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	345197	A. BUILDING _____ B. WING _____	C 12/15/2017

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		1/11/18

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

Electronically Signed | 01/12/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to promote an environment that enhanced dining with dignity for 1 of 2 sampled residents reviewed for dignity (Resident #36). The findings included: Resident #36 was admitted to the facility on 11/21/13. Her diagnoses included Alzheimer's disease, mood disorder, psychosis, and major depressive disorder. The annual Minimum Data Set dated 10/10/17 coded her with severely impaired cognition, requiring limited assistance with most activities of daily living skills and being frequently incontinent of bowel and bladder. On 12/13/17 at 8:29 AM the bedroom smelled of urine. At this time the roommate was served breakfast by Nurse Aide (NA #1). Then on 12/13/17 at 8:30 AM, Resident #36 was served breakfast as she laid in bed by NA #2. NA #2 encouraged Resident #36 to get up and eat. On 12/13/17 at 8:33 AM, Resident #36 was observed talking to herself, she reached her hand inside her incontinent brief and stated her brief was "soggy wet." Staff were not in the room at this time, however, the room smelled strongly of urine. Resident #36 repeatedly stated she was wet, however when asked about calling for assistance and using her call light, the resident did not comprehend the instruction. On 12/13/14 at 8:41 AM she proceeded to feed herself sitting	F 550	F550 Regarding the alleged deficient practice of failure to provide an environment that enhanced dining with dignity for resident #36, resident #36 was observed being served breakfast trays while soiled and in an environment that smelled of urine, the Director of Nursing(DON) provided an in-service education on December 15, 2017 for NA#1, NA#2 and other assigned staff, regarding resident□s rights- dining with dignity, ensuring area is free of odors for dining. Alleged resident will be toileted or incontinent care provided prior to meals. Current facility residents are at risk for alleged deficient practice of failure to provide dining with dignity. The DON/ADON/Designee provided in service education for current facility staff beginning December 15 2017 and to commence January 11th, 2018. The DON/ADON/Administrator ensured no other residents were immediately affected in regards to failure to provide an environment that enhanced dining with dignity. In service education, will be provided during new hire orientation in regards to dining with dignity during new hire orientation. The administrator, DON, ADON and designee will observe 10	

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F 550	Continued From page 2 on the bed. On 12/13/17 at 8:57 AM, NA #3 entered the room and picked up the roommate's tray. The room still had a strong odor of urine. On 12/13/17 at 9:48 AM, NA #1 stated she was assigned to Resident #36 this date. NA #1 stated she had checked her this morning and she was dry. When asked about the urine odor, NA #1 stated she assumed the odor was from the roommate. Interview with NA #1 on 12/13/17 at 10:48 AM revealed that she smelled the urine odor when she delivered Resident #36's tray to her, however, stated the roommate has a habit of hiding her soiled pull-ups and assumed the odor was from that behavior. Interview with the Director of Nursing revealed that when staff noticed the urine odor in the room at the time of delivering the breakfast trays, they should have investigated the source of the odor. She stated Resident #36 should not have had to eat breakfast in a room that smelled of urine. Interview with the Administrator on 12/15/17 at 12:40 PM revealed he would have expected staff to offer to serve Resident #36's breakfast tray at a different location.	F 550	resident rooms/ dining areas weekly for 4 weeks, then 15 resident rooms/dining areas monthly for 3 months to validate that residents are provided with dignity with dining. Residents Rights will be reviewed during monthly meetings with facility staff. The administrator and/or the Social Worker (SW) will identify residents concerns as they relate and will implement appropriate interventions to prevent deficient practice. The Administrator and/or the SW will review audits to identify patterns and or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meetings for at least 6 months or until satisfactory compliance is maintained.	
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to	F 553		1/11/18

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F 553	Continued From page 3 request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews; the facility failed to observe the resident or responsible party's right to be included in care plan meetings for 4 of 5 residents reviewed (Resident #42, #69, #23, #11). Findings included: 1. Resident #42 was admitted to the facility on 6/26/15 with diagnoses that included: diabetes, cerebral arteriosclerosis, abnormalities of gait and mobility, arteriosclerotic heart disease heart	F 553	Regarding the alleged deficient practice of failure to observe the resident or responsible party□s right to be included in care plan meetings for resident # 42, 69, 23 and 11, the facility could not provide evidence that residents and/or care plan were invited to Care plan meetings. The Administrator provided an in-service education on December 15, 2017 for SW #1, SW #2, MDS Nurse #1 and MDS Nurse #2, regarding resident□s rights-inclusion of resident/responsible party for	

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F 553	Continued From page 4 failure, unspecified dementia, insomnia, and arthritis, among others. Review of Resident #42's most recent Minimum Data Set (MDS) dated 10/13/17 and coded as a quarterly review revealed resident to be cognitively intact with no noted behaviors. Resident needed extensive assistance with all activities of daily living (ADL) except she was totally dependent with bathing and locomotion off unit. Resident #49 was coded as being always incontinent of bowel and bladder and was not on a toileting program. On 12/12/17 at 9:20 AM an interview with Resident #42 was conducted. The interview revealed the facility used to invite Resident #42 to her care plan meetings. She reported the facility even used to hold the care plan meetings in her room. She informed that she had not been invited to a care plan meeting in some time. When asked she stated she had not attended one or been invited to one in over a year. She also reported she would like to attend her care plan meetings as she felt she had a right to be there so she could have some input into her care. An interview with the Director of Social Services on 12/12/17 at 4:19 PM revealed he was the one who sent out care plan notification letters to families. He informed he had recently begun saving the letters he sent out due to there being some missed care plan meetings. When asked to elaborate he stated the MDS Nurse was responsible for notifying him of residents that needed a care plan schedule and he would send a letter out. He reported that the MDS Nurse had missed some time at work and during that time, he had not been made aware of residents that required a care plan. He was unable to inform how many residents had missed care plans.	F 553	care plan meetings. No other current facility residents are at immediate risk for alleged deficient practice of failure to include in residents care plan. The DON/ADON/Designee provided in service education for current facility staff beginning December 15 2017 and to commence January 11th, 2018. SW reviewed current plan of care with all affected residents; completed on January 5, 2018. Social Worker will provide notification of upcoming care plan meeting in writing to resident and responsible party no less than one week prior to the scheduled meeting. The Interdisciplinary care plan team will hold meetings in the resident s room if necessary to ensure that residents are involved in the plan of care. SW/Designee will provide administrator with a copy of all care plan meeting attendance logs to ensure inclusion of residents/responsible party. The Social Worker will document in resident record, the participation of resident and/or family in the care plan meeting Administrator will audit 3-5 care plan meetings attendance sheets per week for a period of 4 weeks and then audit 5 care plan meeting attendance sheets per month for a period of 3 months. The Social Worker will report issues or trends which identify patterns with attendance during monthly QAPI meetings to adjust plans to maintain compliance for at least 6 months or until satisfactory compliance is maintained.	

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F 553	Continued From page 5 An interview with the MDS Nurse on 12/13/17 at 10:37 AM revealed she was responsible for notifying the Director of Social Services when care plan meetings needed to be scheduled. She reported she had a calendar in her office which let her know which residents needed care plans for a particular month. She reported once she let the Director of Social Services know which residents needed care plans scheduled, it was his responsibility to invite the residents, responsible party and interested family. She reported she had been out recently and was unaware if any care plan meetings had not been scheduled. She reported she does not attend care plan meetings so she could not speak to if residents or family were in attendance. During an interview with the Director of Nursing on 12/14/17 at 2:03 PM she reported it was her expectation that residents were given the opportunity to attend their care plan meetings and that responsible parties and interested family were also given the opportunity to attend if they wanted. She reported when care plan meetings are held, a care conference summary form is completed and everyone in attendance signs their name to show they were in attendance. She reported if the resident's or responsible party's name was on the form, then they were not in attendance. An interview with the Administrator on 12/14/17 at 2:31 PM revealed he expected every resident to be invited to their care plan each time it is scheduled. He also reported he expected families and responsible parties be informed of scheduled care plan meeting so they may attend if they wanted.	F 553		

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Review of Resident #42's available care plan summary sheets revealed no signature of resident on the form to indicate she was in attendance of any care plan meetings.

Review of electronic progress notes revealed multiple notes labeled IDT Meeting and Care Plan Notes. Review of above notes made available revealed no mention of resident or resident's family attending.

2. Resident #69 was admitted to the facility on 7/13/17 with diagnoses that included: Chronic fatigue, major depressive disorder - single severe episode with psychotic features, weakness, other psychoactive substance use - unspecified with psychoactive substance induced psychotic disorder with delusions, Parkinson's disease, unspecified dementia without behaviors, insomnia, unspecified lack of coordination, among others. Review of Resident #69's most recent MDS dated 10/25/17 and coded as a quarterly review revealed Resident #69 to be cognitively intact with no behaviors or signs or symptoms of psychosis. She was coded as independent with all ADL's except bathing which she needed physical help with part of bathing activity. Further review revealed Resident #69 was coded as receiving an antipsychotic, antianxiety, antidepressant and hypnotic 7 of 7 days during the look back period.

An interview with Resident #69 on 12/13/17 at 12:32 PM revealed she was unsure if care plan meetings ever occurred. She reported she had never been informed of one taking place and had never been invited to one. She reported she would attend if she were informed when they

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occurred.

An interview with the Director of Social Services on 12/12/17 at 4:19 PM revealed he was the one who sent out care plan notification letters to families. He informed he had recently begun saving the letters he sent out due to there being some missed care plan meetings. When asked to elaborate he stated the MDS Nurse was responsible for notifying him of residents that needed a care plan schedule and he would send a letter out. He reported that the MDS Nurse had missed some time at work and during that time, he had not been made aware of residents that required a care plan. He was unable to inform how many residents had missed care plans.

An interview with the MDS Nurse on 12/13/17 at 10:37 AM revealed she was responsible for notifying the Director of Social Services when care plan meetings needed to be scheduled. She reported she had a calendar in her office which let her know which residents needed care plans for a particular month. She reported once she let the Director of Social Services know which residents needed care plans scheduled, it was his responsibility to invite the residents, responsible party and interested family. She reported she had been out recently and was unaware if any care plan meetings had not been scheduled. She reported she does not attend care plan meetings so she could not speak to if residents or family were in attendance.

During an interview with the Director of Nursing on 12/14/17 at 2:03 PM she reported it was her expectation that residents were given the opportunity to attend their care plan meetings and that responsible parties and interested family

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were also given the opportunity to attend if they wanted. She reported when care plan meetings are held, a care conference summary form is completed and everyone in attendance signs their name to show they were in attendance. She reported if the resident's or responsible party's name was on the form, then they were not in attendance.

An interview with the Administrator on 12/14/17 at 2:31 PM revealed he expected every resident to be invited to their care plan each time it is scheduled. He also reported he expected families and responsible parties be informed of scheduled care plan meeting so they may attend if they wanted.

Review of Resident #69's available care plan summary sheets revealed no signature of resident on the form to indicate she was in attendance of any care plan meetings.

Review of electronic progress notes revealed multiple notes labeled IDT Meeting and Plan of Care Notes. Review of above notes made available revealed no mention of resident or resident's family attending.

3. Resident #23 was admitted to the facility on 4/28/17 with diagnoses that included: history of hip fracture, anxiety disorder, hyponatremia and hypertension . Review of Resident #23's most recent MDS dated 10/06/17 and coded as a quarterly review revealed Resident #23 to be cognitively intact with no behaviors or signs or symptoms of psychosis. She was coded as independent with locomotion on/off unit and eating. Resident #23 was coded as needing limited assistance with all other Activities of Daily

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Living. Further review revealed resident to be occasionally incontinent of bladder and always continent of bowel.

An interview with Resident #23 on 12/13/17 at 12:14 PM revealed resident had not been invited to any plan of care meetings since her arrival to the facility in July. She stated it bothered her that she was not consulted about her care as she felt she knew more than anyone about her care needs and what was going on with her body. She reported she would attend the care plan meetings if she were invited.

An interview with the Director of Social Services on 12/12/17 at 4:19 PM revealed he was the one who sent out care plan notification letters to families. He informed he had recently begun saving the letters he sent out due to there being some missed care plan meetings. When asked to elaborate he stated the MDS Nurse was responsible for notifying him of residents that needed a care plan schedule and he would send a letter out. He reported that the MDS Nurse had missed some time at work and during that time, he had not been made aware of residents that required a care plan. He was unable to inform how many residents had missed care plans.

An interview with the MDS Nurse on 12/13/17 at 10:37 AM revealed she was responsible for notifying the Director of Social Services when care plan meetings needed to be scheduled. She reported she had a calendar in her office which let her know which residents needed care plans for a particular month. She reported once she let the Director of Social Services know which residents needed care plans scheduled, it was his responsibility to invite the residents, responsible

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party and interested family. She reported she had been out recently and was unaware if any care plan meetings had not been scheduled. She reported she does not attend care plan meetings so she could not speak to if residents or family were in attendance.

During an interview with the Director of Nursing on 12/14/17 at 2:03 PM she reported it was her expectation that residents were given the opportunity to attend their care plan meetings and that responsible parties and interested family were also given the opportunity to attend if they wanted. She reported when care plan meetings are held, a care conference summary form is completed and everyone in attendance signs their name to show they were in attendance. She reported if the resident's or responsible party's name was on the form, then they were not in attendance.

An interview with the Administrator on 12/14/17 at 2:31 PM revealed he expected every resident to be invited to their care plan each time it is scheduled. He also reported he expected families and responsible parties be informed of scheduled care plan meeting so they may attend if they wanted.

Review of Resident #23's available care plan summary sheets revealed no signature of resident on the form to indicate she was in attendance of any care plan meetings.

Review of electronic progress notes revealed multiple notes labeled IDT Meeting and Plan of Care Notes. Review of above notes made available revealed no mention of resident or resident's family attending.

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4. Resident #11 was admitted to the facility on 1/8/14 with diagnoses that included:: undifferentiated schizophrenia, aphasia, quadriplegia, disorder of the brain, unspecified convulsions, gastrostomy complication, mild cognitive impairment, bipolar disorder, post-traumatic stress disorder, other specified problems related to psychosocial circumstances, spastic quadriplegic cerebral palsy and metabolic encephalopathy, among others. Review of Resident #11's most recent comprehensive MDS dated 10/01/17 and coded as an annual revealed resident to be severely impaired with no signs or symptoms of psychosis and verbal behaviors directed towards others occurring 1-3 days during the look back period. He was coded as total dependence with all ADL activities and was coded as not being on a toileting program and always incontinent of bowel and bladder. Further review revealed he was coded as receiving an antianxiety medication 1:7 days and an antidepressant 7:7 days during the look back period.

An interview with Resident #11's responsible party on 12/13/17 at 2:54 PM revealed the Resident #11 had been at the facility for approximately 5 years. She reported she was Resident #11's guardian and had been for the duration of his stay at the facility. She informed although the facility kept her informed of medication changes, changes in condition and the times he was sent out of the facility, she had never been invited to "a single care plan meeting". She reported she would like to attend care plan meetings and would attend if notified of when they were to be held. She stated it bothered her to not have a say in the care

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F 553	Continued From page 12	F 553		

Resident #11 received at the facility and felt she should be included in care planning.

An interview with the Director of Social Services on 12/12/17 4:19 PM revealed he was the one who sent out care plan notification letters to families. He informed he had recently begun saving the letters he sent out due to there being some missed care plan meetings. When asked to elaborate he stated the MDS Nurse was responsible for notifying him of residents that needed a care plan schedule and he would send a letter out. He reported that the MDS Nurse had missed some time at work and during that time, he had not been made aware of residents that required a care plan. He was unable to inform how many residents had missed care plans.

An interview with the MDS Nurse on 12/13/17 at 10:37 AM revealed she was responsible for notifying the Director of Social Services when care plan meetings needed to be scheduled. She reported she had a calendar in her office which let her know which residents needed care plans for a particular month. She reported once she let the Director of Social Services know which residents needed care plans scheduled, it was his responsibility to invite the residents, responsible party and interested family. She reported she had been out recently and was unaware if any care plan meetings had not been scheduled. She reported she does not attend care plan meetings so she could not speak to if residents or family were in attendance.

During an interview with the Director of Nursing on 12/14/17 at 2:03 PM she reported it was her expectation that residents were given the opportunity to attend their care plan meetings and

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F 553	Continued From page 13 that responsible parties and interested family were also given the opportunity to attend if they wanted. She reported when care plan meetings are held, a care conference summary form is completed and everyone in attendance signs their name to show they were in attendance. She reported if the resident's or responsible party's name was on the form, then they were not in attendance. An interview with the Administrator on 12/14/17 at 2:31 PM revealed he expected every resident to be invited to their care plan each time it is scheduled. He also reported he expected families and responsible parties be informed of scheduled care plan meeting so they may attend if they wanted. Review of Resident #11's available care plan summary sheets revealed no signature of resident's responsible on the form to indicate she was in attendance of any care plan meetings. Review of electronic progress notes revealed multiple notes labeled IDT Meeting and Plan of Care Notes. Review of above notes made available revealed no mention of resident or resident's family attending.	F 553		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		1/12/18

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F 561	Continued From page 14 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to allow a safe smoker to smoke without supervision and smoke whenever he wanted and failed to provide a resident with their preferred number of showers a week for 2 of 3 residents reviewed for choices (Resident #116, #63). The findings included: The facility's smoking policy, not dated, included the following procedures: 1. Staff will dispense the resident's cigarettes. 2. Residents may smoke outside of the designated times ONLY if a family member or other responsible people visiting that resident	F 561	Regarding the alleged deficient practice of failure to observe the resident right in regards to choice specifically in allowing a safe smoker to smoke without supervision and failure to provide a resident with their preferred number of showers per week for resident #116 and #63, the facility did not allow for freedom of choice in regards to smoking and showers. Specifically facility did not reassess when a smoker had improved to be safe and the facility did not offer choice(wishes) in regards to resident's choice for their shower. Social Workers #1 and #2 were in-serviced by administrator on December 18, 2017 in regards to smokers	

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F 561	Continued From page 15 agree to stay with the resident and return all smoking materials to the nurse. 3. All residents smoke only in designated areas. 4. All cigarettes, lighters and any other smoking materials will be kept at the nurses' station or facility designated secure area. 5. Residents who choose to smoke will be taken to the designated smoking area by facility staff. 6. Residents who assess as requiring supervision or assistance will comply with the established smoking schedule of 10:00 AM, 2:00 PM, 4:00 PM, 7:00 PM, 9:30 PM. 1. Resident #116 was admitted to the facility on 11/22/17 with diagnoses of anemia, malnutrition, anxiety, depression, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set dated 11/29/17 revealed Resident #116 was cognitively intact with no moods or behaviors during the assessment period. Review of the care plan dated 12/07/17 revealed Resident #116 was a smoker. The goal was to not suffer injury from unsafe smoking practices through the review date and not to smoke without supervision through the review date. The interventions included: instruct him about the facility policy on smoking locations, times, and safety concerns. Notify charge nurse immediately if suspected that he has violated the facility smoking policy, observe clothing and skin for signs of cigarette burns. Required supervision while smoking. Smoking supplies stored in locked box at nurses station. Review of the facility Smoking Assessment dated 11/22/17 for Resident #116 revealed he had no	F 561	assessment for identification of residents that are independent smokers or supervised smokers. Resident #116 who was affected by this alleged deficient practice was scheduled to be discharged to home on December 15, 2017, as part of his plan of care and is no longer affected by alleged deficient practice. Current facility residents who smoke were reassessed by Social Worker December 22nd 2017, residents that were identified as independent smokers were provided a safe area to smoke, smoker□s contract updated, care plan updated and allowed to smoke independently. The Social worker or licensed nurse will assess residents who smoke upon admission, quarterly, annually and with significant change. The resident will sign the smoker□s contract upon admission and/or upon a change of condition. The licensed nurse will initiate or update the care plan to support independent or supervised smoking. The facility will provide a safe area for the resident to smoke. Administrator/DON/Designee will maintain a log of all current smokers both supervised and independent and ensure residents are provided access to a safe and accessible area to smoke. The Administrator, DON and/ or the ADON provided in service education for current facility staff beginning December 15, 2017 and to commence January 11th, 2018 on resident□s rights in regards to choices. DON, ADON, and /or Social workers will	

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F 561	Continued From page 16 cognitive loss, no vision problems, and no dexterity problems. The assessment revealed Resident #116 had been a smoker for 30 years and smoked 10 plus cigarettes a day, and liked to smoke in the mornings, afternoon, evenings and nights. The assessment revealed he wasn't interested in a smoking cessation program and he could light his own cigarette. Resident was checked for supervision under the resident need for adaptive equipment section on the assessment. Observations made on 12/13/17 at 4:15 PM and 12/14/17 at 2:20 PM revealed Resident #116 in the designated smoking area with the other smokers and being supervised by a Nurse Aide. Resident #116 was observed lighting his own cigarette and using the ash tray for his ashes. An interview conducted on 12/13/17 at 12:04 PM with Resident #116 revealed he was told on admission that he could only smoke at the scheduled smoking times with supervision. He stated he would like to smoke as often as did at home. An interview conducted on 12/14/17 at 9:52 AM with Social Worker (SW) #2 revealed she did not complete Resident #116's smoking assessment but she stated there was no reason from the smoking assessment completed on 11/22/17 that he should need supervision to smoke. She did state she felt Resident #116 needed supervision due to his gait being very poor when he was admitted and she didn't think he could get in and out of the door from the smoking area. She further stated his gait didn't make him an unsafe smoker.	F 561	review smoking assessments ongoing for new admissions and with quarterly, annual, significant change assessments to validate accuracy of assessment. The DON and/or Social Worker will review audits and reviews to identify patterns/trends and will adjust plan as needed to assure continued compliance. The DON and/or Social Worker will review plan during monthly QAPI meetings for 3 months or until compliance is maintained. Regarding the alleged deficient practice to observe the resident rights in regards to choice specifically in providing the number of showers resident # 63 requested. The Licensed nurse interviewed resident #63 on December 15, 2017, in regards to her choice for showers. The licensed nurse updated the shower schedule for the resident to include the resident choice. The DON and/or the ADON provided in service education for the nursing staff in regards to residents choice for their shower and documentation of showers and refusals. Current facility residents have the potential to be affected by the alleged deficient practice. The DON, ADON, and unit coordinators interviewed current facility residents in regards to their preferences as they relate to bathing including preferred days/times which was completed by December 22, 2017. The DON, and/or the ADON provided in-service education to all nursing staff in regards to resident rights related to choices. The licensed nurses will interview residents upon admission regarding preferences of bathing and will	

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F 561	Continued From page 17 An interview conducted on 12/14/17 at 11:05 AM with the Director of Nursing revealed there was no reason from the smoking assessment completed on 11/22/17 that Resident #116 needed to be supervised while smoking. She stated he was very unsteady when he was admitted to the facility and they didn't think he could go in and out of the door to the smoking area unassisted and that is why he was marked as needing supervision. She stated his gait was much better now and he could go in and out of the door unassisted but there wasn't a doorbell on the door and they were afraid if he was unsupervised and fell no one would see him or he wouldn't be able to get back inside when he was ready to come in. An interview conducted on 12/15/17 at 10:06 AM with the Administrator revealed if a resident was assessed as safe smoker they should be able to smoke when they chose to smoke. 2. Resident #63 was admitted to the facility on 10/23/17. Her diagnoses included dementia without behaviors. On 10/23/17 Resident #63 was noted to have the shower preference of 2 showers per week during day shift. The admission Minimum Data Set (MDS) dated 10/30/17 coded her with intact cognition, rejecting care 1 - 3 days in the previous 7 and requiring	F 561	update shower schedule to accommodate the residents preference. The DON and/or the ADON will observe 10 residents shower logs weekly for 4 weeks, then 15 residents shower logs monthly for 3 months to validate that residents are provided with choice in regards to their shower times. Resident Rights will be reviewed during monthly meetings with facility staff by Administrator. The administrator and/or the Social Worker will identify residents concerns as they relate and will implement appropriate interventions to support resident rights and choices. The DON will review audits/monitors to identify patterns and or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meetings for at least 6 months or until satisfactory compliance is maintained.	

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F 561	Continued From page 18 extensive assistance with most activities of daily living skills including bathing. Social Notes dated 10/30/17 stated Resident #63 had refused medications on 10/25/17. Interview with Resident #63 on 12/11/17 at 11:24 AM revealed she did not receive the number of showers she wanted each week. She stated she only received about 3 showers since being admitted to the facility. She further stated one time she asked for a shower and they promised to give her one but staff did not give her a shower that day. On 12/14/17 at 405 PM, Nurse #1 stated showers were documented on sheets maintained at the nursing station. These sheets should also include documentation of refusals of showers. Review of the shower sheets for Resident #63 revealed since admission she missed 5 out of 13 scheduled showers on 11/06/17, 11/09/17, 11/13/17, 11/27/17 and 11/30/17. Interview with the Administrator on 12/15/17 at 12:40 PM revealed that showers were to be given as scheduled per choice and documentation had to reveal refusals. .	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F 578		1/11/18

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F 578	Continued From page 19 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to clarify code status for 1 of 2 residents reviewed for advanced directives (Resident #228).	F 578	Regarding the alleged deficient practice of failure to clarify code status for resident #228. It was noted that the Advanced Directive form was signed by the	

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F 578	Continued From page 20 The findings included: Resident #228 was admitted to the facility on 12/02/17 with diagnoses of Parkinson's disease, heart failure, and chronic kidney disease. Review of the admission Minimum Data Set dated 12/09/17 revealed Resident #228 was moderately cognitively impaired but could make her needs known. Review of the care plan dated 12/11/17 revealed Resident #228 was at risk for alteration in code status, she was a Do Not Resuscitate (DNR) and would not have any aggressive life sustaining technology if it did not meet goals agreed upon by the resident/family/physician ongoing through the review date. Interventions included: Effectively communicate DNR wishes by placing in front of the chart, and/or when resident must transferred out of the facility. Review of Resident #228's medical record revealed no DNR, code status or advanced directives in the chart. An interview conducted on 12/14/17 at 11:05 AM with Nurse #1 revealed it was the nurse that admitted the resident to the facility to ask them about their code status. She stated if they wanted to be a DNR the nurse had them sign the advanced directive and placed it in the doctor's book for him to sign. She stated the forms should be on the resident's medical record within 3 to 5 days. She further stated Resident #228 did not have any advanced directives on her chart and if she coded staff would assume she was a full code and all lifesaving means would be initiated.	F 578	resident/POA on December 2, 2017 and the Physician order was in the electronic medical record on December 3, 2017. The canary form which is a form for transport services, and the Advanced Directive form was in the physicians box to be reviewed and the facility had not been placed on the chart. The forms were signed on December 11,2017, and placed in the residents chart on December 12, 2017. Current facility residents have the potential to be affected by the alleged deficient practice of failure to clarify code status. The Social Workers completed an audit of Advanced Directives for current facility residents on December 22,2018, to validate Advanced Directive form, Physician orders and the canary transport form are consistent and available in the residents chart. No other discrepancies were identified. The DON and/or the ADON provided in service education for the licensed nursing staff and social workers regarding completion of Advanced Directives upon admission to include Advanced Directives form, Physician order and the canary transport form completed by January 11, 2018. The Licensed Nurses or the Social worker will assist the resident and/or the family to complete the Advanced Directive form upon admission. If the resident wishes are for a Do not resuscitate (DNR), the Physician will be notified and an order written to support the resident wishes, and the canary transport form will be completed and signed by the physician. The forms will be placed in the	

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F 578	Continued From page 21 An interview conducted on 12/14/17 at 11:15 AM with the Director of Nursing (DON) revealed it was her expectation for the resident's code status and advanced directives to be on the medical record within a couple of days after admission. She stated Resident #228 should have had orders with her code status on her record.	F 578	residents medical record upon completion. The Physicians order will be included in the order section of the residents electronic medical record. The Social worker will monitor and/or review the residents code status ongoing through quarterly, annual and significant change of condition assessment schedule, and will update the Advance Directive form, physician orders and canary form as needed to support the resident wishes. The Social worker will review audits and monitors to identify patterns/trends and will adjust plan as necessary to maintain compliance. The plan will be reviewed during the monthly QAPI meeting every month for 3 months or until compliance is maintained.	
F 636 SS=E	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.	F 636		1/11/18

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(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).
(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

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F 636	Continued From page 23 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 review and staff interviews, the facility failed to complete Care Area Assessments (CAA) that addressed the underlying causes and contributing factors for triggered areas for 10 out of 28 sampled residents (Residents #5, #36, #63, #30, #35, #82, #110, #18, #99, #71). The findings included: 1. Resident #5 was admitted to the facility on 02/18/16. Her diagnoses included dementia, pyschosis, traumatic brain injury, anxiety, and major depressive disorder. The significant change Minimum Data Set (MDS) dated 06/09/17 coded her with severely impaired cognition, having mood indicators, having no behaviors, being nonambulatory, needing extensive assistance with most activities of daily living skills, and receiving anitipsychotic, antidepressant and antianxiety medications 7 out of the previous 7 days. The MDS also coded her with having had a fall with minor injury and a fall with a major injury. a. The CAA for cognition dated 06/09/17 stated the resident had a fall with stitches, had been diagnosed with dementia, had confusion and was alert to self and family, and has been placed under Hospice care. The CAA failed to describe how her confusion and dementia affected her ability to make decisions and affected her day to day function.	F 636	Regarding the alleged deficient practice of failure to address underlying causes and contributing factors for triggered areas for residents #5, 36, 63, 30, 35, 82, 110, 18, 99, 71; MDS nurse 1 and 2 had not identified underlying causes and contributing factors and have those clearly stated throughout the CAA process. MDS nurses #1and #2, reviewed those identified resident CAAS, and determined that it did not affect the resident□s care plan and outcome. The MDS and CAA□s will be updated during the next annual or significant change assessment to include underlying causes and contributing factors. The regional director of MDS provided an in service on December 19, 2017 to MDS nurse #1 and MDS nurse #2, regarding CAAs documentation to include underlying causes and contributing factors. The MDS nurse #1 and #2 will attend state offered training February 22, 2018 Current facility residents have the potential to be affected by the alleged deficient practice. The MDS nurses audited current residents CAA□s to identify CAA□s that may have affected resident care planning and outcome. There were no residents affected. The MDS nurses provided an in-service education for the interdisciplinary staff that complete the MDS and CAA□s, to include underlying causes and contributing factors	

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F 636	Continued From page 24 Interview on 12/15/17 at 11:56 AM with Social Worker #1, who completed this CAA, revealed that the cognition CAA did not describe her cognition and how it affected her day to day abilities or her abilities to make decisions. b. The CAA for psychotropic drug use dated 06/12/17 stated that she received an antipsychotic for dementia, an antidepressant for psychosis, and an as needed antianxiety for anxiety. The CAA continued stated that the combination of antianxiety and antidepressant medications was used for migraines and she was at risk for drug related side effects. There was no analysis of how she reacted or any benefits from the medications or how they impacted her day to day function. Interview on 12/15/17 at 12:09 PM with MDS Nurse #1 who completed this CAA revealed the CAA did not explain the individual details for the triggered areas. c. The CAA for falls dated 06/12/17 stated that she was under Hospice care due to an intracranial hemorrhage. She was noted to have had multiple falls, including one with fractures. She was non-ambulatory, had poor safety awareness, used psychotropic medications, was incontinent and had decreased mobility. The CAA did not identify the circumstances of her falls or details as to how a nonambulatory resident fell so often or how the falling affected her day to day function. Interview on 12/15/17 at 12:09 PM with MDS Nurse #1 who completed this CAA revealed the CAA did not explain the individual details for the triggered areas.	F 636	in the CAA documentation. The Director of Nursing(DON) will audit all completed CAA□s weekly for 8 weeks, to ensure comprehensive completion including identification of underlying causes and contributing factors. The director of Nursing/Designated RN will audit 10% of completed assessments thereafter for a period of 6 months. The Director of Nursing/Designated RN will report audit findings in monthly QAPI meetings to identify patterns or trends and will adjust plan to maintain compliance and review plan for a period of 6 months or until compliance is maintained.	

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2. Resident #36 was admitted to the facility on 11/21/13. Her diagnoses included Alzheimer's Disease, mood disorder, psychosis, presenile depression and major depressive disorder.

The annual Minimum DAta Set (MDS) dated 10/10/17 coded her with severely impaired cognition and receiving antidepressants and hypnotics over the previous 7 days.

a. The CAA for cognition dated 10/11/17 stated Resident #36 had major depressive disorder, Alzheimer disease, had a Do Not Rescusitate advanced directive, was not able to answer questions, refused and spit out medications, would speak and then say I'm fat, and was here for long term care. The CAA did not describe if she was able to make decisions or how her deficit affected her day to day function.

Interview on 12/15/17 at 11:56 AM with Social Worker #1, who completed this CAA, revealed that the cognition CAA did not describe her cognition and how it affected her day to day abilities to make decisions.

b. The CAA for psychtropic drug use dated 10/17/17 stated she was alert and able to make her needs known, had Alzheimers, had clear speech and some problem with hearing. He had frequentl incontinent episodes, required extensive assistance with toilet use and limited assistance with transfers. She was not a candiate for a toileting program. The CAA continues to stated with had a diagnoses of insomnia with hypnotics in use, hypertension, hypothyroidism, osteoporosis, derpression with antideprssant in use and was at risk for drug related side effects.

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Interview on 12/15/17 at 12:09 PM with MDS Nurse #1 who completed this CAA revealed the CAA did not explain the individual details for the triggered areas.

3. Resident #63 was admitted to the facility on 10/23/17 with diagnoses including dementia, diabetes, atriial fibrillation and Alzheiemr's disease.

The admission Minimum Data Set dated 10/30/17 coded her with minimum difficulty hearing, having intact cognition, being occassionaly incontinent of urine, having no natural teeth and having a fall prior to admission.

a. The CAA for communication (hearing) dated 10/30/17 stated she had dementia, an advanced directive, did not wear glasses, did wear dentures, had moderate difficutly hearing, refused medications on 10/25/17, ambulated with a walker and was not sure if she would be discharged home. The CAA did not indicate how her hearing deficit affected her communication skills.

Interview on 12/15/17 at 11:56 AM with Social Worker #1, who completed this CAA, revealed that the communication CAA did not describe her hearing and how the deficit impacted her communication skills.

b. The CAA for incontinence dated 11/02/17 stated that she was alert and able to make her needs known, had minimum difficutly hearing, had no natural teeth, had frequent episodes of bowel incontinence and was usually cntinent of

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bladder, used a wheelchair, was nonambulatory, required extensive assistance with toileting and was at risk for complications related to her current bowel and bladder status. The CAA failed to explan the causative factors for incontinence or how incontinence affected her day to day function.

Interview on 12/15/17 at 12:09 PM with MDS Nurse #1 who completed this CAA revealed the CAA did not explain the individual details for the triggered areas.

c. The CAA for dental care dated 11/02/17 stated she had no natural teeth, had an upper and lower detnure but her bottom dentures were broken. She was noted to require set up for eating. The CAA failed to describe how having no teeth and a broken denture affected her eating.

Interview on 12/15/17 at 12:09 PM with MDS Nurse #1 who completed this CAA revealed the CAA did not explain the individual details for the triggered areas.

d. The CAA for falls dated 11/02/17 noted she was cognitiviely intact, had a diagnoses of dementia, was alert, able to make her needs known, had minimum difficulty hearing, had frequent episodes of bowel incontinence and was usually continent of bladder. She was noted as being nonambulatory and used a wheelchair. She was noted as requiring extensive assistance with bed mobility, transfers, drressing, toileting and bathing and was at risk for falls. The CAA failed to identify the causative factors for her actual fall.

Interview on 12/15/17 at 12:09 PM with MDS

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Nurse #1 who completed this CAA revealed the CAA did not explain the individual details for the triggered areas.

4. Resident #30 was admitted to the facility on 07/31/17 with diagnoses heart failure, non-Alzheimer's dementia, and thyroid disorder.

Review of the admission Minimum Data Set dated 08/07/17 revealed Resident #30 was moderately cognitively impaired and required extensive assistance with most activities of daily living (ADL).

Review of the Care Area Assessment (CAA) for ADL dated 08/14/17 revealed Resident #30 per resident interview/observations, ADL flow sheet, nurse's notes, staff interviews resident was alert, speech was clear, and no problem with communication noted. Unsteady balance and gait noted. Behavioral problems noted, see nurses notes for 08/04/17, 08/07/17. Two falls noted since admit, see nurses notes for 08/02/17, 08/05/17. Frequent episodes of bladder incontinence, incontinence of bowels. Diagnoses of vascular dementia, undifferentiated schizophrenia (antipsychotic in use), atrial fibrillation, seizure disorder, neuropathic pain, hypothyroidism, depression (antidepressant in use), insomnia, urinary frequency, high blood pressure, anxiety (PRN antianxiety in use). Requires extensive assist with bed mobility, transfers, dressing, and total assist with personal hygiene, bathing, and assist of 1 for toileting. Resident at risk for decline in his current level of ADL status. Will care plan to reflect for staff to observe for signs and symptoms of decline in his current level of ADL. The CAA summary did not

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indicate how Resident #30's ADL function affected his day to day routine or his ability to do things for himself.

An interview conducted on 11/15/17 at 12:09 PM with MDS Nurse #2 revealed she wrote the CAA for Resident #30 and MDS Nurse #1 signed off on it. MDS Nurse #2 stated she writes a CAA by gathering all of her information from her observations, staff and resident interviews and nurses notes and writes a summary of the information. She stated she writes each CAA the same way and had never been told the CAA needed to show how the area actually affected the resident's day to day life, decisions and daily activities. She stated she did not include that in her CAA summaries.

5. Resident #35 was admitted to the facility on 06/14/17 with diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and depression.

Review of the admission Minimum Data Set dated 06/21/17 revealed Resident #35 was moderately cognitively impaired and received an antianxiety medication 3 times during the assessment period.

Review of the Care Area Assessment dated 06/23/17 revealed Resident #35 was a new admission for the long term care and short term therapy, she was admitted to the memory care unit. Per physician notes, progress notes, resident, staff and family interviews, medication administration record, activities of daily living flow sheets, treatment records Resident #35 was admitted with diagnoses of a left hip fracture, dementia, without behavioral disturbances, depression, anxiety, and Alzheimer's disease.

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Resident alert and oriented with clear speech, understands and understood, able to make all needs known to staff. During the assessment period resident received extensive to total assist with bed mobility, transfers, toileting, bathing, hygiene, dressing, locomotion in wheel chair. Resident feeds self with set up and supervision. Resident with impaired balance. Up in wheelchair daily and participates with therapy. Resident had no complaints of pain in past 5 days. Frequently incontinent of urine and incontinent of bowel, not of new onset. Resident has history of falls with fracture. Resident takes psychotropic medication as needed for anxiety. Admitted with intact skin. The CAA did not analyze how the psychotropic medications actually affected her day to day function and activities. The CAA summary did not indicate if there had been any adverse reactions or state if a referral was needed for psychiatric services.

An interview conducted on 11/15/17 at 12:09 PM with MDS Nurse #2 revealed she wrote the CAA for Resident #35 and MDS Nurse #1 signed off on it. MDS Nurse #2 stated she writes a CAA by gathering all of her information from her observations, staff and resident interviews and nurses notes and writes a summary of the information. She stated she writes each CAA the same way and had never been told the CAA needed to show how the area actually affected the resident's day to day life, decisions and daily activities. She stated she did not include that in her CAA summaries.

6. Resident #82 was admitted to the facility on 10/06/17 with diagnoses of Alzheimer's disease, non-Alzheimer's dementia, depression, and psychotic disorder.

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Review of the admission Minimum Data Set dated 10/13/17 revealed Resident #82 was severely cognitively impaired and received antipsychotic medications 5 days during the assessment period.

Review of the Care Area Assessment (CAA) dated 10/18/17 revealed Resident #82 was a new admission for short term rehabilitation and possible long term care. She was admitted to the memory care unit from another nursing home with diagnoses of collapsed vertebra, high blood pressure, Alzheimer's disease, dementia with behavioral disturbances, muscle weakness, unsteadiness on her feet, unspecified lack of coordination, cognitive communication deficit, insomnia, diabetes, delusional disorder, constipation, diabetic retinopathy, depression, coronary artery disease, and arterial fibrillation. Per nurses notes, activity of daily living sheets, medication administration record, treatment record, progress notes, staff, resident, and family interviews the resident is alert to person, received extensive to total assist with bed mobility, transfers, toileting, dressing, locomotion, bathing, hygiene, and eating. Resident attempted to ambulate with extensive assist at times, has a history of falls and has fallen since admission. Resident has impaired safety awareness, impaired balance and required staff to regain. Resident participating in therapy. Resident has impaired vision. Takes psychotropic medications daily and as needed pain medications. Resident frequently incontinent of bladder and is incontinent of bowel, not of new onset. The CAA did not analyze how the psychotropic medications actually affected her day to day function and activities. The CAA summary did not indicate if

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there had been any adverse reactions, gradual dose reduction attempts, or state if a referral was needed for psychiatric services.

An interview conducted on 11/15/17 at 12:09 PM with MDS Nurse #2 revealed she wrote the CAA for Resident #82 and MDS Nurse #1 signed off on it. MDS Nurse #2 stated she writes a CAA by gathering all of her information from her observations, staff and resident interviews and nurses notes and writes a summary of the information. She stated she writes each CAA the same way and had never been told the CAA needed to show how the area actually affected the resident's day to day life, decisions and daily activities. She stated she did not include that in her CAA summaries.

7. Resident #110 was admitted to the facility on 04/11/17 with diagnoses of Alzheimer's, non-Alzheimer's dementia, anxiety, and depression.

Review of the significant change Minimum Data Set dated 11/27/17 revealed Resident #110 was severely cognitively impaired and received antipsychotic medications 7 days during the assessment period.

Review of the Care Area Assessment (CAA) dated 11/30/17 revealed Resident #110 was readmitted to the facility from the psychiatric hospital 11/10/17 and went back to an acute hospital on 11/16/17. Resident was readmitted from the acute hospital on 11/20/17. Per hospital discharge summary, progress notes, facility nurses notes, progress notes, activity of daily living sheets, medication administration record, treatment record, resident, family and staff

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interviews: Resident readmitted with diagnoses of aspiration pneumonia, chronic renal disease, Alzheimer's disease, altered mental status - somnolence, dementia and behavioral disturbance, major neurocognitive disorder, atherosclerotic heart disease, generalized muscle weakness, hyperlipidemia, vitamin D deficiency, gout, anxiety and depression. Due to overall decline, a significant change assessment is being done. During the look back period resident received extensive assist with bed mobility, transfers, ambulation, locomotion of wheelchair, dressing, eating, toileting, hygiene, and total assist with bathing. Resident has impaired balance and requires staff to regain, participates in therapy. Resident takes psychotropic medications daily (antipsychotic for diagnoses of behaviors). He at risk for drug related side effects. The CAA did not analyze how the psychotropic medications actually affected his day to day function and activities. The CAA summary did not indicate if there had been any adverse reactions, gradual dose reduction attempts, or state if a referral was needed for psychiatric services.

An interview conducted on 11/15/17 at 12:09 PM with MDS Nurse #2 revealed she wrote the CAA for Resident #110 and MDS Nurse #1 signed off on it. MDS Nurse #2 stated she writes a CAA by gathering all of her information from her observations, staff and resident interviews and nurses notes and writes a summary of the information. She stated she writes each CAA the same way and had never been told the CAA needed to show how the area actually affected the resident's day to day life, decisions and daily activities. She stated she did not include that in her CAA summaries.

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8. Resident # 18 was admitted 05/24/2017 with diagnosis that included paraplegia, pressure ulcers on his right hip and sacral area.

On his Minimum Data Set (MDS) he was assessed as being he was assessed as cognitively intact for daily decision making. It indicated his function as needing extensive assistance with his activities of daily living. It documented he had stage 4 pressure ulcers and was receiving treatment for them.

A review of the CAA worksheet dated 06/02/2017 documented his cognitive loss limits his mobility, however he was evaluated to be cognitively intact for daily decision making on his MDS.

Interview on 12/15/2017 at 12:06 PM with the MDS Nurse #1 revealed a complete an analysis of the underlying causes and contributing factors for his triggered area for pressure ulcers was necessary.

9. Resident #99 was admitted 02/10/2017 with diagnoses that included intellectual disabilities, impulse disorder anxiety disorder, psychosis and major depressive disorder.

On his quarterly MDS dated 11/14/2017 he was assessed as having long and short term memory problems. Behaviors including pushing, kicking, cursing were documented and rejection of care was documented. Use of psychotropic medications was coded.

Review of his CAA dated 02/22/2017 for use of psychotropic medication did not have an analysis of the resident's behaviors, and the how he

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reacted to the medications and the impact they had on his daily functioning. It did not delineate the causes and contributing factors for this triggered care area.

Interview on 12/15/2017 at 12:06 PM with MDS Nurse #1 revealed the analysis of the resident's mental health and behavioral conditions and issues needed to be completely documented and addressed in the analysis of the comprehensive assessment.

10. Resident #71 was admitted to the facility on 11/20/15 with diagnoses that included anxiety disorder, insomnia, unspecified psychosis, vitamin B12 deficiency, essential hypertension, muscle weakness, difficulty in walking, atrial fibrillation, polyneuropathy, major depressive disorder and cerebrovascular disease.

Review of the admission Minimum Data Set dated 10/30/17 revealed Resident #71 was cognitively intact and required extensive assistance with most activities of daily living (ADL).

Review of the Care Area Assessment (CAA) for falls dated 10/25/17 revealed Resident #71 had no falls since the last review. It discussed the medications she was taking and some of Resident #71's behaviors. Further review of resident's CAA for falls revealed description of required assistance with all of her Activities of Daily Living (ADL). The CAA did not identify the reason for the concern for resident falling nor did it discuss how the risk of falling impacted Resident #71's day to day activities.

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F 636	Continued From page 36 An interview completed on 12/15/17 at 12:09 PM with MDS Nurse #1 revealed the CAA did not explain the individual details for the triggered areas.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 28 sampled residents. Resident #63's denture status and Resident #5's psychotropic medication use were not accurately coded on the MDS. The findings included: 1. Resident #63 was admitted to the facility on 10/23/17 with diagnoses of dementia, diabetes, and atrial fibrillation. The admission Minimum Data Set (MDS) dated 10/30/17 coded her with having intact cognition, with ambulation not occurring during the look back period, and having no natural teeth. The MDS did not check any problems with broken or loosely fitting full or partial dentures. a. The dental Care Care Area Assessment dated 11/02/17 noted she had no natural teeth and has an upper and lower denture, however the bottom dentures were broken. During interview on 12/11/17 at 11:35 AM	F 641	Regarding the alleged deficient practice of failure to properly code the MDS assessment on resident #63 and Resident #5, the MDS nurses misinterpreted the data on the Electronic medication administration record and therefore, miscoded the assessment. The MDS nurse completed a corrected MDS and submitted on December 22, 2017. The Regional Director of MDS provided an in service on December 19, 2017 to MDS nurse #1 and MDS nurse #2, regarding accurate completion of MDS assessments. MDS # 1 and #2 will be attending the state offered training on February 22, 2018. Current facility residents are at risk for the alleged deficient practice of failure to properly code MDS. An audit was completed by MDS nurse #1 by December 22, 2017 of all areas surrounding the alleged deficient practice. MDS corrections were made and transmitted by December 22, 2017. Associated care plans in conjunction with MDS miscoding were reviewed and found	1/11/18

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F 641	Continued From page 37 Resident #63 stated that her dentures broke at the facility she was previously in and since she had no teeth some foods were hard to chew. She stated she did not want them fixed as the dentures did not fit well. Interview with the MDS Nurse #1 on 12/15/17 at 11:25 AM revealed she inaccurately did not mark the MDS section relating to broken dentures. b. Review of the physical therapy notes revealed she began physical therapy on 10/24/17 with one of the interventions for gait training. Review of the notes revealed that on 10/24/17 she participated in 15 minutes of gait training over a level surface with a rolling walker and minimum assistance of one staff with verbal cues to increase step length in order to improve the quality of her gait. Notes reflected that on 10/30/17 she participated in 15 minutes of gait training using a rolling walker and care giver assistance with instructions for increased step height. Interview with the MDS Nurse #1 on 12/15/17 at 11:25 AM revealed she received the information for the ambulation coding from the activities of daily living flow sheets and she never saw her walk or received any information about ambulation. She further stated she did not go to therapy to watch her and could not recall asking therapy about ambulation. 2. Resident #5 was admitted to the facility on 02/18/16. Her diagnoses included psychosis, traumatic brain injury, anxiety, and major depressive disorder. Review of the Medication Administration record	F 641	to appropriately reflect residents needs and not affected by the coding of the MDS. The Director of Nursing(DON) will audit completed MDS to ensure accurate completion 10% of completed assessments weekly for 4 weeks. The Director of Nursing/Designated RN will audit 5% of completed assessments weekly thereafter for a period of 4 weeks. The Director of Nursing/Designated RN will audit 10% of completed assessments per month thereafter for a period of 6 months. The Director of Nursing/Designated RN will report audit findings in monthly QAPI meetings to identify patterns or trends and will adjust plan to maintain compliance and review plan for a period of 6 months or until compliance is maintained.	

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F 641	Continued From page 38 for September 2017 revealed the antidepressant medication Celexa was administered daily from 09/01/17 through 09/09/17 and the antipsychotic medication of Seroquel was administered daily from 09/01/17 through 09/09/17. The quarterly Minimum Data Set (MDS) dated 09/09/17 coded her with receiving antidepressant medication 4 days out of the previous 7 days and antipsychotic medications 4 days out of the previous 7 days. Interview with MDS Nurse #1 on 12/15/17 at 11:25 AM revealed she miscoded the antidepressant medications and antipsychotic medications received during the look back period for the MDS of 09/09/17 as she misread the coding on the electronic Medication Administration Record.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		1/11/18

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F 656	Continued From page 39 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement the care planned interventions to reduce the risk of injuries due to falls for 1 of 6 residents sampled for falls. Resident #5 was not provided with a fall mat or gripper strips to the bedroom floor. The findings included: Resident #5 was admitted to the facility on 02/18/16. Her diagnoses included dementia, status post hip fracture, hypertension, migraines, psychosis, traumatic brain injury, anxiety	F 656	Regarding the alleged deficient practice of implementing care planned interventions to reduce the risk of injuries due to falls for Resident #5, the Director of nursing verified the presence of the care planned interventions of fall mats and non-skid tape. The facility relocate interventions to a new resident room when a resident had a room change. Current nursing staff were in serviced by the Director of Nursing on December 19,2017, regarding interventions to reduce falls and the assurance that interventions	

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F 656	Continued From page 40 disorder,and major depressive disorder. Review of the incident report dated 05/29/17 at 2:10 PM stated she was found on her back on the floor with bleeding from the temporal area from a laceration. She was diagnosed with interparenchymal hemorrhage in the left frontal lobe and she had a hematoma and laceration with 6 sutures . A nursing note dated 05/30/17 at 6:38 AM revealed the hospital X-ray reports showed a fracture of the left superior pubic ramus. The incident report dated 06/02/17 at 9:55 AM stated she was found lying on the floor with a large amount of blood noted from a laceration above her left eye and a hematoma. Discoloration was noted to the left eye with swelling noted to the left side of her face. An abrasion with swelling was noted to the left knee. Nursing notes dated 06/02/17 at 9:55 AM noted she complained of her back hurting. She was sent to the hospital for evaluation. A follow up note dated 06/02/17 at 3:21 PM noted an order had been written for non-skid gripper tape to be placed in the floor of the room at bedside, in front of sink and in front of the closet. The note stated the resident was moved to a room closer to the nursing station. Upon return from the hospital she was diagnosed with a new region of hemorrhage in the right frontal lobe with previous intraventricular hemorrhage resolved. All fall interventions were in place. The most recent comprehensive assessment was a significant change Minimum Data Set (MDS) dated 06/09/17. The MDS coded Resident #5 with severely impaired cognition, trouble sleeping,	F 656	remain in place. Current facility residents were at risk for the alleged practice of not implementing care planned interventions to reduce the risk of falls. The Director of Nursing, ADON and unit coordinators audited current residents□ rooms and care plans to ensure that identified interventions to reduce the risk of falls were in place. Audit was completed by December 22, 2017. The Director of Nursing (DON) and ADON provided in service education for the nursing staff, beginning on December 19th and commencing January 11, 2018, regarding implementation of interventions to reduce falls and assurance that interventions remain in place for residents. Newly hired nursing staff will receive in service education during orientation. The DON, ADON/Unit Coordinators will observe 10 residents/rooms weekly for 4 weeks then 20 residents/rooms monthly for 3 months, to validate that interventions are in place to reduce falls, according to resident care plan. The DON and/or the ADON will review audit/ monitors to identify patterns/trends and will adjust plan as needed to maintain compliance. The plan will be reviewed during monthly QAPI for 6 months or until compliance is maintained.	

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F 656	Continued From page 41	F 656		

being tired, trouble with concentration, requiring total extensive assistance with most activities of daily living skills, and being nonambulatory. In addition the MDS coded her as being under Hospice services and having 2 falls, one with no major injury and the other with major injury.

The Care Area Assessment (CAA) that addressed falls was dated 06/12/17. Under the analysis of findings, the CAA stated falls was a potential problem and that the assessment was a significant change as the resident was under Hospice care due to an intracranial hemorrhage. Resident #5 was noted to have experienced multiple falls including one with a fracture. She was described as having poor safety awareness, was nonambulatory, and had decreased mobility. She was also noted to receive psychotropic medications, had impaired cognition and was incontinent. She remained at high risk for falls related injury.

Review of the incident report dated 07/23/17 at 7:42 PM revealed Resident #5 was found on the floor with the wheelchair sitting directly over her face but did not make contact. She stated she slid out of her wheelchair and hit the back of her head on the floor. The family opted not to send her to the emergency room. A follow up noted dated 07/27/17 at 1:12 PM noted several fall interventions were in place and after discussing with Hospice a dycem was to be placed in the wheelchair.

Another incident report dated 09/19/17 at 7:00 PM revealed that staff stood the resident up for incontinent care, turned to obtain some wipes and the resident started falling. Resident #5 was noted to sustain a pop knot to the back of the left

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F 656	Continued From page 42	F 656		

side of her head measuring approximately 4 centimeters in diameter. A follow up note dated 09/20/17 at 2:59 PM revealed that staff were to attempt to obtain 2 staff member for stand by assistance when resident was in a standing position.

The care plan, revised most recently on 09/25/17 noted the problem was her high risk for falls related injury. The goal was for her to not sustain another serious injury through the next review date. Interventions included:
*fall mats; and
*gripper adhesive to the resident's floor.

Observations made of Resident #5 throughout the survey revealed there was no fall mat while she was in bed and no gripper strips located on the floor by her bed, by her closet or by the sink on
*12/11/17 at 11:10 AM as she rested in bed;
*12/12/17 at 4:33 PM as she remained in bed;
*12/13/17 at 8:24 AM as she remained in bed;
*12/13/17 at 3:14 PM as she slept in bed;
*12/14/17 at 8:35 AM as she was up in a wheelchair eating breakfast;
*12/14/17 at 4:36 PM as she was up in a wheelchair in her room;
*12/15/17 at 8:31 AM as she was observed in bed; and
*12/15/17 at 10:18 AM as she was in bed.

Interview with Nurse Aide (NA) #4 on 12/15/17 at 10:40 AM revealed she worked on this hall but not normally with Resident #5. she stated she was helping another nurse aide with Resident #5 this date and did not know any safety interventions planned for her or if she was a fall risk.

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F 656	Continued From page 43 NA #5 who was assigned to Resident #5 was interviewed on 12/15/17 at 10:42 AM. NA #5 stated she had worked with Resident #5 for the four months she had worked in the facility. NA #5 stated that she has not seen any fall mats or gripper strips on the floor while caring for Resident #5. During an interview with the Director of Nursing on 12/15/17 at 9:55 AM she revealed that the fall mat and grippers on the floor should still be in place for Resident #5. She further stated that the resident had changed rooms and guessed the nonskid strips did not move with her. She stated it was nursing's responsibility to ensure all interventions were in place.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide the compression stockings as ordered by the physician to treat lower extremity edema. This affected 1 of 1 resident sampled with an order for compression stockings (Resident #176).	F 684	Regarding the alleged deficient practice of failure to provide compression stockings as ordered by the physician for resident # 176. The Director of Nursing obtained the compression stockings and applied to resident□s lower extremities on December 14, 2017.	1/11/18

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F 684	Continued From page 44 The findings included: Resident #176 was admitted to the facility on 12/09/17 with diagnoses including sepsis, major depressive disorder, anxiety disorder and chronic obstructive pulmonary disease. Nursing notes dated 12/09/17 at 2:30 PM revealed Resident #176 was alert and oriented times 4 spheres. Nursing notes dated 12/11/17 at 1:12 PM revealed the physician was in and ordered compression stockings for lower bilateral extremities to be worn daily. Observations on 12/11/17 at 3:56 PM revealed Resident #176 had edema in bilateral feet. Nursing notes dated 12/11/17 at 10:48 PM noted plus 1 edema noted to bilateral lower extremities. On 12/12/17 at 8:55 AM, Resident #176 was observed with edema in her bilateral feet and stated the physician saw her yesterday and ordered compression stockings but she had not received them yet. A physician order was written for compression stockings to bilateral lower extremities daily on 12/11/17. Nursing notes dated 12/12/17 at 10:25 PM revealed Resident #176 had plus 1 edema in bilateral lower extremities. Resident #176 was observed on 12/13/17 at 8:26 AM in bed. feet still swollen but not as much. She stated at this time she has been sleeping	F 684	The director of nursing discovered that the order had been entered incorrectly and therefore was not displaying on the treatment record to alert licensed staff of ordered intervention. Current facility residents were at risk for the alleged practice of not implementing physician orders. The Director of Nursing, ADON, and unit coordinators audited current residents orders for compression stockings to assure compression stockings were available and implemented. This was completed by December 22, 2017. The DON and/or the ADON provided in service education for the licensed nurses regarding following/implementing physician orders to be completed by January 11, 2018. The DON/ADON/unit coordinators/supervisors will review physician orders daily ongoing to validate orders are implemented. The Director of Nursing/ADON/unit coordinator will conduct audits of 3-5 residents and their treatment orders per week for a period of 4 weeks to verify interventions are in place. The Director of Nursing/Designated RN will report audit findings in monthly QAPI meetings to identify patterns or trends and will adjust plan to maintain compliance and review plan for a period of 6 months or until compliance is maintained.	

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F 684	Continued From page 45 with her feet elevated. Resident #176 was observed in a wheelchair on 12/13/17 at 3:40 PM without compression stockings. The Central Supply Clerk was interviewed on 12/14/17 at 11:28 AM. She stated she had compression stockings in stock and just delivered some to several residents. Resident #176 was not on the list and she stated she was not aware of any order for her to have them. On 12/14/17 at 11:29 AM, Resident #176 was observed in therapy without compression stockings in place. Nurse Aide (NA) #6 stated she cared for Resident #176 this date and further stated the resident dressed herself. NA #6 stated she was unaware of her having compression stockings. On 12/14/17 at 11:37 AM, Nurse #1 looked in the computer and verified an order for compression stockings was entered into the electronic record on 12/11/17. Interview with Nurse #2 on 12/14/17 at 11:40 AM revealed she had helped another nurse with physician orders on 12/11/17 and entered the order into the system. She stated she normally placed the new order on the report sheet for follow up for the next shift but was not sure she did this. This caused the order to not be filled.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		1/11/18

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F 689	Continued From page 46 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain implemented interventions to prevent falls for 1 of 6 sampled residents reviewed for accidents (Resident #5). The findings included: Resident #5 was admitted to the facility on 02/18/16. Her diagnoses included dementia, status post hip fracture, hypertension, migraines, psychosis, traumatic brain injury, anxiety disorder,and major depressive disorder. Review of the incident report dated 05/29/17 at 2:10 PM stated she was found on her back on the floor with bleeding from the temporal area from a laceration. Her right eye pupil was slow to respond to light and she was sent to the emergency department. Nursing notes dated 05/29/17 at 10:34 PM revealed the hospital diagnoses was interparenchymal hemorrhage in the left frontal lobe and she had a hematoma and laceration with 6 sutures . A nursing note dated 05/30/17 at 6:38 AM revealed the hospital X-ray reports showed a fracture of the left superior pubic ramus. A follow up note dated 05/30/17 at 4:36 PM stated the resident transferred herself to and from the	F 689	Regarding the alleged deficient practice of maintaining implemented care planned interventions to reduce the risk of injuries due to falls for Resident #5, the facility did not move the gripper tape, fall mats to the residents new room. On December 15th, the Director of nursing verified the presence of the care planned interventions of fall mats and non-skid tape. Current nursing staff were in serviced by the Director of Nursing on December 19, regarding interventions to reduce falls and the assurance that interventions remain in place. Current facility residents were at risk for the alleged practice of not maintaining implemented care planned interventions to reduce the risk of falls. The Director of Nursing, ADON and unit coordinators audited current residents rooms and care plans to ensure that identified interventions to reduce the risk of falls were in place. Audit was completed by December 22, 2017. The Director of Nursing (DON) and ADON provided in service education for all of the nursing staff, completed by January 11, 2018 regarding implementation of interventions to reduce falls and assurance that interventions remain in	

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F 689	Continued From page 47 wheelchair and independently stood at the dresser, closet or restroom. The call bell was wrapped in brightly colored tape. The incident report dated 06/02/17 at 9:55 AM stated she was found lying on the floor with a large amount of blood noted from a laceration above her left eye and a hematoma. Discoloration was noted to the left eye with swelling noted to the left side of her face. An abrasion with swelling was noted to the left knee. Nursing notes dated 06/02/17 at 9:55 AM noted she complained of her back hurting. She was sent to the hospital for evaluation. A follow up note dated 06/02/17 at 3:21 PM noted an order had been written for non-skid gripper tape to be placed in the floor of the room at bedside, in front of sink and in front of the closet. The note stated the resident was moved to a room closer to the nursing station. Upon return from the hospital she was diagnosed with a new region of hemorrhage in the right frontal lobe with previous intraventricular hemorrhage resolved. All fall interventions were in place. The most recent comprehensive assessment was a significant change Minimum Data Set (MDS) dated 06/09/17. The MDS coded Resident #5 with severely impaired cognition, trouble sleeping, being tired, trouble with concentration, requiring total extensive assistance with most activities of daily living skills, and being nonambulatory. In addition the MDS coded her as being under Hospice services and having 2 falls, one with no major injury and the other with major injury. The Care Area Assessment (CAA) that addressed falls was dated 06/12/17. Under the	F 689	place for residents. Newly hired nursing staff will receive in service education during orientation. The DON,ADON/Unit Coordinators will observe 10 residents/rooms weekly for 4 weeks then 20 residents/rooms monthly for 3 months, to validate that interventions are in place to reduce falls, according to resident care plan. The DON and/or the ADON will review audit/ monitors to identify patterns/trends and will adjust plan as needed to maintain compliance. The plan will be reviewed during monthly QAPI for 6 months or until compliance is maintained.	

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analysis of findings, the CAA stated falls was a potential problem and that the assessment was a significant change as the resident was under Hospice care due to an intracranial hemorrhage. Resident #5 was noted to have experienced multiple falls including one with a fracture. She was described as having poor safety awareness, was nonambulatory, and had decreased mobility. She was also noted to receive psychotropic medications, had impaired cognition and was incontinent. She remained at high risk for falls related injury.

Review of the incident report dated 07/23/17 at 7:42 PM revealed Resident #5 was found on the floor with the wheelchair sitting directly over her face but did not make contact. She stated she slid out of her wheelchair and hit the back of her head on the floor. The family opted not to send her to the emergency room. A follow up noted dated 07/27/17 at 1:12 PM noted several fall interventions in place including anti-roll backs and anti-tippers on the wheelchair which were functioning properly. She had a drop wheelchair seat in place and after discussing with Hospice a dycem was to be placed in the wheelchair.

Another incident report dated 09/19/17 at 7:00 PM revealed that staff stood the resident up for incontinent care, turned to obtain some wipes and the resident started falling. Resident #5 was noted to sustain a pop knot to the back of the left side of her head measuring approximately 4 centimeters in diameter. A follow up note dated 09/20/17 at 2:59 PM revealed that staff were to attempt to obtain 2 staff member for stand by assistance when resident was in a standing position.

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The care plan, revised most recently on 09/25/17 noted the problem was her high risk for falls related injury. The goal was for her to not sustain another serious injury through the next review date. Interventions included:
*fall mats; and
*gripper adhesive to the resident's floor.

Observations made of Resident #5 throughout the survey revealed there was no fall mat while she was in bed and no gripper strips located on the floor by her bed, by her closet or by the sink on
*12/11/17 at 11:10 AM as she rested in bed;
*12/12/17 at 4:33 PM as she remained in bed;
*12/13/17 at 8:24 AM as she remained in bed;
*12/13/17 at 3:14 PM as she slept in bed;
*12/14/17 at 8:35 AM as she was up in a wheelchair eating breakfast;
*12/14/17 at 4:36 PM as she was up in a wheelchair in her room;
*12/15/17 at 8:31 AM as she was observed in bed; and
*12/15/17 at 10:18 AM as she was in bed.

Interview with Nurse Aide (NA) #4 on 12/15/17 at 10:40 AM revealed she worked on this hall but not normally with Resident #5. she stated she was helping another nurse aide with Resident #5 this date and did not know any safety interventions planned for her or if she was a fall risk.

NA #5 who was assigned to Resident #5 was interviewed on 12/15/17 at 10:42 AM. NA #5 stated she had worked with Resident #5 for the four months she had worked in the facility. NA #5 stated that she has not seen any fall mats or gripper strips on the floor while caring for

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F 689	Continued From page 50 Resident #5. During an interview with the Director of Nursing on 12/15/17 at 9:55 AM she revealed that the fall mat and grippers on the floor should still be in place for Resident #5. She further stated that the resident had changed rooms and guessed the nonskid strips did not move with her. She stated it was nursing's responsibility to ensure all interventions were in place.	F 689		
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 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.	F 761		1/11/18

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F 761	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to remove expired medication from 1 of 3 medication refrigerators. Findings included: Review of the facility's medication storage policy revised April 2007 revealed the nursing staff shall be responsible for maintaining medication storage and the facility shall not use discontinued, outdated or deteriorated drugs or biological's. All such drugs shall be returned to the dispensing pharmacy or destroyed. Interview on 12/14/2017 at 10:22 AM with Nurse #3 revealed stated medications were good for 30 days after they were opened or until the manufacturer's expiration date. She stated the night shift goes through the medication carts and medication storage rooms at night. She stated any nurse can through them. Observation on 12/14/2017 at 10:34 AM with Nurse #4 of medication storage room C refrigerator revealed one vial of tuberculin purified protein derivative 5TU/0.1ml opened 8/31. The manufacturer instructions on the box stated to throw it away 30 days after opening. Interview on 12/14/2017 at 10:34 AM with Nurse #4 revealed the nurses went through the refrigerators and medication storage areas and medication carts looking for expired medications. She stated there was a policy that stated they go by what the manufacturer says. Interview on 12/14/2017 at 12:07 PM with the	F 761	Regarding the alleged deficient practice of failure to discard 1 vial of tuberculin purified protein derivative 5TU/0.1ml opened 8/31 the unit coordinator removed and discarded the vial on December 14, 2017. The facility did not follow procedure of ensuring expired medications were removed from the medication room and discarded properly. The DON provided inservices to the Unit coordinator and nurse 3 and 4 regarding Policy and Procedure for dating and labeling and expiration dates for medications once opened. Current facility residents are at risk of being affected by the alleged deficient practice related to labeling and storage of medications. The DON, Assistant DON, and unit coordinators performed and audit of facility medication carts, treatment carts and medication rooms on December 15, 2017, to assure medications were dated/labeled and discarded according to facility policy and procedure. Medications were dated/labeled appropriately, and no medications were observed to be expired. The DON and/or the ADON provided in service education for current facility licensed nurses beginning on December 18 and completed January 11, 2018, regarding Dating/Labeling/Storage of medications and recommended expiration dates once medications are opened. Education will be provided for new hires during orientation. The DON, ADON and/or the Unit Coordinators will audit medication carts and medication rooms	

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F 761	Continued From page 52 Director of Nursing (DON) revealed the unit coordinators go through medication storage and they do spot checks. She stated each nurse was responsible for pulling expired medications, medications no longer being used and medications for discharged residents. She stated her expectation was that everything was in date. She expected each nurse would check the carts and medication storage areas. She expected that the unit managers would spot check the medications storage refrigerators.	F 761	daily for 4 weeks, then 3 times a week for 4 weeks then once weekly ongoing to validate medications are dated/labeled/stored and disposed of per facility policy. The DON will review audits for patterns/trends and will adjust plan to maintain compliance and will review plan during the monthly QAPI meeting for 6 months or until compliance is maintained.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 observations, record review and staff interviews, the facility failed to maintain sanitary vents, walls and ceiling and have a system to	F 812	Regarding the alleged deficient practice of maintaining sanitary vents, walls and ceilings and having a system to routinely	12/20/17

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F 812	Continued From page 53 routinely check the sanitation in the cool water dish machine. The findings included: 1. On 12/11/17 at 9:53 AM the dish machine was observed in use for 3 cycles. The rinse cycle was noted to be at 118 degrees Fahrenheit and the wash cycle reached 150 degrees Fahrenheit. The Dietary Manager stated at this time that the dish machine had been converted to a cool water machine approximately 2 months ago and a company was out last week and set up the sanitation settings. When asked about checking the sanitation levels the Dietary Manager stated that staff never checked the sanitation levels and was not instructed to do so when the dish machine was converted to cool water. On 12/13/17 at 10:15 AM the company's representative who supplied the sanitation for the dish machine was interviewed with the Dietary Manager. The company representative stated he had recently taken over for a previous representative. The company representative stated the sanitation levels should be checked each meal. He stated he normally visited facilities once a month and checked the sanitation levels last week when he came and they were within the appropriate range. Again at this time, the Dietary Manager stated she had never been told or given testing strips to use since the dish machine was converted. She has as of this date been provided with testing strips and the kitchen staff has been educated on the testing procedure. 2. During tour of the kitchen on 12/13/17 at 9:53 AM, the baffle vents above the stove area was	F 812	check the sanitation in the cool water dish machine; the dietary manager had not ensured the test strips were obtained when the machine was converted to the cool water sanitizer. The facility also did not maintain the baffle vents and electrical box cleanliness. The dietary manager cleaned the baffle vents and spattering on electrical box immediately on December 12, 2017. Sanitizer strips were obtained December 13, 2017 and staff were in serviced on that date regarding the use of the sanitizer strips for the cool water dish machine. Corporate consultant dietitians provided an in service regarding dietary sanitation on December 20, 2017. Consultant dietitians performed a department audit of kitchen sanitation on December 20,2017. Staff began checking sanitizer solution of cool water dish machine each shift on December 13, 2017 and recording results on a sanitizer solution log. Dietary manager will monitor kitchen sanitation and cleaning lists to ensure completion weekly. Dietary manager will audit sanitizer solution log and cleanliness of the kitchen 3-5 X□s per week X 4 weeks, identifying any areas which are not maintained and addressing as needed. Consulting dietitian(s) will monitor kitchen sanitation and compliance with sanitizer test strips monthly and report findings to Administrator. Dietary manager will report findings from sanitizer solution log and weekly cleaning list in monthly QAPI meeting x 3 months to identify trends or practices which need	

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F 812	Continued From page 54 observed with dark and yellow build up that looked like grease. The Dietary Manager stated on 12/13/17 at 10:25 AM that the vents were cleaned by a contract company every 6 months. On 12/13/17 at 11:27 AM the Dietary Manager stated the vents were last cleaned on 09/26/17 and she was informed that the baffles needed to be replaced. She was unable to say if the debris was rust or grease but did state that when they were last cleaned on 09/26/17 they looked cleaner. Follow up interview with the Dietary Manager on 12/13/17 at 11:46 AM stated she was told verbally by kitchen staff that the baffles needed to be replaced. She stated she was waiting for pricing but there was a mix up with the email account and she never received the written report for the last cleaning or the pricing for the new baffles. Review of the cleaning report completed on 09/26/17 at 7:00 PM revealed there was a heavy grease build up around and on the fan, in the ducts, in the hood and in the filters. The report further stated that baffle filters were old and falling apart. 3. During tour of the kitchen on 12/13/17 at 9:53 AM, there was a dried dark spattering of food debris across the electrical box located on the wall and the ceiling above the mixer which was used to puree foods. On 12/13/17 at 11:27 AM the Dietary Manager stated the splatters on the electrical box and ceiling should have been wiped off.	F 812	modified, monitored or changed to maintain compliance.	

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F 867	Continued From page 55	F 867		
F 867 SS=E	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, observations, and resident and staff interviews the facility Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification/complaint survey of 11/04/16 and the complaint survey of 05/10/17. This was for 6 deficiencies originally cited in September 2016 and 1 deficiency cited in May 2017. These 6 deficiencies were subsequently recited on the current recertification and complaint survey of 12/15/17. The findings included: These tags cross referenced to: 483.10: Self Determination: Based on observations, record review and resident and staff interviews the facility failed to allow a safe smoker to smoke without supervision and smoke whenever he wanted and failed to provide a resident with their preferred number of showers a week for 2 of 3 residents reviewed for choices (Resident #116, #63). During the recertification and complaint survey of	F 867	Regarding the alleged deficient practice of failure to observe the resident right in regards to choice specifically in allowing a safe smoker to smoke without supervision and failure to provide a resident with their preferred number of showers per week for resident #116 and #63. Social Workers #1 and #2 were in-serviced by administrator on December 18, 2017 in regards to smokers assessment for identification of residents that are independent smokers or supervised smokers. Resident #116 who was affected by this alleged deficient practice was scheduled to be discharged to home on December 15, 2017, as part of his plan of care and is no longer affected by alleged deficient practice. Current facility residents who smoke were reassessed by Social Worker December 22nd 2017, residents that were identified as independent smokers were provided a safe area to smoke, smoker s contract updated, care plan updated and allowed to smoke independently. The Social worker or licensed nurse will assess residents who smoke upon	1/11/18

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F 867	Continued From page 56 11/04/16 the facility was cited for failure to honor the choice to smoke when desired. 483.10: Resident Rights: Based on observations, record review and staff interviews, the facility failed to promote an environment that enhanced dining with dignity for 1 of 2 sampled residents reviewed for dignity (Resident #36). During the recertification and complaint survey of 11/04/17 the facility was cited for failure to provide a dignified dining experience in 1 of 4 dining rooms. 483.20: Comprehensive Assessments and Timing: Based on Record review and staff interviews, the facility failed to complete Care Area Assessments (CAA) that addressed the underlying causes and contributing factors for triggered areas for 10 out of 28 sampled residents (Residents #5, #36, #63, #30, #35, #82, #110, #18, #99, and #71). During the recertification and complaint survey of 11/04/17 the facility was cited for failure to complete Care Area Assessments that addressed the underlying causes, contributing factors, and risk factors related to pressure ulcers, activities of daily living, nutrition, psychotropic medication use, urinary incontinence, falls, nutrition, and behaviors. 483.20: Accuracy of Assessments: Based on record review, resident interview and staff	F 867	admission, quarterly, annually and with significant change. The resident will sign the smoker□s contract upon admission and/or upon a change of condition. The licensed nurse will initiate or update the care plan to support independent or supervised smoking. The facility will provide a safe area for the resident to smoke. Administrator/DON/Designee will maintain a log of all current smokers both supervised and independent and ensure residents are provided access to a safe and accessible area to smoke. The Administrator, DON and/ or the ADON provided in service education for current facility staff beginning December 15, 2017 and to commence January 11th, 2018 on resident□s rights in regards to choices. DON, ADON, and /or Social workers will review smoking assessments ongoing for new admissions and with quarterly, annual, significant change assessments to validate accuracy of assessment. The DON and/or Social Worker will review audits and reviews to identify patterns/trends and will adjust plan as needed to assure continued compliance. The DON and/or Social Worker will review plan during monthly QAPI meetings for 3 months or until compliance is maintained. Regarding the alleged deficient practice to observe the resident rights in regards to choice specifically in providing the number of showers resident # 63 requested. The Licensed nurse interviewed resident #63 on December 15, 2017, in regards to her choice for showers. The licensed nurse	

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F 867	Continued From page 57 interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 28 sampled residents. Resident #63's denture status and Resident #5's psychotropic medication use were not accurately coded on the MDS. During the recertification/complaint survey of 11/04/16 and the complaint survey of 05/10/17 the facility was cited for failure to accurately code information regarding falls, dental condition, smoking, and continence. 483.25: Free of Accident Hazards/Supervision/Devices: Based on observations, record review and staff interviews, the facility failed to maintain implemented interventions to prevent falls for 1 of 6 sampled residents reviewed for accidents (Resident #5). During the recertification/complaint survey of 11/04/17 the facility was cited for failure to analyze the root cause for repeated falls and implement changes to the care plan to prevent further falls. 483.60: Food Procurement, Store/Prepare/Serve - Sanitary: Based on observations, record review and staff interviews, the facility failed to maintain sanitary vents, walls and ceiling and have a system to routinely check the sanitation in the cool water dish machine. During the recertification/complaint survey of 11/04/17 the facility was cited for failure to date	F 867	updated the shower schedule for the resident to include the resident choice. The DON and/or the ADON provided in service education for the nursing staff in regards to residents choice for their shower and documentation of showers and refusals. Current facility residents have the potential to be affected by the alleged deficient practice. The DON, ADON, and unit coordinators interviewed current facility residents in regards to their preferences as they relate to bathing including preferred days/times which was completed by December 22, 2017. The DON, and/or the ADON provided in-service education to all nursing staff in regards to resident rights related to choices. The licensed nurses will interview residents upon admission regarding preferences of bathing and will update shower schedule to accommodate the residents preference. The DON and/or the ADON will observe 10 residents shower logs weekly for 4 weeks, then 15 residents shower logs monthly for 3 months to validate that residents are provided with choice in regards to their shower times. Resident Rights will be reviewed during monthly meetings with facility staff by Administrator. The administrator and/or the Social Worker will identify residents concerns as they relate and will implement appropriate interventions to support resident rights and choices. The DON will review audits/monitors to identify patterns and or trends and will adjust plan to maintain compliance and	

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F 867	Continued From page 58 stored food and discard expired food in 1 of 3 nourishment rooms and 1 of 2 kitchen freezers. During an interview conducted on 12/15/17 at 11:37 AM the Administrator stated they had focused some much on the little things of the previous citations that they had not been monitoring the broader aspects of the citations resulting in a lack of focus to fixing the problems.	F 867	review plan during the monthly QAPI meetings for at least 6 months or until satisfactory compliance is maintained. Regarding the alleged deficient practice of failure to provide an environment that enhanced dining with dignity for resident #36 the Director of Nursing(DON) provided an in-service education on December 15, 2017 for NA#1, NA#2 and other assigned staff, regarding resident□s rights- dining with dignity, ensuring area is free of odors for dining. Alleged resident will be toileted or incontinent care provided prior to meals. Current facility residents are at risk for alleged deficient practice of failure to provide dining with dignity. The DON/ADON/Designee provided in service education for current facility staff beginning December 15 2017 and to commence January 11th, 2018. The DON/ADON/Administrator ensured no other residents were immediately affected in regards to failure to provide an environment that enhanced dining with dignity. In service education, will be provided during new hire orientation in regards to dining with dignity during new hire orientation. The administrator, DON, ADON and designee will observe 10 resident rooms/ dining areas weekly for 4 weeks, then 15 resident rooms/dining areas monthly for 3 months to validate that residents are provided with dignity with dining. Residents Rights will be reviewed during monthly meetings with facility staff. The administrator and/or the	

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	345197	A. BUILDING _____ B. WING _____	C 12/15/2017

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F 867	Continued From page 59	F 867	Social Worker (SW) will identify residents concerns as they relate and will implement appropriate interventions to prevent deficient practice. The Administrator and/or the SW will review audits to identify patterns and or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meetings for at least 6 months or until satisfactory compliance is maintained. Regarding the alleged deficient practice of failure to address underlying causes and contributing factors for triggered areas for residents #5, 36, 63, 30, 35, 82, 110, 18, 99, 71, MDS nurses #1and #2, reviewed those identified resident CAAS, and determined that it did not affect the resident s care plan and outcome. The MDS and CAA s will be updated during the next annual or significant change assessment to include underlying causes and contributing factors. The regional director of MDS provided an in service on December 19, 2017 to MDS nurse #1 and MDS nurse #2, regarding CAAs documentation to include underlying causes and contributing factors. The MDS nurse #1 and #2 will attend state offered training February 22, 2018 Current facility residents have the potential to be affected by the alleged deficient practice. The MDS nurses audited current residents CAA s to identify CAA s that may have affected resident care planning and outcome. There were no residents affected. The MDS nurses provided an in-service	

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F 867	Continued From page 60	F 867	education for the interdisciplinary staff that complete the MDS and CAA□s, to include underlying causes and contributing factors in the CAA documentation. The Director of Nursing(DON) will audit all completed CAA□s weekly for 8 weeks, to ensure comprehensive completion including identification of underlying causes and contributing factors. The director of Nursing/Designated RN will audit 10% of completed assessments thereafter for a period of 6 months. The Director of Nursing/Designated RN will report audit findings in monthly QAPI meetings to identify patterns or trends and will adjust plan to maintain compliance and review plan for a period of 6 months or until compliance is maintained. Regarding the alleged deficient practice of failure to properly code the MDS assessment on resident #63 and Resident #5, the MDS nurse completed a corrected MDS and submitted on December 22, 2017. The Regional Director of MDS provided an in service on December 19, 2017 to MDS nurse #1 and MDS nurse #2, regarding accurate completion of MDS assessments. MDS # 1 and #2 will be attending the state offered training on February 22, 2018. Current facility residents are at risk for the alleged deficient practice of failure to properly code MDS. An audit was completed by MDS nurse #1 by December 22, 2017 of all areas surrounding the alleged deficient practice. MDS corrections were made and transmitted by December 22, 2017.	

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F 867	Continued From page 61	F 867	Associated care plans in conjunction with MDS miscoding were reviewed and found to appropriately reflect residents needs and not affected by the coding of the MDS. The Director of Nursing(DON) will audit completed MDS to ensure accurate completion 10% of completed assessments weekly for 4 weeks. The Director of Nursing/Designated RN will audit 5% of completed assessments weekly thereafter for a period of 4 weeks. The Director of Nursing/Designated RN will audit 10% of completed assessments per month thereafter for a period of 6 months. The Director of Nursing/Designated RN will report audit findings in monthly QAPI meetings to identify patterns or trends and will adjust plan to maintain compliance and review plan for a period of 6 months or until compliance is maintained. Regarding the alleged deficient practice of implementing care planned interventions to reduce the risk of injuries due to falls for Resident #5, the Director of nursing verified the presence of the care planned interventions of fall mats and non-skid tape. Current nursing staff were in serviced by the Director of Nursing on December 19,2017, regarding interventions to reduce falls and the assurance that interventions remain in place. Current facility residents were at risk for the alleged practice of not implementing care planned interventions to reduce the risk of falls. The Director of Nursing,	

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F 867	Continued From page 62	F 867	ADON and unit coordinators audited current residents rooms and care plans to ensure that identified interventions to reduce the risk of falls were in place. Audit was completed by December 22, 2017. The Director of Nursing (DON) and ADON provided in service education for the nursing staff, beginning on December 19th and commencing January 11, 2018, regarding implementation of interventions to reduce falls and assurance that interventions remain in place for residents. Newly hired nursing staff will receive in service education during orientation. The DON, ADON/Unit Coordinators will observe 10 residents/rooms weekly for 4 weeks then 20 residents/rooms monthly for 3 months, to validate that interventions are in place to reduce falls, according to resident care plan. The DON and/or the ADON will review audit/ monitors to identify patterns/trends and will adjust plan as needed to maintain compliance. The plan will be reviewed during monthly QAPI for 6 months or until compliance is maintained. Regarding the alleged deficient practice of maintaining sanitary vents, walls and ceilings and having a system to routinely check the sanitation in the cool water dish machine; the dietary manager cleaned the baffle vents and spattering on electrical box immediately. Sanitizer strips were obtained December 13, 2017 and staff were in serviced on that date regarding the use of the sanitizer strips for the cool water dish machine.	

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F 867	Continued From page 63	F 867	Corporate consultant dietitians provided an in service regarding dietary sanitation on December 20, 2017. Consultant dietitians performed a department audit of kitchen sanitation on December 20,2017. Staff began checking sanitizer solution of cool water dish machine each shift on December 13, 2017 and recording results on a sanitizer solution log. Dietary manager will monitor kitchen sanitation and cleaning lists to ensure completion weekly. Dietary manager will audit sanitizer solution log and cleanliness of the kitchen 3-5 X□s per week X 4 weeks, identifying any areas which are not maintained and addressing as needed. Consulting dietitian(s) will monitor kitchen sanitation and compliance with sanitizer test strips monthly and report findings to Administrator. Dietary manager will report findings from sanitizer solution log and weekly cleaning list in monthly QAPI meeting x 3 months to identify trends or practices which need modified, monitored or changed to maintain compliance. The Regional Director of Clinical Services provided in service education for the Management team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS coordinators, Social Worker, Activities Director and Infection Control Nurse, regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance.	

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F 867	Continued From page 64	F 867	The Administrator and/or the SW will review audits to identify patterns and/or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meeting and report to interdisciplinary members consisting of but not limited to Administrator, Director of Nursing, Assistant Director of Nursing, MDS coordinators, Social Worker, Activities Director and Infection Control Nurse, consultant pharmacist and Medical director for at least 6 months or until compliance is maintained.	