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E 000	Initial Comments An unannoucned Recertification survey was conducted on 01/13/2020 through 01/16/2020. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID HDDG11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint survey was conducted on 01/13/2020 through 01/16/2020. There were 2 complaint allegations investigated and 1 was substantiated. Event ID HDDG11.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		

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

Electronically Signed

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide full visual privacy to a resident that was performing a self in and out catheterization for 1 of 1 resident reviewed for privacy (Resident #17). The findings included: Resident #17 was readmitted to the facility on 03/15/19 with diagnoses that included neuromuscular dysfunction of the bladder and others. A physician's order dated 05/31/19 read, continue to self catheterize every 4 hours. If draining more than 400 milliliters (ml) each time will need to catheterize more frequently. Review of a quarterly Minimum Data Set (MDS) dated 10/27/19 indicated that Resident #17 was cognitively intact and required extensive assistance with toileting. Intermittent catheterization was noted during the assessment reference period. No behaviors or rejection of care was noted during the assessment reference period.	F 583		

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An observation of Resident #17 was made on 01/13/2020 at 10:07 AM. Upon arriving at Resident #17's room the door was open and the privacy curtain between the 2 beds in the was room was pulled to its full capacity. Resident #17's lower half of his body was fully exposed to the hallway. His brief was pulled down and his penis was exposed as he was beginning to self catheterize. Upon entry into Resident #17's room the curtain was pulled down to cover the lower half of Resident #17's body which then exposed the top half of his body. The privacy curtain when pulled to it maximum capacity was approximately 34 inches long and Resident #17's waist to his stumps including his groin area were visible from the hallway.

An interview was conducted with Resident #17 on 01/13/2020 at 2:34 PM. Resident #17 stated that he had to catheterize himself every 4 hours throughout the day. He stated that he had an accident years ago that left him paralyzed and his bladder did not empty like it should. Resident #17 stated that he kept his supplies on his over the bed table as he was a double amputee and could not get up to get them each time. He added that maintenance needed to come and fix his privacy curtain as it was bunched at the top. He stated that it has been like that for 6 months, but he doesn't think he had reported it to anyone. Resident #17 replied "ma'am I just do what I can, I have no legs to get up and do anything."

An observation of Resident #17 was made on 01/14/2020 at 8:59 AM. Upon arriving at Resident #17's room the door was open and the privacy curtain between the 2 beds in the was room was pulled to its full capacity. Resident #17's lower

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half of his body was fully exposed to the hallway. His brief was pulled down and his penis was exposed as he was self catheterizing. Upon entry into Resident #17's room the curtain was pulled down to cover the lower half of Resident #17's body which then exposed the top half of his body. The privacy curtain when pulled to it maximum capacity was approximately 34 inches long and Resident #17's waist to his stumps including his groin area were visible from the hallway.

An observation of Resident #17 was made on 01/14/2020 at 2:01 PM. Upon arriving to Resident #17's room he was observed resting in bed with a t-shirt on a wore only a brief on his lower body. The brief was fastened around him but was fully visible from the hall way. The privacy curtain was pulled to its maximum capacity approximately 34 inches and did not cover Resident #17's waist to his stumps including his groin area were visible from the hallway.

An interview was conducted with Nurse #2 on 01/15/2020 at 2:25 PM. Nurse #2 confirmed that she was responsible for Resident #17. Nurse #2 stated that the staff always knocked on door before entering the room and they kept the privacy curtain pulled between the 2 beds in each room. Nurse #2 stated that the staff had been to the office several times about Resident #17 being exposed but it continued. She stated that the curtain was always pulled, and they tried to keep the door shut when he was performing a self-catheterization. Nurse #2 stated the privacy curtain should provide full privacy and he should not be visible from the hallway especially when he is exposed to perform his self catheterization.

An observation was made of Residents #17's

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room along with the Director of Nursing (DON) on 01/15/2020 at 3:03 PM. Resident #17 was out of bed and out of the room. The DON observed the privacy curtain opened at its full capacity of approximately 34 inches and agreed it did not provide full privacy of Resident #17. She added that Resident #17 voiced his needs and desires and the staff adjusted to his preference but added that the facility needed to provide 100% privacy for everyone including Resident 17's roommate and the female residents across the hall. The DON stated that the facility needed to respect the privacy of others.

An observation and interview were conducted with the Environmental Services Director (ESD) on 01/15/2020 at 3:11 PM. The ESD confirmed that the privacy curtain did not provide full privacy for Resident #17 because it was looped over itself at the time and was unable to be pulled apart. He stated that the privacy curtains were changed as needed and when the rooms were deep cleaned. The ESD added he could not recall when Resident #17's privacy curtain had been replaced but stated he could fix it quickly. The ESD was observed to remove the shorter privacy curtain and hang a long privacy curtain that closed entirely around the bed providing full privacy of Resident #17's bed.

An interview was conducted with the Restorative Aide (RA) on 01/16/2020 at 11:54 AM. The RA confirmed that she cared for Resident #17 on 01/13/2020. She stated that she kept the privacy curtain pulled as far as it would go but Resident #17 did not turn the call light when he was catheterizing himself, so she was not always aware when he was performing it to close the door. The RA confirmed that curtain did not cover

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F 583	Continued From page 5 the entire bed and Resident #17 was visible from the hallway. An interview was conducted with the Administrator on 01/16/2020 at 2:30 PM. The Administrator stated she expected the facility to uphold resident rights in the facility at all times.	F 583		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to accurately code the minimum data set to reflect the residents correct height for 1 of 5 residents reviewed for unnecessary medications (Resident #17). The finding included: Resident #17 was readmitted to the facility on 03/15/19 with diagnoses that included: acquired absence of right and left above knee amputation and others. Review of the quarterly Minimum Data Set (MDS) dated 10/27/19 revealed that Resident #17 was cognitively intact and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #17 had bilateral impairment to lower extremities and was 68 inches tall (5 foot 8 inches tall). An observation and interview were conducted	F 641		

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with Resident #17 on 01/13/2020 at 10:07 AM. Resident #17 was resting in bed and was observed to be a bilateral above the knee amputee. Both of his stumps were resting on the mattress and he indicated he had lost his legs at different times several years ago. When asked how tall Resident #17 he was replied "half as tall as I used to be."

Review of Resident #17's medical record revealed on 01/16/2020 his height was 38.5 inches.

An interview was conducted with the MDS Coordinator on 01/16/2020 at 10:28 AM. She confirmed that Dietary Manager (DM) #1 had been assisting the facility with completing MDS assessments during some staff changes. She added that she reviewed their work for completion and timeliness but not for accuracy. The MDS Coordinator further stated that she did not check every assessment but would spot check for accuracy if there were unusual circumstances that needed to be reflected on the MDS. She further stated it would be the responsibility of the staff member completing the section to ensure the MDS was coded accurately.

An interview was conducted with DM #1 on 01/16/2020 at 11:58 AM. DM #1 confirmed that she had completed the quarterly MDS dated 10/27/19 for Resident #17. She explained she was helping the facility while staff changes were being made. DM #1 stated that the when she completed the quarterly MDS the information was copied from the previous assessment then she had to go through each question and verify the information was correct. DM #1 state that even if the resident was a double amputee, she always

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F 641	Continued From page 7 placed the resident's original height because she had been instructed to do so by her corporation. She further explained that when height and weight was entered into the system it would calculate the resident nutritional needs and if they used his height that reflected the amputation status it would skew his nutritional calculations. An interview was conducted with the Director of Nursing (DON) on 01/16/2020 at 1:58 PM. The DON stated she expected the MDS to be completed following the federal guidelines in regard to height. She further stated the facility did not have a policy for obtaining height so they would use the federal guidelines. An interview was conducted with the Administrator on 01/16/2020 at 2:30 PM. The Administrator stated that she expected the MDS to be coded appropriately following the federal guidelines.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to keep a dependent resident fingernails clean for 1 of 3 residents reviewed for activities of daily living (Resident #77). The findings included:	F 677		

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Resident #77 was admitted to the facility on 02/01/19 with diagnoses that included: hemiplegia following a cerebral vascular accident and contracture of right upper arm.

Review of a quarterly Minimum Data Set (MDS) dated 01/04/2020 revealed that Resident #77 was moderately cognitively impaired for daily decision making and required extensive assistance with personal hygiene. The MDS further revealed that Resident #77 had no behaviors or rejection of care during the assessment reference period.

An observation of Resident #77 was made on 01/13/2020 at 10:12 AM. Resident #77 was resting in bed with eyes open, he was alert and non-verbal. His right hand was contracted but Resident #77 was able to open his hand enough to visualize his fingernails which were clean and filed. Resident #77's left first, second, and fourth fingernail and thumb nail were approximately ½ inch long with dried dark brown/black substance under them. Resident #77's third left fingertip had been amputated.

An observation of Resident #77 was made on 01/14/2020 at 8:56 AM. Resident #77 was resting in bed with eyes open, was alert and non-verbal. His right hand was contracted but Resident #77 was able to open his hand enough to visualize his fingernails which were clean and filed. Resident #77's left first, second, and fourth fingernail and thumb nail were approximately ¼ inch long with dried dark brown/black substance under them. Resident #77's third left fingertip had been amputated. Resident #77's breakfast tray was in front of him and he was using the left hand to feed himself orange slices that were on the meal tray.

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An observation of Resident #77 was made on 01/15/2020 at 9:15 AM. Resident #77 was resting in bed with eyes open, was alert and non-verbal. His right hand was contracted but Resident #77 was able to open his hand enough to visualize his fingernails which were clean and filed. Resident #77's left first, second, and fourth fingernail and thumb nail were approximately ¼ inch long with dried dark brown/black substance under them. Resident #77's third left fingertip had been amputated.

An observation was made on 01/15/2020 at 10:29 AM. Nurse Aide (NA) #1 and NA #2 had just completed morning care for Resident #77. They had washed him up and placed a clean dry brief on him. NA #1 confirmed that they had just completed care for Resident #77 and would get him up later in the day. NA #1 stated that she had not noticed Resident #77's nails on his left-hand during care but she could certainly get a brush and get them cleaned up. NA #1 visualized Resident #77's fingernails on his right hand and noted they were clean and filed.

An interview was conducted with Nurse #2 on 01/15/2020 at 2:25 PM. Nurse #2 confirmed that she cared for Resident #77. She stated that the NAs perform nail care during care and then activities assisted by painting and cleaning nails weekly to the resident that attended the activity. Nurse #2 stated that if Resident #77's left fingernails were dirty she would expect the NAs to clean them during care.

An interview was conducted with the Restorative Aide (RA) on 01/16/2020 at 9:13 AM. The RA stated that she kept a list of residents that were

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F 677	Continued From page 10 on the restorative program and that included Resident #77. She explained that Resident #77 wore a splint on his right hand and each day she would go in and help him relax and stretch that right hand. She stated she would clean it and make sure his nails were trimmed and filed and it was clean before applying this brace. The RA stated that he generally did not refuse the treatment but at times she would have to come back to him later in the day and he would always allow her to do the treatment and apply his splint. She added that she was so focused on his right hand that she had not noticed the long/dirty nails on his left hand. The RA stated if she would have noticed them, she would have cleaned and/or trimmed them. An interview was conducted with the Director of Nursing (DON) on 01/16/2020 at 1:48 PM. The DON stated that "it was a struggle because his family brought in food" and he used that left hand to eat with. She added she would expect the staff to clean his fingernails when they were visible soiled after meals and during care rounds. An interview was conducted with the Administrator on 01/16/2020 at 2:26 PM. The Administrator stated she expected the staff to clean Resident #77's nails as tolerated by the resident and according to his preference.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

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care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interview the facility failed to replace oxygen tubing after it had been on the floor for 1 of 3 residents reviewed for oxygen use (Resident #36).

The findings included:

Resident #36 was readmitted to the facility on 12/24/19 with diagnoses that included pneumonia and heart disease.

The resident's quarterly Minimum Data Set (MDS) dated 10/13/19 revealed that Resident #36 was cognitively intact and required extensive assistance with activities of daily living. No shortness of breath or oxygen use was identified on the assessment.

Resident #36's physician order dated 12/31/19 read, oxygen at 2 liters per minute as needed.

An observation and interview were conducted with Resident #36 on 01/13/2020 at 11:08 AM. Resident #36 was resting in bed with her eyes open. There was an oxygen concentrator on and set to deliver 2 liters of oxygen. The oxygen tubing was noted lying on the floor and the tubing contained the initials of Nurse #1 where the oxygen tubing was connected to the concentrator. Resident #36 stated that she wore her oxygen at all times and reached for the oxygen tubing that was on the floor but could not reach it. Resident

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#36 denied any shortness of breath but requested her oxygen tubing again that was lying on the floor. Nurse #2 was notified that Resident #36 requested her oxygen tubing.

An observation of Nurse #2 was made on 01/13/2020 at 11:21 AM. Nurse #2 entered Resident #36's room and exited the room at 11:22 AM.

An observation of Resident #36 was made on 01/13/2020 at 11:23 AM. Resident #36 was resting in bed with eyes open. She had her oxygen tubing in her nose and was connected to the concentrator sitting next to her bed and was set to deliver 2 liters of oxygen. The oxygen tubing contained the initial of Nurse #1 where the oxygen tubing was connected to the concentrator.

An interview was conducted with Nurse #2 on 01/13/2020 at 11:25 AM. Nurse #2 stated that Resident #36 was normally able to take off and replace her oxygen with no issue, but she had dropped the oxygen tubing and could not reach it, so she had to help her get it back in place.

An observation of Resident #36 was made on 01/14/2020 at 9:05 AM. Resident #36 was resting in bed with eyes open. Resident #36's oxygen tubing was resting on her chest and she placed the oxygen tubing back in her nose. The oxygen tubing was connected a concentrator sitting next to her bed and was set to deliver 2 liters. The tubing contained the initials of Nurse #1 where the oxygen tubing connected to the concentrator. Resident #36 denied any shortness of breath.

An observation of Resident #36 was made on 01/15/2020 at 1:20 PM. Resident #36 was resting

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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 695	Continued From page 13	F 695		

in bed with oxygen in her nose. The tubing was connected to a concentrator sitting next to her bed and was set to deliver 2 liters of oxygen. The tubing contained the initials of Nurse #1 where the oxygen tubing connected to the concentrator.

A follow up interview was conducted with Nurse #2 on 01/15/2020 at 2:25 PM. Nurse #2 stated that the oxygen tubing was changed weekly on Sunday evening. She added that if the oxygen tubing fell on the floor new tubing had to be obtained. Nurse #2 stated that when she entered Resident #36's room on 01/13/2020 at 11:21 AM to hand her the oxygen tubing that had fallen, she obtained new tubing on from her bottom drawer and placed it on her face/nose.

A follow up interview was conducted with Resident #36 on 01/15/2020 at 2:47 PM. Resident #36 stated she could not recall if Nurse #2 obtained new oxygen tubing on 01/13/2020. She stated that the staff generally changed it every week at night while she was sleeping.

An interview was conducted with Nurse #1 on 01/15/2020 at 3:55 PM. Nurse #1 confirmed that she was responsible for changing oxygen tubing weekly on Sunday evenings. She added that she kept a list of residents who had oxygen and she would make a round and double check any new admission or additional equipment that may have been added during the week. Nurse #1 stated that she placed new oxygen tubing on the concentrator and on the portable tanks that were in the resident room. She added that she always placed her initials on the oxygen tubing where the oxygen tubing connected to the concentrator. Nurse #1 confirmed that she had replaced Resident #36's oxygen tubing on 01/12/2020 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 01/16/2020

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placed her initials on the tubing where the oxygen tubing connected to the concentrator. She added she had not worked since 01/12/2020 and that was the last time she had changed Resident #36's oxygen tubing.

An interview and observation were conducted with the Director of Nursing (DON) on 01/15/2020 at 4:13 PM. The DON observed Resident #36 resting in bed with her eyes open and oxygen tubing in her nose. The tubing was connected to a concentrator sitting next to her bed and was set to deliver 2 liters of oxygen. The tubing contained the initials of Nurse #1 where the tubing was connected to the concentrator. The DON confirmed that Nurse #1 had changed the oxygen tubing on Sunday 01/12/2020 and stated that she would have expected Nurse #2 to change the oxygen tubing when it was on the floor.

An observation of Resident #36 was made on 01/16/2020 at 11:26 AM. Resident #36 was resting in bed with eyes open. She had oxygen tubing in her nose that was connected to concentrator sitting next to her bed. The concentrator was set to deliver 2 liters of oxygen. The oxygen tubing contained the initials of Nurse #1 where the oxygen tubing connected to the concentrator.

A follow up interview was conducted with the DON on 01/16/2020 at 2:04 PM. The DON stated that she expected the nurses to follow best practice guidelines on handling and changing oxygen tubing when necessary or as per the manufacturer's guidelines.