12/4/19 at 3:10 PM. On 12/5/19 at 5:00 PM, the facility provided the following credible allegation of Immediate Jeopardy removal:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

In the written statements, Nurse Aide #1, who had transferred the resident, acknowledged that when she placed the resident in the lift sling, she had not placed the lift sling under the resident ' s legs or between her legs and had transferred the resident without the help of another staff member. Resident #50 slid out of the sling, hitting her head on the legs of the mechanical lift.

Beginning on 11/22/19, Nurse Aide #1 was not

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allowed to work with residents in the skilled unit or residents requiring transfer with a mechanical lift until she was retrained on lift sling selection by weight and girth as included in the Owner ' s Operators Maintenance Manual for Patient Slings, the proper technique for transferring the resident and the need to use two staff members to transfer a resident. Nurse Aide #1 was able to verbalize expectations in following the care card, how to select the proper lift sling and provided a return demonstration to the administrative nursing team starting on 11/22/19 and ended on 12/4/19. The Community ' s Maintenance Director inspected both the sling and mechanical lift that had been used to transfer Resident #50.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Staff that includes nurse aides, licensed staff, physical therapists (PT) and occupational therapists (OT) will receive re-education, with completion on 12/5/19, on choosing the correct lift pad by the instructions in the Owner ' s Operators Maintenance Manual for Patient Slings. The slings will be kept in the Community Spas, and a size chart of the lift slings will be posted above the rack holding the slings. The re-education and return demonstration will be documented on individual Lift Assessment Sheets and on Community In-Service sheets. Education on where to find the lift slings, how to choose the correct size of sling, correct technique for applying the sling to the resident and following the community ' s policy will be included in orientation for all new nursing assistants, licensed staff, PTs and OTs. The SDC will maintain a skills checklist for all newly hired nursing assistants and licensed

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staff. The nurse aides were instructed that under no circumstance was a transfer to be completed by one staff person.

Education on where to find the lift slings, how to choose the correct size of sling, correct technique for applying the sling to the resident and following the community ' s policy will be included in orientation for all new nursing assistants, licensed staff, PTs and OTs. This initial training will be provided by the Staff Development Coordinator, DON or another licensed nurse designated by the DON. Prior to working with residents that require transfer via mechanical lift, the nurse aides, licensed staff, PT or OT in orientation will demonstrate to the Staff Development Coordinator (SDC), DON or another licensed nurse appointed by the DON that he/she is capable of safely transferring residents via mechanical lift, using the correct sling, correctly applying the sling prior to transferring the resident and with the assistance of another staff member.

The Administrator, DON, ADON and other Administrative nurses are responsible for the implementation of the credible allegation of immediate jeopardy removal. The date of the community ' s alleged removal of the immediate jeopardy is 12/5/19.

On 12/3/19 at 10:20 AM, during an observation of the bed to chair lift transfer, provided by Nurse Aide #8 and Nurse Aide #7. They explained the procedure to the resident, took the large sling, correct size for the resident, and put it under the resident on the bed. The total lift was ready in resident ' s room. Nurse Aide #8 gently crossed the straps between resident ' s legs and hooked up the sling to the lift. Both nurse aides

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F 726	Continued From page 36 transferred the resident to the chair, repositioned the resident in the chair and disconnected the lift from the sling. During the procedure, the resident did not show signs of discomfort or pain. The credible allegation was verified on 12/6/19 at 1:25 PM as evidenced by licensed and non-licensed nursing staff interviews on each of the halls. The staff had been re-educated on the implementation of appropriate procedure of residents ' lift transfer by two staff members at all the time, completed in-service/training in regards to location of residents ' care cards and lift slings and proper technique of the lift sling application. Interviews with the licensed and unlicensed staff confirmed they were in-serviced prior to working on the floor. The facility's credible allegation of immediate jeopardy removal was verified as having been implemented as of 12/5/19.	F 726		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		12/26/19

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F 727	Continued From page 37 Based on record review and staff interview, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours a day for 3 out of 35 days reviewed for staffing (11/9/19, 11/10/19, and 11/23/19). Findings included: The Daily Assignment sheets were reviewed from November 1, 2019 to December 5, 2019 and it revealed that on November 9, 10, and 23, there were no RN assigned to work in the facility. Review of the Daily Nurse Staffing hours from November 1, 2019 to December 5, 2019 revealed there was a RN hour counted on 11/9/19, 11/10/19, and 11/23/19 and didn't match the daily assignment sheet provided. An interview with Nurse #4 (Supervisor) on 12/5/19 at 4:00 PM was conducted. The nurse was shown the Daily Assignment sheets and after Nurse #4 was done looking at the pages, she stated that there were no RN listed working in the facility on 11/9/19, 11/10/19, and 11/23/19. Interview with the Human Resources (HR)/Payroll staff was done on 12/6/17 at 8:42 AM. The HR/Payroll staff indicated that her computer was not properly working so she went to the Administrator's office to get the list of RNs working on 11/9/19, 11/10/19, and 11/23/19. She came back and provided a written information of RN staff working on those requested days. The written information showed that on 11/10/19 Nurse #2 was listed working and on 11/09/19 and 11/23/19, the Director of Nursing (DON) was listed working.	F 727	F727- A Registered Nurse (RN) was provided 8 hours a day on 11/9/19, 11/10/19 and 11/23/19. The Registered nurse in the building was the Director of Nursing (DON). The DON did not act as a charge nurse, but was supervising Medication Aides in the building. There was no time card that listed in and out times for the DON since she is a salaried employee and is not required to use a time clock. Each nurse assigned a hall is considered the charge nurse for her/his hall and is competent and capable to evaluate the condition of her/his residents. No resident□s needs were unmet and policies and procedures were maintained on the 3 days the DON was in the community supervising the Medication Aides. The DON was available during her time in the community to answer questions, evaluate, plan and implement resident care as needed. During 11/9/19, 11/10/19 and 11/23/19 only 2 residents were discharged from the facility. On 11/9/19 one resident, who had a DO NOT RESUSCITATE in place expectedly expired. The family was aware of the change in the resident□s condition and had opted not to hospitalize the resident. On 11/23/19, a resident was sent to the hospital after the charge nurse communicated with the physician and an order was obtained for transfer for further evaluation. With the expectation that illness, vacations and last- minute call outs exist, it is the expectation the community will require a RN to be available on short	

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F 727	Continued From page 38 Record review of the Labor Detail Report (official report of all personnel clocked-in and working in the facility) for the facility for 11/9/19, 11/10/19, and 11/23/19 provided by the Administrator indicated there were no RN staff listed. The Labor Detail Report didn't show any RN working on 11/9/19, 11/10/19, and 11/23/19. An interview with Nurse #2 was conducted on 12/6/19 at 9:59 AM. Initially, Nurse #2 stated he only work during the week and on Saturdays and does not work on Sundays. When asked if he came to work on 11/10/19 (Sunday), he stated he came in the facility to supervise. Nurse #2 also stated that he always clocks in when he comes to work. And when Nurse #2 was shown the Labor Detail Report that didn't show his name listed as working on 11/10/19, the Nurse just shrugged his shoulders and offered no further comment. Interview with the DON on 12/6/19 at 10:46 AM, she stated that she comes to the facility to supervise nurses when there's no RN on duty. She further stated that they don't have a policy for On-Call nurses. The Administrator was interviewed on 12/6/19 at 10:54 AM and he stated the facility don't use any staffing agency and the administrative nurses coordinates RN staff to work in the facility daily. Further interview at 01:24 PM, the Administrator concluded that the DON will cover any RN coverage in the facility when there's no RN working.	F 727	notice to provide the 8 hours per day requirement. The facility will diligently advertise for RNs at a wage that is comparable to community standards. At the beginning of the week, the scheduler or DON/ADON, will review the RN coverage for the coming week. If a day with no RN coverage is identified, the DON will ask for a RN volunteer to provide the 8 hours of RN coverage for the day. This could be 8 hours from 1 RN or 8 hours provided by several RNs working a few hours. If there is no volunteer, the DON will appoint one of the staff RN/RNs to provide the RN coverage for the day. The Regional Director of Operations (RDO) will educate the Administrator and the DON on the need for RN coverage 8 hours per day, not to include coverage by the DON. The Administrator and/or the DON will maintain a calendar of nurses that provided daily RN coverage. The RDO will review this calendar monthly to assure the community has 8 hours of continuous RN coverage daily without using the DON. The Administrator will present the results of the daily calendar to the QAPI committee monthly x 3 or until sustained compliance is achieved.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		12/26/19

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F 883	Continued From page 39 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 40 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to offer flu vaccine and record education pertaining the benefits and potential risk for 1 of 5 Residents (Resident #28) reviewed for immunization. Findings included: The facility policy for immunization with the effective date of November 2017 stated in part, "All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually ..."It further stated that "A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record." Resident #28 was admitted on 7/6/18 with a diagnosis of Alzheimer's disease and Type 2 Diabetes. The Minimum Data Set (MDS) dated 10/4/19 revealed Resident #28 was severely cognitively impaired.	F 883	F883 Resident #28□s family had been presented with the educational materials related to the influenza (flu) vaccination via mail, but had not returned the information. The educational material for the 2018 flu season was presented to the surveyor during the survey process. In conversation with the family post survey, the family acknowledged Resident #28 had received the flu immunization during the 2019. All residents living in the community are at risk of not receiving education and/or the flu immunization if desired. The Director of Nursing (DON), ADON and unit managers conducted an audit of resident charts starting on 12/10/19 and ending on 12/16/19. A Systems Check for Resident Immunization form was completed indicating if and when consents were obtained from residents and/or responsible parties (RPs) desiring or declining the flu immunization. Those	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 41 Record review of the resident's immunization information did not show Resident #28 was provided education for the benefits and potential risk of flu vaccine. A cumulative list of all immunization record in the facility provided by Nurse #3 that was printed on 12/3/19 at 3:05 PM did not show Resident #28 was listed in the roster. An interview with Nurse #3 on 12/5/19 at 11:05 AM was conducted. She stated they have sent the vaccination consent forms to all residents/representative last summer to have the consents in hand ready when flu vaccine comes available. Nurse #3 was not able to find any documentation that they have sent the information to Resident #28's representative. The Nurse also stated she did not do an audit of who signed consents or declined. Nurse #3 also stated that the flu vaccine was available on the last week of September 2019. Interview with the Director of Nursing (DON) was conducted on 12/6/19 at 1:25 PM. The DON stated that the education and consent form is provided during admission and yearly to all residents. DON also stated that Nurse #3 was responsible for all the immunization in the facility. The DON also indicated that the information of immunization and vaccination should be current, and the documentation placed in the chart.	F 883	residents and or RPs desiring the flu immunization for their resident received the immunization after education was given and consent granted. This was completed 12/16/19. The Assistant DON and Unit Managers (UM) were educated by the DON beginning on 12/20/19 and completed by 12/24/19. Education will include documentation of flu immunization education, resident and/or RP consent or decline and administration of the flu immunization. Education regarding the flu immunization should be given within 72 hours of admission with the resident receiving the immunization immediately upon consent. The administrative nursing staff were also educated that education and consents/refusals had to be completed annually either prior to flu season or during early flu season. The education on immunizations will be included in orientation for all new licensed staff. The DON, ADON and UM will audit all new admissions during the clinical meeting the next business day after admission to assure immunization education and consent/decline forms are signed. If the education has not been given or the forms signed, the administrative nursing staff will educate and obtain consent/decline of the immunization within 7 days post admission. The results of new admission chart audits for immunizations will be recorded on the Systems Check for Resident Immunization sheet. The DON or other members of the administrative nurse team will present	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 12/06/2019

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F 883	Continued From page 42	F 883	results of the audit to the QAPI committee monthly x 3 or until substantial compliance is sustained.	