STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 04/08/19 through 04/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6XO511.	E 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		5/8/19

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

Electronically Signed | 05/06/2019

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F 578	Continued From page 1 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have accurate and complete advance directives in the medical record for 2 of 2 residents reviewed for advance directives (Resident # 192 and Resident # 58). The findings included: 1. Resident #192 was admitted to the facility 04/03/19 with diagnoses including osteomyelitis of the right foot and a diabetic foot ulcer. Review of the medical record for Resident #192 revealed a form titled Advance Directives Discussion Document dated 04/03/19 that stated she wished to withhold cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. The was no Physician's order in the medical record for Resident #192 to have a Do Not Resuscitate (DNR) code status, there was no goldenrod DNR form in the medical record, and there was no Medical Order for Scope of Treatment (MOST) form in the medical record. An interview with Nurse #3 on 04/09/19 at 10:49 AM revealed the Advance Directives Discussion	F 578	On 04/09/2019 Resident #192 had order written for Do Not Resuscitate. On 04/04/2019 the Goldenrod with the Medical Order for Scope of Treatment was placed in the medical record. Resident #192 discharged on 04/26/2019. On 04/10/2019 resident #58 had a order written for Code status clarification of Full Code and was placed in the medical record. On 04/19/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring of all resident's code statuses. Any issues identified were addressed. On 04/04/2019 through 05/07/2019 all licensed nurses were re-educated by the Director of Nursing and/or Designee on obtaining code status orders, Goldenrods, and Medical Order for Scope of Treatment and placing in medical record when complete. Newly hired staff will be educated upon hire	

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F 578	Continued From page 2 Document was completed upon admission for all residents and was not a Physician's order. Nurse #1 stated there should have been a Physician's order for DNR and a goldenrod DNR and/or a MOST form in Resident #192's medical record. Nurse #1 stated nursing staff should have called the Physician and gotten a DNR order for Resident #192's medical record. On 04/9/19 at 11:15 AM the Minimum Data Set (MDS) Nurse provided a copy of Resident #192's goldenrod DNR form and MOST form which stated DNR. The MDS nurse stated she located the documents in the medical records office. The goldenrod DNR form and MOST forms were signed and dated by the Nurse Practitioner (NP) on 04/04/19. An interview with the medical records staff member on 04/09/19 at 2:28 PM revealed she received completed DNR and MOST forms and filed them in the medical record. The medical records staff member stated she usually received the completed DNR and MOST forms the day after the provider completed them and filed them in the medical record at that time. The medical record staff member stated she was not sure why Resident #192's DNR and MOST forms were not on her chart. An interview with the Director of Nursing (DON) on 04/09/19 at 2:40 PM revealed Resident #192's medical record should have contained the DNR and MOST forms. The DON also stated there should have been a Physician's order for DNR in the medical record. The DON stated in the event of cardiopulmonary arrest he expected staff to check the medical records department for advance directive information and if the medical	F 578	On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring on code status three times a week for four weeks, then two times a week for four weeks, and then one time monthly for three months. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nursing Assistant, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Improvement Performance Improvement Committee meets monthly and quarterly at a minimum.	

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F 578	Continued From page 3	F 578		

records department is closed to get the key from the charge nurse and check the medical records department.

2. Resident #58 was admitted to the facility on 06/05/13. His diagnoses included heart failure, hypertension, and diabetes.

The annual Minimum Data Set (MDS) dated 10/25/18 coded him with severely impaired cognitive skills.

Review of the medical record revealed conflicting advanced directives. Under the tab for Advanced Directives were several forms. The first page had a plastic sheet which stated to provide cardiopulmonary resuscitation (CPR), artificial respiration and artificial nutrition. Behind this sheet in the same plastic sleeve was page 2 with the date of 06/05/13. The next plastic sleeve contained a form dated 11/20/18 that stated to hold CPR. Behind that was another plastic sleeve with the actual telephone order dated 11/20/18 for Do Not Resuscitate orders.

Review of the physician signed computerized monthly printed orders revealed Resident #58 was a full code in December 2018, January 2019, February 2019, and March 2019.

The most recent Minimum Data Set, a quarterly dated 02/19/19 coded him with moderately impaired cognitive skills.

Interview with Nurse #2 on 04/09/19 at 2:55 PM revealed she was new to the facility. She looked at the record and flipped to the advanced directives tab and stated she would provide full code to Resident #58.

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F 578	Continued From page 4 On 04/09/19 at 2:58 PM, the Regional Nurse reviewed the chart and stated that nurses were to go off the signed physician's order which was do not resuscitate. On 04/09/19 at 3:02 PM the Director of Nursing (DON) reviewed the chart and noted that the computerized physician orders for full code was dated 07/02/13 and had not been updated with the new telephone order dated 11/20/18. An interview was conducted with the MDS Nurse on 04/09/19. Review of the care plan for advanced directives revealed when last reviewed with Resident #58 on 04/08/19, Resident #58 wanted to be a full code. The MDS Nurse stated since the care plan already stated full code she did not need to change it. She stated she failed to review physician orders but knew Resident #58 wanted to be full code.	F 578		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		5/8/19

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F 600	Continued From page 5 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family and staff interview's the facility staff neglected to acknowledge resident call bells for 2 of 4 sampled residents,(Resident #139 and Resident #45), failed to provide incontinence care for an hour time from 4:05 PM to 5:20 PM for 1 of 4 residents, (Resident #139), and failed to provide a bed pan upon request for 1 of 4 sampled residents dependent on staff for continence care. (Resident #45). The findings included: 1. Resident #139 was admitted to the facility on 04/09/19 with diagnosis that included: Alzheimer's disease, cerebrovascular accident (CVA) and aphasia. Review of the initial admission nursing assessment dated 04/09/19 revealed Resident #139 was oriented to self, requiring limited assistance of one staff member with toileting. Review of a Physician Order dated 04/10/19 at 2:00 PM revealed an order which read, "Fleets enema x 1 now". A continuous observation was made of Resident #139 on 04/10/19 at 4:05 PM through 5:31 PM. Resident #139's call light was turned on at 4:05 PM, a staff member from Medical Records entered the room at 4:56 PM and was informed by Resident #139 and her family member the resident needed incontinence care. The Medical Records staff member stated to Resident #139 that she would let one of the Nursing Assistants	F 600	Resident #139 had incontinent care provided by Certified Nursing Assistant on 4/10/2019. Resident #45 had incontinent care provided by Certified Nursing Assistant on 4/9/2019. A Facility Reportable Incident was initiated on 4/11/2019. The Certified Nursing Assistant was suspended pending investigation. On 4/23/2019 Director of Nursing and/or designee performed a Quality Improvement Monitoring for all residents that require incontinence care. No other issues were identified. On 4/9/2019 through 5/07/2019 Director of Nursing and/or designee provided re-education to current staff on Abuse and Neglect. Newly hired staff will be educated upon hire. On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring of call light response time for cognitively intact residents and random observation of cognitively impaired residents incontinent needs to be completed two times a week for four weeks, then one time a week for eight weeks, then one time a month for three months. Any discrepancies identified to be reviewed and revised by the Interdisciplinary Team as appropriate.	

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F 600	Continued From page 6 (NAs) know so Resident #139 could be cleaned up and turned off the call light as she exited the room without providing incontinence care. At 5:10 PM Resident #139's family member stepped into the hallway, NA #1 then asked Resident #139 if she needed to use the restroom. The family member stated to NA #1 that Resident # 139 had already had a bowel movement on herself and would need her clothing changed, NA #1 exited the room stating she would be back to provide incontinent care to the resident. At 5:20 PM NA #1 entered Resident #139's room and provided incontinent care, she exited the room at 5:31 PM. On 04/10/19 at 5:32 PM an interview was conducted with NA #1. The interview revealed two NAs were working on Resident #139's hall and both NA's were giving other residents showers during the observation of Resident #139's call light. NA #1 stated following giving a resident a shower she went on break in the breakroom. She stated during her break she was notified by the Medical Records staff member that call lights were going off on the resident hall and residents needed assistance. NA #1 stated the Medical Records staff member did not specify which residents needed assistance. NA #1 stated once she got to the resident hall no call lights were on. She stated when she assisted Resident #139 she was upset due to having a bowel movement on her clothing. NA #1 stated she assisted Resident#139 with incontinence care, changed her clothing and assisted her back in her wheelchair. On 04/10/19 at 5:45 PM an interview was conducted with the Medical Records staff member. The interview revealed she had answered and turned off Resident #139's call	F 600	The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI committee monthly and Quality Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nursing Assistant, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Director, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. AOC: May 8, 2019	

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light, stating the resident needed the NAs to change her due to incontinence. She stated she went into the break room to find NA #1 and told her residents on the hall needed assistance. The interview revealed the other NA on the hall was giving a shower in the shower room. She stated following notifying NA #1 she returned to her office and did not follow up to see if Resident #139 had received assistance.

On 04/10/19 at 5:00 PM an interview was conducted with Family Member #1. The interview revealed Resident #139 was administered an enema by nursing staff at 2:00 PM. The family member stated she had turned Resident #139's call light on at 4:05 PM because Resident #139 had an increased urgency to use the restroom due to effects of the enema previously administered. She stated she assisted Resident #139 to her wheelchair because of having to wait so long however could not assist her to the restroom alone. The interview revealed Resident #139 had a bowel movement on herself due to having to wait to use the restroom. Family member #1 stated Resident #139 was confused and had never had to sit in feces before. Resident #139 was visibly upset during the interview with Family member #1.

On 04/10/19 at 5:47 PM an interview was conducted with the Director of Nursing (DON). The DON stated call lights should be answered within a 15-minute time frame, stating residents having to wait over 15-minutes was unacceptable from staff. The interview revealed a NA was expected to be on the resident's hall at all times and two NAs should not be off of the hall at the same time. He stated the Medical Records staff member should have left the call light on upon

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exiting Resident #139's room to notify staff members the resident still needed assistance. The DON stated it was unacceptable for Resident #139 to have waited over an hour for incontinence care.

2. Resident #45 was admitted to the facility on 09/30/15 and readmitted on 11/12/18. His diagnoses included cerebrovascular accident (CVA), hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

Review of his most recent quarterly Minimum Data Set (MDS) dated 02/08/19 revealed Resident #45 was cognitively intact for daily decision making. The MDS also revealed he required extensive assistance with toileting. The MDS further revealed he was frequently incontinent of stool.

Review of his annual ADL care area assessment (CAA) summary dated 08/31/18 revealed Resident #45 was pleasant, alert and oriented and stated he participated in ADL care as he was able. The CAA summary further revealed he preferred to stay in bed and received bed baths as opposed to showers and stated staff assisted resident with personal hygiene to maintain clean and odor-free appearance and maintain resident's dignity.

An interview was conducted with Resident #45 on 04/09/19 at 8:37 AM. The resident stated the evening before on 04/08/19 at approximately 6:15 PM he had put his light on for assistance with the bed pan. He stated his assigned nurse aide (NA) #6 came in and turned out his light and he had asked for the bed pan. According to the resident,

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NA #6 told him she could not offer him the bed pan while trays were on the floor. The NA told him she would be back to put him on the bed pain once the trays were off the floor. The resident stated he waited and waited and she did not return to put him on the bed pain. Resident #45 stated it made him feel "pretty rotten" that he had to have his bowel movement in the bed when he had asked for the bed pan. The resident also stated if someone told him they would be back to provide a service for him he expected them to keep their word, especially when it was something that he could not do for himself. Resident #45 stated he put his light on again around 7:00 PM to get himself cleaned up and stated the nurse came in around 7:10 PM and told him she would find a NA to assist him and turned out the light before leaving the room. The resident stated the nurse did not offer to clean him up but told him she would find a NA to come and assist him. Resident #45 stated finally between 7:20 and 7:30 PM a second shift NA came in and cleaned him up.

On 04/10/19 at 2:31 PM an interview was conducted with NA #6. The interview revealed she had taken care of Resident #45 on 04/09/19 and had entered his room around 6:15 PM and she stated he had asked for the bed pan and she had told him she could not give him the bed pain while trays were on the floor. She stated she told him she would return once the trays were picked up and assist him at that time. NA #6 stated she was then asked to go to another hall and assist with feeding residents. She stated she fed residents and then left because her shift had ended. NA #6 stated she had forgotten to go back and assist Resident #45 with the bed pan.

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On 04/10/19 at 4:13 PM an interview was conducted with the Director of Nursing (DON). The interview revealed it was the policy of the facility not to provide incontinence or continence care while passing out meal trays. The DON stated he expected the staff to finish passing trays and then go back and provide care or ask for assistance from other staff to pass trays while the NA provided the care. He stated he would expect them to provide continence care prior to providing assistance with meals. The DON also stated the call light should not be turned off until the resident's needs are provided.

On 04/10/19 at 4:17 PM an interview was conducted with the Work Force Manager (WFM). The interview revealed the WFM expected NAs to finish passing trays and then provide continence care to residents or stated they could ask for assistance from other staff to pass trays while they provided continence care. The WFM stated she would not expect them to assist with meals prior to providing continence care. The WFM also stated the call light should not be turned off unless the needs of the resident were provided while the NA was in the room.

On 04/11/19 at 3:27 PM an interview was conducted with the nurse assigned to Resident #45 on 04/08/19. Nurse #8 stated she had taken care of the resident on that evening and stated he had not asked her for the bed pan when she answered his light because it was too late for the bed pan. Nurse #8 stated Resident #45 had already had his bowel movement in the bed and had requested to be cleaned up. Nurse #8 stated she had found his NA and asked her to clean the resident. Nurse #8 stated she had not offered to clean the resident when she answered his call

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F 600	Continued From page 11 light and stated she had turned the light out prior to leaving the room. On 04/11/19 at 3:46 PM an interview was conducted with the Director of Nursing (DON). The interview revealed it was his expectation that call lights be answered within 15 minutes, and stated residents having to wait over 15 minutes was unacceptable. The interview revealed a NA was expected to be on the resident's hall at all times. He stated the resident's call light should have been left on until the resident's needs had been met. The DON stated it was unacceptable for Resident #45 to have waited over an hour for continence care and stated it was unacceptable that the resident had his bowel movement in the bed because he was not offered a bed pan.	F 600		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide a tube feeding as ordered for 1 of 2 residents reviewed for tube feeding (Resident # 8). The findings included: Resident #8 was admitted to the facility 05/27/16 with diagnoses including malnutrition and dysphagia (difficulty swallowing).	F 658	Resident #8 tube feed nutrition was started on 4/10/2019. The Physician was notified on 4/11/2019 with a new order to extend the tube feeding, Jevity 1.5 @ 80ml/hour until 12 noon on 4/11/2019 or as tolerated. On 4/23/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for all residents with tube feed nutrition to ensure following	5/8/19

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F 658	Continued From page 12 Review of Resident #8's care plan for nutrition/hydration last updated 02/25/19 revealed Resident #8 had a feeding tube due to poor intake and had a history of disconnecting himself from his tube feeding. The quarterly Minimum Data Set (MDS) dated 03/26/19 revealed Resident #8 was cognitively intact, had a feeding tube, and received 51% or more calories from the feeding tube. Review of the Physician's orders revealed Resident #8 was to receive Jevity 1.5 (a tube feeding formula) at 80 milliliters (ml) an hour for 12 hours a day through his feeding tube. Review of Resident #8's medication administration record (MAR) for April 2019 revealed he was to receive Jevity 1.5 at 80ml/hour for 12 hours a day starting at 7:00 PM and infusing until 7:00 AM. The April 2019 MAR revealed Jevity 1.5 was initialed as being started at 7:00 PM on 04/10/19. An observation of Resident #8 on 04/11/19 at 5:50 AM revealed he was sitting on the side of his bed with his tube feeding unhooked from his feeding tube. An interview with Resident #8 on 04/11/19 at 5:51 AM revealed he unhooked his tube feeding himself earlier on 04/11/19 to get ready for a Physician's appointment. Resident #8 stated his tube feeding was not started until 12:30 AM 04/11/19 and it should have been started at 7:00 PM on 04/10/19. Resident #8 stated there had been several occasions when his feeding was not started at 7:00 PM as ordered but he could not	F 658	physicians order. No other issues were identified. On 4/9/2019 through 5/07/2019 the Director of Nursing and/or designee provided re-education to all Licensed Nurses on following physicians orders and/or to notify physician if unable to follow order. Newly hired staff will be educated upon hire. On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring of tube feed nutrition to be completed two times a week for four weeks, then one time a week for eight weeks and then one time a month for three months. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by QAPI committee monthly and Quality Monitoring (audits) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nursing Assistant, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance	

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F 658	Continued From page 13 recall the last time his tube feeding was not started on time. An interview with Nurse #4 on 04/11/19 at 6:00 AM revealed she started her shift at midnight on 04/11/19 and the nurse who worked the 3:00 PM to 11:00 PM shift had just started Resident #8's tube feeding when she started her shift. Nurse #4 stated Resident #8's tube feeding was usually infusing as ordered when she worked her shift from midnight to 7:00 AM. An interview with Nurse #5 on 04/11/19 at 11:10 AM revealed she worked 04/10/19 on the 3:00 PM to 11:00 PM shift. Nurse #5 stated she thought Resident #8's tube feeding should have been started at 8:00 PM on 04/10/19 but she wasn't sure. Nurse #5 stated she started Resident #8's tube feeding at 10:30 PM on 04/10/19. Nurse #5 stated she was late starting the tube feeding because she was the shift supervisor, she was also assigned to a hall, and she was running behind. Nurse #5 stated she did not notify the on call provider that Resident #8's tube feeding was started late and she did not pass on to the oncoming shift Resident #8's tube feeding was started late. An interview with the Nurse Practitioner (NP) on 04/11/19 at 11:21 AM revealed she expected tube feedings to be started on time as ordered by the provider. The NP stated she expected the provider to be notified if the tube feeding was not started on time so additional orders could be given. An interview with the Director of Nursing (DON) on 04/11/19 at 1:55 PM revealed he expected Resident #8's tube feeding to have been started	F 658	Performance Improvement committee meets monthly and quarterly at a minimum. AOC: May 8, 2019	

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F 658	Continued From page 14 within the time ordered by the provider and if it was not the provider should have been notified. A subsequent interview with Nurse #5 on 04/11/19 at 3:34 PM revealed she should have made a notation on the MAR that Resident #8's tube feeding wasn't started until 10:30 PM on 04/10/19 but she was so busy she did not make a notation stating when the tube feeding was started.	F 658		
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 observation, record review, resident and staff interview's the facility failed to provide assistance with toileting for 2 of 4 residents reviewed for assistance with activities of daily living (Resident # 139 and Resident # 45). The findings included: 1. Resident #139 was admitted to the facility on 04/09/19 with diagnosis that included: Alzheimer's disease, cerebrovascular accident (CVA) and aphasia. Review of the initial admission nursing assessment dated 04/09/19 revealed Resident #139 was oriented to self, requiring limited assistance of one staff member with toileting. A continuous observation was made of Resident	F 677	Resident #139 had incontinent care provided by Certified Nursing Assistant on 4/10/2019. Resident #45 had incontinent care provided by Certified Nursing Assistant on 4/9/2019. A Facility Reportable Incident was initiated on 4/11/2019. The Certified Nursing Assistant was suspended pending an investigation. On 4/23/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for all residents that require assistance with toileting. No other issues were identified. On 4/9/2019 through 5/7/2019 the Director of Nursing and/or designee provided re-education to Licensed Nurses and Certified Nurses Assistants on	5/8/19

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F 677	Continued From page 15 #139 on 04/10/19 at 4:05 PM through 5:31 PM. Resident #139's call light was turned on at 4:05 PM, a staff member from Medical Records entered the room at 4:56 PM and was informed by Resident #139 and her family member the resident needed incontinence care. The Medical Records staff member stated to Resident #139 that she would let one of the Nursing Assistants (NAs) know so Resident #139 could be cleaned up and turned off the call light as she exited the room without providing incontinence care. At 5:10 PM Resident #139's family member stepped into the hallway, NA #1 then asked Resident #139 if she needed to use the restroom. The family member stated to NA #1 Resident #139 had already had a bowel movement on herself and would need her clothing changed, NA #1 exited the room stating she would be back to provide incontinent care to the resident. At 5:20 PM NA #1 entered Resident #139's room and provided incontinent care, she exited the room at 5:31 PM. On 04/10/19 at 5:32 PM an interview was conducted with NA #1. The interview revealed two NAs were working on Resident #139's hall and both NAs were giving other residents showers during the observation of Resident #139's call light. NA #1 stated following giving a resident a shower she went on break in the breakroom. She stated during her break she was notified by the Medical Records staff member that call lights were going off on the resident hall and residents needed assistance. NA #1 stated the Medical Records staff member did not specify which residents needed assistance. The interview revealed once she got to the resident hall no call lights were on. She stated when she assisted Resident #139 she was upset due to having a bowel movement on her clothing. NA #1 stated	F 677	meeting resident toileting/bedpan needs to include toileting/bedpan needs during meal time. Newly hired staff will be educated upon hire. On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring of residents that require assistance to toilet/bedpan through observation of cognitively impaired residents and resident interviews with cognitively intact residents to be completed two times a week for four weeks, then one time a week for eight weeks, then one time a month for three months. Any discrepancies to be reviewed and revised by the Interdisciplinary Team as appropriate. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by the QAPI committee monthly and Quality Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nursing Assistant, Dietary Manager, Housekeeping Supervisor, Maintenance Director, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement committee	

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F 677	Continued From page 16 she assisted Resident#139 with incontinence care, changed her clothing and assisted her back in her wheelchair. On 04/10/19 at 5:45 PM an interview was conducted with the Medical Records staff member. The interview revealed she had answered and turned off Resident #139's call light, stating the resident needed the NA's to change her due to incontinence. She stated she went into the break room to find NA #1 and told her residents on the hall needed assistance. The interview revealed the other NA on the hall was giving a shower in the shower room. She stated following notifying NA #1 she returned to her office and did not follow up to see if Resident #139 had received assistance. On 04/10/19 at 5:00 PM an interview was conducted with Family Member #1. The interview revealed Resident #139 was administered an enema by nursing staff at 2:00 PM. The family member stated she had turned Resident #139's call light on at 4:05 PM because Resident #139 had an increased urgency to use the restroom due to effects of the enema previously administered. She stated she assisted Resident #139 to her wheelchair because of having to wait so long however could not assist her to the restroom alone. The interview revealed Resident #139 had a bowel movement on herself due to having to wait to use the restroom. Family member #1 stated Resident #139 was confused and had never had to sit in feces before. Resident #139 was visibly upset during the interview with Family member #1. Review of a Physician Order dated 04/10/19 at 2:00 PM revealed an order which read, "Fleets	F 677	meets monthly and quarterly at a minimum. AOC: May 8, 2019	

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F 677	Continued From page 17	F 677		

enema x 1 now".

On 04/10/19 at 5:47 PM an interview was conducted with the Director of Nursing (DON). The DON stated call lights should be answered within a 15-minute time frame, stating residents having to wait over 15-minutes was unacceptable from staff. The interview revealed a NA was expected to be on the resident's hall at all times and two NAs should not be off of the hall at the same time. He stated the Medical Records staff member should have left the call light on upon exiting Resident #139's room to notify staff members the resident still needed assistance. The DON stated it was unacceptable for Resident #139 to have waited over an hour for incontinence care.

2. Resident #45 was admitted to the facility on 09/30/15 and readmitted on 11/12/18. His diagnoses included cerebrovascular accident (CVA), hypertension, chronic obstructive pulmonary disease and diabetes mellitus.

Review of his most recent quarterly Minimum Data Set (MDS) dated 02/08/19 revealed Resident #45 was cognitively intact for daily decision making. The MDS also revealed he required extensive assistance with toileting. The MDS further revealed he was frequently incontinent of stool.

Review of his annual ADL care area assessment (CAA) summary dated 08/31/18 revealed Resident #45 was pleasant, alert and oriented and stated he participated in ADL care as he was able. The CAA summary further revealed he preferred to stay in bed and received bed baths as opposed to showers and stated staff assisted

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resident with personal hygiene to maintain clean and odor-free appearance and maintain resident's dignity.

An interview was conducted with Resident #45 on 04/09/19 at 8:37 AM. The resident stated the evening before on 04/08/19 at approximately 6:15 PM he had put his light on for assistance with the bed pan. He stated his assigned nurse aide (NA) #6 came in and turned out his light and he had asked for the bed pan. According to the resident, NA #6 told him she could not offer him the bed pan while trays were on the floor. The NA told him she would be back to put him on the bed pain once the trays were off the floor. The resident stated he waited and waited and she did not return to put him on the bed pain. Resident #45 stated it made him feel "pretty rotten" that he had to have his bowel movement in the bed when he had asked for the bed pan. The resident also stated if someone told him they would be back to provide a service for him he expected them to keep their word, especially when it was something that he could not do for himself. Resident #45 stated he put his light on again around 7:00 PM to get himself cleaned up and stated the nurse came in around 7:10 PM and told him she would find a NA to assist him and turned out the light before leaving the room. The resident stated the nurse did not offer to clean him up but told him she would find a NA to come and assist him. Resident #45 stated finally between 7:20 and 7:30 PM a second shift NA came in and cleaned him up.

On 04/10/19 at 2:31 PM an interview was conducted with NA #6. The interview revealed she had taken care of Resident #45 on 04/09/19 and had entered his room around 6:15 PM and

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she stated he had asked for the bed pan and she had told him she could not give him the bed pain while trays were on the floor. She stated she told him she would return once the trays were picked up and assist him at that time. NA #6 stated she was then asked to go to another hall and assist with feeding residents. She stated she fed residents and then left because her shift had ended. NA #6 stated she had forgotten to go back and assist Resident #45 with the bed pan.

On 04/10/19 at 4:13 PM an interview was conducted with the Director of Nursing (DON). The interview revealed it was the policy of the facility not to provide incontinence or continence care while passing out meal trays. The DON stated he expected the staff to finish passing trays and then go back and provide care or ask for assistance from other staff to pass trays while the NA provided the care. He stated he would expect them to provide continence care prior to providing assistance with meals. The DON also stated the call light should not be turned off until the resident's needs are provided.

On 04/10/19 at 4:17 PM an interview was conducted with the Work Force Manager (WFM). The interview revealed the WFM expected NAs to finish passing trays and then provide continence care to residents or stated they could ask for assistance from other staff to pass trays while they provided continence care. The WFM stated she would not expect them to assist with meals prior to providing continence care. The WFM also stated the call light should not be turned off unless the needs of the resident were provided while the NA was in the room.

On 04/11/19 at 3:27 PM an interview was

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F 677	Continued From page 20 conducted with the nurse assigned to Resident #45 on 04/08/19. Nurse #8 stated she had taken care of the resident on that evening and stated he had not asked her for the bed pan when she answered his light because it was too late for the bed pan. Nurse #8 stated Resident #45 had already had his bowel movement in the bed and had requested to be cleaned up. Nurse #8 stated she had found his NA and asked her to clean the resident. Nurse #8 stated she had not offered to clean the resident when she answered his call light and stated she had turned the light out prior to leaving the room. On 04/11/19 at 3:46 PM an interview was conducted with the Director of Nursing (DON). The interview revealed it was his expectation that call lights be answered within 15 minutes, and stated residents having to wait over 15 minutes was unacceptable. The interview revealed a NA was expected to be on the resident's hall at all times. He stated the resident's call light should have been left on until the resident's needs had been met. The DON stated it was unacceptable for Resident #45 to have waited over an hour for continence care and stated it was unacceptable that the resident had his bowel movement in the bed because he was not offered a bed pan.	F 677		
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 condition is or becomes such that continence is not possible to maintain.	F 690		5/8/19

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F 690	Continued From page 21 §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 observations, record review, and family and staff interviews the facility failed to maintain a urinary catheter bag below the level of the bladder to facilitate the flow of urine (Resident #186) and failed to keep the urinary catheter bag off the floor to reduce the risk of infection (Resident # 36) for 2 of 2 residents reviewed for urinary catheters. The findings included:	F 690	Resident #36 catheter bag was placed appropriately while lying in the bed by the licensed nurse immediately on 4/11/2019. Resident #186 catheter bag was placed appropriately by licensed nurse immediately while lying in bed on 4/09/2019. On 4/23/2019 the Director of Nursing and/or designee performed a Quality	

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F 690	Continued From page 22 1. Resident # 186 was admitted to the facility 04/02/19 with diagnoses including a stroke and urinary retention. Review of the medical record revealed a Minimum Data Set (MDS) was not completed because Resident #186 was admitted to the facility only 6 days prior. A review of Resident #186's baseline care plan dated 04/04/19 revealed he had an indwelling urinary catheter and was to receive urinary catheter care each shift and as needed. Observation of Resident #186 on 04/09/19 at 9:58 AM revealed he was lying in bed with his urinary catheter bag hanging on the upper quarter side rail of his bed and the urinary catheter tubing was filled with urine. The urinary catheter bag was above the level of the bladder. An interview with Resident #186's family member on 04/09/19 at 9:59 AM revealed Resident #186's urinary catheter bag had been hanging on the upper quarter side rail of his bed since she came to visit at approximately 8:00 AM on 04/09/19. An interview with Nurse #6 on 04/09/19 at 10:00 AM revealed Resident #186's urinary catheter bag should be below the level of his bladder and he was not sure how long the urinary catheter bag had been hanging on the upper quarter side rail of the bed. An interview with nurse aide (NA) #2 and NA #3 on 04/09/19 at 10:02 AM revealed they repositioned Resident #186 around 9:00 AM on 04/09/19. NA #2 and NA #3 stated they did not	F 690	Improvement Monitoring for all residents with catheters for proper placement. No other issues were identified. On 4/9/2019 through 5/7/2019 the Director of Nursing and/or designee provided re-education to Licensed Nurses and Certified Nursing Assistants, Dietary, and Therapy on appropriate catheter placement. Newly hired staff will be educated upon hire. On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring of proper foley catheter bag placement to be completed two times a week for four weeks, then one time a week for eight weeks, and then one time a month for three months. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by the QAPI committee monthly and Quality Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions,	

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F 690	Continued From page 23 place Resident #186's urinary catheter bag on the upper quarter side rail of the bed and did not know how it got there. NA #2 and NA #3 stated they hung the urinary catheter bag below the level of the bladder on Resident #186's bed frame. An interview with the Director of Nursing (DON) on 04/09/19 at 10:12 AM revealed he expected urinary catheter bags to be below the level of the bladder. 2. Resident #36 was admitted to the facility 03/23/18 with diagnoses including urine retention, diabetes, and hypertension (high blood pressure). Review of the annual Minimum Data Set (MDS) for Resident #36 dated 02/01/19 revealed he was moderately impaired for cognition and had an indwelling urinary catheter. A review of Resident #36's care plan for elimination last updated 04/10/19 revealed he had a urinary catheter, had a history of urinary tract infections (UTI), and had a goal of not developing symptoms of a urinary tract infection (UTI). Observation of Resident #36 on 04/11/19 at 6:30 AM revealed he was lying on his back in bed with his urinary catheter bag on the floor. An interview with Nurse #7 on 04/11/19 at 6:32 AM revealed Resident # 36's urinary catheter bag should not be on the floor. Nurse #7 stated he did not know how long the urinary catheter bag had been on the floor. An interview with NA #4 on 04/11/19 at 6:35 AM revealed she last emptied Resident #36's urinary catheter at 5:45 AM on 04/11/19 and when she	F 690	Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement committee meets monthly and quarterly at a minimum. AOC: May 8, 2019	

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F 690	Continued From page 24 was done emptying the bag she placed the urinary catheter bag on a hook on the bed below the level of the bladder. NA #4 stated she did not know how the urinary catheter bag got on the floor. An interview with NA #5 on 04/11/19 at 6:37 AM revealed she had been working on Resident #36's hall for the 11:00 PM to 7:00 AM shift on 04/10/19 and was not sure when or how Resident #36's urinary catheter bag got on the floor. An interview with the DON on 04/11/19 at 8:20 AM revealed he expected the urinary catheter to be below the level of the bladder and not on the floor.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		5/8/19

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F 812	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to remove a black substance from all 4 walls of the walk-in cooler, failed to repair 1 of 4 walls from rust damage in the walk-in cooler, failed to keep the floor in the walk-in cooler free from debris, failed to repair a leak in the ceiling of the walk-in cooler, failed to repair a gap in the wall of the walk-in cooler for 1 of 1 walk in coolers. The facility also failed to remove a pink substance from the hot shield in the ice machine for 1 of 1 ice machines, and maintain clean vents for 1 of 1 ice machines. The findings included: 1. An initial tour of the kitchen on 04/08/19 at 11:12 AM revealed a black substance that was able to be easily removed with a paper towel on all 4 walls of the walk-in cooler. The wall to the right of the door in the walk in cooler near the floor was observed to have an approximately 12 inch area of rust. 1 drink lid, 1 packet of artificial sweetener, 1 piece of aluminum foil, and 1 strip of tape were observed in the corner of the walk in cooler floor. The middle of the ceiling in the walk in cooler was observed with water droplets beaded up that dripped onto the floor. In the corner of the walk in cooler an irregular gap was noted between the cooler walls. An interview with the Food Service Director (FSD) on 04/08/19 at 11:17 AM revealed there should not be a black substance on all 4 walls of the walk-in cooler. The FSD stated the wall of the walk-in cooler had been rusted since he began working at the facility approximately 1 year ago. The FSD stated there should not be trash in the	F 812	The walk-in cooler was cleaned on 4/9/2019. Ice in the ice machine was discarded and new ice purchased on 4/9/2019, the ice machine was cleaned on 4/9/2019. Replacement of the walk-in cooler has been initiated. On 04/15/19 the walk-in cooler and the ice machine have been placed on a two times a week cleaning schedule. On 4/23/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for al other walk-cooler and ice machines for a black substance on walls, repairs needed, debris on the floor, a pink substance and clean vents. No other issues were identified. On 4/9/2019 through 5/7/2019 the Director of Nursing and/or designee provided re-education to dietary staff and maintenance staff on appropriate and timely repairs, cleaning of ice machines and walk-in cooler. Newly hired staff will be educated upon hire. On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring of walk-in cooler and ice machines for cleanliness to be completed two times a week for four weeks, then one time a week for eight weeks, and then one time a month for three months.	

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F 812	Continued From page 26 walk-in cooler floor. The FSD stated he was not aware of the leak in the ceiling of the walk-in cooler. An interview with the Maintenance Director on 04/08/19 at 11:27 AM revealed the ceiling of the walk-in cooler had been leaking since January 2019 and he had contacted a repair company that had not given him a quote for repair. The Maintenance Director stated he did not remember when he contacted the repair company. The Maintenance Director stated he was not aware of the rust on the wall of the walk-in cooler. The Maintenance Director stated the gap in the corner of the walk-in cooler was the result of being hit by a vehicle since the summer of 2018 and had been repaired on the outside. The Maintenance Director stated he had also contacted the repair company for a quote on fixing the gap on the inside of the walk-in cooler corner but had not yet received a quote. The Maintenance Director stated he did not remember when he contacted the repair company to get the quote for repair. A subsequent interview with the Maintenance Director on 04/08/19 at 3:02 PM revealed it was possible the black substance on the walk-in cooler walls could be caused by the leak in the ceiling of the walk-in cooler. The Maintenance Director also stated when the outside of the walk-in cooler was repaired the repair company told him the gap in the walk-in cooler wall should not affect the inside of the walk-in cooler. An observation of the walk-in cooler on 04/09/19 at 9:00 AM revealed a black substance on all 4 walk-in cooler walls. An observation of the corner of the walk-in cooler floor revealed there was 1 drink lid, 1 packet of artificial sweetener, 1 piece	F 812	The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by the QAPI committee monthly and Quality Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement committee meets monthly and quarterly at a minimum. AOC: May 8, 2019	

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F 812	Continued From page 27	F 812		

of aluminum foil, and 1 strip of tape. The middle of the ceiling in the walk-in cooler was observed with water droplets beaded up that dripped onto a cart filled with cups of juice.

A tour of the walk-in cooler was conducted with the Administrator on 04/09/19 at 9:37 AM. The Administrator stated he would not expect to find a black substance on the 4 walls of the walk-in cooler.
An interview with a district manager from the contract company that provided dietary services to the facility on 04/09/19 at 10:30 AM revealed all the cups of juice under the ceiling leak in the walk-in cooler were discarded.

An observation of the walk-in cooler on 04/10/19 at 8:39 AM revealed a black substance on all 4 walk-in cooler walls that was easily removable with a paper towel.

An observation of the walk-in cooler on 04/11/19 at 7:50 AM revealed a black substance on all 4 walk-in cooler walls that was easily removable with a paper towel.

A subsequent interview with the Maintenance Director on 04/11/19 at 7:57 AM revealed the gap in the walk-in cooler wall had been there for 2 years. The outside of the cooler wall was fixed and the repair company told the Maintenance Director there was nothing they could do to fix the gap inside the walk-in cooler wall. The repair company also told the Maintenance Director there was no way water could get inside the walk-in cooler. The Maintenance Director stated a whole new walk-in cooler may need to be obtained. The Maintenance Director stated he could fix the section of the walk-in cooler wall that was rusted.

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F 812	Continued From page 28	F 812		

The Maintenance Director stated the walk-in cooler roof had been leaking since January 2019 and a repair company came 04/10/19 to check the roof and it was the roof of the walk-in cooler that was leaking instead of the ceiling. The Maintenance Director stated he had been trying to get a quote from the vendor approved by the facility since January 2019 and they would never call him back. The Maintenance Director stated he called a different company and they checked the roof on 04/10/19 and were going to have him a quote for repairs in 1 to 2 days. The Maintenance Director stated he expected staff to notify him if there were any maintenance issues.

2. An observation of the ice machine on 04/08/19 at 11:15 AM revealed a pink substance that was removable with a paper towel on the hot shield of the ice machine. The 2 filters on the ice machine were observed to be covered with dust.

An interview with the FSD on 04/08/19 at 11:17 AM revealed the maintenance department cleaned the inside of the ice machine and the filters every 3 months and dietary staff wiped down the outside of the ice machine daily.

An interview with the Maintenance Director on 04/08/19 at 11:27 AM the Maintenance Director stated the ice machine including the filters were cleaned by maintenance monthly and were cleaned recently but he could not remember the date. The Maintenance Director stated there should not be a pink substance on the hot shield inside the ice machine and the filters should not be covered with dust.

A review of the ice machine cleaning schedule revealed it was last cleaned by the maintenance

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F 812	Continued From page 29 department on 03/21/19. An observation of the ice machine on 04/08/19 at 9:08 AM revealed a pink substance on the hot shield. The 2 filters on the ice machine were observed to be covered with dust. The ice machine was observed with the Administrator on 04/09/19 at 10:37 AM. The Administrator stated he would not expect to see a pink substance on the hot shield of the ice machine and he would not expect dust to be on the ice machine filters. An interview with a district manager from the contract company that provided dietary services to the facility on 04/09/19 at 10:30 AM revealed the ice in the ice machine was discarded and maintenance was cleaning the ice machine. A subsequent interview with the Maintenance Director on 04/11/19 at 7:57 AM revealed he saw the pink substance on the ice machine every month when he cleaned the machine and it might not be a bad idea to clean it more often.	F 812		
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 observation and staff interviews the facility failed to keep the dumpster area free of debris for 3 of 3 dumpsters. The findings included:	F 814	On 4/11/2019 the area around all three dumpsters was cleaned and made free from debris. On 5/6/2019 the Executive Director and/or designee performed a Quality	5/8/19

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F 814	Continued From page 30 During the tour of the dumpster area on 04/11/19 at 11:21 AM with the Food Service Director (FSD) observations revealed cigarette butts and clear plastic wrap on the ground around dumpster #1, partially eaten food and a medicine cup on the ground around dumpster #2, 2 cardboard boxes were visible under dumpster #3, and a cardboard box was lying on the ground next to dumpster #3. The FSD stated he was not sure who was supposed to keep the dumpster area clean but he would not expect the dumpster area to have debris on the ground. An interview with the Regional Director of Clinical Services (RDCS) on 04/11/19 at 5:21 PM revealed cleaning the area around the dumpsters was a collective effort between the maintenance and dietary departments. The RDCS stated the area around the dumpsters should be free of debris.	F 814	Improvement Monitoring of all dumpsters. Any issues identified were addressed. On 5/1/2019 through 5/7/2019 the Maintenance Department and the Dietary Departments were re-educated by the Executive Director and/or designee on maintaining the area around the dumpsters clean and free from debris. Newly hired staff will be educated upon hire. On 05/08/19 the Executive Director and/or designee will perform Quality Improvement Monitoring on dumpster area five times a week for four weeks, then three times a week for four weeks, then two times weekly for three months. The Executive Director and/or designee will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by the QAPI committee monthly and Quality Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance	

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F 814	Continued From page 31	F 814	Performance Improvement committee meets monthly and quarterly at a minimum. AOC: May 8, 2019	
F 842 SS=D	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;	F 842		5/8/19

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F 842	Continued From page 32 (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, 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 interviews, the facility failed to document complete and accurate information in the medical record for 1 of 3 sampled residents (Resident #139).	F 842	On 4/10/2019 at 4pm resident #139 had order placed for enema on the Medication Administration Record and 24 hour report. On 4/11/2019 resident # 139 Medication	

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F 842	Continued From page 33 The findings included: 1. Resident #139 was admitted to the facility on 04/09/19 with diagnosis that included: Alzheimer's disease, cerebrovascular accident (CVA) and aphasia. Review of the initial admission nursing assessment dated 04/09/19 revealed Resident #139 was oriented to self, requiring limited assistance of one staff member with toileting. A review of Physician orders revealed an order dated 04/10/19 at 2:00 PM which read, "Fleets enema x 1 now". Review of Resident #139's Medication Administration Record (MAR) for April 2019 revealed no order or documented administration of a fleet enema at 2:00 PM. On 04/10/19 at 5:46 PM an interview was conducted with Nurse #1. Nurse #1 stated Nurse #3 had received the physician order and administered the enema to Resident #139 at 2:00 PM. The interview revealed Nurse #1 had called Nurse #3 by telephone to verify if the enema was administered to the resident. Nurse #1 stated it was the responsibility of the nurse receiving the physician order to place the order on the residents MAR and document administration accordingly which was Nurse #3. Nurse #1 stated Resident #139 should have been included on the hall report on 04/09/19. On 04/11/19 at 2:00 PM an interview was conducted with Nurse #3. Nurse #3 stated she received the physician order on 04/10/19 and administered the enema to Resident #139 at 2:00	F 842	Administration Record was signed for administration of enema that was ordered on 4/10/2019. On 5/1/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for the past 30 days for all residents to ensure orders were transcribed to the Medication Administration Record and 24 hour report. No other issues were identified. On 4/9/2019 through 5/7/2019 the Director of Nursing and/or designee provided re-education to Licensed Nurses about transcribing new orders to the Medication Administration Record and 24 hour report. Newly hired staff will be educated upon hire. On 05/08/19 the Director of Nursing and/or designee will perform Quality Improvement Monitoring of all residents orders to include transcription to the Medication Administration Record and placed on the 24 hour report to be completed two times a week for four weeks, then one time a week for eight weeks, then one time a month for three months. The Director of Nursing will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by the QAPI committee monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 34 PM. She stated she did not transcribe the physician order onto the residents MAR or document the administration of the enema in a nursing note. Nurse #3 stated she did not include Resident #139 onto the hall handoff report given to Nurse #2. The interview revealed Nurse #3 should have transcribed the physician order onto Resident #139's MAR and documented the administration of the enema accordingly. On 04/10/19 at 5:47 PM an interview was conducted with the Director of Nursing (DON). The DON stated nursing staff was responsible for receiving physician orders and transcribing the orders onto the MAR to document the administration of the ordered medication. The interview revealed the initial step should have been putting the order onto the MAR prior to administering the enema and documentation should have been made following administration. The DON stated all residents with new orders should be included onto the hall shift report and Resident #139 should have been on the list.	F 842	and Quality Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement committee consists of but not limited to the Executive Director, Director of Nursing, Work Force Manager, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement committee meets monthly and quarterly at a minimum. AOC: May 8, 2019	