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E 000	Initial Comments An unannounced Recertification survey was conducted on 1/27-31/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JRRW11.	E 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		4/15/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/24/2020

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

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§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, resident and staff interviews, the facility failed to resolve repeated concerns reported during resident council meetings related to; not answering call lights for 3 consecutive months, showers not being cleaned for 6 consecutive months, and not passing out ice water for 5 consecutive months.

Findings included:

The Resident Council Meeting Minutes from August 9, 2019 to January 3, 2020 were reviewed. The review revealed the following concerns were voiced during the monthly Resident Council meetings and the facility's response:

The Resident Council Meeting Minutes from August 9, 2019 specified concerns related to:
A. Nursing Assistants (NA) not cleaning shower room after showers.
B. Residents must wait 30-45 minutes for call lights to be answered; (The NA turns off the light and leaves the room without addressing the concern)
The facility's response for both concerns was recorded on the response form as, "it will be addressed at NA meetings on 9/11,12,14 and 15 by nursing admin". Response form was filled out by the Assistant Director of Nursing (ADON) and signed by the administrator on 09/13/19.

1.Corrective actions for those residents found to have been affected by the deficient practice. On 1/31/20 shower room 300 the gray colored grout was cleaned, the shower floor cleaned, and the walls were cleaned of the long streaks of direct white drainage.
On 1/31/20 Shower room on the 500/600 hall the floor was cleaned, the washcloth with the dark brown spots and the wadded-up washcloth was removed.
2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. All residents are at risk of deficient practice.
3. Measure/ systemic practice put in place to ensure the deficient practice does not reoccur.
On February 20. 2020 the current staff began re-education by the Staff development coordinator and/or the Director of Nursing on resident rights to organize and participate in groups in the facility, and the facility must provide a designated staff person who is approved by the resident or family group and the facility who will be responsible for providing assistance and respond to a written request or concerns that result from a group meeting. Also on February 20, 2020 the current staff began

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F 565	Continued From page 2 The Resident Council Meeting Minutes from September 6, 2019 specified concerns related to: A. Nursing Assistants (NA) not cleaning shower room after shower B. Residents must wait 30-45 minutes for call lights to be answered; (The NA turns off the light and leaves the room without addressing the concern) C. Ice water not being passed to residents . The facility's response for concerns A and B were recorded on the response form as, "it will be addressed at the NA meetings as there are multiple concerns". Concern C response was recorded as, "It is being written on shift assignment sheets and asked that it be added to the NA assignment sheets" Response form was signed by the ADON and signed by the administrator on 9/13/19. The Resident Council Meeting Minutes from October 4, 2019 specified concerns related to: A. Nursing Assistants (NA) not cleaning shower room after shower, B. Residents must wait 30-45 minutes for call lights to be answered; (The NA turns off the light and leaves the room without addressing the concern) C. Ice water not being passed out to residents. The facility's response for concern A was recorded as, "Reviewed with all NA ' s on 7:00 AM and 3:00 PM shift and advised RN supervisor to review with 2nd, 3rd, and Baylor shifts to clean chairs after every resident shower." Concern B response, "Reviewed with the 7:00 AM and 3:00 PM shift and advised RN supervisor to review with 2nd, 3rd, and Baylor shift. Call Bells are everyone ' s responsibility." Concern C response; "Placed on NA schedule sheet and NA assignment sheet and asked that it be added to	F 565	re-education by the Staff development coordinator and/ or the Director of Nursing on the showers rooms must be cleaned after each use and report to housekeeping any areas that may need more cleaning, removing soled linen from shower rooms, answering call lights timely and not turning off light until the resident□s needs has been met, and passing ice each shift and as needed. New employees will receive the education during orientation. The Activities Director will continue to provide in writing the request and or concerns voiced during resident council to the appropriate department head, the department head will provide a timely written response and monitor for completion before the next resident council meeting. The Activities Director will provide a report during the next resident council meeting of the results. The Administrator will be responsible for ensuring this process. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur. The Director of Nursing, Staff Developing Coordinator and/or the Unit Manager will visually observe 5 residents to ensure their call lights are being answered and need addressed timely 5x per week for 4 weeks and 3x per week for 2 months. The Director of Nursing, Staff Development Coordinator, and or the Unit manager will visually observe the shower rooms for cleanliness and that soiled linen is removed 5xper week for 4 weeks than 3x per for 2 months. The Director of Nursing, Staff	

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F 565	Continued From page 3 the NA assignment sheets." Response form was completed by the ADON and signed by the by the administrator on 10/23/19. The Resident Council meeting minutes from November 1, 2019 specified concerns related to: A. Nursing Assistants (NA) not cleaning shower room after shower B. Ice water not being passed out to residents The facility's response for concern A was recorded as; "Reviewed in mandatory staff meeting in mid-November." Concern B response; "Reviewed in mandatory staff meeting. Unit managers and 2nd shift supervisor is doing rounds." Response form was completed by the ADON and signed by the by the administrator on 11/6/19. The Resident Council meeting minutes from December 6, 2019 specified concerns related to: A. Nursing Assistants (NA) not cleaning shower room after shower B. Ice water not being passed out to residents The facility's response for concern A was recorded as; "An In-service related to cleaning shower chairs will be completed." Concern B response; "The Unit manager and charge registered nurse are addressing and devising a plan." Response form was completed by the ADON and signed by the by the administrator on 12/11/19. The Resident Council Meeting Minutes from January 3, 2020 specified concerns related to: A. Nursing Assistants (NA) not cleaning shower room after shower B. Ice water not being passed out to residents on the 500 halls, all shifts The facility's response for concern A; "Addressed	F 565	development Coordinator, and/ or Unit Manager will visually observe 5 residents that they are receiving ice each shift and as needed 5x per for 4 weeks than 3xper week for 2 months. The Administrator will follow-up with the Resident Council President monthly x3 months to ensure resident council concerns or request are addressed timely. The Administrator will review Resident Council Departmental Responses form to ensure completion of resolution and will provide information to the Quality Assurance Performance Improvement committee monthly. The Administrator will present results of the visual audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance. Chiles Healthcare Consulting LLC has been contracted on March 9 2020 to completed Root Cause Analysis in regards to the Directed Plan of Correction. The Root Cause Analysis will be completed by 3/13/2020. On 3/16/2020 on site observations, interviews and training will begin.	

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by unit managers in unit NA meeting". Concern B response; "Unit managers have ice assigned to assignment sheet." Response form was completed by nursing and signed by the by the administrator on 1/3/20.

An interview with the resident council group was held on January 29, 2020 at 11:00 AM, and 23 residents attended the interview. During the interview, residents voiced concerns that the facility was not resolving grievances that were voiced during resident council meetings. Residents stated, "They act like they are interested, and nothing happens." "The showers are not cleaned, and they say they will jump right on it, but nothing gets done." "Call lights are being answered because you (meaning state surveyors) are here this week, as soon as you leave the building, it will go back to normal."

13 out of 23 residents that attended the resident group interview raised their hands to indicate the NA ' s will come into their rooms, turn off their call light and leave their room without addressing their concern.
An observation of the 500/600 shower room was completed on January 28, 2020 at 2:30 PM which revealed dry skin on the shower stretcher in the shower room.

An observation of the 300 shower room was complete on 1/29/20 at 10:00 AM. Gray colored grout was black in several areas. Loose black flaky particles were noted on the shower floor. The shower walls had long streaks of dried white drainage.

An observation of the 500/600 shower room was completed on January 28, 2020 at 4:00 PM. Dark

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black grout was observed on some of the floor tiles on one of the shower stalls. A white washcloth with dark brown spots was hanging on the shower curtain bar in a shower stall. A second wet wash cloth was wadded up and lying on the shower shelf in a stall, as well as dark black grout noted on some of the floor tiles.
An interview was completed with the Activities Director (AD) on 1/31/2020 at 11:04 AM. AD stated that she attends the meetings with one of the social workers. We will read over the old business and I will read the response sheet. If it is still an issue, we will put this as new business for the current meeting. AD stated that she fills out the form and gives the concern form to the appropriate department. I make a copy so I can track it. Departments have three days to get it back to me. AD stated they have had different departments come and speak at the resident council meeting

An interview was completed with the ADON on 1/31/20 at 9:40 AM who stated the process for the concern form from the resident council meeting is, the activity department fills out the forms and gives them to the appropriate department related to the concern. The appropriate department fills out the response and it goes to the administrator to review and sign and submitted to the activity department. For the nursing department it is either the Director of Nursing (DON) or the ADON that completes the response form. The ADON stated we discuss the concerns with the unit managers. I have brought the concerns to the staff meeting to discuss. Regarding the ice water it is assigned to each shift. When asked how she knows it is being completed the ADON stated she will walk around to check, and the residents have ice water.

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F 565	Continued From page 6 An interview was completed with the DON on 1/31/2020 at 6:07 PM. DON stated the concern forms from the resident council meetings are given to us by the AD and the DON or ADON we review the form. If it concerning one specific staff person, we will address it with them, if the concern is regarding a hall, nursing administration will complete an in-service. DON was asked how they track and trend the issue to see if it is being completed. DON stated that our unit managers have been watching to see if the tasks are being completed. "For example, first shift I know what two staff are assigned to waters and I will look at it". DON stated regarding call lights it is the expectation that it should not be turned off until the need is met. For example, if the business office manager is on the hall and she checks on someone who has their call light on, if she cannot meet the need she is to let a nursing assistant or nurse know what the need is. Sometimes, the residents may have to wait but the resident should be acknowledged letting them know they will be right back after they finish with their current task. An interview was completed with the Administrator on 01/31/2020 at 6:42 PM who stated, "when Resident Council fills out the response sheet, the department head gets the response sheet and I have to sign off in five days. My expectation is to follow up and the plan that has been put into place has worked." "Our staff has been in-serviced if they cannot take care of that call light, they need to leave it on and not to turn it off."	F 565		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		4/15/20

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F 600	Continued From page 7 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident, family and staff interviews the facility failed to protect a resident ' s right to be free from physical abuse for 1 of 1 resident investigated for staff to resident abuse (resident #73). Findings Included: Resident #73 was admitted to the facility on 11-29-18 with diagnoses which included Hemiplegia, Aphasia, and Deaf/ non-speaking. Resident #73 ' s annual Minimum Data Set assessment dated 12/2/19 specified the resident ' s cognition was severely impaired and required two- person physical assistance with Activities of Daily Living. Behaviors were coded as not present. Pain was assessed and coded for PRN medication only, not requiring a scheduled pain medication regimen.	F 600	1. The corrective action accomplished for resident #73. On March 22, 2019, the resident was assessed for injury. No injuries were noted, NA #7 was suspended immediately pending investigation, Other alert and oriented residents were interviewed by the RN Unit Manager regarding abuse, no negative findings, the Director of Nursing, and the Administrator were notified. A 24-hour report was completed and sent to the Health Care personnel Registry. On March 29, 2019 a 5-day report was completed and sent to the Health Care Personnel Registry. 2. Identify other residents who have the potential to be affected by the same deficient practice and the corrective actions taken. All residents are at risk for deficient practice. Interview able residents	

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Review of the initial allegation report dated 3/22/19 revealed Nursing Assistant (NA) #6 observed NA#7 slap resident #73 on the hand during care. NA #7 was immediately suspended pending an investigation. The incident was reported to have happened at 10:32 PM. Unit Manager on duty assessed Resident #73 ' s hand and found no injury to his hand including no bruising or redness.

A review of the Facility Investigation (5-day report) was completed and faxed to the Health Care Personnel Registry on 3/29/19. The Investigation report read in part, NA#7 gave her statement which read "that during care (Resident #73) tapped her hand to instruct her of pain and she asked him "why do you do that" and tapped his hand back. The statement from NA #6 who was in the room with NA #7 validated the above story but stated that after the accused "popped" his hand she stated to the resident #73, "you are not going to treat me like a damn child" (the accused, NA #7 denied making this statement). NA #6 asked NA #7 to leave the room and she reported the incident to her hall nurse and RN unit manager. Investigation report indicated all staff were educated on abuse. All alert and oriented residents on the same hall as Resident #73 were interviewed about abuse with no negative response gathered.

An interview was completed on 1/29/20 at 6:09 PM with NA #6 who witnessed the abuse. NA #6 stated she and NA #7 went to change resident #73. "We had to roll him, and NA #7 was being rough." Resident #73 popped NA #7 on her hand and NA #7 stated to the resident "you won ' t treat me like a damn child" and popped his hand back." NA #6 told NA #7 to leave the room. NA #6

F 600

were interviewed by the Social Worker and/or the Administrator asking questions regarding abuse on 2/18/20. No other concerns regarding abuse were voiced. On 2/12/20the Director of Nursing and/or the Unit Managers reviewed all non-interview able residents for changes in demeaner, behaviors along with body audits to ensure no signs of abuse were indicated. No other residents were found to be affected.

3. The facility is required to provide a safe environment for all residents along with prohibiting and preventing abuse, neglect, exploitation, and misappropriation of resident□s property. This is accomplished by written policy that include screening, training, prevention, identification, investigation, along with protecting and reporting. Education of all staff began on February 20, 2020 provided by the Director of Nursing and/or the Staff Development coordinated on the facility□s Abuse and Neglect policy. In addition to the abuse policy the education included on how to recognize abuse and neglect, exploitation, misappropriation, reporting and maintaining safety of the resident involved and providing medical and psychosocial interventions. Education also included signs of employee burnout and how employees can debrief with the Social Worker.

4. Monitoring of the corrective action to ensure the deficient practice will not reoccur: Beginning February 20, 2020 the Social Worker and/or the Administrator

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reported she finished changing resident #73 and then immediately told the nurse on her hall who in turn called the nurse supervisor. The nurse supervisor called the administrator.

An interview was completed on 1/29/2020 at 10:40 AM with Resident #73 and his family member. Resident #73 is non-verbal and deaf. Resident #73 understands words by reading lips and sign language. Family member was aware of the incident with NA #7 and understood that the she "got a little rough." Resident #73 communicated through his family member that he was not afraid of staff. Family member did state that he has been told that Resident #73 will "pop" staff if the care he is receiving causes him pain.

An interview was completed on 1/30/2020 at 8:51 AM with the Director of Nursing (DON) regarding the incident on 3/22/19. DON stated that she was notified regarding the allegation and she told her staff to obtain a statement and to suspend her during the investigation. DON contacted the administrator and the Assistant Director of Nursing. (ADON). The ADON was instructed to call the police, and the administrator completed the 24-hour report. DON stated that they do educate their staff if a resident is being combative the staff should step away and notify a nurse. DON stated Resident #73 will tap the staff and we have done training about residents who exhibit these behaviors and how to handle them.

A phone call was placed to NA #7 to discuss the incident, she was not available.

The Facility investigation report dated 3/29/19 substantiated the allegation. NA #7 was terminated on 4/1/19.

F 600

will interview 5 residents with a BIMs score above an 8 regarding any concerns regarding abuse. The residents with a BIMS score below an 8 the Director of Nursing, the Assistant Director of Nursing, and/ or the Unit Mangers will observe 5 residents with changes in demeaner or behaviors along with body audits to identify any signs of abuse. The Social worker will interview 5 staff members on the abuse policy, and regarding recognizing and reporting abuse. These audits / interviews will be conducted 5x per week for 4 weeks than 3x per week for 2 months. The Social Worker will report esults of audits will to the Quality Assurance performance Improvement committee monthly x3. The QAPI committee can modify plan to ensure the facility remains in compliance

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F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide written notification to the resident regarding bed hold when the resident was hospitalized for 2 of 2 residents reviewed for hospitalization (Resident #120 and 86). Resident #120 was readmitted to the facility on 11/18/2019 and Resident #86 was	F 625	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #120 was re-educated of the Bed Hold policy to make him aware that he should receive it anytime he is sent to the hospital. This re-education was	4/15/20

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readmitted to the facility on 12/27/2019.

Findings included:

1. Resident #120 was admitted to the facility on 10/05/2019 with diagnoses to include aspiration pneumonia, weakness and tremors. The admission Minimum Data Set (MDS) assessment dated 10/11/2019 assessed Resident #120 to be cognitively intact.

The medical record for Resident #120 revealed a nursing note written on 11/14/2019 that documented Resident #120 had been out with a family member on leave of absence and had been admitted to the hospital.

A social service note dated 11/15/2019 documented a phone call had been made to Resident #120 ' s family member to explain the bed hold policy.

A review of the electronic medical record and the hard chart for Resident #120 revealed no copy of a signed bed hold policy.

The quarterly MDS dated 11/25/2019 assessed Resident #120 to be cognitively intact and documented he was readmitted to the facility from an acute care hospital on 11/18/2019.

Resident #120 was interviewed on 1/27/2020 at 3:15 PM. Resident #120 reported he was admitted to the hospital on 11/14/2019 because he had chest pain.

Resident #120 was interviewed again on 1/30/2020 at 10:22 AM. Resident #120 reported he could not recall if he had been given a bed

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provided by the Social Worker on 2/18/20. Resident #86 has expired.

2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken. All residents are at risk. A 100% audit was completed by the Social Worker on February 21, 2020 of all residents discharged to the hospital within the last 30 days to verify if the resident or family member were given the Bed Hold policy.

3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur. The Administrator re-educated the Social Worker on the facility Bed Hold policy on February 21, 2020. The Social worker will be responsible in verifying the Bed hold policy was given to the resident and/or family member upon discharge to the hospital. The Director of Nursing and/or the Staff Development Coordinator Re-educated the licensed nursing staff on the facility Bed Hold policy and informing the Licensed nursing staff that it is their responsibility to send the Bed hold policy with the resident upon discharge to the hospital. This education was completed on February 21, 2020. New hire will receive education upon hire. All hospital discharges will be discussed 5x per week during morning meeting.

Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Social Worker will audit all discharges to the hospital to verify that a copy of the Bed Hold policy was given to the resident and/or family member. This audit will be completed 5xper week for 4

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F 625	Continued From page 12 hold notice from the facility when he was admitted to the hospital. The Social Worker was interviewed on 1/31/2020 at 9:14 AM and she reported she was not responsible for the bed hold policy to be sent with residents transferred to the hospital and the Unit Manager called the family or resident. An interview was conducted with Nurse #4 on 1/31/2020 at 11:29 AM. Nurse #3 reported she had not sent out a bed hold policy with any resident when they were transferred to the hospital. The Unit Secretary was interviewed on 1/31/2020 at 11:30 AM. The Unit Secretary reported she was responsible for printing forms for a resident if they were transferred to the hospital and she not aware a bed hold policy should be sent with residents when they are transferred to the hospital. The Unit Secretary reported she had not sent a bed hold policy with any resident when they were transferred to the hospital. An interview was conducted on 1/31/2020 at 11:31 AM with the Unit Manager. The Unit Manager reported the facility called the family about the bed hold policy when a resident was sent to the hospital, but the facility had not sent a copy with the resident. The Unit Manager reported the residents received a bed hold policy when they were admitted to the facility, but she was not aware a bed hold policy should be sent when they were discharged to the hospital. The Director of Nurses (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported she was not aware a resident should receive a bed	F 625	weeks than 3xper week for 2 months. The Social Worker will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance	

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hold policy when they are transferred from the facility to the hospital.

An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The Administrator reported he was not aware a copy of the bed hold policy should be given to residents upon transfer to the hospital.

2. Resident #86 was admitted to the facility 12/4/2019 with diagnoses to include congestive heart failure, diabetes and hypertension.

The discharge-return anticipated Minimum Data Set (MDS) dated 12/15/2019 documented Resident #86 was discharged to the hospital.

The most recent annual MDS assessment dated 1/2/2020 assessed Resident #86 to be cognitively intact. The MDS documented a reentry from the hospital on 12/27/2019.

A review of the electronic medical record and the hard chart for Resident #86 revealed no copy of a signed bed hold policy.

Resident #86 was interviewed on 1/27/2020 at 3:25 PM. Resident #86 reported he was discharged from the facility to the hospital on 12/15/2019 and he did not receive a copy of the facility ' s bed hold policy. Resident #86 reported the facility had called him to explain the bed hold policy and he was able to return to the facility without any issues.

The Social Worker was interviewed on 1/31/2020 at 9:14 AM and she reported she was not responsible for the bed hold policy to be sent with residents transferred to the hospital and the Unit

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Manager called the family or resident.

An interview was conducted with Nurse #4 on 1/31/2020 at 11:29 AM. Nurse #3 reported she had not sent out a bed hold policy with any resident when they were transferred to the hospital.

The Unit Secretary was interviewed on 1/31/2020 at 11:30 AM. The Unit Secretary reported she was responsible for printing forms for a resident if they were transferred to the hospital and she not aware a bed hold policy should be sent with residents when they are transferred to the hospital. The Unit Secretary reported she had not sent a bed hold policy with any resident when they were transferred to the hospital.

An interview was conducted on 1/31/2020 at 11:31 AM with the Unit Manager. The Unit Manager reported the facility called the family about the bed hold policy when a resident was sent to the hospital, but the facility had not sent a copy with the resident. The Unit Manager reported the residents received a bed hold policy when they were admitted to the facility, but she was not aware a bed hold policy should be sent when they were discharged to the hospital.

The Director of Nurses (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported she was not aware a resident should receive a bed hold policy when they are transferred from the facility to the hospital.

An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The Administrator reported he was not aware a copy of the bed hold policy should be given to

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F 625	Continued From page 15 residents upon transfer to the hospital.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F 636		4/15/20

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F 636	Continued From page 16 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete admission comprehensive Minimum Data Set (MDS) assessment 14 days after the assessment reference date (ARD) for 1 of 7 residents reviewed (Resident #21), failed to complete an annual MDS assessment 14 days after the ARD for 1 of 7 residents reviewed for resident assessment (Resident #110) and failed to complete Care Area Assessments (CAA) 14 days after the ARD for 2 of 7 residents reviewed for resident assessments (Resident #21 and #110). Findings included:	F 636	1. Corrective action was accomplished for those residents found to have been affected by deficient practice. The alleged deficiency occurred when the admission comprehensive minimum data set assessments and Care Areas were not completed in a timely manner for residents #21. The admission assessment was completed on February 21, 2019 and the Care area assessment was completed on February 21, 2019 by the Minimal Data set Coordinator. For resident #110 the Annual Minimal Data set was completed on July 18, 2019 and the care area	

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1. A. Resident #21 was admitted to the facility on 2/7/2019 with diagnoses to include diabetes and hypertension.

The admission Minimum Data Set (MDS) assessment for Resident #21 had an assessment reference date (ARD) of 2/14/2019 and the completion date was 2/21/2019.

The MDS coordinator was interviewed on 1/31/2020 at 1:34 PM and she reported the MDS for Resident #21 was completed prior to her working at the facility, but the admission MDS should have been completed on 2/20/2019.

The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM and she reported she was not aware the admission MDS for Resident #21 had been late.
The Administrator was interviewed on 1/31/2020 at 6:34 PM and he reported it was his expectation that MDS assessments were completed within the specified timeframe.

b. The Care Area Assessment (CAA) for the admission MDS dated 2/14/2019 for Resident #21 had a completion date of 2/21/2019.

The MDS coordinator was interviewed on 1/31/2020 at 1:34 PM and she reported the MDS for Resident #21 was completed prior to her working at the facility, but the admission MDS CAA ' s should have been completed on 2/20/2019.

The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM and she reported she was not aware the admission CAAs for Resident

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assessment was completed on July 18, 2019 the assessments were accurate and no changes were made to the assessments.

2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. All residents are at risk for deficient practice.
By February 20, 2020 the Minimal Data Set Coordinator audited current residents to ensure comprehensive assessments, and the care area assessments have been completed as scheduled for the past 30 days. No outstanding late assessments were found.

3. The Minimal Data set coordinator was re-educating by the Regional MDS Consultant on February 17, 2019 on the completion of the comprehensive assessment and the care area assessment timely based on the Resident Assessment Instrument. (RAI) manual. Any new hire Minimal Data Set Coordinator will be educated upon hire.

4. Monitoring of corrective Action to ensure the deficient practice will not reoccur.
The regional Minimal Data Set Coordinator will audit 3 residents that have scheduled comprehensive assessments weekly for 4 weeks and monthly for 2 months to ensure they are completed timely based on the RAI manual. This audit will be documented on

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#21 had been late.

The Administrator was interviewed on 1/31/2020 at 6:34 PM and he reported it was his expectation that CAAs were completed within the specified timeframe.

2. Resident #110 was admitted to the facility on 8/18/2014 with diagnoses to include pressure ulcer and muscle weakness.

A. The annual Minimum Data Set (MDS) assessment for Resident #110 had an assessment reference date (ARD) of 7/3/2019 and the completion dated was 7/18/2019.

An interview was conducted on 1/31/2020 at 1:34 PM with the MDS coordinator and she reported she was not aware Resident #110 ' s MDS was late and reported the annual assessment should have been completed on 7/16/2019. The MDS coordinator reported she had completed the MDS for Resident #110 and the late assessment was an oversight.

The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM and she reported she was not aware the MDS was late for the annual assessment for Resident #110.

An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM and he reported it was his expectation that MDS assessments were completed within the specified time frame.

B. The annual Care Area Assessment (CAA) for the annual MDS dated 7/3/2019 for Resident

an MDS audit tool.
The administrator will present the results of the audits to the quality assurance performance improvement committee (QAPI) for recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance.

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F 636	Continued From page 19 #110 had the completion date of 7/18/2019. An interview was conducted on 1/31/2020 at 1:34 PM with the MDS coordinator and she reported she was not aware Resident #110 ' s MDS was late and reported the CAAs should have been completed on 7/16/2019. The MDS coordinator reported she had completed the MDS for Resident #110 and the late assessment was an oversight. The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM and she reported she was not aware the CAAs were late for the annual assessment for Resident #110. An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM and he reported it was his expectation that MDS assessments were completed within the specified time frame.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 637		4/15/20

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by:

Based on observations, staff interviews and record review, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment to address a decline in Activities of Daily Living (ADL) and a significant weight loss for 1 of 8 residents (Resident #101) reviewed for significant change assessments.

Findings included:

Resident #101 was admitted to the facility on 11/11/19 with diagnoses that included dementia, adult failure to thrive, anorexia, difficulty walking, cognitive communication deficit, rheumatoid arthritis and major depressive disorder.

The resident's Admission MDS assessment dated 11/18/19 revealed Resident #101 was able to eat independently when her meal was set up. The resident's admission weight was noted as 137 pounds.

The resident's Quarterly MDS assessment dated 1/9/20 revealed Resident #101 required extensive assistance for eating with 1 person assistance and had experienced a 5% significant weight loss. The resident's weight was documented at 121 pounds on the MDS. The resident's weight loss from 137 pounds when admitted to 121 pounds as documented on the 1/9/20 quarterly MDS represented an 11.68% significant weight loss.

Resident #101's MDS assessments revealed a Significant Change in Status Assessment had not been completed to address the resident's significant weight loss and the decline in the resident's ability to eat.

F 637

1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice
Resident #101 significant change assessment completed and transmitted on 1/31/20
2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents are at risk for deficient practice, therefore, all current active resident□s Minimal Data Set (MDS) for the last 30 days were reviewed to determine if a significant change assessment was needed. Audit was conducted by the Minimal Data Set Coordinator (MDSC) for residents with a decline in ADLs and significant weight loss. Audit was completed on February 20, 2020 No other residents were identified

3. On February 17, 2020 the Minimal Data Set coordinator was re-educated by the Regional MDS Nurse Consultant regarding the guidelines used to determine whether a significant change assessment is required based on the resident assessment instrument (RAI) manual

4.Effective February 20,2020, to ensure the alleged practice does not recur include: In clinical meeting (Monday-Friday) both MDS nurses and morning clinical team will evaluate and

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F 637	Continued From page 21 An observation was completed on 1/28/19 at 12:30 AM of Resident #101 in the dining room. One of the resident's family members and staff were observed coaxing the resident to eat. She dosed off frequently, she woke up to her name being called and ate or drank when encouraged. An interview was completed on 1/29/20 at 3:00 PM with the facility's Registered Dietician (RD). She stated that she was concerned about Resident #101's weight loss and she had noted on the Kardex for the resident to be provided with feeding assistance on 1/14/20 and that staff were to cue the resident to eat. An interview was conducted on 1/31/20 at 1:30 PM with the MDS Coordinator. The significant change in the ADLs and Resident #101's weight loss was reviewed. She stated she had noticed that the Significant Change assessment was not completed. She stated that a significant change MDS assessment should have been completed for Resident #101 to address the resident's significant weight loss and decline in her ability to eat. On 1/31/20 at 6:01 PM an interview was completed with the Director of Nursing (DON) regarding the MDS assessment for Resident #101. She stated her expectations are that the MDS assessments are completed accurately and that significant change assessments are done timely. She stated that she was aware of the decline in ADL and the weight loss for Resident #101, but was not aware the MDS Significant change was not completed . An interview was completed with the Administrator on 1/31/20 at 6:42 PM regarding	F 637	compare current MDS that is being completed to the previous MDS to determine if a significant change has occurred. The daily 24-hour report will be reviewed by the Director of Nursing and MDS Coordinators Monday- Friday to determine if a resident has had a change in status that would warrant a significant change regarding MDS. Effective February 20, 2020 the Minimal Data set Coordinators will alternate on each other□s assessments by conducting ten random audits per week x□s 5 weeks then monthly x 3 months. If a significant change has occurred, the resident will be scheduled for a significant change assessment. This information will be documented on the significant change form. The MDS Nurse will present the results of the audit to the monthly Quality Assurance Performance Committee meeting monthly x3. The QAPI committee can modify this plan to ensure the facility remains in compliance	

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F 637	Continued From page 22 the MDS Significant Change Assessment for Resident #101 not being completed. He stated that his expectation was that MDS assessments would be completed correctly.	F 637		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interview the facility failed to maintain a hazard free environment by not removing accumulated dried leaves from the designated resident outdoor smoking patio for 1 of 1 sampled resident reviewed for smoking. (Resident #32) Findings Included: Resident #32 was admitted to the facility on 6/30/17. The Minimum Data Set of 11/11/19 coded the resident as being cognitively intact. Record review for Resident #32 revealed she was evaluated for smoking on a regular basis (11/6/19, 8/26/19, 7/24/19 and 7/4/19) and required supervision. The resident was care planned on 11/11/19 regarding smoking. The care plan dated 11/11/19 indicated the following: Patient may smoke with supervision per smoking assessment.	F 689	1. Corrective actions accomplished for residents found to be affected by the deficient practice. On 1/31/20 the dried leaves were removed from the patio, the 10-cigarette butts were removed from the patio. 2. Identify other residents who have the potential to be affected by deficient practice and what actions were taken. All residents who smoke are at risk for deficient practice. 3. Measure/systemic changes put in place to ensure the deficient practice does not reoccur. Effective on February 20, 2020 the Social worker provided re-education for the residents who uses the facility smoking area on safe smoking practices. Residents were re-educated to use the metal smoking receptacle to depose of cigarette ashes and Butts. Re-education	4/15/20

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F 689	Continued From page 23 An observation on 1/28/20 at 3:45 p.m. of the designated smoking area revealed several dried leaves on the patio area under the tent where residents smoked. In addition, the metal receptacle where the residents of their cigarette butts was sitting approximately two inches away from dried leaves. An observation of Resident #32 smoking on 1/28/20 at 4:00 p.m. was conducted. Resident #32, who was a supervised smoker, was sitting under the tent in the designated smoking patio with Nursing Assistant (NA) #11. Under the tent were several dried leaves on the ground approximately two inches away from the metal receptacle where the residents disposed of their cigarette butts. As Resident #32 smoked a cigarette she was observed to flick her ashes in the metal receptacle. The resident ' s cigarette ashes landed in the metal receptacle. NA #11 was sitting in a chair next to Resident #32 conversing with her. Observations on 1/29/20 at 8:38 a.m. and on 1/31/20 at 9:20 a.m. of the designated smoking area revealed several dried leaves on the patio area under the tent where residents smoke. The metal receptacle where the residents dispose of their cigarette butts was sitting approximately two inches from the dried leaves. No smokers were present on the patio. The smoking area had not been cleared of dried leaves. An observation on 1/31/20 at 10:50 a.m. of the designated smoking area revealed several dried leaves on the patio area under the tent where residents smoke. The metal receptacle where the residents dispose of their cigarette butts was	F 689	beginning on February 20, 2020 was provided by the Director of Nursing and /or the Staff Developing coordinated for all staff regarding safe smoking practices for the residents. Staff was educated to report to the maintenance director and/or the assistant maintenance director if dried leaves or pine needles are located near the smoking metal receptacles while in the resident smoking area. Staff was also educated to remind the residents to depose of ashes and cigarette butts in the metal smoking receptacles. The maintenance director and /or the assistant director maintenance director will clean the smoking area 3xper week and as needed of dried leaves and pine needles. 4. Monitoring of the corrective action to ensure the deficient practice does not reoccur: The maintenance director and /or the assistant maintenance director will monitor the resident smoking area for dried leaves or pine needles located near the metal smoking receptacles 5x per week for 4 weeks than 3x per week for 2 months and remove any dried leaves or pine needles if observed. The maintenance director will present the results of the audit to the Quality Assurance Performance Improvement Committee monthly x3 months. The QAPI committee can modify plan to ensure the facility remains in compliance.	

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F 689	Continued From page 24 sitting near the dried leaves. In addition, 10 used cigarette butts were observed lying in the pine needles to the right of the exit door where residents smoke. During an interview with Resident #32 on 1/28/20 at 4:00 p.m. she stated the residents were not allowed to smoke near the pine needles as they could ignite. Resident #32 stated the times that she could smoke were at 9:00 AM, 11:00 AM, 2:00 PM, 4:00 PM, 6:30 PM and 8:30 PM. She stated she was allowed two cigarettes per 20 minutes per smoking times. An interview on 1/31/20 at 11:00 a.m. with the Assistant Maintenance Director (AMD) who stated, "the yard crew comes and blows the leaves weekly." "I guess we should be blowing the leaves off the patio (the resident smoking area)". The AMD stated housekeeping empties the metal receptacle. The Administrator was interviewed on 1/31/20 at 6:42 p.m. The Administrator stated, "Environmental Services (housekeeping) is probably responsible for cleaning off the patio (resident smoking area)." He stated visitors can smoke in the resident ' s smoking area if they are visiting a resident who was assessed as being able to smoke.	F 689		
F 695 SS=E	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		4/15/20

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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 record reviews, observations and staff interviews, the facility failed to clean filters on oxygen concentrators for 5 of 5 residents reviewed for oxygen therapy (Residents # 18, 41, 79, 89 and 108).

Findings included:

1. Resident #108 was admitted to the facility 11/18/2019 with diagnoses to include chronic obstructive lung disease, diabetes and arteriosclerotic heart disease. The most recent quarterly Minimum Data Set assessment dated 1/10/2020 assessed Resident #108 to be cognitively intact and used oxygen.

Physician orders for Resident #108 dated 1/27/2020 for oxygen 4 liters per minute by nasal cannula.

A physician order dated 1/27/2020 for Resident #108 directed to clean the filter on the oxygen concentrator weekly on Wednesday night shift. The medication administration record documented 1/29/2020 as completed by evidence of the nurse ' s initials.

Resident #108 was observed on 1/30/2020 at 12:08 PM wearing a nasal cannula and oxygen was infusing at 4 liters per minute. The observation was made with the Respiratory Therapist (RT). The filter on the oxygen concentrator was covered with fluffy grey material

Provider's Plan of Correction:

1. The corrective action will be accomplished for the residents found to have been affected by the deficient practice. On 1/2/30/20the filters on the oxygen concentrators were removed and cleaned for residents # 18, 41, 79,89, and108. Nurses #1 and #5 were re-educated on providing oxygen therapy for residents and that the filters on the concentrators must be cleaned weekly on February 20, 2020 by the Staff Development Coordinator.
2. All residents currently on oxygen therapy, 9 residents, are at risk for the deficient practice. By February 21, 2020 a 100% audit was performed by the Unit Manager and/or the Director of Nursing identifying residents currently on oxygen therapy per physician orders oxygen contractor filter was observed for cleanliness. Those found not to be clean were removed and cleaned and placed back in oxygen concentrator.
3. The following measures were put in place by February 20, 2020 to ensure the Plan of Correction is effective and remains in compliance. All Licensed Nursing staff were re-educated by the Director of Nursing and/or the staff development coordinator to ensure all residents who require oxygen therapy are provided the necessary services needed to maintain and receive oxygen in

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F 695	Continued From page 26 imbedded in the material of the filter. The RT reported the filter was dirty. The RT was interviewed on 1/30/2020 at 12:27 PM and she reported she was not responsible for cleaning the filters on resident ' s oxygen concentrators. The RT reported dirty air filters on oxygen concentrators were a fire hazard and the dust can cause respiratory irritation for residents. The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported that staff were signing off cleaning the filters and if the filters were dirty, the staff were not cleaning the filters. The DON reported all staff received an in-service on oxygen concentrators and cleaning the filters in 2019. The DON reported it was her expectation the oxygen concentrator filters were cleaned as ordered. An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The Administrator reported it was his expectation the oxygen concentrator filters were cleaned once per week. 2. Resident #89 was admitted to the facility 9/28/2018 with diagnoses to include chronic obstructive lung disease, hypertension and atrial fibrillation. The most recent quarterly Minimum Data Set assessment dated 1/3/2020 assessed Resident #89 to be cognitively intact. The physician orders for Resident #89 were reviewed. An order dated 12/24/2019 for oxygen 2 liters per minute by nasal cannula as needed for shortness of breath was noted. No orders were found in Resident #89 ' s chart to	F 695	accordance with the physician order by ensuring the concentrator filter is clean and free of fluffy gray material. An order must be placed on MAR or TAR to clean the oxygen concentrator filter weekly. The filter must be cleaned weekly. New hire will be educated upon hire. 4. Monitoring: Progress of daily audits are discussed in morning stand -up meeting with the interdisciplinary team. Beginning February 21, 2020, the Unit Manager and/or the Director of nursing will audit 5 residents daily requiring oxygen therapy to verify the oxygen concentrators filters are clean. This audit will occur 5x weekly for 4 weeks, then 3 times weekly for 2 months. The results of audits will be discussed monthly in the Quality Assurance and performance improvement committee meeting by the Director of Nursing for 3 months. The QAPI committee can make changes to plan to ensure facility compliance.	

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clean the filter on the oxygen concentrator.

Resident #89 was observed on 1/30/2020 at 12:12 PM wearing a nasal cannula and oxygen was infusing at 2 liters per minute. The observation was made with the Respiratory Therapist (RT). The filter on the oxygen concentrator was covered with fluffy grey material imbedded in the material of the filter. The RT reported the filter was dirty.

An interview was conducted with Resident #89 on 1/30/2020 at 12:12 PM. Resident #89 reported she had not observed staff cleaning the filters on the oxygen concentrator.

The RT was interviewed on 1/30/2020 at 12:27 PM and she reported she was not responsible for cleaning the filters on resident ' s oxygen concentrators. The RT reported dirty air filters on oxygen concentrators were a fire hazard and the dust can cause respiratory irritation for residents.

The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported that staff were signing off cleaning the filters and if the filters were dirty, the staff were not cleaning the filters. The DON reported all staff received an in-service on oxygen concentrators and cleaning the filters in 2019. The DON reported it was her expectation the oxygen concentrator filters were cleaned as ordered.

An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The Administrator reported it was his expectation the oxygen concentrator filters were cleaned once per week.

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F 695	Continued From page 28 3. Resident #18 was admitted to the facility on 12/5/2018 and readmitted 4/1/2019. The most recent quarterly Minimum Data Set assessment dated 1/22/2020 assessed Resident #18 to be cognitively intact and to use oxygen. The physician orders for Resident #18 were reviewed and an order dated 12/23/2019 ordered oxygen at 2 liters per nasal cannula to be administered continuously. No orders were found in Resident #89 ' s chart to clean the filter on the oxygen concentrator. Resident #18 was observed on 1/28/2020 at 1:31 PM. Resident #18 had oxygen running at 2 liters per minute by nasal cannula. The filter on the oxygen concentrator was covered with a fluffy grey material. An observation of Resident #18 ' s oxygen concentrator was completed on 1/30/2020 at 12:16 PM with the Respiratory Therapist (RT). The filter on the oxygen concentrator was covered with fluffy grey material imbedded in the material of the filter. The RT reported the filter was dirty. An interview was conducted with Nurse #5 on 1/30/2020 at 12:18 PM and she reported the filters on oxygen concentrators should be removed and cleaned weekly. Nurse #5 reported she had not noticed the oxygen concentrator filters were dirty. The RT was interviewed on 1/30/2020 at 12:27 PM and she reported she was not responsible for cleaning the filters on resident ' s oxygen concentrators. The RT reported dirty air filters on	F 695		

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oxygen concentrators were a fire hazard and the dust can cause respiratory irritation for residents.

The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported that staff were signing off cleaning the filters and if the filters were dirty, the staff were not cleaning the filters. The DON reported all staff received an in-service on oxygen concentrators and cleaning the filters in 2019. The DON reported it was her expectation the oxygen concentrator filters were cleaned as ordered.

An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The Administrator reported it was his expectation the oxygen concentrator filters were cleaned once per week.

4. Resident #41 was admitted to the facility on 3/31/2016 with diagnoses to include asthma, heart failure and Alzheimer ' s disease. The most recent quarterly Minimum Data Set assessment assessed Resident #41 to be severely cognitively impaired and to use oxygen.

The physician orders for Resident #41 were reviewed and order dated 12/19/2019 for oxygen as needed at 2 liters per minute.

A physician order for Resident #41 directed to clean the filter on the oxygen concentrator weekly on Wednesday night shift dated 2/20/2019 was noted. The medication administration record documented 1/29/2020 as completed by nurse ' s initials.

The oxygen concentrator for Resident #41 was observed on 1/27/2020 at 10:00 AM. The filter on

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the oxygen concentrator was covered with a fluffy grey material.

An observation of Resident #41 ' s oxygen concentrator was completed on 1/30/2020 at 12:18 PM with the Respiratory Therapist (RT). The filter on the oxygen concentrator was covered with fluffy grey material imbedded in the material of the filter. The RT reported the filter was dirty.

An interview was conducted with Nurse #5 on 1/30/2020 at 12:18 PM and she reported the filters on oxygen concentrators should be removed and cleaned weekly. Nurse #5 reported the oxygen concentrator was very dusty and dirty and needed to be cleaned. Nurse #5 reported she had not noticed the oxygen concentrator filters were dirty.

The RT was interviewed on 1/30/2020 at 12:27 PM and she reported she was not responsible for cleaning the filters on resident ' s oxygen concentrators. The RT reported dirty air filters on oxygen concentrators were a fire hazard and the dust can cause respiratory irritation for residents.

The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported that staff were signing off cleaning the filters and if the filters were dirty, the staff were not cleaning the filters. The DON reported all staff received an in-service on oxygen concentrators and cleaning the filters in 2019. The DON reported it was her expectation the oxygen concentrator filters were cleaned as ordered.

An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The

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Administrator reported it was his expectation the oxygen concentrator filters were cleaned once per week.

5. Resident #79 was admitted to the facility on 1/19/2018 with diagnoses to include chronic obstructive lung disease, sleep apnea and diabetes. The most recent quarterly Minimum Data Set assessment dated 1/17/2020 assessed Resident #79 to be moderately cognitively impaired and to use oxygen.

A physician order dated 1/25/2018 for Resident #79 ordered oxygen at 2 liters per minute by nasal cannula to be administered continuously.

No orders were found in Resident #89 ' s chart to clean the filter on the oxygen concentrator.

An observation of Resident #79 ' s oxygen concentrator was completed on 1/30/2020 at 12:22 PM with the Respiratory Therapist (RT). The filter on the oxygen concentrator was covered with fluffy grey material imbedded in the material of the filter. The RT reported the filter was dirty.

An interview was conducted with Nurse #1 on 1/30/2020 at 12:22 PM and she reported the filters on oxygen concentrators should be removed and cleaned weekly. Nurse #1 reported the oxygen concentrator was very dusty and dirty and needed to be cleaned. Nurse #1 reported she was not aware Resident #79 ' s oxygen concentrator filter was dirty.

The RT was interviewed on 1/30/2020 at 12:27 PM and she reported she was not responsible for

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F 695	Continued From page 32 cleaning the filters on resident ' s oxygen concentrators. The RT reported dirty air filters on oxygen concentrators were a fire hazard and the dust can cause respiratory irritation for residents. The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported that staff were signing off cleaning the filters and if the filters were dirty, the staff were not cleaning the filters. The DON reported it was her expectation the oxygen concentrator filters were cleaned as ordered. An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The Administrator reported it was his expectation the oxygen concentrator filters were cleaned once per week.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		4/15/20

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F 761	Continued From page 33 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep medications secure by leaving two medications on top of an unattended medication cart for 1 of 2 medication hall carts observed (600 hallway medication cart). Findings included: Observations on 1/30/20 at 9:20 AM revealed Nurse #5 was administering medications to residents from the 600 hallway medication cart. At 9:25 AM Nurse #5 left the medication cart unattended on the 600 hallway to administer medications in a resident's room. Nurse #5 left two medications unsecured on top of the unattended medication cart when she went to administer medications in a resident's room. The unsecured medications on top of the medication cart were a bottle of Baclofen suspension 5 milligrams/milliliter and a pill card with 14 daily dose packets of Namzaric 14milligrams-10milligrams capsules. The unattended medication cart was out of the nurse's view while she was in the resident's room. At 9:35 AM Nurse #5 returned to the medication cart and residents were observed in close proximity to the medication cart. Observations on 1/30/20 at 9:40 AM revealed	F 761	1. Corrective actions accomplished for those residents found to have been affected by deficient practice. On January 30, 2020 the unattended medications observed on the 600-hall medication cart (Baclofen and Namzaric) were remove immediately. On January 30, 2020 Nurse #5 was reeducated on medication storage by the Staff development coordinator. The nurse was re-educated do not leave medication unattended on top of the mediation carts. 2. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. All residents are at risk for deficient practice. By February 20, 2020 a complete observation of all resident care areas was observed for inappropriate storage of medication (unattended medication medications left on top of medication cart) and all inappropriately storing of medications in reach of any residents. This audit was completed by the Director of nursing, the Assistant Director of Nursing and /or the Unit Manager. No other areas of concerns were observed. 3. Measures/ systemic changes put in	

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Nurse #5 left the medication cart unattended on the 600 hallway with the Baclofen and Namzaric medication still unsecured on top of the cart. The medication cart was out of Nurse #5's view when she administered medications in a resident's room on the 600 hall. A resident was observed sitting in front of the unattended medication cart. At 09:55 Nurse #5 was observed to return to the medication cart.

During an interview with Nurse #5 on 1/30/20 at 3:10 PM she stated she left the Baclofen medication on top of the medication cart to keep her from having to go to the refrigerator to get the Baclofen. She further stated that the 14 doses of Namzaric that were in the monthly pill pack had been discontinued. So, she pulled the Namzaric out of the medication cart drawer and placed it on top of the medication cart to remember to send the pack of medication back to the pharmacy.

During an interview with the Director of Nursing (DON) on 1/31/20 at 8:54 AM stated the 2 medications that were left on top of the unattended medication cart by Nurse #5 should have been secured in a locked cart or placed in the locked medication storage room. She stated that medications should not be left on top of the medication cart anytime the nurse walks away from the medication cart and leaves the medications unattended.

An interview was completed with the Administrator on 1/31/20 at 6:42 PM regarding the medication administration process and failure to ensure medications were stored securely. He stated he expected medication storage guidelines to be followed.

F 761

place to ensure the deficient practice does not reoccur. Beginning February 20.2020, the Director of Nursing and /or the Staff development coordinator re-educated the licensed nursing staff on the proper medication storage process. All medications must be stored in a locked medication cart or medication room in all resident care areas when unattended, and only authorized personnel have access to the keys to the medication rooms and the medication carts.

4. Monitoring of corrected actions to ensure the deficient practice will not reoccur. To ensure that medications are properly stored and locked in the medication carts and/ or medication rooms when unattended. The Director of Nursing and/or the Unit Manager will audit using an auditing tool 5x per week for 4 weeks and 3x per week for 2 months for compliance. The Director of Nursing will report findings of audits to the Quality Assurance Performance improvement committee meeting monthly x3 months. The QAPI committee can make changes to ensure facility compliance of deficient practice.

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F 806	Continued From page 35	F 806		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interview and record review the facility failed to ensure resident food preferences were honored and soft foods as preferred were served at meals for 2 of 8 residents reviewed for food preferences (Resident #112 and Resident #60). Findings included: 1. Resident #112 was admitted to the facility on 4/24/2012 with diagnoses of chronic obstructive pulmonary disease and diabetes. An Annual Minimum Data Set (MDS) Assessment dated 1/14/2020 revealed Resident #112 was cognitively intact and required only set up assistance with her meal trays. An observation of Resident #112's lunch meal tray being served on 1/29/2020 at 12:51 PM revealed she was served turkey with gravy, dressing, peas, and chocolate cake with white frosting. Nurse Aide #1 delivered Resident #112's tray and began was cutting up her turkey.	F 806	1. Corrected actions accomplished for those residents found to have been affected by the deficient practice. Resident #112 the Dietary Manager met with the resident on 1/30/20to verify likes and dislikes and to update preferences on the tray card and to ensure that resident does not receive turkey or fish. The Administrator re-educated the Dietary Manager on honoring food preferences and updating tray card slips as needed on 1/30/20. Resident # 60 a dietary communication form regarding changing diet to a soft diet was delivered to dietary on 1/30/20. Nurse #3 was re-educated by the Staff development Coordinator on 1/30/20 to always complete a dietary communication form and give to dietary when there is a change in a resident□s diet. On January 29, 2020 resident #60 received a soft diet tray 2. Identify other residents who have the potential to have been affected by the	4/15/20

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F 806

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Resident #112 stated she did not eat turkey and it was recorded on the dislikes listed on her tray card. Nurse Aide #1 offered Resident #112 the alternate meal and Resident #112 stated "they just keep sending turkey to me." Review of the meal tray card for this meal revealed turkey and fish were two to the foods Resident #112 disliked.

During an interview with Nurse Aide #1 on 1/29/2020 at 2:26 PM she stated Resident #112 does not like turkey or fish and they are both listed on her meal tray card under dislikes. Nurse Aide #1 stated this was the second time recently the kitchen sent turkey to Resident #112 and she had to return the tray to them for an alternate meal. Nurse Aide #1 stated the dislikes are listed on the meal tray card and the kitchen should review it when preparing Resident #112's meal.

On 1/30/2020 at 2:31 PM an interview with Nurse #3 indicated she was aware Resident #112 did not eat turkey or fish, but she had not been told by the Nurse Aides she had received turkey or fish on her meal trays. Nurse #3 stated the dietary slips served with resident meals list each resident's likes and dislikes and the dietary staff should review the dietary slips when preparing Resident #112's tray and not serve turkey or fish..

The Administrator stated during an interview on 1/31/2020 at 6:21 PM the Dietary Manager goes to each resident at their admission to the facility and obtains their likes and dislikes regarding food choices and any time a resident has a complaint regarding their food choices. The Administrator stated the residents should not receive any foods they have informed staff they do not like.

2. Resident #60 was admitted to the facility on

F 806

same deficient practice and what corrective actions were taken. All residents are at risk therefore a 100% audit to verify diet orders and ensure the residents are receiving diets as ordered was completed by the dietary manager on February 21, 2020 and the dietary manager reviewed, an updated residents□ food preferences with residents and family members and updated tray card slip by February 21, 2020.

3. Measure/systemic changes put in place to ensure the deficient practice does not reoccur. The Dietary Manager Re-educated the dietary staff on honoring food preferences according to likes and dislikes listed on tray card slip and to serve diets as ordered. This re-education was completed on February 21, 2020. This education will be provided upon hire with new hires.
Re-education provided by the Director of Nursing and/or the staff developing coordinator for the Certified Nursing Assistants and the Licensed nurses on providing diets as ordered, offering substitutes, following and honoring food preferences listed on the dietary tray slip, and completing the dietary communication form when there is a change in a diet order. This education was completed on February 21, 2020. This education will be provided upon hire with new hires. The Interdisciplinary team will review diet changes during morning meeting and verify that dietary communication forms are completed upon changes in diet and with new admissions.

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10/14/17 with diagnoses of stroke and weakness.

The physician's orders revealed Resident #60 had a regular, liberalized diabetic diet order dated 10/10/17. No other diet orders were found.

A recent Minimum Data Set (MDS) Quarterly Assessment dated 1/22/2020 revealed Resident #60 was cognitively intact and required set up assistance with her meal tray.

The Nurse's Notes revealed a note written by Nurse #3 dated 1/23/2020 at 2:44 PM that stated Resident #60 returned form the dentist and had 4 teeth pulled. The Nurse's Note further stated the resident complained of mild soreness to her mouth and a soft/liquid diet was ordered.

During an interview with Resident #60 on 1/28/2020 at 9:06 AM she stated she had requested a soft diet because she had mouth pain from the dental work on 1/23/2020. Resident #60 stated they brought her hard cereal for breakfast and the Nurse Aide told her to let the cereal soften up with milk. Resident #6 stated she tried to eat the hard cereal but was unable to chew the cereal because it hurt her mouth and she asked staff to bring her grits.

On 1/29/2020 at 8:10 AM an observation of Resident #60 revealed she was sitting up in bed and Nurse Aide #1 delivered her breakfast meal tray to her. Resident #60 stated she could not eat the hard cereal that was served on her tray because she had recently had dental work. Nurse Aide #1 told the resident there was a banana on her tray that was soft. Resident #60 stated she needed something soft to eat. Nurse Aide #1 stated she would see what was available

F 806

4. Monitoring of corrected actions to ensure the deficient practice will not reoccur.
The Dietary Manager and/or the Administrator will visually audit the tray line during meals to verify that the dietary staff is reviewing the tray cards honoring food preferences and providing diets as ordered. This auditing will be completed 5x per week for 4 weeks and 3xper week x2 months.
The Dietary manager will present the results of the audit to the monthly Quality Assurance Performance Improvement committee for 3 months. The QAPI committee can make changes to ensure the facility remains in compliance.

The Director of Nursing, Assistant Director of nursing and/or the unit manager will visually audit new orders to and verify that dietary communication forms are completed and sent to dietary with any changes in diet. This audit will be completed 5x per week for 4 weeks and 3x per week for 2 weeks. The Director of Nursing will present the results of this audit to the Quality Assurance Performance improvement committee monthly x3 months. The QAPI committee can make changes to ensure the facility remains in compliance.

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from the kitchen that was soft. Nurse Aide #1 went out into the hallway and spoke with the Dietary Manager. The Dietary Manager stated she would get Resident #60 a soft breakfast meal.

The Dietary Manager was interviewed on 1/29/2020 at 8:10 AM and stated she was not aware Resident #60 needed a soft meal tray due to her recent dental work. The Dietary Manager stated a Dietary Communication Form had not been sent to the kitchen regarding Resident #60's request for a soft diet.

An interview with Nurse Aide #2 on 1/29/2020 at 10:36 AM revealed she usually cared for Resident #60 on her assignment. Nurse Aide #2 stated she knew Resident #60 had oral surgery two weeks ago. Nurse Aide #2 stated Resident #60's family member brought her back from the oral surgeon and told the kitchen she was to have a soft diet that night. Nurse Aide #2 stated she thought Nurse #3 had completed a Dietary Communication Form regarding the change in diet for that night.

During an interview with the facility's Registered Dietician on 1/29/2020 at 3:52 PM she stated Nurse #3 had written a Nurse's Note that stated she had ordered a soft liquid diet after Resident #60's dental appointment for that evening (1/23/2020) only. But there was no order found on the resident's medical record to change the resident's diet to a soft diet.

During an observation of Resident #60 on 1/30/2020 at 8:30 AM she again received hard cereal and a banana on her breakfast tray. She asked the Nurse Aide, who served the breakfast

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F 806	Continued From page 39 meal tray, to bring her oatmeal because she could not chew the hard cereal that she was served. During an interview with Nurse #3 on 1/30/2020 at 2:32 PM she stated the Nurse Aides did not let her know Resident #60 had continued to request soft foods after the evening she returned from the oral surgeon and Resident #60 had not complained about needing soft foods to her. Nurse #3 stated she had sent a Dietary Communication Form to the kitchen for Resident #60 to receive a soft liquid diet for 1/23/2020 after she returned from the Oral Surgeon's office. Nurse #3 stated the Oral Surgeon stated Resident #60 should not have continued to have pain after the evening of the oral surgery. The Director of Nursing was interviewed on 1/31/2020 at 5:35 PM and stated on 1/23/2020 the nursing staff should have filled out a Dietary Communication Form and sent it to the Dietary Department regarding Resident #60's request to have a soft diet. The Director of Nursing stated Nurse #3 should have obtained an order to continue the soft diet when Resident #60 continued to request it. During an interview with the Administrator on 1/31/2020 at 6:31 PM he stated the nursing staff should ensure resident's choices regarding dietary preferences are communicated to the dietary staff and an order should be obtained for any changes in the resident's diet if it is needed. The Administrator stated Resident #60's choice to receive a soft diet should have been honored.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/15/20

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F 812	Continued From page 40 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on staff interviews, observation, and record review the facility failed to clean or sanitize a thermometer which was used to check the internal temperatures of foods that were to be served to resident during 1 of 2 meals observed. The facility also failed to ensure the kitchen's dish machine reached minimum temperatures during the wash and rinse cycles to effectively clean and sanitize items washed in the machine. This had the potential to affect 119 of 119 residents who ate meals at the facility. Findings included: 1. An observation of the Main Dining Room serving area during lunch on 1/27/2020 at 12:22 PM revealed Dietary Aide #1 used a thermometer to check the internal temperatures of foods that	F 812	1. Corrective action had taken place in regard to the dishwasher maintaining appropriate temperatures for wash and rinse cycles on 1/29/20. Antiseptic wipes were provided for Dietary Aide #1 on 1/31/20 to ensure proper procedure in obtaining food temperatures. 2. Antiseptic wipes have been provided for all 3 dining rooms to ensure proper procedure in obtaining of food temperature. A daily temperature log has been put into place on 2/28/2020 to be utilized for dish washing machines to ensure appropriate temperature for wash and rinse cycles. Dietary Manager will check daily to ensure antiseptic wipes are available in the dining rooms. The Dietary	

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were to be served to the residents from the tray line. Dietary Aide #1 stated she checked the temperature of foods before each meal was served to ensure they are at the proper temperature. Observations of Dietary Aide #1 using the thermometer to check each food in the steam table revealed after she obtained the temperature of each food item she rinsed the thermometer's temperature probe in water and dried it with a paper towel. Dietary Aide #1 was not observed to use anything to clean or sanitize the thermometer's probe while using it to check the food temperatures.

An interview was conducted with Dietary Aide #1 on 1/29/2020 at 9:48 AM. Dietary Aide #1 stated she checked the temperature of each food in the steam table before she served the food to the residents. Dietary Aide #1 stated she washed the thermometer with water and hand soap in the hand washing sink between each food as she checked the food temperatures. Dietary Aide #1 stated she did not have antiseptic wipes available to use in the main dining room to sanitize the thermometer, but she was aware she should use the antiseptic wipes to clean the thermometer before using the thermometer to take food temperatures and between foods when checking food temperatures.

During an interview with the Dietary Manager on 1/29/2020 at 11:46 AM she stated Dietary Aide #1 should have cleaned the thermometer with antiseptic wipes before she began checking the temperature of the foods on the steam table and between each individual food she checked. Dietary Manager also stated she should have ensured the antiseptic wipes were available to Dietary Aide #1 in the Main Dining Room to utilize

F 812

Manager will ensure the dish washer temperatures will be maintained on a log and if temperatures are not within regulation maintenance personal will be immediately notified.

3. Dietary Manager to in-service staff on proper procedure in obtaining food temperatures, logging dish washer machine temperatures and process for notifying maintenance staff in the event of faulty equipment.

4. Dietary Manager/ designee will audit dish machine temperatures daily and notify maintenance if temperatures are not in compliance for 4 weeks and then check log weekly for 2 months and report findings to QAPI. Dietary Manager/ designee to randomly audit dining rooms to ensure antiseptic wipes are available 5 X weekly for 3 months and report findings to QAPI. The QAPI committee can make changes to ensure the facility remains in compliance

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to clean and sanitize the thermometer when she checked the food temperatures on the steam table.

The Administrator was interviewed on 1/31/2020 at 6:31 PM and stated Dietary Aide #1 should have cleaned the thermometer and then sanitized the thermometer with an antiseptic wipe before she used the thermometer and between each food when she checked food temperatures in the Main Dining Room serving area.

2. An observation of the kitchen on 1/29/2020 at AM 7:35 AM revealed the dietary staff, including dietary Aide #2, were actively washing dishes in the kitchen's dish washing machine. Dishes were observed going through the dish machine and staff were storing dishes for use. Observation of the dish washing machine's wash cycle and rinse cycle temperature gauges revealed they were both registering zero. The machine's wash temperature gauge stated the temperature should be at 160 degrees during the wash cycle and the machine's rinse temperature gauge stated the temperature should be at 180 degrees during the rinse cycle. Dietary Aide #2 stopped the dish washing machine and notified the Dietary Manager the dish machine was not reaching its minimum temperatures during the wash and rinse cycles.

Dietary Aide #2 stated during an interview on 1/29/2020 at 10:11 am she had not noticed the dish machine's gauges for the wash and rinse temperatures were not registering temperatures. Dietary Aide #2 also stated she should have checked the temperatures while washing dishes in the machine this morning but had not.

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The Dietary Manager stated during an interview on 1/29/2020 at 11:46 AM Dietary Aide #2 should have checked the dish machine's gauges for the wash and rinse cycles as she was washing dishes. The Dietary Manager stated there had not been any issues with the dish washing machine but a new hot water tank was added recently. The Dietary Manager also stated the staff had not refilled the hot water tank this morning and that was the reason the water in the dish washing machine did not heat up. The Dietary Manager stated Dietary Aide #2 was educated on how to open and close the tank and how to operate the dish machine recently. The Dietary Manager stated the dish machine minimum wash and rinse temperatures are noted on the wash and rinse gauges on the machine, and the temperature should reach at least 160 degrees for wash cycle and 180 degrees for rinse cycle.

During an interview with the Maintenance Director on 1/30/2020 at 9:14 AM he stated a booster heater was a separate machine that was mounted to the wall above the dish washer that boosted the temperature of the rinse water to the dish washing machine. He stated the booster heater was not required but the facility had it installed about 5 years ago to ensure the water temperature remained consistent. The Maintenance Director stated the dietary staff had turned the fill valve on and forgot to close it and that was the reason the dish washing machine did not have any hot water during the morning of 1/29/2020. He stated they must have forgot to turn off the fill valve.

The Administrator was interviewed on 1/31/2020 at 6:34 PM and stated the equipment in the

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F 812	Continued From page 44 kitchen should always be kept in proper working order. He also stated any faulty equipment should be brought to his and the Maintenance Director's attention to be repaired. The Administrator stated he was not aware of any problems with the dish washing machine.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide.	F 849		4/15/20

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F 849	Continued From page 45 (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms	F 849		

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F 849	Continued From page 46	F 849		

associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is

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F 849	Continued From page 47 responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.	F 849		

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F 849	Continued From page 48 §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and hospice staff interviews, the facility failed to keep hospice records of daily visit notes and the most current hospice plan of care in a resident ' s chart for 1 of 1 resident reviewed for hospice care (Resident #81). Findings included: Resident #81 was admitted to the facility on 9/26/2019 with diagnoses to include malignant neoplasm of the lung and endocarditis (an inflammation around the heart). A physician order for Resident #81 dated 9/28/2019 ordered hospice services admission. Resident #81 ' s chart revealed hospice documentation dated 9/28/2019, 9/29/2019 and 10/1/2019. No hospice documentation was in the chart dated after 10/1/2019. Resident #81 ' s chart revealed a hospice plan of care dated 9/28/2019. The plan of care indicated the next care plan was due 12/27/2019. No hospice plan of care was in the chart dated after 9/28/2019. The quarterly Minimum Data Set assessment	F 849	1. Hospice notes and documentation obtained for resident #81 and chart is complete. 2. Residents' currently on hospice services have had their charts audited and verify appropriate and correct documentation. on 2/27/2020. Four residents in total. 3. Interdisciplinary Team to be educated on the documentation requirements of hospice services for the facility. 4. Director of Nursing/ Assistant Director of Nursing will audit 5 random residents' under hospice services to ensure appropriate and complete documentation is provided weekly for 1 month, then 5 times monthly for 2 months. DON will present audits to the Quality Assurance Process Improvement committee for review and further recommendation	

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dated 1/2/2020 documented Resident #81 was cognitively intact and that he received hospice services.

An interview was attempted with Resident #81 on 1/28/2020 at 2:21 PM but he was unable to participate.
Nurse #5 was interviewed on 1/28/2020 at 2:45 PM. Nurse #5 reported she provided care to Resident #81 frequently and that the hospice nurse would give verbal report to the facility nursing staff after making a visit to Resident #81. Nurse #5 reported she was not aware there were no hospice visit notes dated after 10/1/2019 in Resident #81 ' s chart. Nurse #5 was also not aware there was no hospice plan of care in Resident #81 ' s chart after 9/28/19.

Nurse #1 was interviewed on 1/28/2020 at 2:49 PM and she reported she was unable to locate Resident #81 ' s hospice notes or current hospice plan of care in his chart.

The hospice nurse was interviewed by phone on 1/29/2020 at 9:29 AM and she reported the hospice notes and care plan were faxed by the hospice social worker from hospice to be placed in Resident #81 ' s chart. The hospice nurse reported Resident #81 should have a current hospice plan of care dated 12/27/2019 in his chart.

A phone interview was conducted with the hospice social worker on 1/30/2020 at 9:00 AM. The hospice social worker reported the hospice visit notes were to be faxed from hospice to the facility every two weeks. The hospice social worker went on to explain the notes and the initial care plan were faxed to the facility on 10/4/2019,

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F 849	Continued From page 50 but not faxed again until 1/14/2020 because she was on a leave of absence. The hospice social worker reported she was not aware hospice visit documentation after 10/1/2019 and the current hospice plan of care dated 12/27/19 was not in Resident #81 ' s chart. The facility physician was interviewed on 1/30/2020 at 10:58 AM and he reported the hospice staff called him to report changes and he rarely used the hospice notes and hospice care plan in the chart. An additional interview was conducted with the hospice social worker on 1/30/2020 at 1:59 PM. The hospice social worker reported she had faxed hospice notes and the resident ' s current hospice plan of care to the wrong facility fax number on 01/14/20. The facility social worker (SW) was interviewed on 1/31/2020 at 9:49 AM. The SW reported she called the hospice social worker directly with questions or information. The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM. The DON reported hospice verbally communicated before and after a visit with the nursing staff to communicate changes and to give report. The DON was not aware the hospice visit note documentation and the current hospice plan of care dated 12/27/19 was not in the chart for Resident #81. The DON reported she expected all hospice visit notes and the current hospice plan of care to be in the resident ' s hard chart and available to any staff. An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. The	F 849		

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F 849	Continued From page 51 Administrator reported he did not know why the hospice notes and current hospice plan of care were not in Resident #81 ' s chart. The Administrator reported it was his expectation the notes and the care plan were available to staff in the hard chart.	F 849		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews. observation and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place in February 2019. This was for 1 re-cited deficiency which was originally cited on 2/14/2019 during the recertification survey and on the current recertification survey on 1/31/2020. The recited deficiency was a failure to prepare and serve food in accordance with professional standards for food service safety (F-812). The continued failure of the facility during the two Federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referred to: F-812 Based on staff interviews, observation, and	F 867	1. On 1/30/20 the Medical Directors notified of Department of Health Services Regulatory exit with recommendation of repeat tag F812 for failure to prepare and serve food in accordance with professional standards for food service and safety by the Administrator. Increase monitoring suggested for compliance 2. On 1/31/20 the facility Quality Assurance Process Improvement Committee held a meeting to review the purpose and function of the QAPI committee and review on-going compliance issues. The Administrator, Director of Nursing, Minimum Data Set nurse, Minimum Data Set Coordinator, Maintenance Director, Supply Clerk, Dietary Manager, Assistant Dietary Manager Activity Directors, Medical Record Supervisor and Housekeeping Supervisor will attend QAPI Committee	4/15/20

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F 867	Continued From page 52 record review the facility failed to clean or sanitize a thermometer which was used to check the internal temperatures of foods that were to be served to resident during 1 of 2 meals observed. The facility also failed to ensure the kitchen's dish machine reached minimum temperatures during the wash and rinse cycles to effectively clean and sanitize items washed in the machine. This had the potential to affect 119 of 119 residents who ate meals at the facility. During the facility ' s recertification and compliant investigation of 2/14/2019 F-812 was cited for failure to clean or sanitize a thermometer which was used to the check the internal temperatures of foods that were to be served to residents. The Administrator was interviewed on 1/31/2020 at 6:53 PM and he reported the QAPI committee met monthly with the department managers participating in the meeting. The Administrator explained that during the monthly meetings reports were reviewed and the QAPI committee determined the areas of concern that required the focus of the committee. The Administrator reported the kitchen had been identified as an area of concern because the prior Dietary Manager had a poor understanding of the regulations and a large staff turn-over. The Administrator reported the current Dietary Manager had a better understanding of the kitchen regulations. The Administrator reported the QAPI committee had monitored the kitchen in the past, but it was not currently monitored.	F 867	Meetings on an ongoing basis and will assign additional team members as appropriate. 3. On 2/24/20 the administrator re-educated the department heads related to the appropriate functioning of the Quality Assurance Process Improvement Committee and the purpose of the committee is to include identify issues and correct repeated deficiencies related to preventing accidents. 4. On 2/17/20 the Administrator was re-educated on the Quality Assurance and Improvement Plan policy by the regional nurse Consultant. Resources for further education, and ongoing support provided. 5. The Facility Quality Assurance Process Improvement Committee will meet at a minimum of monthly and QAPI committee meeting a minimum of quarterly to identify issues related to failure to prepare and serve food in accordance with professional standards for food service and safety. 6. Interdisciplinary Team meetings will be held 5X week for 4 weeks for 12 weeks to review residents at risk for preparation and serving of food in accordance with professional standards for food service safety. 7. The QAPI committee will continue to meet at a minimum of Quarterly. The QAPI Committee, includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Social Workers, and Activity Directors will review quarterly compiled QAPI report information, review trends, and review corrective actions	

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F 867	Continued From page 53	F 867	taken and the dates of completion. The QAPI Committee will validate the facilitys progress in correction of deficient practices or identify concerns. 8. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		4/15/20

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F 880	Continued From page 54 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and	F 880	1. Corrective action accomplished for	

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F 880	Continued From page 55 observation the facility failed to provide hand hygiene between 5 of 5 resident rooms observed during meal tray delivery; the facility failed to remove soiled gloves and perform hand hygiene after removing a soiled dressing and used an antimicrobial equipment wipe to wipe her hands after wound care for 1 of 1 resident reviewed for wound care (Resident #110); and failed to wash their hands when changing gloves for medication administration when giving medications through an enteral feeding tube and the Percutaneous Inserted Central Catheter (PICC). The nurse also used her mouth to remove the cap off a saline syringe to flush the PICC line. Findings included: A review of the facility's Hand Hygiene Infection Control Policy and Procedure dated 2/15/01 and reviewed on 11/15/19 revealed staff should wash their hands or use alcohol based hand rubs before and after patient care and contact with the patient's environment. 1.a. During an observation of Nurse Aide #3 on 1/29/2020 at 8:14 AM she entered room #221 with breakfast meal tray and set it on the table. She then assisted the resident with positioning in the bed and adjusted her bed linens before setting the breakfast meal tray in front of her on the table. The door to room #221 was open and Nurse Aide #3 was always in view in the room. Nurse Aide #3 did not wash her hands or use hand sanitizer. Nurse Aide proceeded to the food cart and placed a drink on a breakfast meal tray and carried the breakfast meal tray into room #214. Nurse Aide #3 placed the breakfast meal tray on the table and uncovered the food, opened the drink, and opened the silverware. Nurse Aide	F 880	those residents found to have been affected by deficient practice. The wound nurse was re-educated one on one by the Staff development Coordinator on the Facility�s handwashing policy. Instructed to always wash hands when appling and removing gloves, do not ware the same gloves between placing medication via g-tube, caring for a PICC line or a Dressing change to remove gloves and wash hands between each. Remove soiled gloves wash hands, apply new gloves to clean dressing equipment with proper solution/ wipes before replacing in treatment cart. Remove gloves and wash hand again. Never place any items used to provide care for a resident in your mouth. This re-education was completed on February 21, 2020. Nurse aides #2 and #3 were re-educated by the Staff Development Coordinator on the facility�s hand hygiene policy. To wash hands between residents when passing trays using soap and water or hand sanitizer. To wash hands if they touch the resident or any objects in the room. This re-education was completed on February 21, 2020. 2. Identify other residents who have the potential to be affected by deficient practice and what corrective actions were taken. All residents are at risk for deficient practice therefore all Licensed nurses and Certified Nursing Assistants were re-educated on the facility�s policy on Hand hygiene. This re-education was provided by the Staff Development Coordinator and completed by February 21, 2020. 3. Measures/ systemic changes put in	

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F 880	Continued From page 56 #3 also assisted the resident with positioning in the bed. The door to the room was open and Nurse Aide #3 was in view while in the room and did not wash her hands or use hand sanitizer. Nurse Aide #3 returned to the food cart and placed a drink on another breakfast meal tray and delivered the breakfast meal tray to room #209. Nurse Aide #3 placed the tray on the table, uncovered the food, opened the drink, and opened the silverware. The door to the room was open and Nurse Aide #3 did not wash her hands or use hand sanitizer. On 1/29/2020 at 2:38 PM an interview was conducted with Nurse Aide #3 and she stated she should have washed her hands or used hand sanitizer between each resident when she passed trays and assisted residents. Nurse Aide #3 stated she was very anxious and just forgot to wash her hands. Nurse Aide #3 stated she had an in-service when she went through orientation about the importance of washing her hands or using hand sanitizer to prevent the spread of infections when providing care to residents. 1.b. During an observation of Nurse Aide #2 on 1/29/2020 at 8:20 am she entered room #203 with a breakfast meal tray and placed it on the table. Nurse Aide #2 moved the table over the resident. Nurse Aide #2 was always visible from the hallway while in the room, she did not wash her hands or use hand sanitizer. Nurse Aide #2 returned to the to the meal cart and retrieved another breakfast meal tray and went to room #210. She placed the tray on the table, moved the table over the resident, moved a chair close to the resident, and began feeding the resident without washing her hands or using hand sanitizer. Nurse Aide #2 was in view the entire time she was in the room.	F 880	place to ensure deficient practice does not reoccur. The Staff Development coordinator re-educated the Licensed Nurses and the Certified Nursing Assistants on the facility□s Hand Hygiene policy. This education was completed on February 21, 2020. Education will be provided upon hire for new hires. 4. Monitoring of corrected action to ensure the deficient practice will not reoccur. The Staff Development Coordinator will visually audit the wound nurse providing dressing changes, the licensed nurses administering, medication via a feeding tube, administering medication via PICC line for proper hand hygiene, and audit Certified Nursing Assistants delivering trays and providing care for resident to ensure proper hand hygiene is performed. This auditing will be completed 5xper week for 4 weeks and 3x per week for 2 months. The Staff development Coordinator will present results of audits to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI Committee can make changes to ensure the facility remains in compliance.	

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An interview on 1/29/2020 at 2:40 pm with Nurse Aide #2 revealed she understood the importance of washing her hands when she provided care to the residents to prevent the spread of infection. Nurse Aide #2 stated she was in a hurry this morning during breakfast and had forgot to wash her hands or use hand sanitizer when passing out the breakfast trays.

During an interview with the Staff Development Coordinator on 1/30/2020 at 2:00 PM she stated the handwashing education is conducted annually unless there is an issue involving infection control. The Staff Development Coordinator stated the Hand Washing education was completed in March 2019 and staff receive the in-service during orientation.

During an interview with the Director of Nursing on 1/31/2020 at 2:37 PM she stated a Hand Washing education is done annually and whenever an issue arises. She stated the Staff Development Coordinator monitors the staff for compliance with hand washing but they do not document the monitoring. The Director of Nursing also stated she expected the Nursing Staff to wash their hands when delivering meal trays and between residents when providing care.

An interview with the Administrator on 1/31/2020 at 6:34 PM revealed he expected the staff to wash their hands before and after providing care to residents and when handling meal trays. The Administrator stated he also expected the staff to adhere to all infection control policies to prevent the spread of infection in the facility.

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F 880	Continued From page 58 The package of disinfectant wipes was reviewed, and the packaging read, in part: "Not for use on skin; Disinfecting towelettes are multi-purpose disinfectant cleaning wipes for use on hard, non-porous inanimate surfaces; (the disinfectant) is a one-step cleaner and disinfectant; for use on hard, non-porous surfaces such as ... patient support equipment" The facility ' s hand hygiene policy dated 02/15/2001 with a revision date of 11/28/2017 stated in part: "Perform hand hygiene after any contact with ... body fluids, even if gloves are worn; after patient care; after contact with the patient ' s environment." 2. Wound care for Resident #110 was observed on 1/30/2020 at 9:44 AM performed by the Wound Care nurse. a. The Wound Care nurse removed the soiled dressing from the wound and disposed of the soiled dressing in the trash. The Wound Care nurse then picked up wound care equipment on the bedside table with the soiled gloves on her hands. The Wound Care nurse was observed putting the wound care equipment into the drawer of the treatment cart after the wound care treatment was completed. The Wound Care nurse was interviewed on 1/30/2020 at 10:15 AM. The Wound Care nurse reported she was nervous during the wound care and she had forgotten her gloves were soiled when she touched the items on the bedside table. An interview was conducted with the Wound Care nurse on 1/30/2020 at 11:08 AM. The Wound Care nurse reported she had put the wound care equipment into her treatment cart without disinfecting because she was nervous.	F 880		

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b. The Wound Care nurse touched Resident #110 ' s face with her hands in the soiled gloves and brushed a piece of dry skin from a reddened, raised area of skin. The Wound Care nurse was interviewed on 1/30/2020 at 10:15 AM. The Wound Care nurse reported she was nervous during the wound care and she had forgotten her gloves were soiled when she touched Resident #110 ' s face.

c. The Wound Care nurse replaced the wound dressing and removed the soiled gloves. The Wound Care nurse did not perform hand hygiene and picked up all the wound care items from the bedside table and returned to the treatment cart. The Wound Care nurse took a disinfecting wipe and wiped the front and back of her hands with the disinfecting wipe. The Wound Care nurse was interviewed on 1/30/2020 at 10:15 AM. The Wound Care nurse reported she frequently used the disinfectant wipes to perform hand hygiene after wound care and she was not aware the instructions read to not use on skin.

The Director of Nursing (DON) was interviewed on 1/31/2020 at 5:36 PM and she reported all staff, including the Wound Care nurse have received in-services on handwashing and the Wound Care nurse had been observed performing wound care in the past. The DON reported she thought the Wound Care nurse was nervous during the observation. The DON reported it as her expectation that all staff follow the hand hygiene protocol and perform hand hygiene after glove removal.

An interview was conducted with the Administrator on 1/31/2020 at 6:34 PM. He

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F 880	Continued From page 60 reported he expected staff to perform hand hygiene after removing gloves. 3. Review of the Infection Control Policy for Hand Hygiene dated 11/15/19 stated hand hygiene must be performed before an aseptic procedure. There is no policy about syringe cap removal. On 1/30/20 at 9:20 AM an observation was done of the medication administration process. Medications were given by Nurse #5 to Resident #115 utilizing the resident's enteral feeding tube and her PICC line. Nurse #5 failed to wash her hands when removing the gloves after giving the medications via the feeding tube. She immediately donned new gloves and flushed the PICC line with 20 cc of normal saline solution (2 syringes) utilizing pre-packaged 10ml saline filled syringes. Nurse #5 also failed to follow infection control practices when she placed the syringe to her mouth to remove the caps prior to instilling the saline flush into the PICC line. On 1/30/20 at 3:10 PM an interview with RN #5 was done regarding the medication administration process observed earlier that morning. Discussion related to the infection control practices with medication administration were done and she was asked about using her mouth to remove the cap from the sterile saline syringes. Nurse #5 stated she was not aware that she was doing this. During the interview her process for removing gloves following the medication administration through the gastrostomy tube, and then putting on new gloves to flush the PICC line without washing her hands was discussed. She stated she should have washed her hands or used hand sanitizer when changing gloves. On 1/31/20 at 8:54 AM an interview was	F 880		

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F 880	Continued From page 61 completed with the Director of Nursing (DON). The observations of the medication administration process from 1/30/20 were reviewed as related to the staff infection control practices. This surveyor reviewed the observation of medications administered on 1/30/20 via a feeding tube with gloves on. Nurse #5 then changed her gloves and immediately flushed the PICC line. She stated that when the nurse removed the gloves she would have expected the nurse to wash her hands or use hand sanitizer before applying new gloves. The observation was shared that the nurse put the saline flush syringes in her mouth and removed the caps with both saline syringes. She stated the PICC tip should be cleaned and the nurse should then manipulate the catheter so she would be able to easily remove the cap with her hands. An interview was completed with the Administrator on 1/31/20 at 6:42 PM regarding the medication administration process and failure to follow the infection control guidelines related to hand hygiene and removing syringe caps with the nurse's mouth. He was informed of the discussion with the DON on 1-31-20 and he stated he would follow up with the DON related to the medication concerns. He stated he expected infection control guidelines to be followed.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.	F 919		4/15/20

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F 919	Continued From page 62 §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on record review, observations, family and staff interviews the facility failed to ensure the bedside call light was operational for 1 of 5 sampled resident whose call lights were checked. (Resident #55) The findings include: Resident #55 was admitted on 3/10/16 and had diagnoses which included Heart Failure, Gastroesophageal Reflux Disease, Diabetes mellitus, Dementia, and Depression. Resident #55 ' s Minimum Data Set assessment dated 12/5/19 specified the resident ' s cognition was severely impaired and required one- person physical assistance with Activities of Daily Living. During an interview on 1/27/20 at 3:38 PM with one of Resident #55 ' s family members, the family member stated the resident ' s call light was not working. The family member stated another of the resident ' s family members visited the resident during the previous week and reported to a nurse the resident ' s call light was not working. Observation of Resident #55 ' s bedside call light on 1/27/20 at 3:38 p.m. revealed when an attempt was made to activate the call light it would not activate. The call light made no audible sound and the call light in the hallway above the room ' s doorway did not activate. Observation of Resident #55 ' s bedside call light	F 919	1. Resident #55 had call bell repaired on 1/30/20 2. All facility call bells were audited to ensure proper function on 2/20/20. No other malfunctioning call bells were identified. 3. Staff to be educated on the process of filling out Maintenance Work Orders by SDC. 4. Maintenance will randomly audit the function of 5 call bells weekly for 1 month and then 10 call bells monthly for 2 months to ensure proper function. Results of the audits will be reported to QAPI for review and recommendation. NHA/ designee to randomly audit work orders for completion 5xs weekly for 1 month and then 10x monthly for 2 months to ensure appropriate follow up action. Findings to be reported to the QAPI committee for review and recommendation.	

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on 1/28/20 at 9:00 AM revealed when an attempt was made to activate the call light it would not activate. The call bell made no audible sound and the call light in the hallway above the room ' s doorway did not activate.

Observation of Resident #55 ' s bedside call light on 1/29/20 at 8:40 a.m. revealed when an attempt was made to activate the call light it would not activate. The call bell made no audible sound and the call light in the hallway above the room ' s doorway did not activate.

A phone interview with another of Resident #55 ' s family members was conducted on 1/29/20 at 3:23 PM. The family member stated he visited Resident #55 at the facility last Wednesday on 01/22/20 and at approximately 4:30 PM he went to the nurse ' s station on the 500 hall and told the nurse Resident #55 ' s call light was not working. The nurse told the family member she would be putting in a work order to get it fixed.

Maintenance work orders for January 18 to January 28, 2020 revealed there was not a work order created to fix Residents #55 call light.

During an interview with Nursing Assistant (NA) #5 on January 29, 2020 at 8:50 AM was asked how she knows if a resident needs assistance. NA #5 stated "I know a resident needs help if the call light goes on. I normally do rounds every 2 hours." NA #5 stated, for Resident #55 "we must remind her to turn on her call light."

During an interview with facility ' s work force manager on 1/29/20 at 8:52 PM she stated she was informed on 1/29/20 that Resident #55 ' s bedside call light was not working. She stated the

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F 919	Continued From page 64 resident ' s call light had a kinked cord and she will notify maintenance to check on it, but the call light was now working. During an interview with the maintenance manager on 1/30/20 at 7:40 AM he stated Resident #55 ' s call bell cord was replaced, and the call bell was now working. A review of the work order to fix the call light revealed the work order was created on 1/29/20 at 8:58 AM and indicated the call bell cord was replaced. The work order was noted as closed on 1/29/20 at 9:40 AM.	F 919		