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	345143	A. BUILDING _____ B. WING _____	C 11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET SILER CITY, NC 27344

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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		11/21/18

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

Electronically Signed | 11/18/2018

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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 record review, observation, and staff interview, the facility failed to sit at eye level while assisting a resident with his meal and referred to the resident as a "feeder" in his presence (Resident #9), and failed to provide another resident with feeding assistance, who was seated at the same table as other residents, for 20 minutes after her meal was served (Resident #109) for 2 of 4 residents reviewed for dignity. Findings included: 1. Resident #9 was admitted to the facility on 6/28/11 with the diagnoses of cerebral vascular accident (CVA). A review of the quarterly Minimum Data Set dated 7/18/18 revealed the resident had a severely impaired cognition. Activities of daily living meals were total dependence of one staff member physical assist. The active diagnoses were non-Alzheimer's dementia, CVA, and contracture of right and left forearms and hands, A review of the resident ' s care plan dated 9/27/18 revealed diagnoses of dysphagia with pureed diet as ordered and at risk for nutritional concern. The resident was to be assisted with his meals and monitored for changes in nutritional status (changes in intake and ability to feed self). On 10/29/18 at 12:30 pm Resident #9 was observed as a staff member feed him his lunch meal. The resident did not participate in	F 550	1. Nurse Aide #1 and Nurse Aide #2 were immediately reeducated on Residents Rights □ Dignity on 10/29/18 by the Nursing Supervisor. Education included when assisting residents with meals, nursing staff must be seated at eye level with the resident, those residents requiring assistance with eating will be referred to as requires assistance with feeding. Reeducation also included that all residents who are seated at the same table should be served and assisted with eating (if needed) at the same time. 2. Center Nurse Executive (CNE) and Nursing Supervisor(s) completed an audit to identify those residents requiring assistance with eating on 11/14/18. Those residents requiring assistance with feeding will be seated at a table together. Four residents were identified as requires assistance with feeding. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will re-educate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant) by 11/21/18, concerning Resident Rights □ Dignity. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. Re-education will include when assisting residents with meals, nursing staff must be seated at eye level with the resident, those residents requiring	

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F 550	Continued From page 2 self-feed. Nursing Assistant (NA) #2 fed the resident his entire lunch while standing. The resident had very limited verbal ability to make his needs known. The resident did not verbalize an assistance preference. There was a folded chair leaning against the wall behind NA #2. There was ample room to use the folding chair on the right side of the resident to sit. The NA stated that the resident was a "feeder" and required assistance while in the resident ' s presence. The meal took approximately 15 minutes to complete. On 10/29/18 at 12:35 pm an interview was conducted of NA #2 who stated she was familiar with the resident. NA #2 continued to state that she was standing to assist the feeder because his reclining chair took a lot of space and there was not enough room to place a chair where she was standing (to the left side of the resident). NA #2 commented that there was room on the other side of the resident ' s chair but felt standing was easier due to limited space. NA #2 was aware of the facility ' s requirement to sit while assisting the residents to eat. On 10/30/18 at 12:27 pm an observation was done of the resident ' s meal assistance by a different NA and she was sitting to feed the resident. On 11/1/18 at 1:15 pm an interview was conducted with the Director of Nursing who stated she expected staff to sit with residents at eye level for assistance with feeding meals and not to refer to residents as "feeders" when they required feeding assistance. 2. Resident #109 was admitted to the facility on 7/27/18 with diagnoses that included vascular dementia with behavioral disturbance.	F 550	assistance with eating will be refer to as requires assistance with feeding. Reeducation also included that all residents who are seated at the same table should be served and assisted with eating (if needed) at the same time. 4. The Interdisciplinary Team (IDT), including Center Executive Director, Center Nurse Executive, Nursing Supervisors, Social Workers, Recreation Director, Registered Dietitian and Admissions Director will complete random audits of 5 residents and each dining room daily times two weeks, three times a week times 2 weeks, then one time a week times two months ensure staff are seated while feeding and residents are being served and eating at the same time. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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The quarterly Minimum Data Set assessment dated 10/4/18 indicated Resident #109 had severe cognitive impairment. She was assessed with hallucinations, delusions, and rejection of care on 1 to 3 days during the review period. Resident #109 was dependent on the staff ' s physical assistance with eating.

Resident #109 ' s care plan included the focus area of assistance/dependence for Activities of Daily Living (ADL) care related to weakness, impaired balance, and limited mobility. This area was initiated on 7/27/18. Resident #109's care plan also included the focus area of nutritional risk related to a diagnosis of fracture of the right femur, osteoporosis, vascular dementia, muscle weakness, anxiety, and cognitive communication deficit. This focus area was initiated on 8/2/18 and most recently revised on 10/17/18.

An observation was conducted of the lunch meal on the 500 hall locked unit on 10/29/28 beginning at 12:20 PM. There were 4 Nursing Assistants (NAs) on the unit at the time of lunch observation. Resident #109 was observed seated at a table in the 500 hall dining room with 4 other residents. All 5 residents at Resident #109 ' s table, including Resident #109, had been served their meal trays by 12:25 PM. Two of the residents at Resident #109 ' s table ate independently and were provided with set up assistance by an NA when their meal trays were served. Two of the residents at Resident #109 ' s table required assistance with eating and they were provided with assistance by separate NAs when their meal trays were served. Resident #109 remained seated at the table with her covered tray on the table in front of her as the 4 residents seated with

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her ate either independently or with the assistance of an NA. At 12:45 PM, 20 minutes after her tray was served, Resident #109 was approached by an NA and set up and feeding assistance was provided.

An interview was conducted with NA #1 on 11/1/18 at 9:36 AM. NA #1 stated she had worked at the facility for over 2 years and normally worked the 1st shift (7:00 AM to 3:00 PM) on the 500 hall locked unit. She confirmed she was working the 1st shift on 10/29/18. NA #1 was asked about Resident #109 ' s delayed assistance with eating on 10/29/18 during the lunch meal observation. She explained that there were 5 residents who required assistance with eating on the 500 hall locked unit. She stated that normally there were 3 NAs working on the 1st shift and they tried to assist the residents who ate faster first so that the remaining residents didn ' t have to wait a long time. She reported that on 10/29/18 there was an additional NA who came from another area to assist with the lunch meal on the 500 hall. NA #1 confirmed that Resident #109 was the last resident who was assisted with eating on 10/29/18 during lunch. She also confirmed that Resident #109 was seated at a table with 4 other residents who were eating for a 20 minute period prior to Resident #109 being assisted with her meal. NA #1 indicated that normally, Resident #109 was not seated with 4 other residents as she often sat at her own table because she tended to become agitated when there was a lot of stimulation around her.

An interview was conducted with the Director of Nursing on 11/1/18 at 1:01 PM. She stated that she expected residents to be treated with dignity

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F 550	Continued From page 5 during their dining experience. She indicated that residents who were seated at the same table should be served and assisted with eating (if needed) at the same time.	F 550		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced	F 604		11/21/18

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by:
Based on observation, record review, staff interview, and physician interview, the facility failed to have a medical symptom to justify the use of a physical restraint (Residents #15 and #34) and also failed to conduct a thorough re-evaluation of the physical restraint to ensure it was used for the least amount of time necessary (Resident #34) for 2 of 2 residents reviewed for physical restraints.

The findings included:

1. Resident #34 was admitted to the facility on 10/9/17 and most recently readmitted on 3/25/18 with diagnoses that included dementia with behavioral disturbance, Parkinson ' s disease, polyneuropathy, insomnia, mood disorder, delusional disorder, and anxiety disorder.

An assessment note dated 2/7/18 completed by Nurse Supervisor #1 indicated Resident #34 continued to try to get up and walk unassisted almost daily.

A physician ' s order dated 2/14/18 indicated, "Self release clasp seatbelt when up in wheelchair [related to] decreased safety awareness with unsteady gait. Check and release for activities, meals, and toileting."

A Restraint Evaluation/Reduction assessment for Resident #34 dated 2/14/18 completed by Nurse #11 indicated the following:
- What is medical symptom: decreased safety awareness and unsteady gait
- What is type of restraint/device: waist
- Describe restraint/device specifics: self-release clasp seat belt when up in wheelchair

1. Resident #34 was assessed by Occupational Therapy (OT)on 11/07/18 and Resident #15 was assessed by Occupational Therapy (OT) on 11/08/18 for restraint reduction, positioning and medical symptoms. Both residents are on OT caseload for treatment as ordered.
2. All residents with restraints have the potential to be effected. 100% audit of residents with restraints was completed by the Center Nurse Executive (CNE) to on 11/12/18, to ensure that an appropriate restraint reduction assessment has been completed and include appropriate medical symptoms to justify use of restraint. Audit revealed the usage of one seatbelt and three poise rolls. All four were referred to Occupational Therapy (OT) for restraint reduction, positioning and medical symptoms.
3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses (including weekend and prn licensed nurses) by 11/21/18, regarding completion of restraint reduction evaluations, documenting results of restraint reduction trials and ensure medical symptoms to warrant use of restraint are present and documented. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift.
4. Center Executive Director (CED), Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC) or Nursing Supervisor will review the

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F 604	Continued From page 7 - What alternatives have been tried: increased monitoring, diversional activity, verbal/visual reminders - How long was the alternative tried: 3 months - What was the resident ' s response to the alternative: enjoys activities, continued to have falls Resident #34 ' s care plan included the focus area of risk for complications of restraint use related to a clasp seatbelt when resident was up in wheelchair for decreased safety awareness with unsteady gait. This focus area was initiated on 2/14/18. The interventions included the completion of a restraint assessment/reduction per protocol. A Restraint Evaluation/Reduction assessment for Resident #34 dated 3/14/18 completed by Nurse #2 indicated the following: - What is medical symptom: decreased safety awareness and unsteady gait - What is type of restraint/device: waist - Describe restraint/device specifics: self-release clasp seat belt when up in wheelchair - What alternatives have been tried: increased monitoring, diversional activity, verbal/visual reminders - How long was the alternative tried: 3 months - What was the resident ' s response to the alternative: enjoys activities, continued to have falls A Restraint Evaluation/Reduction assessment for Resident #34 dated 3/29/18 completed by Nurse #11 indicated the following: - What is medical symptom: decreased safety awareness and unsteady gait	F 604	Restraint Reduction Evaluation(s) that are scheduled each week five times/weekly and quarterly in clinical review meeting. Clinical review meeting includes Center Executive Director (CED), Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC), Nursing Supervisor, and Social Worker(s). Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 604	Continued From page 8 - What is type of restraint/device: waist - Describe restraint/device specifics: self-release clasp seat belt when up in wheelchair - What alternatives have been tried: increased monitoring, diversional activity, verbal/visual reminders - How long was the alternative tried: 3 months - What was the resident ' s response to the alternative: enjoys activities, continued to have falls The quarterly Minimum Data Set (MDS) assessment dated 3/31/18 indicated Resident #34 ' s cognition was severely impaired. He had no behaviors and no rejection of care. Resident #34 required the extensive assistance of 1 staff with bed mobility and locomotion on/off the unit. He required the extensive assistance 2 or more staff with transfers and was dependent on 2 or more staff with dressing, toileting, and personal hygiene. Resident #34 was not steady on his feet and was only able to stabilize with staff assistance. He had impairment to one side of his lower extremities and utilized a wheelchair. Resident #34 was always incontinent of bowel and bladder. He had no falls. A trunk restraint was used daily for Resident #34 when in chair/out of bed. On 4/9/18 the physician ' s order for Resident #34 dated 2/14/18 for a self release clasp seatbelt when up in wheelchair related to decreased safety awareness with unsteady gait was discontinued. A physician ' s order for Resident #34 dated 4/9/18 indicated, "Clasp seat belt when up in wheelchair [related to] decreased safety	F 604		

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awareness with unsteady gait. Check and release for activities, meals, and toileting." This physician ' s order for the trunk restraint had no stop date.

A Restraint Evaluation/Reduction assessment for Resident #34 dated 4/29/18 completed by Nurse #2 indicated the following:
- What is medical symptom: decreased safety awareness
- What is type of restraint/device: waist
- Describe restraint/device specifics: self-release clasp seat belt when up in wheelchair
- What alternatives have been tried: increased monitoring, diversional activity, verbal/visual reminders
- How long was the alternative tried: 3 months
- What was the resident ' s response to the alternative: enjoys activities, continued to have falls

The Nursing Assistant Care Guide/Kardex, dated 5/16/18, indicated Resident #34 had a trunk restraint to be utilized when out of bed and released per physician ' s orders.

A Restraint Evaluation/Reduction assessment for Resident #34 dated 5/29/18 completed by Nurse #2 indicated the following:
- What is medical symptom: decreased safety awareness
- What is type of restraint/device: waist
- Describe restraint/device specifics: self-release clasp seat belt when up in wheelchair
- What alternatives have been tried: increased monitoring, diversional activity, verbal/visual reminders
- How long was the alternative tried: 3 months

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F 604	Continued From page 10 - What was the resident ' s response to the alternative: enjoys activities, continued to have falls The quarterly MDS assessment dated 8/15/18 indicated Resident #34 ' s cognition was severely impaired. He had no behaviors and no rejection of care. Resident #34 required the extensive assistance of 1 staff with bed mobility and the extensive assistance of 2 or more staff with transfers. He was dependent on 1 staff for toileting and personal hygiene and dependent on 2or more staff with dressing. Resident #34 was independent with locomotion on and off the unit, had no impairment with range of motion, and utilized a wheelchair. He was not steady on his feet and was only able to stabilize with staff assistance. Resident #34 was always incontinent of bowel and bladder. He had no falls. A trunk restraint was used daily for Resident #34 when in chair/out of bed. A Restraint Evaluation/Reduction assessment for Resident #34 dated 8/29/18 completed by Nurse #1 indicated the following: - What is medical symptom: decreased safety awareness - What is type of restraint/device: waist - Describe restraint/device specifics: self-release clasp seat belt when up in wheelchair - What alternatives have been tried: increased monitoring, diversional activity, verbal/visual reminders - How long was the alternative tried: 3 months - What was the resident ' s response to the alternative: enjoys activities, continued to have falls	F 604		

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An observation was conducted of Resident #34 on 10/29/18 at 2:45 PM. He was seated in his wheelchair in a common area of the facility. The clasp seatbelt restraint was buckled. Resident #34 was leaning forward and self-propelling very slowly with shuffled feet. He was alert, but unable to engage in meaningful conversation.

An observation was conducted of Resident #34 on 10/30/18 at 11:45 AM. He was seated in his wheelchair in a common area of the facility. The clasp seatbelt restraint was buckled. Resident #34 was leaning forward and self-propelling very slowly with shuffled feet.

An interview was conducted with Nursing Assistant (NA) #4 on 10/30/18 at 2:45 PM. She confirmed that Resident #34 had a seatbelt restraint when he was out of bed. She said they released the seatbelt for meals, activities, and personal care. She stated that Resident #34 was not able to remove the seatbelt independently. NA #4 reported she thought he had the seatbelt on because he often leaned forward and reached toward the ground.

An interview was conducted with NA #9 on 10/30/18 at 2:47 PM. She confirmed that Resident #34 had a seatbelt restraint when he was out of bed. She stated that he was not able to remove the seatbelt independently. NA #9 reported she thought he had the seatbelt on for fall prevention as he often leaned forward in his wheelchair.

An interview was conducted with Nurse Supervisor #1 on 10/30/18 at 11:37 AM. She

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confirmed that Resident #34 had an order for the seatbelt restraint since 2/14/18. She stated he was unable to release the seatbelt independently and confirmed it was assessed as a restraint. Nurse Supervisor #1 was asked why the seatbelt was implemented and she stated that it was due to decreased safety awareness with repeated falls and an unsteady gait. She reported that he had multiple falls and they had attempted increased supervision, increased activities, and re-education to Resident #34, but these interventions had been unsuccessful to decrease his falls. She was asked who was responsible for completion of the restraint assessments and attempts at reduction and she reported the nurses on the hall completed the restraint assessments.

An interview was conducted with Nurse #2 on 10/31/18 at 4:45 PM. She confirmed that Resident #34 had an order for the seatbelt restraint. She stated he was unable to release the seatbelt independently and verified it was assessed as a restraint. She reported that she believed the seatbelt restraint was implemented for Resident #34 because he kept "scooting" out of his wheelchair and falling. Nurse #2 confirmed she completed the Restraint Evaluation/Reduction assessment forms dated 3/14/18, 4/29/18, and 5/29/18 for Resident #34. She was asked what the process was for completion of the Restraint/Evaluation Reduction assessment form. She stated that the Electronic Medical Records (EMR) system informed her when she needed to complete a Restraint Evaluation/Reduction form. She revealed that when she completed this form for Resident #34 she had not attempted a restraint reduction. Nurse #2 was asked about the increased

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monitoring, diversional activity, and verbal/visual reminders that were noted as alternative interventions tried for a period of three months. She explained that these were interventions that were attempted prior to the initiation of the seatbelt restraint on 2/14/18.

An interview was conducted with Nurse #1 on 10/30/18 at 1:45 PM. She reported that she believed the seatbelt restraint was implemented for Resident #34 because he was "falling all the time". She stated the seatbelt had prevented him from falling. Nurse #1 confirmed she completed the Restraint Evaluation/Reduction assessment form dated 8/29/18 for Resident #34. She was asked what the process was for completion of the Restraint/Evaluation Reduction assessment form. She stated that she believed she had taken the seatbelt off of Resident #34 for about 15 to 30 minutes to see if he tried to stand up without assistance. Nurse #1 indicated that Resident #34 tried to stand up as soon as she had released the seatbelt. She reported she had kept him at the nurse ' s station for the period of time when the seatbelt was removed. She was asked about the increased monitoring, diversional activity, and verbal/visual reminders that were noted as alternative interventions tried for a period of three months. Nurse #1 explained that these were interventions that were attempted prior to the initiation of the seatbelt restraint on 2/14/18.

An interview was conducted with the physician on 10/31/18 at 5:20 PM. The physician was asked what Resident #34 ' s medical symptom was to justify the use of a physical restraint. He indicated he and the facility staff were unable to find another way to keep him from standing up without assistance. He stated that Resident #34

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had Parkinson ' s disease, muscle rigidity, an inability to walk, and a lack of awareness of his limitations. The physician reported that Resident #34 had several falls prior to the implementation of the physical restraint.

An interview was conducted with the Director of Nursing (DON) on 10/31/18 at 5:00 PM. She was asked what the protocol was for restraint assessment/reduction. The DON stated that restraints were assessed on admission, readmission, quarterly and with any significant change. She stated that she expected a restraint reduction to be attempted each time an assessment was completed. The DON was asked what Resident #34 ' s medical symptom was for the use of his physical restraint. She stated that it was decreased safety awareness. She revealed she was unaware that decreased safety awareness was not an appropriate medical symptom to justify the use of a physical restraint. She additionally revealed she was unaware that attempts at restraint reduction had not been thoroughly conducted for Resident #34 since the implementation of the seatbelt restraint on 2/14/18.

2.

A review of the Resident #15 ' s quarterly Minimum Data Set (MDS) dated 7/24/18 revealed documentation that the resident had unclear speech, usually understands and was usually understood. The resident had impaired vision. The cognition was severely impaired. The resident required extensive assistance of 2 staff for transfer and one for all other activities of daily

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living. The resident was not assessed as having a physical restraint on this assessment.

A review of the social work #1 ' s note dated 10/1/18 revealed the resident can be confused and combative.

A review of the resident ' s incident report revealed she fell on 10/28/18 and hit her left forehead with discoloration. The resident was confused and had increased restlessness. The fall report documented that the resident's representative and physician were notified.

A review of the nurses ' note dated 10/28/18 at 10:00 am revealed the resident fell and sustained left forehead discoloration in the morning. The physician was notified and order to monitor the resident was obtained.

A review of the October 2018 physician ' s orders did not reveal an order for a bed restraint.

A review of the care plan updated 10/28/18 revealed an addition under category of falling pillow rolls were attached to the bed to prevent falling out of bed for safety awareness. The pillow rolls were not indicated as a restraint.

On 10/29/18 at 2:00 pm the resident was observed in her bed in the reclining position and had pillow rolls attached to each side of her bed midway, which equaled one third of the bed length.
On 10/29/18 at 2:00 pm Nurse #3 stated that the resident had recently fallen and was impulsive not to ask for help to get out of bed. The resident was able to get out of bed on her own without the pillow rolls but was not safe alone.

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On 10/29/18 at 2:30 pm an interview was conducted with Nursing Assistant (NA) #3 who was assigned to and familiar with the resident. NA #3 stated that the pillow roll guard attached to each side of the bed mattress were added to the resident's bed after she fell with an injury. The rolls were to prevent the resident from getting out of bed without assistance and from falling out of bed. NA #3 was not on shift when the resident fell.

A review of the nurses' note dated 10/30/18 revealed the restraint evaluation was completed by the facility (after observation of the resident ' s restraints with NA #3 and Nurse #3 on 10/29/18).

A review of the restraint evaluation, completed by Nurse Supervisor #2, dated 10/30/18 revealed the pillow rolls were placed for safety awareness to prevent falling out of bed and not a restraint.

On 10/31/18 at 12:50 pm an interview was conducted with Nurse #3 who stated that the resident had fallen trying to get out of bed alone. The resident was alert but confused and had a history of falling without injury until 10/28/18 when she fell and sustained bruises to the left forehead, side of her face and neck. At times the resident was agitated and had an order for as needed Ativan 1 mg. Nurse #3 stated the resident was agitated this morning and received an as needed Ativan with good results. The resident had side rails in the past due to falling out of bed. The side rails were removed as required and the resident fell out of bed trying to get up alone and was injured on 10/28/18. On about 10/28/18 pillow rolls were attached to the side of the mattress in place of side rails. The pillow rolls were to keep

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the resident from falling out of bed. The rolls kept the resident from getting out of bed alone. Since the placement of the rolls, the resident had called out for "help" and was assisted without falling. Nurse #3 commented that a restraint assessment was completed for the rolls on 10/30/18. Nurse #3 agreed that the pillow rolls did restrain the resident from being able to get out of the bed alone. The resident required staff assistance to get out of bed and had limited ability to make her needs known. Nurse #3 commented that without the pillow rolls the resident was at risk of falling when she tried to get out of bed alone. Nurse #3 was afraid that without the pillow rolls the resident would fall and be injured.

On 11/1/18 at 11:20 am an interview was conducted with the MDS nurse who stated if the resident was assessed as having a restraint she would be notified that day and a restraint goal and intervention would be added to the care plan. The MDS stated that the resident had pillow rolls and she does not code those on the MDS as a restraint. MDS stated that the nurse who completed the restraint evaluation would determine if a device was a restraint and inform MDS to add restraint to the care plan and code accordingly. The MDS nurse confirmed the pillow rolls were not assessed as a physical restraint prior to them being applied to Resident #15 ' s bed/mattress.

On 11/1/18 at 1:15 pm an interview was conducted with the Director of Nursing who stated she expected a device that restrains a resident to have a medical need. The restraint assessment was completed and determined use was for safety awareness not a restraint.

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F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623		11/21/18

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required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 623	Continued From page 20 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and Ombudsman and staff interview, the facility failed to provide a written discharge notice to the resident/responsible party (RP) and the Ombudsman when a resident was discharged to the hospital for 2 of 2 sampled residents who were discharged to the hospital (Residents # 321 and #30). Findings included: 1. Resident #321 was admitted to the facility on 9/12/18 and was discharged to the hospital on 9/21/18. On 10/31/18 at 11:28 AM, Social Worker (SW) #2 was interviewed. The SW stated that they only involved the Ombudsman when a resident was given a 30 day discharge notice but not when a	F 623	1. Ombudsman was notified of residents #321 and #30 discharge to hospital on 11/21/18 by the Center Executive Director (CED). Resident #321 family was mailed a copy of the Bed Hold Notice to have for their records on 11/21/18. Resident #30 is no longer at the center. Center Executive Director (CED) consulted with Regional Ombudsman regarding processing of notifying her of transfers and/or discharges on 10/31/2018. Once process was established, CED faxed October 2018 Transfer Log to Regional Ombudsman. 2. All transfers for the past 30 days were reviewed and sent to the Ombudsman in writing by the Center Executive Director (CED) on 11/01/18. 3. Center Executive Director, Center	

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F 623	Continued From page 21 resident was discharged to the hospital. SW #2 also stated that she didn't know if nursing had provided the resident or the RP with a written discharge notice when a resident was discharged to the hospital. On 10/31/18 at 11:30 AM, Nurse Supervisor #1 was interviewed. She stated that they had not been providing written discharge notice to the Ombudsman, resident nor the RP when a resident was discharged to the hospital. She added that the nursing staff had called the RP to inform them that the resident was discharged to the hospital but not in writing. On 11/1/18 at 11:58 AM, the Ombudsman was interviewed. She stated that she had not been receiving discharge notice from the facility, however the facility's administrator just called and informed her today that the facility will start sending her the discharge notice. On 11/1/18 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she didn't know that the facility had to provide written discharge notice to the resident/RP and the Ombudsman when a resident was discharged to the hospital. 2. Resident #30 was admitted to the facility on 11/24/17 was discharged to the hospital on 3/1/18. On 10/31/18 at 11:28 AM, Social Worker (SW) #2 was interviewed. The SW stated that they only involved the Ombudsman when a resident was given a 30 day discharge notice but not when a	F 623	Nurse Executive and Nursing Supervisors will educate Business Office, Social Workers (2) and licensed nurses (including weekend and prn licensed nurses) by 11/21/18, regarding written discharge notice to the resident/responsible party and the Regional Ombudsman when a resident is transferred or discharged from the center. For residents that are being transferred to the hospital, responsible parties will be mailed written copy of the center bed hold policy. For residents being discharged home or transferred to another center, resident/family member will be given copy of discharge packet and Social Work and/or licensed nurse will document notification in residents chart. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Center Executive Director will audit resident transfer and discharges weekly times one month then monthly thereafter to ensure those residents and/or families being discharged or transferred are being made aware in writing. Also, to ensure that the Ombudsman is being notified monthly of discharges and transfers. Center Executive Director (CED) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 623	Continued From page 22 resident was discharged to the hospital. SW #2 also stated that she didn't know if nursing had provided the resident or the RP with a written discharge notice when a resident was discharged to the hospital. On 10/31/18 at 11:30 AM, Nurse Supervisor #1 was interviewed. She stated that they had not been providing written discharge notice to the Ombudsman, resident nor the RP when a resident was discharged to the hospital. She added that the nursing staff had called the RP to inform them that the resident was discharged to the hospital but not in writing. On 11/1/18 at 11:58 AM, the Ombudsman was interviewed. She stated that she had not been receiving discharge notice from the facility, however the facility's administrator just called and informed her today that the facility will start sending her the discharge notice. On 11/1/18 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she didn't know that the facility had to provide written discharge notice to the resident/RP and the Ombudsman when a resident was discharged to the hospital.	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments	F 636		11/21/18

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§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(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

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F 636	Continued From page 24 timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to comprehensively assess a resident on the Minimum Data Set (MDS) assessment in the areas of cognition and mood for 1 of 1 residents reviewed for hospice (Resident #57). The findings included: Resident #57 was admitted to the facility on 8/31/16 with diagnoses that included vascular dementia without behavioral disturbance. The annual Minimum Data Set (MDS) assessment dated 8/31/18 indicated Resident #57 had clear speech, was sometimes understood by others, and sometimes understood others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #57. Question C0100 was coded to indicate Resident #57 was rarely/never understood and the BIMS (questions C0200 through C0500) was not conducted. Section D, the Mood section, was not comprehensively assessed for Resident #57. Question D0100 was	F 636	1. Modification was completed for Resident #57 for Section C and D on 11/14/18 by Social Worker(s). 2. Clinical Reimbursement Coordinator (CRC) completed a 100% review of all assessments completed in the last 30 days on 11/15/18 to ensure that section C and D were completed according to regulation and RAI Manual with interviews conducted accordingly. Any deviations were corrected with an MDS modification. 3. Re-education will be provided to the Inter Disciplinary Team by the Regional Clinical Reimbursement Coordinator by 11/21/18, regarding the regulation and RAI manual directions related to interviews for Section C and D on MDS. Sections C and D will include an interview per regulation and RAI manual. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Sections C and D will be audited each week five times/weekly and quarterly in clinical review meeting. Clinical review	

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F 636	Continued From page 25 coded to indicate Resident #57 was rarely/never understood and the resident mood interview (questions D0200 through D0300) was not conducted. Section C and D of Resident #57 ' s 8/31/18 MDS was completed by Social Worker (SW) #1. The Care Area Assessment (CAA) related to communication for Resident #57 ' s 8/31/18 MDS indicated she was pleasantly confused and was sometimes able to make her needs known and sometimes understood others. A social services assessment dated 8/31/18 indicated that Resident #57 occasionally spoke a word or two or answered a question. She was noted to often yell out for her sister. An observation of Resident #57 was conducted on 10/29/18 at 2:50 PM. Resident #57 was seated in a geri-chair (geriatric wheelchair) in a common area of the facility. She was alert but was unable to answer questions appropriately. Resident #57 verbalized "yes" to any question that she was asked regardless of what the question was. An interview was conducted with SW #1 on 11/1/18 at 11:18 AM. The SSD indicated she completed Section C and D on Resident #57 ' s annual MDS assessment dated 8/31/18. Section C and D of the 8/31/18 MDS for Resident #57 was reviewed with SW #1. She reported she attempted the resident interviews for Sections C and D with Resident #57, but her answers were nonsensical. She indicated this was the reason she had coded Resident #57 as rarely/never understood. She revealed that Resident #57 sometimes spoke a few words, but she generally	F 636	meeting includes Center Executive Director (CED), Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC), Nursing Supervisor, and Social Worker(s). Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 636	Continued From page 26 was not able to answer questions with appropriate answers. SW #1 indicated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI) manual for the completion of the resident interviews in Sections C and D. An interview was conducted with the Director of Nursing (DON) on 11/1/18 at 1:01 PM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident had a significant change for 1 of 4 residents reviewed for nutrition (Resident #109). The findings included:	F 637	1. A significant change will be completed on resident # 109 on 11/19/18 by the Clinical Reimbursement Coordinator. 2. Nursing Supervisor and Registered Dietitian (RD) completed a 100% review of residents with weight changes and behavior changes in the last 30 days on 11/14/2018, to ensure that a Significant	11/21/18

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F 637	Continued From page 27 Resident #109 was admitted to the facility on 7/27/18 with diagnoses that included vascular dementia with behavioral disturbance. The admission Minimum Data Set (MDS) assessment dated 8/3/18 indicated Resident #109 ' s cognition was severely impaired. She had no potential indicators of psychosis, she exhibited no rejection of care, and her weight was 99 pounds. Resident #109's weight record revealed the following: 94.2 pounds on 9/2/18 89.0 pounds on 10/4/18 A nutritional assessment dated 10/4/18 indicated Resident #109 had significant weight loss of 5.3% in 1 month (9/2/18: 94 pounds and 10/4/18: 89 pounds). The quarterly MDS assessment dated 10/4/18 indicated Resident #109 ' s cognition was severely impaired. She had hallucinations and delusions during the review period. Resident #109 was assessed with rejection of care on 1 to 3 days during the MDS review period. She was noted with unplanned significant weight loss and her current weight was 89 pounds. An interview was conducted with Nursing Assistant (NA) #1 on 11/1/18 at 9:36 AM. She revealed that Resident #109 had some behaviors that included agitation and rejection of care. The MDS Nurse was interviewed on 11/01/18 at 11:08 AM, about why a comprehensive assessment had not been completed within 14	F 637	Change Assessment was completed. Four residents were identified as triggering for a significant change related to weight changes and behavioral changes. All four residents identified have significant changes scheduled. 3. Regional Clinical Reimbursement Coordinator will provide re-education to the Clinic Reimbursement Coordinator on the RAI manuals definition/criteria for implementing a comprehensive assessment after a significant change by 11/21/18. Regional Clinical Reimbursement Coordinator also provided reeducation to the Interdisciplinary Team (IDT), including Center Executive Director, Center Nurse Executive, Nursing Supervisors, Social Workers, Recreation Director and Dietitian on the criteria for a significant change by 11/21/18. 4. Clinical Management Team (Center Nurse Executive, Nurse Practice Educator and Nursing Supervisor(s)) will complete an audit of each Minimum Data Set (MDS) prior to completion to identify whether or not a significant change needs to be implemented and will discuss with the Interdisciplinary Team in clinical review meeting each week five times/weekly for three months. Clinical review meeting includes Center Executive Director (CED), Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC), Nursing Supervisor, and Social Worker(s). Center Nurse Executive will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee	

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F 637	Continued From page 28 days of the two significant areas where this resident had changed. The MDS Nurse reviewed Resident #109's medical record and stated that a Significant Change in Status Assessment (SCSA) should have been completed. She explained that when behavioral changes occurred she liked to wait a little while to ensure the behaviors continued prior to completing an SCSA. She revealed that an SCSA would have been appropriate for Resident #109 as her behaviors had continued. An interview was conducted with the Director of Nursing (DON) on 11/1/18 at 1:01 PM. She indicated her expectation was for SCSAs to be completed as required.	F 637	is responsible for the ongoing compliance.	
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: Base on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of dialysis (Resident #321) for 1 of 2 sampled residents on dialysis, in the area of diagnoses (Resident #55) for 1 of 5 sampled residents reviewed for unnecessary medications and in the area of discharge (Resident #121) for 1 of 3 discharged sample residents . Findings included: 1 Resident # 321 was originally admitted to the facility on 9/12/18 with multiple diagnoses including end stage renal disease (ESRD). The admission MDS assessment dated 9/19/18	F 641	1. Modifications were made to the Minimum Data Set for Resident #321 on 10/30/18, Resident #55 on 11/14/18 and Resident #121 on 11/01/18 by the Clinical Reimbursement Coordinator (CRC). The modification for Resident #321 included add Dialysis to Section O, Resident #55 included adding Depressive Disorder and Hyperlipidemia to resident□s diagnosis list. For Resident #121 the modification included changing residents discharge status to home instead of to acute hospital. 2. Nursing Supervisor(s) completed	11/21/18

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F 641	Continued From page 29 indicated that Resident #321 was not receiving dialysis. Resident #321 had doctor's orders dated 9/12/18 for fluid restriction of 1000 milliliter (ml) per day due to dialysis and AV fistula to left upper arm and to check for bruit and thrill. Resident #321's care plan dated 10/24/19 indicated that he was scheduled to have a dialysis every Tuesday, Thursday and Saturday. On 10/30/18 at 5:15 PM, the MDS Nurse was interviewed. She verified that Resident #321 was on dialysis three times a week since admission on 9/12/18. She also acknowledged that she completed the admission MDS assessment dated 9/19/18 and she missed to code the dialysis. On 11/1/18 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessment to be coded accurately. 2. Resident #55 was admitted to the facility on 5/24/18 with multiple diagnoses including depressive disorder and hyperlipidemia. The quarterly MDS assessment dated 8/30/18 indicated that Resident #55 had received an antidepressant medication for 6 days during the assessment period. The assessment did not indicate that the resident had diagnoses of depression nor hyperlipidemia. Resident #55 had doctor's orders dated 5/24/18 for venlafaxine (antidepressant drug) 37.5 milligrams (mgs) by mouth daily for depression and zocor (used to treat hyperlipidemia) 40 mgs by mouth daily. The Medication Administration Records (MARs) for August 2018 revealed that Resident #55 had received venlafaxine and zocor during the assessment period. On 10/31/18 at 11:50 AM, the MDS Nurse was	F 641	audit of Minimum Data Set (MDS) (most current MDS) for those residents on Dialysis to ensure coding was correct on 11/14/18. Nursing Supervisor(s) completed audit on all residents who were discharged from the center in the last 30 days on 11/14/2018, to ensure discharge location coded correctly. Nursing Supervisor(s) completed audit of most current Minimal Data Set on all residents with diagnosis of Depressive Disorder and Hyperlipidemia to ensure coded correctly on 11/16/18. Any deviations were corrected with a modification assessment. Audits concluded that the Clinical Reimbursement Coordinator completed three modifications on correct discharge location, one modification on receiving dialysis, and twelve modifications on those with diagnosis of Depressive Disorder and Hyperlipidemia. 3. Regional Clinical Reimbursement Coordinator will provide re-education to Clinical Reimbursement Coordinator on MDS accuracy by 11/21/18. 4. Sections I, A and O will be audited each week five times/weekly for three months by the Interdisciplinary Team, including Center Executive Director, Center Nurse Executive, Nursing Supervisors, Social Workers, Recreation Director, and Registered Dietitian in clinical review meeting. The centers Center Nurse Executive will present the results of the audit for accuracy for Sections I, A, and O of the Minimum Data Set that was completed prior to submission monthly to the QAPI Meeting to ensure compliance. The QAPI	

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F 641	Continued From page 30 interviewed. She verified that Resident #55 was on venlafaxine for depression and zocor for hyperlipidemia. She also verified that Resident #55 had received venlafaxine and zocor in August 2018 during the assessment period. The MDS Nurse indicated that she coded the MDS assessment dated 8/30/18 incorrectly in the area of diagnoses. On 11/1/18 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessment to be coded accurately. 3. Resident #121 was admitted to the facility on 9/12/18. The 10/2/18 discharge Minimum Data Set (MDS) assessment indicated Resident #121 was discharged to an acute hospital (question A2100). A review of the medical record indicated Resident #121 was discharged to his home in the community on 10/2/18. An interview was conducted with the MDS Nurse on 11/1/18 at 10:55 AM. She confirmed Resident #121 ' s 10/2/18 discharge MDS assessment was coded incorrectly for discharge status (question A2100). She revealed Resident #121 was discharged to his home in the community on 10/2/18 and not to an acute hospital. She indicated she made an error on Resident #121 ' s 10/2/18 MDS assessment and she was going to make a modification. An interview was conducted with the Director of	F 641	committee is responsible for the ongoing compliance.	

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F 641	Continued From page 31 Nursing on 11/1/18 at 1:01 PM. She stated that she expected the MDS to be coded accurately.	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 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	F 656		11/21/18

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F 656	Continued From page 32 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 record review, observations, and staff and resident interviews, the facility failed to develop a care plan (Resident #15) and to implement the resident ' s care plan for 5 of 24 residents reviewed for care plan (Residents #34, #57, #60, and #323). Findings included: 1. A review of Resident #15 ' s quarterly Minimum Data Set (MDS) dated 7/24/18 revealed documentation that the resident had unclear speech, usually understands and was usually understood. The resident had impaired vision. The cognition was severely impaired. The resident required extensive assistance of 2 staff for transfer and one for all other activities of daily living (ADL). A review of the care plan updated 10/28/18 revealed there were no goals and interventions for self-care deficit of activities of daily living. On 10/29/18 at 2:00 pm Nurse #3 stated that the resident required two staff members for all transfers and one staff member for all activities of daily living. The resident had a limited ability to make her needs known.	F 656	1. Resident #15 currently has a care plan that addresses her self-care deficits of activity of daily living (ADL) needs, Resident #60 Activity Of Daily Living (ADL) needs are being meet daily including eye glasses and nail care, Resident #34 will have an updated Restraint Reduction Assessment upon completion of Occupational Therapy (OT) treatment to include trial restraint reduction. Resident # 323 fall interventions are being followed per care plan, and Resident #57 currently has hand orthotic in place per care plan. 2. Center Executive Director (CED), Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC), and Nursing Supervisor(s) completed an audit of current residents care plans, to ensure interventions are adequate and carried out accordingly, this audit was completed on 11/16/2018. At the conclusion of all audits, care plans were updated to reflect resident s current status and physician orders. Center Nurse Executive and Nursing Supervisor(s) completed an audit of all current residents nails on 11/15/18, to ensure adequate nail care. Nail care (cleaned and trimmed) was provided to	

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F 656	Continued From page 33 On 10/29/18 at 2:30 pm an interview was conducted with NA #3 who was assigned to and familiar with the resident. NA #3 stated that the resident was dependent for incontinence and personal care. The resident could assist with dressing. The resident was assisted for all her meals. On 11/1/18 at 11:20 am an interview was conducted with the MDS nurse who stated if the resident required assistance for activities of daily living, which was coded in the MDS, it should have been included in the care plan. On 11/1/18 at 1:15 pm an interview was conducted with the Director of Nursing who stated she expected care provided to a resident be included in the care plan. 2. A review of Resident #60 ' s care plan dated 9/6/18 revealed the resident had an activities of daily living (ADL) self-care deficit and his needs would be met. The resident had Hospice services for ADL care in addition to facility. A review of the significant change MDS dated 9/6/18 revealed the resident had adequate vision with corrective lenses and had a moderately impaired cognition. The resident required total dependence of 2 staff for all ADLs. Active diagnoses were anemia, arthritis, vertebral vascular accident, and ataxia, On 10/29/18 at 10:30 am an observation was done of the resident in his room sitting up in bed reading the newspaper wearing his eye glasses. The resident ' s nails were long and appeared	F 656	those residents identified during the audit. Center Nurse Executive, Nursing Supervisor(s) and Therapy completed an audit of all current residents with orders/ care plans for orthotics on 11/06/18, to ensure that they are in use as directed. All orthotic devices were found to be in use according to physicians orders. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant) by 11/21/18, concerning implementation of care plan interventions. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Clinical Management Team (Center Nurse Executive, Nurse Practice Educator and Nursing Supervisor(s)) will complete five random audits per unit, per week times one month then five random audits per unit per month times two months of care plan interventions to ensure compliance. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 656	Continued From page 34	F 656		

dirty underneath with dark-brown matter. The resident ' s eye glasses were visibly soiled and had limited view through the lens. The second pair of eye glasses in the drawer also appeared soiled.

On 10/29/18 at 10:30 am an interview was conducted with the resident who commented that his nails were long, and he asked staff to cut them and they do not always cut his nails when asked. There was a delay. The resident took his eye glasses off and looked at them from the opposite side and commented "they are dirty." The resident also commented that he had another pair in the drawer and pointed to the other pair.

On 10/30/18 at 11:00 am an observation was done of the resident and his nails were cleaned but not trimmed (long). The resident was wearing his eye glasses which were in the same condition as the day before. The resident was reading a book. Nursing Assistant (NA) #3 entered the room and observed the resident and asked if he had any needs. The resident replied no. No ADL assistance was provided at this time.

On 10/30/18 at 11:00 am an interview was conducted with the resident who stated his eye glasses were not cleaned today and agreed they were dirty with spots and finger prints. Resident stated when asked "I wish they would clean my glasses," I like to read.

On 10/31/18 at 12:55 pm an observation was done of the resident and his family member. The family member commented the resident ' s eye glasses were clean because the family member cleaned the glasses this morning. The resident '

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s nails were not trimmed.

On 10/31/18 at 12:55 pm an interview was conducted with the resident who commented that his eye glasses were clean by his family member this morning. The resident also commented that he liked to read and required his glasses to be able to read.

On 10/31/18 at 2:00 pm an interview was conducted with Nurse #3 who was assigned to the resident and stated that the nursing assistants were expected to clean the resident ' s eye glasses as needed and check the resident ' s nails with morning care or as needed. Nurse #3 commented that she cleaned the resident ' s eye glasses when needed. Nurse #3 stated that she would speak with NA #3 who was assigned to the resident this week.

On 11/1/18 at 1:15 pm an interview was conducted with the Director of Nursing who stated she expected nursing staff to follow the resident's care plan.

3. Resident #34 was admitted to the facility on 10/9/17 and most recently readmitted on 3/25/18 with diagnoses that included dementia with behavioral disturbance, Parkinson ' s disease, polyneuropathy, insomnia, mood disorder, delusional disorder, and anxiety disorder.

An assessment note dated 2/7/18 completed by Nurse Supervisor #1 indicated Resident #34 continued to try to get up and walk unassisted almost daily.

A physician ' s order for Resident #34 dated

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2/14/18 indicated, "Self release clasp seatbelt when up in wheelchair [related to] decreased safety awareness with unsteady gait. Check and release for activities, meals, and toileting."

Resident #34 ' s care plan included the focus area of risk for complications of restraint use related to a clasp seatbelt when resident was up in wheelchair for decreased safety awareness with unsteady gait. This focus area was initiated on 2/14/18. The interventions included the completion of a restraint assessment/reduction per protocol.

A Restraint Evaluation/Reduction assessment dated 2/14/18 completed by Nurse #11 indicated a self-release clasp seat belt restraint was utilized for Resident #34 when up in wheelchair. Alternative interventions that had been tried for a period of three months were noted as increased monitoring, diversional activity, and verbal/visual reminders.

A Restraint Evaluation/Reduction assessment dated 3/14/18 completed by Nurse #2 indicated a self-release clasp seat belt restraint was utilized for Resident #34 when up in wheelchair. Alternative interventions that had been tried for a period of three months were noted as increased monitoring, diversional activity, and verbal/visual reminders.

A Restraint Evaluation/Reduction assessment dated 3/29/18 completed by Nurse #11 indicated a self-release clasp seat belt restraint was utilized for Resident #34 when up in wheelchair. Alternative interventions that had been tried for a period of three months were noted as increased monitoring, diversional activity, and verbal/visual

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reminders.

The quarterly Minimum Data Set (MDS) assessment dated 3/31/18 indicated Resident #34 ' s cognition was severely impaired. A trunk restraint was used daily for Resident #34 when in chair/out of bed.

On 4/9/18 the physician ' s order for Resident #34 dated 2/14/18 for a self-release clasp seatbelt when up in wheelchair related to decreased safety awareness with unsteady gait was discontinued.

A physician ' s order for Resident #34 dated 4/9/18 indicated, "Clasp seat belt when up in wheelchair [related to] decreased safety awareness with unsteady gait. Check and release for activities, meals, and toileting." This physician ' s order for the trunk restraint had no stop date.

A Restraint Evaluation/Reduction assessment dated 4/29/18 completed by Nurse #2 indicated a self-release clasp seat belt restraint was utilized for Resident #34 when up in wheelchair. Alternative interventions that had been tried for a period of three months were noted as increased monitoring, diversional activity, and verbal/visual reminders.

The Nursing Assistant Care Guide/Kardex, dated 5/16/18, indicated Resident #34 had a trunk restraint to be utilized when out of bed and released per physician ' s orders.

A Restraint Evaluation/Reduction assessment dated 5/29/18 completed by Nurse #2 indicated a self-release clasp seat belt restraint was utilized

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for Resident #34 when up in wheelchair. Alternative interventions that had been tried for a period of three months were noted as increased monitoring, diversional activity, and verbal/visual reminders.

The quarterly MDS assessment dated 8/15/18 indicated Resident #34 ' s cognition was severely impaired. A trunk restraint was used daily for Resident #34 when in chair/out of bed.

A Restraint Evaluation/Reduction assessment dated 8/29/18 completed by Nurse #1 indicated a self-release clasp seat belt restraint was utilized for Resident #34 when up in wheelchair. Alternative interventions that had been tried for a period of three months were noted as increased monitoring, diversional activity, and verbal/visual reminders.

An observation was conducted of Resident #34 on 10/29/18 at 2:45 PM. He was seated in his wheelchair in a common area of the facility. The clasp seatbelt restraint was buckled.

An interview was conducted with Nurse Supervisor #1 on 10/30/18 at 11:37 AM. She confirmed that Resident #34 had an order for the seatbelt restraint since 2/14/18. She was asked who was responsible for completion of the restraint assessments and attempts at reduction and she reported the nurses on the hall completed the restraint assessments.

An interview was conducted with Nurse #2 on 10/31/18 at 4:45 PM. Nurse #2 confirmed she completed the Restraint Evaluation/Reduction assessment forms dated 3/14/18, 4/29/18, and 5/29/18 for Resident #34. She revealed that

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when she completed this form for Resident #34 on 3/14/18, 4/29/18, or on 5/29/18 she had not attempted a restraint reduction. Nurse #2 was asked about the increased monitoring, diversional activity, and verbal/visual reminders that were noted as alternative interventions tried for a period of three months. She explained that these were interventions that were attempted prior to the initiation of the seatbelt restraint on 2/14/18.

An interview was conducted with Nurse #1 on 10/30/18 at 1:45 PM. Nurse #1 confirmed she completed the Restraint Evaluation/Reduction assessment form dated 8/29/18 for Resident #34. She was asked if she attempted alternative interventions for Resident #34 related to restraint reduction when she completed the 8/29/18 assessment. She stated that she believed she had taken the seatbelt off of Resident #34 for about 15 to 30 minutes to see if he tried to stand up without assistance. Nurse #1 was asked about the increased monitoring, diversional activity, and verbal/visual reminders that were noted as alternative interventions tried for a period of three months. She explained that these were interventions that were attempted prior to the initiation of the seatbelt restraint on 2/14/18.

An interview was conducted with the Director of Nursing (DON) on 10/31/18 at 5:00 PM. She was asked what the protocol was for restraint assessment/reduction. The DON stated that restraints were assessed on admission, readmission, quarterly and with any significant change. She stated that she expected a restraint reduction to be attempted each time an assessment was completed. She revealed she was unaware that attempts at restraint reduction had not been thoroughly conducted for Resident

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#34 since the implementation of the seatbelt restraint on 2/14/18. The DON additionally revealed she expected the care plan intervention for completion of a restraint assessment/reduction per protocol to be implemented.

4. Resident #323 was admitted to the facility on 8/12/16 and most recently readmitted on 2/5/18 with diagnoses that included vascular dementia with behavioral disturbance.

The plan of care for Resident #323 included the focus are of the risk for falls due to unsteadiness and lack of safety awareness. This focus area was initiated on 8/12/16. The interventions included, in part, staff to ensure resident is wearing proper footwear (initiated on 12/18/17) and utilize low bed (initiated on 3/8/18).

The Nursing Assistant (NA) care guide/Kardex included the intervention of staff to ensure resident was wearing proper footwear (initiated on 12/15/17) and utilization of a low bed (undated).

The quarterly Minimum Data Set (MDS) assessment dated 5/14/18 indicated Resident #323 ' s cognition was severely impaired. He had no behaviors and no rejection of care. Resident #323 required the extensive assistance of 1 staff for transfers and the limited assistance of 1 staff for bed mobility. Resident #323 was independent with locomotion on/off the unit, dependent on 1 staff for personal hygiene, and dressing and dependent on 2 or more staff for toileting. He had no impairment with range of motion and utilized a wheelchair. Resident #323 was always incontinent of bladder and bowel and he had 2 or more falls with no injury.

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a). An incident report dated 7/22/18 completed by Nurse #6 (Staff Development Coordinator) indicated Resident #323 had an unwitnessed fall in his room with no injury at 2:40 AM. At the time of the fall Resident #323 was noted to have bare feet.

A phone interview was conducted with Nurse #6 on 10/31/18 at 2:50 PM. Nurse #6 verified Resident #323 did not have proper footwear on at the time of his fall. She stated that proper footwear was either non-skid socks or non-skid shoes.

b). An incident report dated 8/2/18 completed by Nurse #7 indicated Resident #323 had an unwitnessed fall in his room with no injury at 11:00 PM. After the fall Resident #323 ' s bed was placed in the lowest position.

A phone interview was conducted with Nurse #7 on 10/31/18 at 3:45 PM. Nurse #7 stated that she was unable to recall any specific information about Resident #323 ' s fall on 8/2/18, but from the documentation on the incident report it sounded like his bed was not in the lowest position at the time of this fall.

A phone interview was conducted with NA #7 on 10/31/18 at 3:05 PM. NA #7 stated he was unable to recall with certainty what position Resident #323 ' s bed was when he observed him on the floor, but he believed the bed was not in the lowest position.

c). An incident report dated 8/24/18 completed by Nurse #8 indicated Resident #323 had an unwitnessed fall in his room with no injury at 4:00

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AM. Nurse #7 was his assigned nurse. Resident #323 was noted on the floor beside his bed. At the time of the fall Resident #323 was noted to have bare feet.

A phone interview was attempted with Nurse #8 on 10/31/18 at 2:34 PM. She was unable to be reached for interview.

A phone interview was conducted with Nurse #7 on 10/31/18 at 3:45 PM. Nurse #7 stated that she was unable to recall any specific information about Resident #323 ' s fall on 8/24/18, but from the documentation on the incident report it sounded like his bed was not in the lowest position and he had bare feet at the time of the fall.

A phone interview was conducted with NA #7 on 10/31/18 at 3:05 PM. NA #7 indicated he was unable to recall with certainty what position Resident #323 ' s bed was when he observed him on the floor, but he thought the bed may have been elevated slightly. He reported he was unable to recall if Resident #323 was supposed to have non-skid socks on when he was in bed.

d). An incident report dated 8/27/18 completed by Nurse #4 indicated Resident #323 had an unwitnessed fall in his room with no injury at 8:30 PM. At the time of the fall Resident #323 was noted to have bare feet.

A phone interview was attempted with Nurse #4 on 10/31/18 at 2:34 PM. She was unable to be reached for interview.

An interview was conducted with NA #6 on 10/31/18 at 3:15 PM. NA #6 was unable to recall

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any specific information about this 8/27/18 fall for Resident #323. She verified that Resident #323 was supposed to have either non-skid socks or non-skid shoes at all times.

e). An incident report dated 9/20/18 completed by Nurse #4 indicated Resident #323 had an unwitnessed fall in his room with no injury at 6:30 PM. At the time of the fall Resident #323 was noted to have plain socks on.

A phone interview was attempted with Nurse #4 on 10/31/18 at 2:34 PM. She was unable to be reached for interview.

A phone interview was conducted with NA #5 on 10/31/18 at 2:51 PM. NA #5 was unable to recall any specific information about this 9/20/18 fall for Resident #323. She revealed she wasn ' t sure if Resident #323 was supposed to have on any certain type of footwear as a fall intervention.

f). An incident report dated 9/25/18 completed by Nurse #9 indicated Resident #323 had a witnessed fall in his room at 9:40 AM. The fall resulted in a small area of bruising to his right cheek bone. At the time of the fall Resident #323 was noted to have plain socks on.

An interview was conducted with Nurse #9 on 10/31/18 at 10:56 AM. Nurse #9 verified Resident #323 was wearing plain socks at the time of the 9/25/18 fall.

A phone interview was conducted with NA #9 on 10/31/18 at 2:36 PM. NA #9 verified Resident #323 had plain socks on at the time of the 9/25/18 fall. She indicated she had just completed morning care for Resident #323 and

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had not had time to put his non-skid socks on when he had fallen. She explained that his family member brought in plain socks for Resident #323 and it seemed that he preferred these socks over the non-skid socks. She further explained that she normally put on his plain socks first with the non-skid socks over top of them.

An interview was conducted with the Director of Nursing on 11/1/18 at 1:01 PM. She stated that she expected care plan interventions related to falls to be consistently implemented.

5. Resident #57 was admitted to the facility on 8/31/16 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction, vascular dementia without behavioral disturbance, and contracture of muscle in the right hand.

A physician ' s order for Resident #57 dated 7/30/18 indicated a right hand orthotic carrot (a cone shaped object resembling a carrot in appearance that was utilized to position the contracted fingers away from the palm) all day each day. The orthotic carrot was to be put in place after morning care and removed at bedtime.

The care plan for Resident #57 included the focus area of extensive to total assistance with Activities of Daily Living (ADL) care. This focus area was initiated on 9/7/16. The interventions included, in part, Resident #57 to wear right hand orthotic carrot all day each day. The carrot was to be put on after morning care and taken off at bedtime. This intervention was initiated on

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7/30/18.

The annual Minimum Data Set (MDS) assessment dated 8/31/18 indicated Resident #57 had short term memory problems, long term memory problems, and severely impaired decision making. She had verbal behaviors on 1 to 3 days and no rejection of care. Resident #57 was dependent on 1 staff for bed mobility, locomotion on/off the unit, dressing, eating, toileting, and personal hygiene. She was dependent on 2 or more staff with transfers. Resident #57 had impairment on one side of her extremities and an active diagnosis of hemiplegia/hemiparesis.

An observation was conducted of Resident #57 on 10/29/18 at 2:50 PM. Resident #57 was seated in a geriatric chair (geri-chair) in a common area of the facility. Her right hand was visibly contracted. There was no orthotic carrot in Resident #57 ' s hand and the orthotic carrot was not observed to be in the vicinity of Resident #57. Resident #57 ' s right hand was empty. She was alert and verbal but had no meaningful communication.

An interview was conducted with NA #12 on 10/31/18 at 4:51 PM. She stated she was familiar with Resident #57 and that she worked with her regularly. She indicated Resident #57 ' s right hand was contracted, and an orthotic carrot was to be placed in her hand after morning care and prior to her going to bed. NA #12 stated that sometimes Resident #57 pulled the orthotic carrot out of her hand and dropped it on the ground. She indicated all of the NAs on Resident #57 ' s unit were aware of this behavior and they monitored her for keeping the orthotic carrot in

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F 656	Continued From page 46 her hand. She stated if it was a day that Resident #57 kept dropping the orthotic carrot then they tried to utilize a rolled wash cloth in its place. An interview was conducted with the Director of Nursing on 11/1/18 at 1:01 PM. She stated that she expected the care plan interventions to be consistently implemented.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		11/21/18

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F 657	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to revise the care plan for smoking for 1 of 2 sampled residents who smokes (Resident #321). Findings included: Resident #321 was admitted to the facility on 9/12/18 and was readmitted on 10/3/18 with multiple diagnoses including obstructive sleep apnea. The admission Minimum Data Set (MDS) assessment dated 9/19/18 indicated that Resident #321's cognition was intact and he was not using tobacco. Resident #321's care plan dated 10/4/18 was reviewed. One of the care plan problems was resident could smoke independently per the smoking assessment and the goal was for the resident to smoke safely. The approaches included to educate the resident on the facility's smoking policy, reassess the resident's ability to smoke independently with any change in condition, ensure that appropriate cigarette disposal receptacles were available in smoking areas, monitor resident's compliance to smoking policy and resident's smoking materials at the nurse's station. The nurse's notes dated 10/3/18 at 6:05 PM revealed that Resident #321 voiced upon readmission that he had no desire to smoke. On 10/30/18 at 4:44 PM, Resident #321 was interviewed. He stated that he used to smoke	F 657	1. Smoking care plan for Resident # 321 was resolved on 10/30/18 by the Social Worker. 2. Social Worker completed an audit of current smokers care plans on 11/15/18. No corrections needed to be made. 3. Center Executive Director will provide re-education to the Interdisciplinary Team (IDT), including Center Nurse Executive, Nursing Supervisors, Social Workers and Recreation Director by 11/21/18, concerning revision of care plans on admission, readmission, and quarterly and with significant change. Smoking care plans will be revised according to smoking status. 4. Social Worker(s) will complete random audits weekly times one month then monthly times two months to ensure appropriateness of smoking care plan. Social Work will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 657	Continued From page 48 when he was at home but had quit smoking since he was admitted to this facility. On 10/30/18 at 4:46 PM, Nurse #4 was interviewed. Nurse #4 was assigned to Resident #321. She stated that she had not seen the resident smoking since he was admitted to the facility. On 10/30/18 at 5:15 PM, the MDS Nurse was interviewed. She stated that Resident #321 had quit smoking on his readmission on 10/3/18. MDS Nurse acknowledged that she reviewed his care plan on 10/4/18 and she should have revised his care plan for smoking but she did not. On 11/1/18 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected Resident #321's care plan revised when he quit smoking during his readmission.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to provide nail and eye glasses care for a resident who had a self-care deficit (Resident #60) for 1 of 2 residents reviewed for activities of daily living (ADL). Findings included: A review of Resident #60 ' s care plan dated	F 677	1. Eye glass care and nail care were provided to resident #60 on 10/31/18. Eye glasses were cleaned and nails were cleaned and cut by certified nursing assistant. 2. Center Nurse Executive (CNE) and Nursing Supervisor(s) completed an audit of each resident□s nails on 11/15/18 and eye glasses on 11/15/18. Residents	11/21/18

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F 677	Continued From page 49 9/6/18 revealed the resident had an activities of daily living (ADL) self-care deficit and his needs would be met. The resident had Hospice services for ADL care in addition to facility. A review of the significant change MDS dated 9/6/18 revealed the resident had adequate vision with corrective lenses and had a moderately impaired cognition. The resident required total dependence of 2 staff for all ADLs. Active diagnoses were anemia, arthritis, vertebral vascular accident, and ataxia, On 10/29/18 at 10:30 am an observation was done of the resident in his room sitting up in bed reading the newspaper wearing his eye glasses. The resident ' s nails were long and appeared dirty underneath with dark-brown matter. The resident ' s eye glasses were visibly soiled and had limited view through the lens. The second pair of eye glasses in the drawer also appeared soiled. On 10/29/18 at 10:30 am an interview was conducted with the resident who commented that his nails were long, and he asked staff to cut them and they do not always cut his nails when asked. There was a delay. The resident took his eye glasses off and looked at them from the opposite side and commented "they are dirty." The resident also commented that he had another pair in the drawer and pointed to the other pair. On 10/30/18 at 11:00 am an observation was done of the resident and his nails were cleaned but not trimmed (long). The resident was wearing his eye glasses which were in the same condition as the day before. The resident was reading a	F 677	requiring nail care (cleaned and cut) at the time of the audit, was provided by certified nursing assistant. List developed of all residents with eye glasses was completed. Twenty-two residents eye glasses were identified as dirty and were cleaned appropriately on 11/15/18. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant) by 11/21/18 on providing eye glasses care when putting on and/or when noticeable dirty and providing nail care during Activities of Daily Living (ADL). Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Social Worker(s) will complete random audits of five residents daily times two weeks then three times a week times two weeks then one time a week times two months. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 677	Continued From page 50	F 677		

book. Nursing Assistant (NA) #3 entered the room and observed the resident and asked if he had any needs. The resident replied no. No ADL assistance was provided at this time.

On 10/30/18 at 11:00 am an interview was conducted with the resident who stated his eye glasses were not cleaned today and agreed they were dirty with spots and finger prints. Resident stated when asked "I wish they would clean my glasses," I like to read.

On 10/31/18 at 12:55 pm an observation was done of the resident and his family member. The family member commented the resident ' s eye glasses were clean because the family member cleaned the glasses this morning. The resident ' s nails were not trimmed.

On 10/31/18 at 12:55 pm an interview was conducted with the resident who commented that his eye glasses were clean by his family member this morning. The resident also commented that he liked to read and required his glasses to be able to read.

On 10/31/18 at 2:00 pm an interview was conducted with Nurse #3 who was assigned to the resident and stated that the nursing assistants were expected to clean the resident ' s eye glasses as needed and check the resident ' s nails with morning care or as needed. Nurse #3 commented that she cleaned the resident ' s eye glasses when needed. Nurse #3 stated that she would speak with NA #3 who was assigned to the resident this week.

On 11/1/18 at 1:15 pm an interview was conducted with the Director of Nursing who stated

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F 677	Continued From page 51 she expected nursing staff to clean the resident ' s eye glasses when they are dirty and to cut finger nails as needed.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to consistently apply an orthotic carrot (a cone shaped object resembling a carrot in appearance that was utilized to position the contracted fingers away from the palm) as ordered by the physician for a resident ' s right-hand contracture for 1 of 2 residents (Resident #57) reviewed for range of motion. The findings included:	F 688	1. Resident #57 currently receiving hand orthotic as ordered/care planned. 2. Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC), and Nursing Supervisor(s) completed an audit of residents□ physician orders and care plans with orthotic devices by 11/21/18, to ensure that interventions were in place accordingly. All orthotic devices were found to be in use according to physicians□ orders.	11/21/18

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F 688	Continued From page 52 Resident #57 was admitted to the facility on 8/31/16 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction, vascular dementia without behavioral disturbance, and contracture of muscle in the right hand. A physician ' s order for Resident #57 dated 7/30/18 indicated a right hand orthotic carrot (a cone shaped object resembling a carrot in appearance that was utilized to position the contracted fingers away from the palm) all day each day. The orthotic carrot was to be put in place after morning care and removed at bedtime. The care plan for Resident #57 included the focus area of extensive to total assistance with Activities of Daily Living (ADL) care. This focus area was initiated on 9/7/16. The interventions included, in part, Resident #57 to wear right hand orthotic carrot all day each day. The carrot was to be put on after morning care and taken off at bedtime. This intervention was initiated on 7/30/18. The annual Minimum Data Set (MDS) assessment dated 8/31/18 indicated Resident #57 had short term memory problems, long term memory problems, and severely impaired decision making. She had verbal behaviors on 1 to 3 days and no rejection of care. Resident #57 was dependent on 1 staff for bed mobility, locomotion on/off the unit, dressing, eating, toileting, and personal hygiene. She was dependent on 2 or more staff with transfers. Resident #57 had impairment on one side of her extremities and an active diagnosis of	F 688	3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant) by 11/21/18 on applying orthotic devices per physicians□ order and care plan. Education also included referring to the residents□ care card/kardex for orthotic devices. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Nursing Supervisors will randomly audit 5 residents for orthotic devices daily times two weeks then three times a week times two weeks then one time a week times two months. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 688	Continued From page 53	F 688		

hemiplegia/hemiparesis.

An observation was conducted of Resident #57 on 10/29/18 at 2:50 PM. Resident #57 was seated in a geriatric chair (geri-chair) in a common area of the facility. Her right hand was visibly contracted. There was no orthotic carrot in Resident #57 ' s hand and the orthotic carrot was not observed to be in the vicinity of Resident #57. Resident #57 ' s right hand was empty. She was alert and verbal but had no meaningful communication.

A nursing note dated 10/30/18 completed by Nurse Supervisor #1 indicated Resident #57 was noted to continuously remove the medical carrot from her hand when placed. A rolled wash cloth was placed in Resident #57 ' s hand instead of the medical carrot and she was noted to leave the wash cloth in place.

An interview was conducted with Nurse Supervisor #1 on 10/31/18 at 2:45 PM. She indicated it was reported to her on 10/30/18 by the Nursing Assistants working on Resident #57 ' s unit that she had dropped her orthotic carrot onto the ground multiple times after it was put in place. She stated that the NAs had then tried to place a rolled wash cloth in Resident #57 ' s hand and she had not dropped that onto the ground. Nurse Supervisor #1 was asked if there had been any previous issues noted with Resident #57 dropping the orthotic carrot. She stated that somedays Resident #57 kept the orthotic carrot in her hand and somedays she wouldn ' t.

An interview was conducted with NA #12 on 10/31/18 at 4:51 PM. She stated she was familiar with Resident #57 and that she worked with her

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F 688	Continued From page 54 regularly. She indicated Resident #57 ' s right hand was contracted, and an orthotic carrot was to be placed in her hand after morning care and prior to her going to bed. NA #12 stated that sometimes Resident #57 pulled the orthotic carrot out of her hand and dropped it on the ground. She indicated all of the NAs on Resident #57 ' s unit were aware of this behavior and they monitored her for keeping the orthotic carrot in her hand. She stated if it was a day that Resident #57 kept dropping the orthotic carrot then they tried to utilize a rolled wash cloth in its place. An interview was conducted with the Director of Nursing on 11/1/18 at 1:01 PM. She stated that she expected the physician ' s order for placement of an orthotic carrot for Resident #57 to be consistently followed.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to consistently implement the fall risk interventions for a resident who had multiple falls (Resident #323) for 1 of 3 residents reviewed for falls. Resident #323 sustained 11 falls in a 4-month period of time and on 6 of the 11 falls one or more of the fall risk	F 689	1. Resident #323 currently has fall interventions in place per care plan. 2. Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC), and Nursing Supervisor(s) completed an audit of residents□ fall care plans for appropriate interventions to	11/21/18

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F 689	Continued From page 55 interventions were not implemented. The findings included: Resident #323 was admitted to the facility on 8/12/16 and most recently readmitted on 2/5/18 with diagnoses that included vascular dementia with behavioral disturbance. The plan of care for Resident #323 included the focus are of the risk for falls due to unsteadiness and lack of safety awareness. This focus area was initiated on 8/12/16. The interventions included, in part, staff to ensure resident was wearing proper footwear (initiated on 12/18/17) and utilization of a low bed (initiated on 3/8/18). The Nursing Assistant (NA) care guide/Kardex included the intervention of staff to ensure resident was wearing proper footwear (initiated on 12/15/17) and utilization of a low bed (undated). The quarterly Minimum Data Set (MDS) assessment dated 5/14/18 indicated Resident #323 ' s cognition was severely impaired. He had no behaviors and no rejection of care. Resident #323 required the extensive assistance of 1 staff for transfers and the limited assistance of 1 staff for bed mobility. Resident #323 was independent with locomotion on/off the unit, dependent on 1 staff for personal hygiene and dressing and dependent on 2 or more staff for toileting. He had no impairment with range of motion and utilized a wheelchair. Resident #323 was always incontinent of bladder and bowel and he had 2 or more falls with no injury. a). An incident report dated 7/22/18 completed by Nurse #6 (Staff Development Coordinator)	F 689	ensure that interventions are in place accordingly; this audit was completed by 11/21/18. During the audit, a comparison was completed to ensure interventions in place accordingly. All current fall interventions were in place according to care plan. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and certified nursing assistant) by 11/21/18, concerning implementation of care planned fall interventions and referring to the residents□ care card/kardex for fall interventions. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Nursing Supervisor(s) will randomly audit 5 residents three times weekly times one month then weekly time one month then monthly thereafter to ensure that fall interventions are in place per care plan. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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indicated Resident #323 had an unwitnessed fall in his room with no injury at 2:40 AM. Resident #323 was noted as seated on the floor next to his bed. He stated he "just rolled out of bed". At the time of the fall Resident #323 was noted to have bare feet. The incident report noted that the preventative measures supposed to be in place prior to this fall included, in part, staff to ensure Resident #323 was wearing proper footwear. The root cause of the fall was identified as, "rolled out of bed". The corrective action was noted as, "staff to assist with repositioning on rounds and [as needed]".

A phone interview was conducted with Nurse #6 on 10/31/18 at 2:50 PM. Nurse #6 stated she was familiar with Resident #323 and confirmed he was a fall risk. The 7/22/18 fall related to Resident #323 was reviewed with Nurse #6. Nurse #6 verified Resident #323 did not have proper footwear on at the time of this fall. She stated that proper footwear was either non-skid socks or non-skid shoes. She revealed Resident #323 had bare feet at the time of his 7/22/18 fall.

A review of the staff schedules indicated that Nursing Assistant (NA) #8 was assigned to Resident #323 at the time of his 7/22/18 fall at 2:40 AM. A phone interview was attempted with NA #8 on 10/31/18 at 2:49 PM. She was unable to be reached for interview.

b). An incident report dated 8/2/18 completed by Nurse #7 indicated Resident #323 had an unwitnessed fall in his room with no injury at 11:00 PM. The oncoming NA (NA #7) was passing the doorway to Resident #323 ' s room when the resident was observed seated on the floor next to his bed. Resident #323 stated he

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"was going to the bathroom". After the fall Resident #323 ' s bed was placed in the lowest position. The incident report noted that the preventative measures supposed to be in place prior to this fall included, in part, bed in low position. The interventions added immediately after the fall included Resident #323 ' s bed in the lowest position. The root cause of the fall was identified as decreased safety awareness secondary to dementia. The corrective action was noted as, "low bed and increased incontinent rounds".

A phone interview was conducted with Nurse #7 on 10/31/18 at 3:45 PM. Nurse #7 stated she was familiar with Resident #323 and confirmed he was a fall risk. The 8/2/18 fall related to Resident #323 was reviewed with Nurse #7. Nurse #7 stated that she was unable to recall any specific information about Resident #323 ' s fall on 8/2/18, but from the documentation on the incident report it sounded like his bed was not in the lowest position at the time of this fall. She revealed that Resident #323 ' s bed should have been in the lowest position at all times.

A phone interview was conducted with NA #7 on 10/31/18 at 3:05 PM. NA #7 stated he was familiar with Resident #323 and confirmed he was a fall risk. The 8/2/18 fall related to Resident #323 was reviewed with NA #7. He confirmed he was the NA who first observed Resident #323 on the floor. He reported he was just coming on shift and he was completing an initial round to observe each of his assigned residents. NA #7 stated he was unable to recall with certainty what position Resident #323 ' s bed was in when he observed him on the floor, but he believed the bed was not in the lowest position. He revealed

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that Resident #323 ' s bed should have been in the lowest position at all times.

c). An incident report dated 8/24/18 completed by Nurse #8 indicated Resident #323 had an unwitnessed fall in his room with no injury at 4:00 AM. Nurse #7 was his assigned nurse. Resident #323 was noted on the floor beside his bed. At the time of the fall Resident #323 was noted to have bare feet. The incident report noted that the preventative measures supposed to be in place prior to this fall included, in part, staff to ensure Resident #323 was wearing proper footwear. The interventions added immediately after the fall included Resident #323 ' s bed in the lowest position and the application of slip resistant socks. The root cause of the fall was identified as, "[Resident #323] was lying [too] close to the edge of the bed and slipped off to the floor". The corrective action was noted as staff to assist with repositioning in bed throughout the night as needed.

A phone interview was attempted with Nurse #8 on 10/31/18 at 2:34 PM. She was unable to be reached for interview.

A phone interview was conducted with Nurse #7 on 10/31/18 at 3:45 PM. The 8/24/18 fall related to Resident #323 was reviewed with Nurse #7. Nurse #7 stated that she was unable to recall any specific information about Resident #323 ' s fall on 8/24/18, but from the documentation on the incident report it sounded like his bed was not in the lowest position and he had bare feet at the time of the fall. She revealed that Resident #323 ' s bed should have been in the lowest position at all times. She additionally revealed that Resident

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#323 should have had proper footwear on at all times. She stated that proper footwear meant non-skid socks or non-skid shoes.

A phone interview was conducted with NA #7 on 10/31/18 at 3:05 PM. The 8/24/18 fall related to Resident #323 was reviewed with NA #7. NA #7 stated he remembered this fall for Resident #323. He stated he was coming out of one of his other assigned resident rooms to grab supplies when he saw Resident #323 on the floor by his bed. NA #7 indicated he was unable to recall with certainty what position Resident #323 ' s bed was when he observed him on the floor, but he thought the bed may have been elevated slightly. He revealed that Resident #323 ' s bed should have been in the lowest position at all times. He reported he was unable to recall if Resident #323 was supposed to have non-skid socks on when he was in bed, but he assumed so because most fall risk residents were supposed to have on proper footwear.

d). An incident report dated 8/27/18 completed by Nurse #4 indicated Resident #323 had an unwitnessed fall in his room with no injury at 8:30 PM. Resident #323 was noted as sitting on his buttocks beside his bed. At the time of the fall Resident #323 was noted to have bare feet. The root cause of the fall was identified as poor safety awareness and the corrective action was noted as a medication review.

A phone interview was attempted with Nurse #4 on 10/31/18 at 2:34 PM. She was unable to be reached for interview.

An interview was conducted with NA #6 on 10/31/18 at 3:15 PM. NA #6 stated she was

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F 689	Continued From page 60	F 689		

familiar with Resident #323 and confirmed he was a fall risk. The 8/27/18 fall related to Resident #323 was reviewed with NA #6. She was unable to recall any specific information about this 8/27/18 fall for Resident #323. She verified that Resident #323 was supposed to have either non-skid socks or non-skid shoes at all times. She reported that there were times when Resident #323 had taken his own socks off. She stated that staff were aware of this and they had to monitor him closely to ensure he had proper footwear on at all times.

e). An incident report dated 9/20/18 completed by Nurse #4 indicated Resident #323 had an unwitnessed fall in his room with no injury at 6:30 PM. Resident #323 was noted as sitting on his buttocks on the mat at bed side. Resident #323 was transferring from wheelchair to his bed without assistance. At the time of the fall Resident #323 was noted to have plain socks on. The interventions added immediately after the fall included the application of non-skid socks for Resident #323. The root cause of the fall was identified as, "Plain socks on. Poor safety awareness". The corrective action was noted as staff to assist resident to bed after supper and as he desired.

A phone interview was attempted with Nurse #4 on 10/31/18 at 2:34 PM. She was unable to be reached for interview.

A phone interview was conducted with NA #5 on 10/31/18 at 2:51 PM. NA #5 reported she worked through an agency and began working at the facility last month (September) 3 days per week. She was asked how she was informed of the interventions in place for her assigned residents.

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F 689	Continued From page 61	F 689		

She stated that she received a report from the NA who worked the shift prior to her each time she came on shift. She indicated she had not looked at any NA care guide/Kardex or any resident care plans. NA #5 stated she was familiar with Resident #323 and confirmed he was a fall risk. The 9/20/18 fall related to Resident #323 was reviewed with NA #5. She was unable to recall any specific information about this 9/20/18 fall for Resident #323. She revealed she wasn ' t sure if Resident #323 was supposed to have on any certain type of footwear as a fall intervention.

f). An incident report dated 9/25/18 completed by Nurse #9 indicated Resident #323 had a witnessed fall in his room at 9:40 AM. The fall resulted in a small area of bruising to his right cheek bone. The NA (NA #9) was in Resident #323 ' s room when he rolled off of his bed and onto his fall mat. The resident had fallen before the NA could reach him to prevent the fall. At the time of the fall Resident #323 was noted to have plain socks on. The root cause of the fall was not identified (the answer to this question was blank) and the corrective action was to assess for side rails.

An interview was conducted with Nurse #9 on 10/31/18 at 10:56 AM. Nurse #9 stated she was familiar with Resident #323 and confirmed he was a fall risk. The 9/25/18 fall related to Resident #323 was reviewed with Nurse #9. She stated she recalled this fall as NA #9 was assigned to Resident #323 and she had been in his room at the time of the fall. She verified Resident #323 was wearing plain socks at the time of the 9/25/18 fall. She stated that his family member brought in plain socks for Resident #323 and he normally was wearing the plain socks when he

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F 689	Continued From page 62 was in bed. A phone interview was conducted with NA #9 on 10/31/18 at 2:36 PM. NA #9 stated she was familiar with Resident #323 and confirmed he was a fall risk. The 9/25/18 fall related to Resident #323 was reviewed with NA #9. She stated she recalled this fall as she was in the room with Resident #323 at the time of the fall. She indicated she had just completed morning care for Resident #323 when she left his side for a moment and he just slipped off the bed onto the mat. She verified Resident #323 had plain socks on at the time of the 9/25/18 fall. She indicated she had not had time to put his non-skid socks on when he had fallen. NA #9 explained that his family member brought in plain socks for Resident #323 and it seemed that he preferred these socks to the non-skid socks. She further explained that she normally put on his plain socks first with the non-skid socks over top of them. She indicated that Resident #323 was able to take his own socks off, but that this wasn ' t a normal behavior for Resident #323. An interview was conducted with the Director of Nursing on 11/1/18 at 1:01 PM. She stated that she expected fall risk interventions to be consistently implemented.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		11/21/18

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F 690	Continued From page 63 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide proper urinary catheter care for 1 of 3 sampled residents with urinary catheter (Resident 30). Findings included: Resident #30 was originally admitted to the facility	F 690	1. Resident #30 is no longer at the center. 2. All residents with indwelling catheters have potential to be effected. Center Nurse Executive completed a 100% audit of current residents with indwelling catheters on 11/15/18, no evidence of infections noted.	

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F 690	Continued From page 64 on 11/24/17 with multiple diagnoses including obstructive and reflux uropathy and urinary retention. The significant change Minimum Data Set (MDS) assessment dated 10/15/18 indicated that Resident #30 had moderate cognitive impairment and had an indwelling urinary catheter. Resident #30's care plan dated 10/15/18 was reviewed. One of the care plan problems was resident has an indwelling urinary catheter and the goal was resident would not have complications related to the use of the indwelling catheter. The approaches included to provide catheter care as ordered and as needed. Resident #30 had a doctor's order dated 3/2/18 for catheter care every shift. On 10/30/18 at 2:00 PM, Resident #30 was observed during catheter care. The resident was observed to have a bowel movement. Nursing Aide (NA) #4 was observed to provide incontinent care. After the incontinent care, NA #4 was observed to provide urinary catheter care without washing her hands nor changing her gloves. On 10/30/18 at 2:10 PM, NA #4 was interviewed. She stated that she didn't think about washing her hands or changing her gloves after providing incontinent care. NA #4 stated that she should have washed her hands and changed her gloves before performing the catheter care. On 10/31/18 at 3:35 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nursing staff to wash hands and to change gloves after providing incontinent care	F 690	3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and certified nursing assistant) by 11/21/18, concerning providing proper urinary catheter care with return demonstration. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Nursing Supervisor(s) will audit catheter care on 3 residents three times weekly times one month then weekly time one month then monthly thereafter for appropriate urinary catheter care. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 690	Continued From page 65	F 690		
	and			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to follow the doctor's order for fluid restriction for 1 of 2 sampled residents on dialysis (Resident #321). Findings included: Resident #321 was originally admitted to the facility on 9/12/18 and was readmitted on 10/3/18 with multiple diagnoses including end stage renal disease (ESRD). The admission Minimum Data Set (MDS) assessment dated 9/19/18 indicated that Resident #321's cognition was intact and he was not receiving dialysis. Resident #321's care plan dated 10/24/18 was reviewed. One of the care plan problems was nutritional risk due to renal dialysis and 1000 milliliter (ml) fluid restriction. The goal was variance in weight can be anticipated due to fluid shift secondary to dialysis and fluid gain versus fluid removal. The approaches included 1000 ml fluid restriction, 720 ml dietary and 280 ml nursing. Resident #321 had a doctor's order dated 9/12/18 for 1000 ml fluid restriction - 720 ml dietary and 280 ml nursing. The October 2018 Medication Administration Records (MARs) were reviewed. The MARs	F 698	1. Resident #321 care plan was updated on 11/02/18 to reflect his non-compliance with physicians order for fluid restrictions. Physician was made aware residents non-compliance via phone on 11/01/18 by Center Nurse Executive (CNE). 2. Center Nurse Executive (CNE), Clinical Reimbursement Coordinator (CRC), and Nursing Supervisor(s) completed an audit of current residents who are on a fluid restriction on 11/14/18, to ensure appropriate documentation in place and/or documentation of non-compliance. All concluded that the appropriate documentation was in place. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant) by 11/21/18 on the importance of following fluid restrictions and of documenting and notifying the physician of resident non-compliance with fluid restrictions. Registered Dietician will re-educate all	11/21/18

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F 698	Continued From page 66 revealed that Resident #321 was provided more than 1000 ml of fluid almost every day. The twenty four (24) hour fluid intake documented on the MAR were 10/7/18 (2040 ml), 10/8/18 (1160 ml), 10/9/18 (1320 ml), 10/10/18 (1120 ml), 10/15/18 (1340 ml), 10/16/18 (1120 ml), 10/17/18 (1380 ml), 10/20/18 (1320 ml), 10/22/18 (1280 ml), 10/23/18 (1180 ml), 10/24/18 (1400 ml), 10/26/18 (1440 ml), 10/27/18 (1400 ml), 10/28/18 (1680 ml), and 10/29/18 (1120 ml). On 10/30/18 at 5:20 PM, Resident #321 was observed in his room. He has a styro foam cup (480 ml) full of water observed on top of the over the bed table. He stated that staff provided him with fresh water every morning and evening. On 10/31/18 at 8:20 AM, Resident #321 was observed in bed eating breakfast. He has a styro foam cup (480 ml) full of coffee on his tray and a bottle of sprite at bedside. At 12:45 PM, he was again observed holding a styro foam cup (480 ml) full of coffee. On 10/31/18 at 12:45 PM, Nursing Aide (NA) #4 was interviewed. She stated that Resident #321 had 2 cups of coffee every meal. She indicated that she was aware that Resident #321 was on fluid restriction. On 10/31/18 at 4:07 PM Nurse #5 was interviewed. She stated that she was assigned to Resident #321 on 10/7/18 and his fluid intake for 8 hours was 1800 ml. Nurse #5 stated that she was aware that the resident was on fluid restriction. On 10/31/18 at 4:31 PM, Dietary Cook was interviewed. She stated that dietary staff didn't provide fluids to residents. Nursing staff served the fluids when they served the trays. On 10/31/18 at 4:32 PM, NA #6 was interviewed. She stated that nursing staff was responsible for	F 698	residents on fluid restrictions on the importance of following these orders by 11/21/18. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Registered Dietician will review all residents with Fluid Restrictions monthly X 3 months, and Quarterly thereafter for compliance with ordered/care planned Fluid Restrictions, providing re-education as necessary and documenting non-compliance. Registered Dietician (RD) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 698	Continued From page 67 serving fluids on the trays. NA #6 indicated that Resident #321 was served 2 cups of coffee every dinner time. He was also provided a styro foam cup (480 ml) with water at bedside. NA #6 stated that he was aware the resident was on fluid restriction. On 11/1/18 at 8:35 AM, Resident #321 was again observed with a styro foam cup (480 ml) full of coffee. He stated that he had 2 cups of coffee every meal. He stated that he didn't know that he was on 1000 ml fluid restriction. On 11/1/18 at 8:50 AM, Nurse Supervisor #1 was interviewed. She verified that the fluid restriction was not being followed as ordered as evidenced by the daily fluid intake documented on the MAR. She also indicated that Resident #321 was not compliant with the fluid restriction however the staff were not documenting the non- compliance and the doctor was not informed. On 11/1/18 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the doctor's order for fluid restriction to be followed and if the resident was non- compliant to document and notify the doctor.	F 698		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		11/21/18

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F 758	Continued From page 68 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and nurse practitioner and physician interviews, the	F 758	1. Resident # 15 physicians order for prn Ativan was scheduled on 11/02/18,	

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F 758	Continued From page 69 facility failed to ensure as needed psychotropic medications were time limited in duration (Residents #15, #33, #57, and #86) for 4 of 5 residents reviewed for as needed psychotropic medication. Findings included: 1. A review of Resident #15 ' s physician ' s order dated 12/22/17 revealed Ativan 1 mg every 4 hours as needed. Last dose documented as being dispensed was dated 10/28/18. A review of the resident ' s consultation report documentation from the pharmacist revealed a review of Ativan that was in place for more than 14 days without a stop date to please discontinue. Nurse Practitioner response was Ativan was started while on Hospice and was effective for episodes of agitation. Will re-evaluate the as needed Ativan order in 60 days. A review of the Resident #15 ' s quarterly Minimum Data Set (MDS) dated 7/24/18 revealed documentation that the resident had unclear speech, usually understands and was usually understood. The resident had impaired vision. The cognition was severely impaired. A review of the social work #1 ' s note dated 10/1/18 revealed the resident can be confused and combative. A review of the care plan updated 10/28/18 revealed goals and interventions for potential complications of psychotropic medication. A review of the resident ' s incident report	F 758	Resident #33 physicians order for prn Ativan was discontinued on 11/02/18, Resident # 57 physicians order for prn Ativan was discontinued on 11/02/18 and Resident # 86 physicians order was clarified to reflect fourteen day time limit on 11/02/18. 2. Center Nurse Executive (CNE) audited each resident receiving as needed (prn) psychotropic medications on 11/05/18 to ensure the orders reflected the 14 day increments. Medications that have not been used, and those not meeting the time limit requirements were discontinued by the physician. There were four residents with orders requiring time limit clarification. Physician was notified for correction/clarification orders. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses (including weekend and prn licensed nurses), Optum Nurse Practitioner, OnSite Care Nurse Practitioner and centers Medical Director by 11/21/18, concerning as needed order (PRN) psychotropic medications to include that this class of medications are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. As needed (prn) psychotropic medications, will be reviewed during clinical standup each week five	

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F 758	Continued From page 70 revealed she fell on 10/28/18 due to confusion and increased restlessness. A review of the nurses ' note dated 10/28/18 at 11:49 am the resident was agitated and restless and was administered as needed Ativan. On 10/29/18 at 2:30 pm an interview was conducted with Nursing Assistant (NA) #3 who was assigned to and familiar with the resident. NA #3 stated that the resident can be agitated and required supervision to prevent falls. On 10/31/18 at 12:50 pm an interview was conducted with Nurse #3 who stated that the resident had been agitated and tried to get out of bed alone. The resident was alert but confused. At times the resident was agitated and had an order for as needed Ativan 1 mg. Nurse #3 stated the resident was agitated this morning and received an as needed Ativan with good results. Nurse #3 was not aware that an as needed psychotropic medication required a stop date within 14 days, evaluation and renewal. On 10/31/18 at 6:15 pm an interview was conducted with the resident ' s physician who stated he was aware of the 14-day stop requirement for as needed psychotropic medication. There was a new nurse practitioner who was not aware of the requirement for stop-date and that he would provide education. The resident ' s as needed Ativan which did not have a stop-date was an error. On 11/1/18 at 1:15 pm an interview was conducted with the Director of Nursing who stated she expected	F 758	times/weekly for three months by Interdisciplinary Team, including Center Executive Director, Center Nurse Executive, Nursing Supervisors and Social Workers in clinical review meeting. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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2.

A review of Resident #33 ' s physician order dated 5/7/18 revealed Ativan 0.5 mg every 8 hours as needed for 4 weeks and re-evaluate.

A review of the resident ' s medication administration record for October 2018 revealed an order dated 6/7/18 for Ativan 0.5 mg every 8 hours for anxiety. Last dose was given on 10/2/18

A review of the resident ' s quarterly Minimum Data Set dated 10/12/18 revealed moderately impaired cognition adequate vision wears corrective lenses. Active diagnoses were non-Alzheimer ' s dementia and anxiety.

The resident ' s care plan updated 10/13/18 revealed dementia care with behaviors, elopement risk, impaired cognitive function, and at risk for complications secondary to psychotropic medication.

A review of the resident ' s pharmacy consultation report dated 6/29/18 recommended to discontinue as needed Ativan in place for greater than 14 days without a stop date. The nurse practitioner response was to continue Ativan secondary to anxiety and to reevaluate in 6 months.

A review of the resident ' s Psychiatry nurse practitioner note dated 9/28/18 recommendation to discontinue the as needed Ativan.

No physician or nurse practitioner progress note or order to respond to the recommendation to

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discontinue the as needed Ativan on 9/28/18 was identified in the resident ' s record.

On 10/31/18 at 6:15 pm an interview was conducted with the resident ' s physician who stated he was aware of the 14-day stop requirement for as needed psychotropic medication. There was a new nurse practitioner who was not aware of the requirement for stop-date and that he would provide education. The resident ' s as needed Ativan which did not have a stop-date was an error.

3. Resident #57 was admitted to the facility on 8/31/16 with diagnoses that included vascular dementia without behavioral disturbance and unspecified psychosis.

A physician ' s order dated 7/28/17 for Resident #57 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) every 4 hours as needed (PRN) for anxiety. There was no stop date for this PRN order.

A Pharmacy Consultation Report dated 1/24/18 indicated a repeat recommendation was made from 11/30/17 to discontinue Resident #57 ' s PRN Ativan 0.5 mg every 4 hours which had been in place for greater than 14 days without a stop date. The physician declined the recommendation on 2/1/18 indicating that Resident #57 was on hospice and to discuss this with the hospice provider.

A Pharmacy Consultation Report dated 2/26/18 indicated a repeat recommendation to discontinue Resident #57 ' s PRN Ativan 0.5 mg every 4 hours which had been in place for greater

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than 14 days without a stop date or for the prescriber to document the indication for use, the intended duration of therapy, and the rationale for the extended time period. The physician declined the recommendation on 3/1/18 indicating that Resident #57 was on hospice and questioned why the 14-day stop date applied to a hospice resident.

A Pharmacy Consultation Report dated 4/24/18 indicated a repeat recommendation to discontinue Resident #57 ' s PRN Ativan 0.5 mg every 4 hours which had been in place for greater than 14 days without a stop date or for the prescriber to document the indication for use, the intended duration of therapy, and the rationale for the extended time period. The physician declined the recommendation on 4/26/18 indicating that Resident #57 was on hospice and to discuss with hospice provider.

A Pharmacy Consultation Report dated 7/26/18 indicated a repeat recommendation to discontinue Resident #57 ' s PRN Ativan 0.5 mg every 4 hours which had been in place for greater than 14 days without a stop date or for the prescriber to document the indication for use, the intended duration of therapy, and the rationale for the extended time period. The physician declined the recommendation on 8/16/18 indicating that Resident #57 was on hospice and they had advised continuing the PRN Ativan with a re-evaluation in 6 to 8 weeks.

The annual Minimum Data Set (MDS) dated 8/31/18 indicated Resident #57 was rarely/never understood and rarely/never understands. She had short-term and long-term memory problems and severely impaired decision making. Resident

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#57 had verbal behaviors on 1 to 3 days during the MDS review period and she received no antianxiety
medication.

A review was conducted of Resident #57 ' a PRN Ativan usage from 8/1/18 through 10/30/18. Resident #57 received PRN Ativan once in August 2018 (8/14/18), none in September 2018, and once in October 2018 (10/2/18).

A review of Resident #57 ' s active orders was conducted on 10/31/18. The 7/28/17 PRN order for Ativan 0.5 mg continued to be an active order with no stop date.

An interview was conducted with the Administrator on 10/31/18 at 4:39 PM. The Administrator was asked who was responsible for responding to pharmacy recommendations related to hospice medications such as PRN Ativan. She stated that the attending physician was responsible for responding to the pharmacy recommendations, not the hospice physician. She was then asked who was responsible for following up with the hospice provider if the attending physician documented on the pharmacy recommendation to discuss the recommendation with the hospice provider. She stated that the Director of Nursing (DON) was responsible for following up. The Administrator indicated that she expected the regulations related to PRN psychotropic medications to be followed for all residents including hospice residents.

An interview was conducted with the DON on 10/31/18 at 4:59 PM. She stated that she was aware the regulation related to PRN psychotropic medication applied to hospice residents. The

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pharmacy recommendations related to Resident #57 ' s PRN Ativan (1/26/18, 2/26/18, 4/24/18, and 7/26/18) with no stop date were reviewed with the DON. She revealed that she had not had any discussions with the hospice provider related to Resident #57 ' s PRN Ativan. She stated that ultimately the decision to discontinue a medication was left with the attending physician and not the hospice physician.

An interview was conducted with the physician on 10/31/18 at 5:20 PM. He stated he was aware of the regulation related to PRN psychotropic medications which was a time limited duration of 14 days, but indicated he was unclear if the regulation applied to hospice residents. He reported he felt like he was caught in the middle with the hospice provider. He stated he was aware that Resident #57 had a PRN order for Ativan with no stop date and reported that staff were working on decreasing its usage.

A phone interview was conducted with the Pharmacy Consultant on 11/1/18 at 11:40 AM. He indicated he expected the regulation related to PRN psychotropic medications to be followed for all residents. He reported he had been making recommendations to discontinue any PRN psychotropics that extended beyond 14 days.

4. Resident #86 was admitted to the facility on 8/28/17 with cumulative diagnoses that included major depressive disorder and generalized anxiety disorder.
The Minimum Data Set (MDS) dated 9/26/18 indicated that the resident was alert and oriented and received 7 out of 7 days of an antidepressant medication during the look back period. There was no coded behavior or rejection of care.

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F 758	Continued From page 76 During a review of the physician orders for Resident #86 revealed a physician order dated 10/30/18 that read: Lorazepam 0.25mg by mouth every 12 hours as needed (PRN) for anxiety. The order did not include a stop date or duration for the PRN Lorazepam. A review of the pharmacy medication reviews revealed they were completed monthly with last review dated 10/17/18. An interview was conducted on 10/31/18 at 5:00 pm with the Director of Nursing (DON) who confirmed there was no stop date for the Lorazepam that was ordered PRN. She stated that it was her expectation for all PRN psychotropic medications to be time limited in duration per the regulation. A telephone interview with the Pharmacist on 11/1/18 at 10:40 am revealed he made recommendations to the physician for any PRN psychotropic medications that did not have a stop date. He stated that it was his expectation for all PRN psychotropic medications to be time limited in duration per the regulation. A telephone interview was conducted with the Nurse Practitioner on 11/1/18 at 11:10 am. She stated that it was an oversight that the PRN psychotropic medication did not have a stop date and would be corrected on her next visit to the facility.	F 758		
F 761 SS=E	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	F 761		11/21/18

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F 761	Continued From page 77 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 3 (100, 400 and 500 medication carts) of 4 medication carts observed. Findings included: 1. On 11/1/18 at 10:10 AM, the medication cart on 500 hall was observed. The following were observed: 1 Used Lantus insulin pen - undated 1 bottle of Vitamin E 400 international units (iu) tablets - expiration date 8/18 1 bottle of Nitrostat (used to relieve chest pain) 0.4 milligrams (mgs) tablets - expiration date 10/17	F 761	1. Expired or unlabeled medications that were identified during observations were discarded immediately 11/01/18 by the nurse. 2. Medication and Treatment Carts, and medication storage rooms were audited by Center Nurse Executive (CNE) and Nursing Supervisor(s) by 11/21/18 for expired or unlabeled/undated medications. Discrepancies were noted on all five medication carts and items were discarded appropriately. No discrepancies were noted during the medication room audit. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses (including weekend and	

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F 761	Continued From page 78 On 11/1/18 at 10:14 AM, Nurse #10 was interviewed. She verified that the Lantus pen was used and was undated and the Vitamin D and Nitrostat were already expired. Nurse #10 stated that the Lantus should have been dated when opened but it was not and the nurses were responsible for checking the medication carts for expired medications. On 11/1/18 at 10:35 AM, Nurse Supervisor #1 was interviewed. She stated that nurses were responsible for checking the medication carts for expired medications and they were supposed to be dating multi dose medications when opened including the insulin and the protein supplements. On 11/1/8 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that night shift nurses were responsible for checking the medication carts for expired and undated medications at least once a week. She also stated that she expected the nurses to check their medication carts and to discard expired medications and to date multi dose medications when opened. 2. On 11/1/18 at 10:20 AM, the medication cart on 400 hall was observed. There was an opened bottle of Proheat (a liquid protein supplement), less than half full, that was undated. The instruction on the bottle read to discard 60 days after opening. On 11/1/18 at 10:22 AM, Nurse #11 was interviewed. Nurse #11 verified the Proheat bottle was undated and stated that it should have been dated when opened.	F 761	prn licensed nurses) by 11/21/18, regarding labeling, dating, storing and discarding drugs appropriately. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Nursing Supervisor(s) will audit all five medication carts and the medication storage room 3 X week for one month, then weekly x 3 months and randomly thereafter to ensure that expired medications are disposed of and medications are dated/labeled appropriately. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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On 11/1/18 at 10:35 AM, Nurse Supervisor #1 was interviewed. She stated that nurses were responsible for checking the medication carts for expired medications and they were supposed to be dating multi dose medications when opened including the insulin and the protein supplements.

On 11/1/8 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that night shift nurses were responsible for checking the medication carts for expired and undated medications at least once a week. She also stated that she expected the nurses to check their medication carts and to discard expired medications and to date multi dose medications when opened.

3. On 11/1/18 at 10:25 AM, the medication cart on 100 hall was observed. The following were observed:

1 opened foil with 10 vials of xopenex/levalbuterol (used to treat and prevent bronchospasm) 0.63 milligrams (mgs)/3 milliliter (ml) inhalation - dated 9/26/18

The instruction on the box of the xopenex read that the vials were good for 2 weeks once the foil pouch was opened.

1 opened foil with 10 vials of xopenex/levalbuterol 0.63 milligrams (mgs)/3 milliliter (ml) inhalation - undated

The instruction on the box of the xopenex read that the vials were good for 2 weeks once the foil pouch was opened.

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F 761	Continued From page 80 On 11/1/18 at 10:27 AM, Nurse # 3 was interviewed. Nurse #3 verified that the opened foil pouch was dated 9/26/18 and the other opened foil pouch was undated. She stated that the foil should have been dated when opened. Nurse #3 didn't know that the xopenex vial was only good for 2 weeks once the foil pouch was opened. On 11/1/18 at 10:35 AM, Nurse Supervisor #1 was interviewed. She stated that nurses were responsible for checking the medication carts for expired medications and they were supposed to be dating multi dose medications when opened including inhalations. On 11/1/8 at 1:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that night shift nurses were responsible for checking the medication carts for expired and undated medications at least once a week. She also stated that she expected the nurses to check their medication carts and to discard expired medications and to date multi dose medications when opened.	F 761		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep the dumpster doors closed and failed to maintain the dumpster area free of debris for 3 of 3 dumpsters observed.	F 814	1. Dumpster area was cleaned thoroughly by Housekeeping/Floor Tech on 11/01/18. 2. Dumpster area was observed by Center Executive Director (CED) on	11/21/18

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F 814	Continued From page 81 The findings included: During an observation on 10/31/18 at 2:25 pm of the dumpster area there were empty cigarette packages, fast food beverage cups, gloves, a respiratory tubing and multiple crayons on the ground around the 2 trash dumpsters and 1 cardboard dumpster. Both trash dumpster doors were open. An interview with the Regional Dietary Manager on 10/31/18 at 2:25 pm revealed that housekeeping was responsible for keeping the areas around the dumpster clean. He added that his staff was expected to close the doors to the dumpsters after they disposed of any garbage. An interview with the Housekeeping Supervisor on 11/1/18 at 8:25 am revealed the housekeeping department was responsible for keeping the area around the dumpsters clean. He stated that a staff member goes out every morning to clean and ensure the doors are closed. During an observation of the dumpster area with the Housekeeping Supervisor on 11/1/18 at 8:30 am revealed the doors to the 2 trash dumpsters and 1 cardboard dumpster were open. Fast food beverage cups and gloves remained around the dumpsters as well as an empty medication bottle, an eye drop bottle, a soiled cloth of some type, empty cigarette package and gloves in between the 2 trash dumpsters. An interview with the Administrator 11/1/18 at 8:45 am revealed that it was her expectation for the dumpster area to be free of debris on the ground and all doors closed.	F 814	11/05/18 and 11/14/18 to ensure the area was free of debris and all doors closed appropriately. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE), Nursing Supervisors Housekeeping Supervisor and Food and Nutrition Director will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), housekeeping (including weekend and prn staff) and dietary staff (including weekend and prn staff) by 11/21/18 on ensuring that the dumpster area is to be free of trash and debris and that doors to the trash dumpsters and cardboard dumpster remained closed when not in use. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Housekeeping Supervisor, Food and Nutrition Director and Center Executive Director will audit the dumpster area daily times one month then weekly thereafter to ensure that dumpster area remains free of clutter and doors to dumpster containers remain closed when not in use. Center Executive Director (CED) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 842	Continued From page 82	F 842		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		11/21/18

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F 842	Continued From page 83 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document and accurately document provision of personal care and the resident ' s refusal of baths for a resident who had a self-care deficit (Resident #60) for 1 of 2 residents reviewed for activities of daily living (ADL). Findings included:	F 842	1. Resident #60 is longer at the center. 2. Clinical Management Team (Center Nurse Executive, Nurse Practice Educator, Assistant Director of Nursing and Nursing Supervisor(s) completed an audit of November 2018 Activities of Daily Living notebook to ensure adequate documentation on 11/14/18. Undocumented areas were identified and	

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F 842	Continued From page 84 Resident #60 was admitted on 12/18/15 and reentered from the hospital on 8/16/18 with the diagnoses of end-stage renal disease (ESRD), severe protein calorie malnutrition, and adult failure to thrive, HTN. A review of the resident ' s 14-day Minimum Data Set dated 8/30/18 revealed the resident re-entered from the hospital, was cognitively intact and required total dependence on one staff member for all ADLs except meals. The resident ' s active diagnoses were anemia, respiratory failure, encounter for other unspecified aftercare, ESRD, dependence on renal dialysis, and other acute osteomyelitis left ankle and foot. A review of the resident ' s care plan updated 8/16/18 revealed to encourage the resident to participate in care, to explain care, and when refused to try again later. The resident was sometimes resistive or became agitated with care just wanted to be left alone. A review of the nurses' notes from 8/1/18 to discharge 9/ 21/18 revealed there was no documentation of refusal of ADL care. A review of the August 2018 ADL flow record documentation revealed in August the resident received bathing and personal care by one staff member every day until 8/7/18. The August flow record documented the resident was in the hospital during 8/8/18 to 8/16/18 and when the resident returned 8/17/18 only personal care was documented as being provided occasionally and there were only 5 bed baths until discharge on 9/21/18. The remaining dates for documentation by date and shift were either blank or had "N/A."	F 842	corrected accordingly. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant) by 11/21/18 on accurately documenting provision of personal care and resident□s refusal of baths in the Activities of Daily Living (ADL) Notebook. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Health Information Management Director (HIM) will randomly audit Activities of Daily Living (ADL) documentation of 10 residents three times a week times one month then weekly thereafter. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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A review of the nurses' note dated 8/16/18 revealed the resident returned from the hospital, was able to make his needs known, and complained of left foot pain and was medicated. Incontinence care was provided by staff.

Nurses ' note dated 8/17/18 documented the resident continued to refuse his Heparin injection. ADLs required 1 staff with extensive assistance and 2 staff for mechanical transfer.

Nurses ' note dated 8/18/18 through 9/5/18 sporadically documented the resident was able to make his needs known and received incontinence care. (No mention of refusal of care).

Review of the September 2018 ADL flow record documentation revealed the resident received two bed baths on 9/2 and 9/5 respectively for day shift and the month's remaining documentation was blank for a bath every day and shift.. Documentation for night shift was either blank or had "N/A" for the month for personal hygiene or a bath. Documentation for evening shift was either "N/A" or blank for the entire month of September for bathing and all were blank but 5 occasions dependent of 1 staff for personal care for the entire month of September.

On 10/31/18 at 10:45 am interview with the Assistant Director of Nursing (ADON) who verified that the resident ' s documented ADL flow record of care was documented 8/10/18 through 9/21/18 had several blanks and "N/A." The ADON stated the record should not be left blank and if there was a refusal "N/A" should not be documented. The nursing assistant should

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document the refusal and the nurse should be informed and try to encourage acceptance of care. If refusal continued, it should be documented in the nurses ' notes.

On 10/31/18 at 11:30 am an interview was conducted with Nursing Assistant (NA) #11 who cared for the resident after his hospitalization and had refused most personal care except incontinence care. The resident had refused all bed baths. NA #11stated that she wrote N/A (not applicable) when the resident refused care and notified the nurse. NA #11 stated that she would return and ask the resident again to offer care and encourage.

On 10/31/18 at 11:52 am an interview was conducted with Nurse #9 who remembered the resident and stated that the resident was known to occasionally refuse his bed bath but not daily. Nurse #9 indicated that she was not informed that the resident was documented as not having received a bed bath for two weeks. Nurse #9 commented that the ADL record should not be blank and "N/A" should not be documented by the nursing assistant if the care was refused. If the resident refused, care there should be documentation and the nurse notified. The resident refused showers because his dialysis access was in his groin area and he was afraid it would get wet. The port was to remain dry. Nurse #9 stated that resident had chronic diarrhea from antibiotics and Nurse #9 was confident and have observed that the resident received incontinence care even if the ADL record was blank. The resident was able to make his needs known and had an intact cognition. Nurse #9 stated she did not remember if the resident's hair appeared dirty; however, the resident ' s hair

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was knotted in the back due to lying in bed and was combed carefully and periodically to prevent discomfort.

On 10/31/18 an interview was conducted with NA #11 who was familiar and frequently assigned to the resident. NA #11 stated that the resident always refused a shower because of his dialysis port in the groin and frequently refused a bed bath after his last hospitalization. The staff would return to ask again and if the refusal continued or there were concerns they informed the nurse or social worker. NA #11 stated that she was aware that the family had concerns regarding the resident's hygiene and that the nurse and social work spoke to the family. The resident's hair had become matted/knotted in the back due to always preferring to be in bed. The staff would comb the resident ' s hair a little at a time to prevent pulling.

On 10/31/18 at 12:10 pm an interview was conducted with Social Worker (SW) #1 who stated she remembered the resident very well. The resident was alert and oriented and able to make his needs known. The resident did not verbalize any concerns with hygiene or any other. The family did not attend the care plan meeting. The resident ' s representative had not voiced any concerns and indicated she was happy with the resident's care. SW #1 stated she had obtained the resident warm clothing to travel to dialysis. The resident frequently felt cold. SW #1 was unaware that there were any concerns with hygiene and had not observed the resident having body odor, dirty or matted hair.

On 11/1/18 at 1:15 pm an interview was conducted with the Director of Nursing who stated she expected staff to document accurately in the

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F 842	Continued From page 88 record and not to leave blanks and use "N/A" with ADL refusals.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		11/21/18

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F 880	Continued From page 89 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide proper hand hygiene when providing urinary catheter care for 1 of 3 sampled residents with urinary catheter (Resident 30). Findings included:	F 880	1. Resident #30 is no longer at the center. 2. All residents with indwelling catheters have potential to be effected. Center Nurse Executive (CNE) and Nurse Practice Educator (NPE) completed a 100% audit of current residents (3) with	

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F 880	Continued From page 90 The facility's policy on "care of indwelling urinary catheter" with the revised date of 1/2/14 was reviewed. The policy indicated to cleanse hands and to put on gloves before providing catheter care. Resident #30 was originally admitted to the facility on 11/24/17 with multiple diagnoses including obstructive and reflux uropathy and urinary retention. The significant change Minimum Data Set (MDS) assessment dated 10/15/18 indicated that Resident #30 had moderate cognitive impairment and had an indwelling urinary catheter. Resident #30's care plan dated 10/15/18 was reviewed. One of the care plan problems was resident has an indwelling urinary catheter and the goal was resident would not have complications related to the use of the indwelling catheter. The approaches included to provide catheter care as ordered and as needed. Resident #30 had a doctor's order dated 3/2/18 for catheter care every shift. On 10/30/18 at 2:00 PM, Resident #30 was observed during catheter care. The resident was observed to have a bowel movement. Nursing Aide (NA) #4 was observed to provide incontinent care and then proceeded to perform the catheter care without washing her hands nor changing her gloves. On 10/30/18 at 2:10 PM, NA #4 was interviewed. She stated that she didn't think about washing her hands or changing her gloves after providing	F 880	indwelling catheters on 11/15/18, no evidence of infections noted. Audits included observations of catheter care by the Nurse Practice Educator (NPE) on 11/15/18. No insufficient practices noted during observations. 3. Nurse Practice Educator (NPE), Center Nurse Executive (CNE) and Nursing Supervisors will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and certified nursing assistant) by 11/21/18, concerning providing proper urinary catheter care with return demonstration as well as hand hygiene. Any staff members not receiving re-education by 11/21/18, will be re-educated prior to working their next scheduled shift. 4. Nursing Supervisor(s) will audit catheter care on three residents three times weekly times one month then weekly time one month then monthly thereafter for appropriate urinary catheter care and hand hygiene techniques. Center Nurse Executive (CNE) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 880	Continued From page 91 incontinent care. NA #4 stated that she should have washed her hands and changed her gloves before performing the catheter care. On 10/31/18 at 3:35 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nursing staff to wash hands and to change gloves after providing incontinent care and before providing catheter care to a resident.	F 880		